



2019 **ANNUAL
MEETING**
& EXHIBIT

October 27-30
Toronto, Canada

Session 021: Drug, Alcohol, and Suicide Epidemics: Actuarial Perspectives and the Need for a National Resilience Strategy

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Deaths of Despair and the Case for Integrated Care in the US

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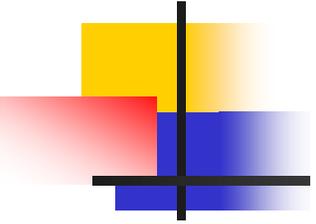
Dr. Nasra is part owner of **Cartesian Solutions LLC** providing consultations to healthcare organizations, accountable provider systems, health plans, and government agencies on the integration of medical and behavioral health services.

The US Current Delivery System

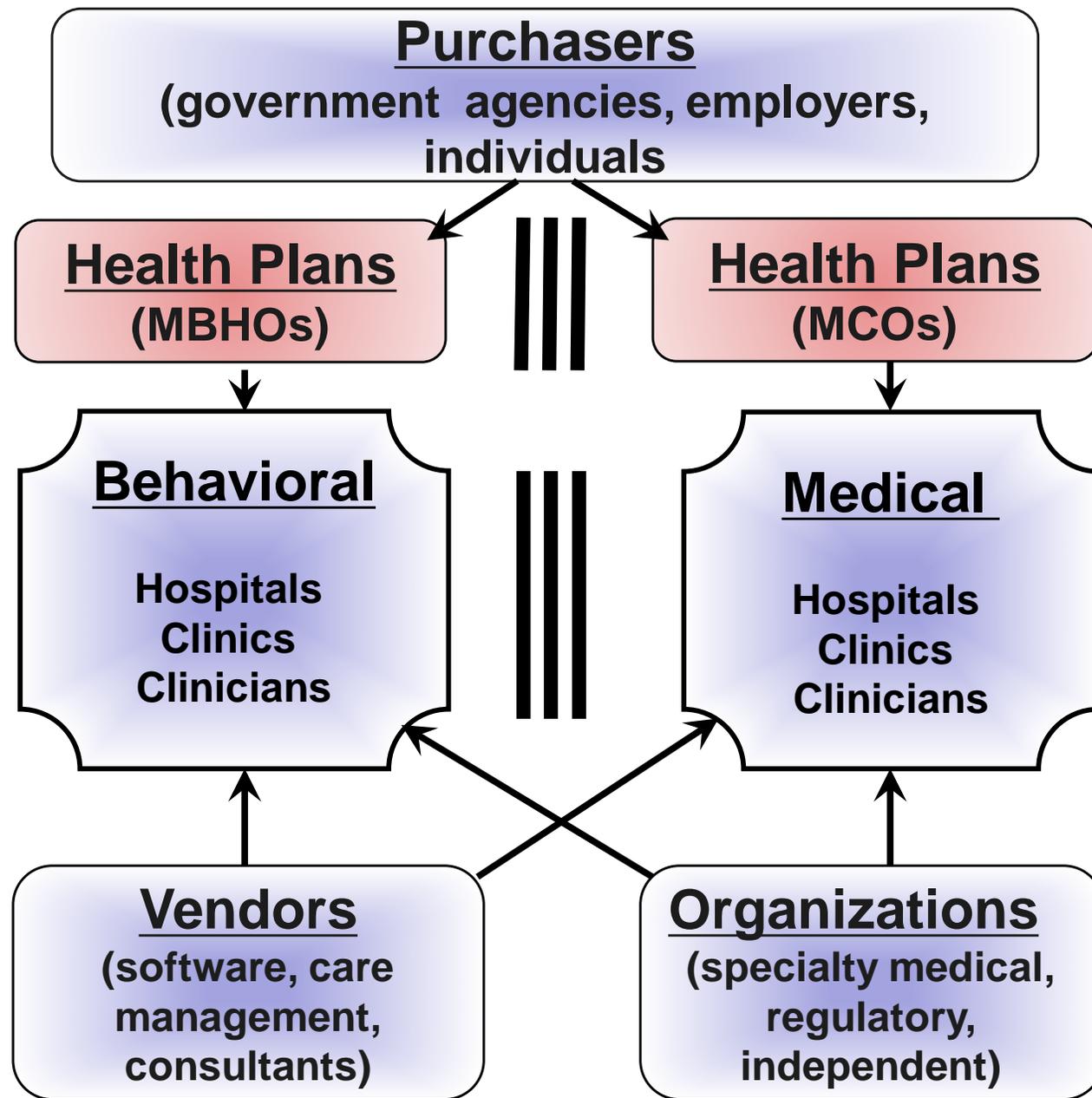


Fragmentation & Siloes

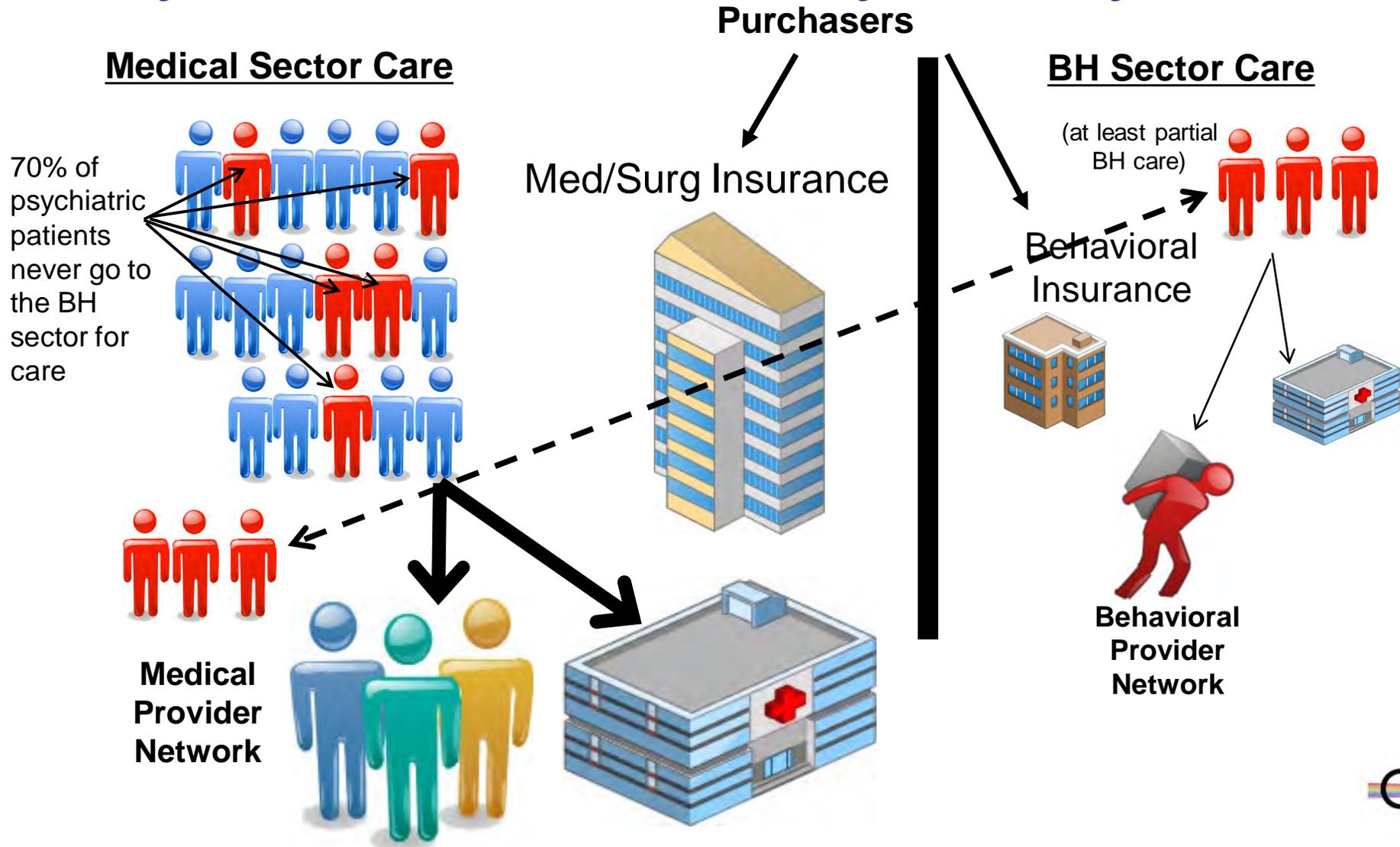




The Primary Cause of Health Cost Excesses in BH Patients: “Two Payors,” i.e., medical & BH



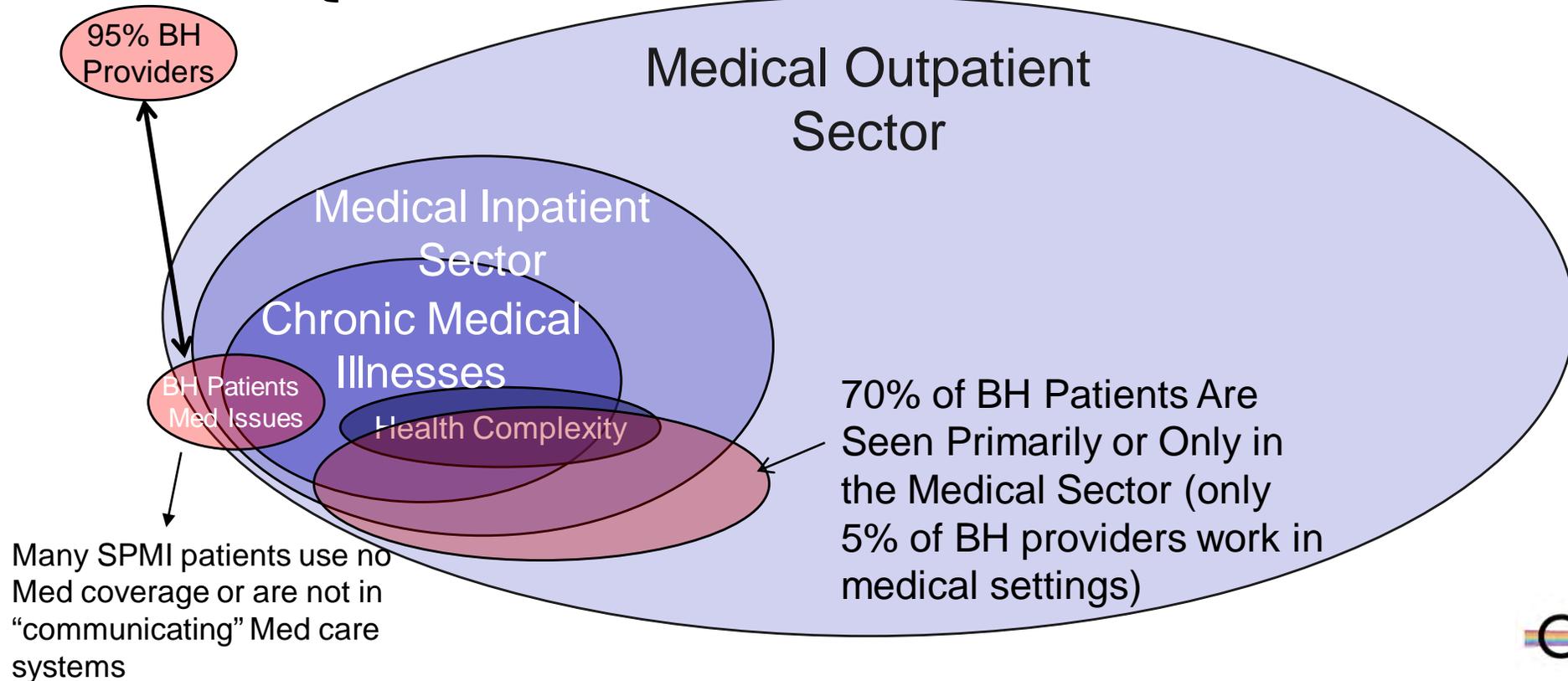
The Non-Communicating Delivery Systems Created by 2 Payors



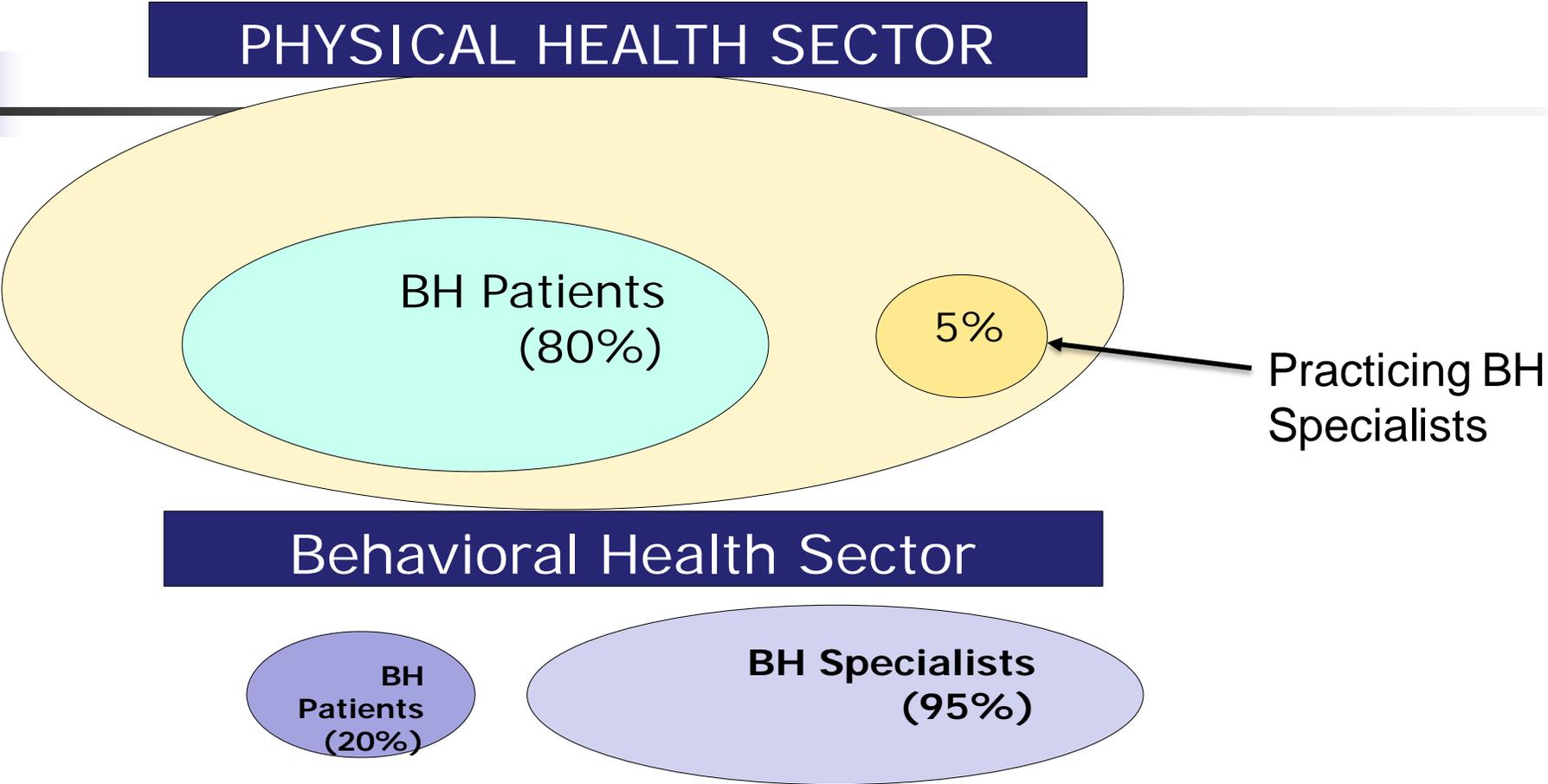
The Effect of Delivery System Segregation

1. Integrated service delivery is not possible
2. High total health care cost is a natural outcome

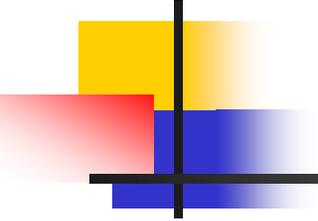
Behavioral Health Sector { BH Patients Seen in the BH Sector (30%)



The Effect of Delivery System Segregation



Kathol, R. et.al. In Clinical Integration 3rd edition. Chapter 11. pp. 380-425. 2015
Convergent Publishing



Can Integrated Care Be Delivered in a Segregated Medical and BH System?

No!

- Reasons that a segregated system does not work:
 - BH providers are paid (forced) to work only in BH settings where most patients (70%) do not go for BH care
 - Segregated geographic, system-based BH service delivery prevents integrated medical and BH care
 - Synchronous and coordinated medical and BH service delivery become logistically impossible, despite significant medical and BH illness interaction
 - Medical and BH providers rarely communicate, if even possible

Suggested Delivery System Update



Integration of Medical and BH Payment and Services

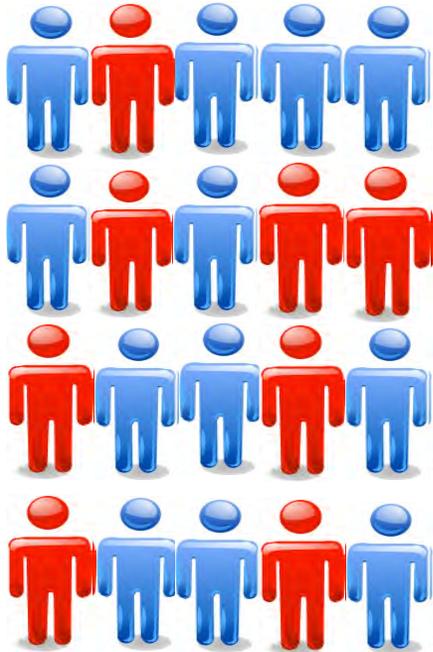
Health Setting Care

Purchasers

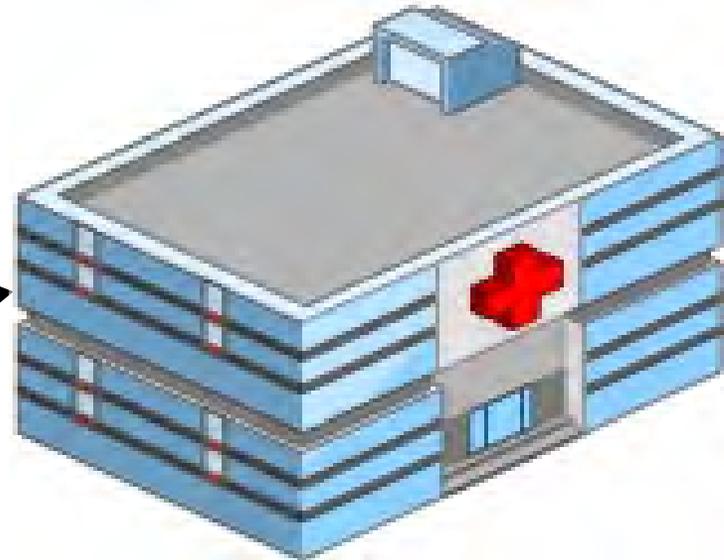
 --medical patients

Medical/BH Insurance

 --medical & BH patients



Covered Population

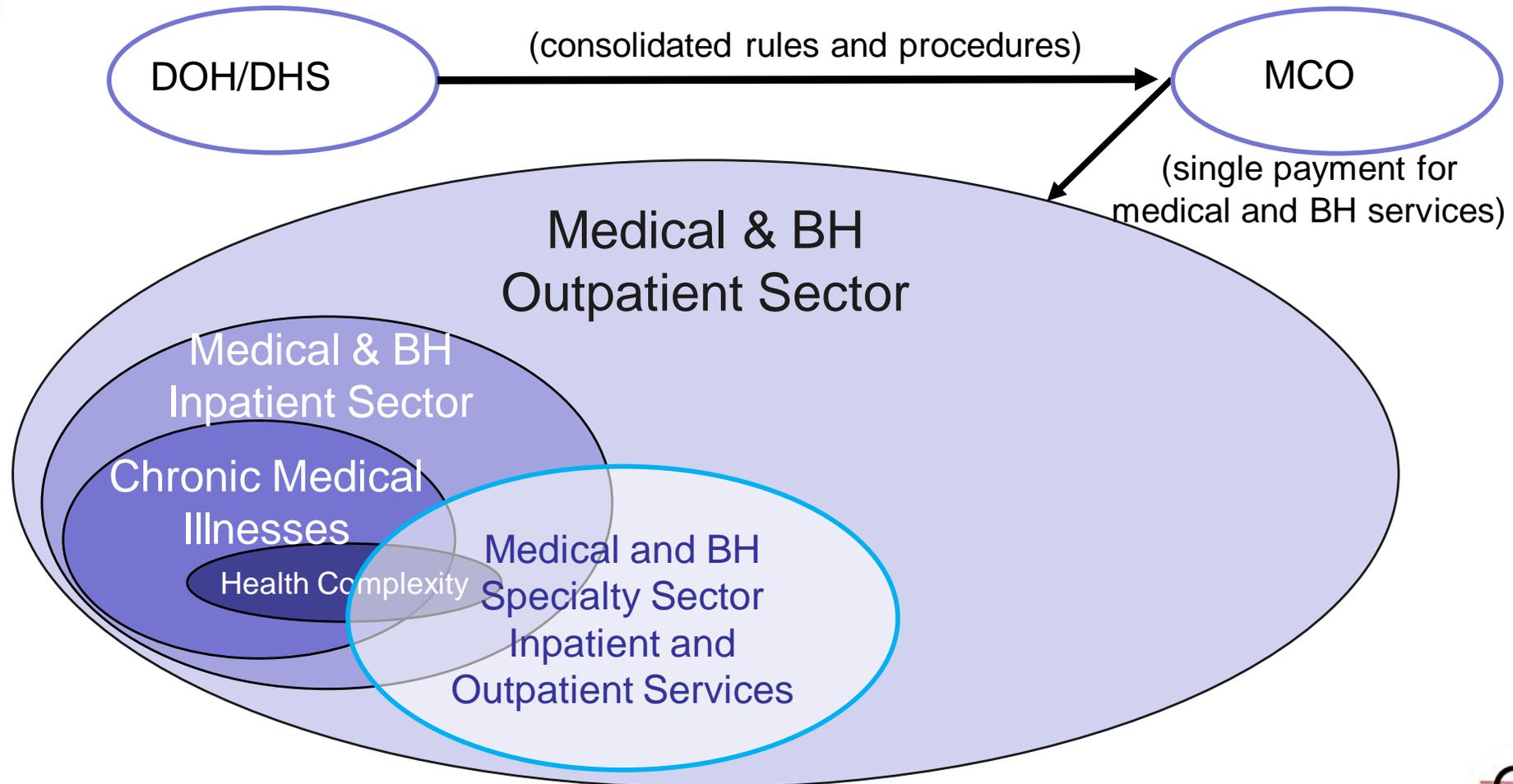


Medical/BH Hospitals and Clinics

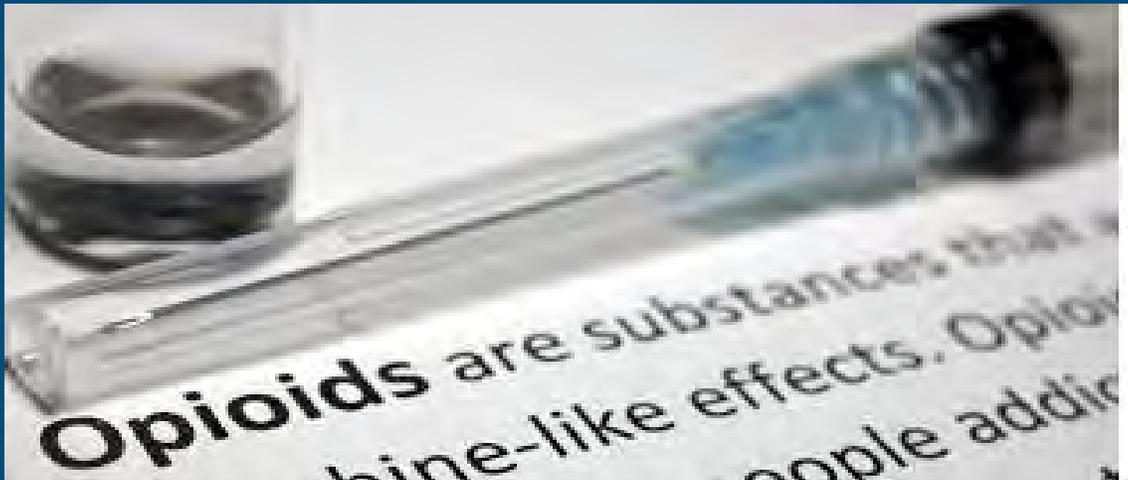
Medical/BH Provider Network



Population Served by an Integrated Health System



The Opioid Epidemic in the US and Western NYS



ADDICTION RARE IN PATIENTS TREATED WITH NARCOTICS

To the Editor: Recently, we examined our current files to determine the incidence of narcotic addiction in 39,946 hospitalized medical patients¹ who were monitored consecutively. Although there were 11,882 patients who received at least one narcotic preparation, there were only four cases of reasonably well documented addiction in patients who had no history of addiction. The addiction was considered major in only one instance. The drugs implicated were meperidine in two patients,² Percodan in one, and hydromorphone in one. We conclude that despite widespread use of narcotic drugs in hospitals, the development of addiction is rare in medical patients with no history of addiction.

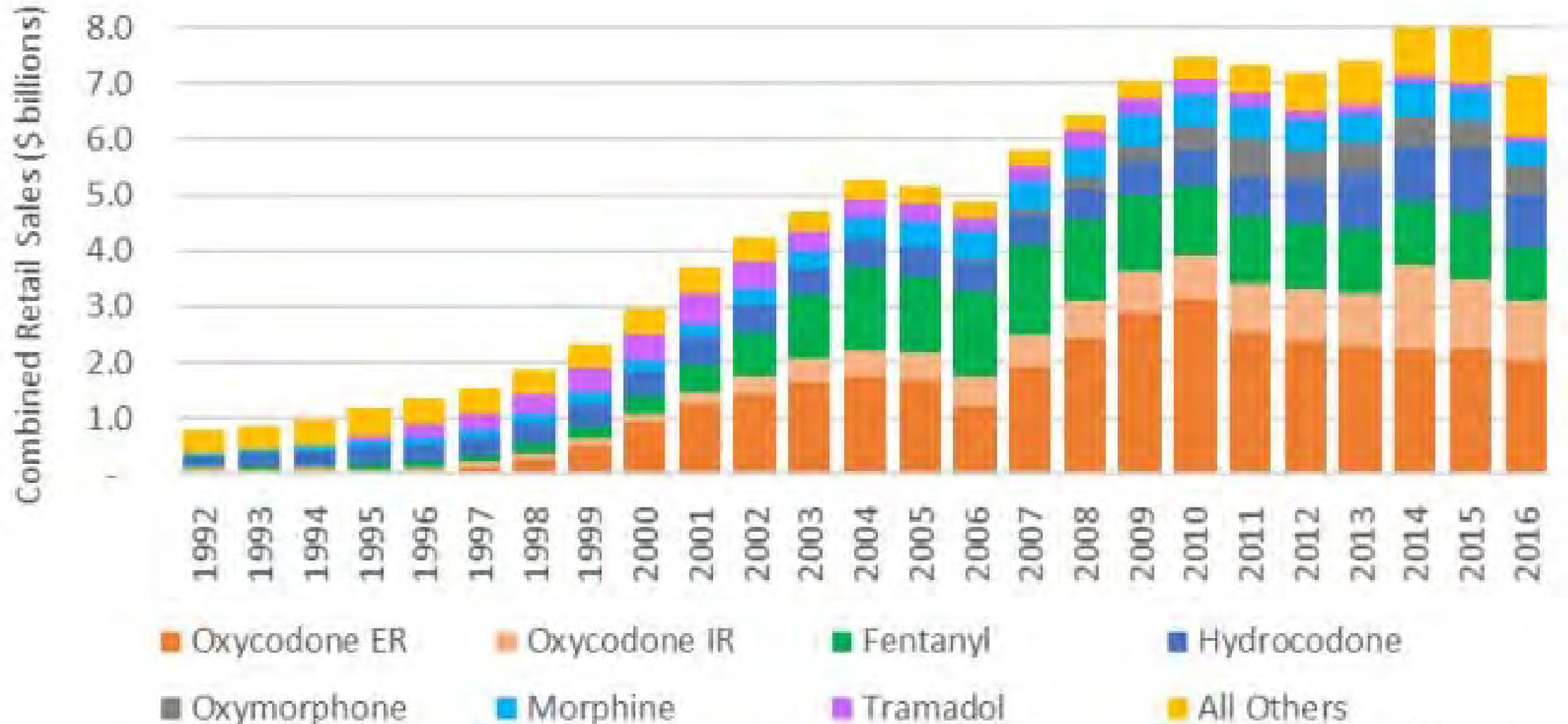
JANE PORTER
HERSHEL JICK, M.D.
Boston Collaborative Drug
Surveillance Program

Waltham, MA 02154

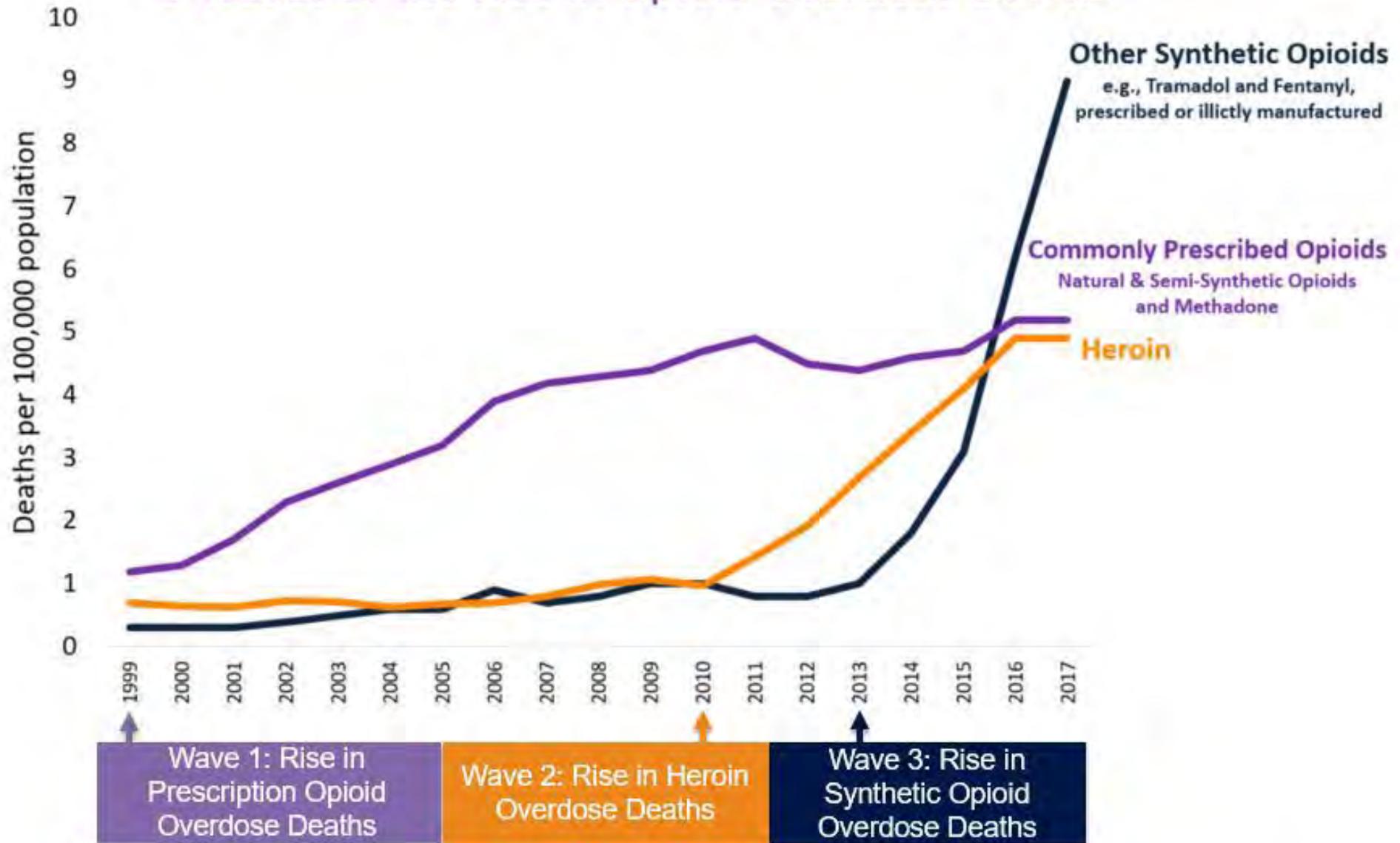
Boston University Medical Center

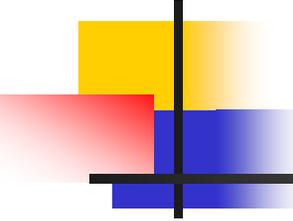
1. Jick H, Miettinen OS, Shapiro S, Lewis GP, Siskind Y, Slone D. Comprehensive drug surveillance. *JAMA*. 1970; 213:1455-60.
2. Miller RR, Jick H. Clinical effects of meperidine in hospitalized medical patients. *J Clin Pharmacol*. 1978; 18:180-8.

Combined Retail Sales of Opioid Products



3 Waves of the Rise in Opioid Overdose Deaths





Clinicians are stuck in the middle

- Wanting to provide compassionate patient focused care
- Few alternatives to treat pain
- Simply taking everyone off of chronic opioids is not the answer
- Limited resources to treat Opioid Use Disorder

Equianalgesic Table for Adults

Half-life, Duration,
Costs and Guidelines

The 5th Vital Sign Pain.

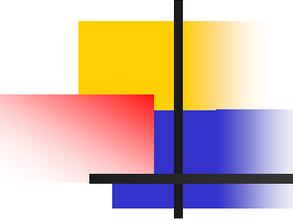
Community Principles of Pain Management

Developed by ViaHealth Pain Initiative
Revised by Strong Health Palliative Care 11/01
Revised by Specialty Advisory Committee, 2/02
Adopted by Excellus BlueCrossBlueShield 5/02
Reviewed and adopted by AAHPM 12/09

Guidelines and principles are intended to be flexible. They serve as reference points or recommendations, not rigid criteria. Guidelines & principles should be followed in most cases, but there is an understanding that, depending on the patient, the setting, the circumstances, or other factors, care can and should be tailored to fit individual needs. Approved on May 18, 2010. Next scheduled Update by May 2012.

Deaths of Despair





Deaths of Despair

ANNE CASE

Princeton University

ANGUS DEATON

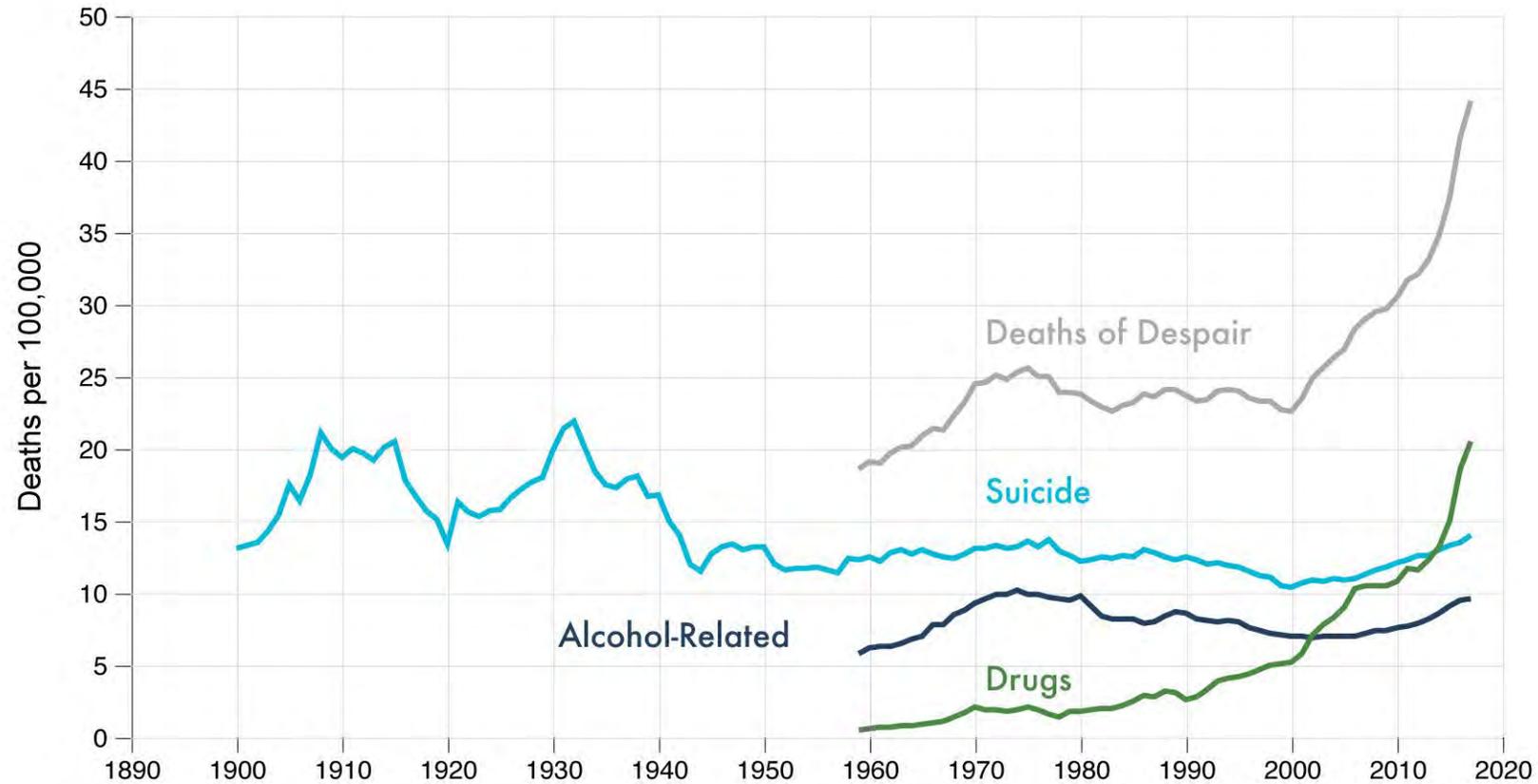
Princeton University

Mortality and Morbidity in the 21st Century

ABSTRACT Building on our earlier research (Case and Deaton 2015), we

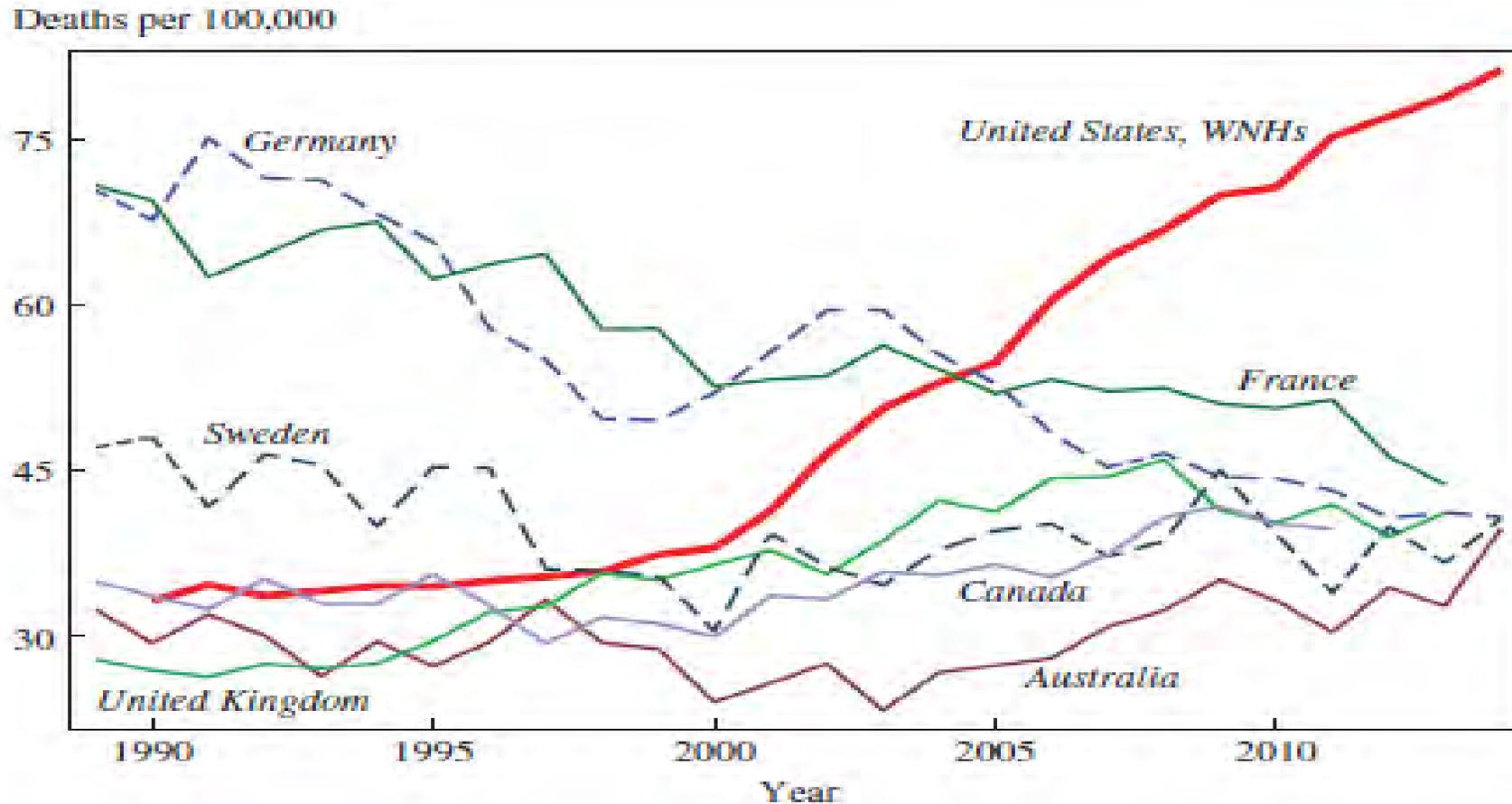
continue to explore the causes of the increase in deaths of despair in the United States.

Deaths of Despair and Its Components, 1900-2017, Age-Adjusted Death Rates



Source: SOCIAL CAPITAL PROJECT REPORT NO. 4-19 | SEPTEMBER 2019

Deaths of Despair by Country for Age 50-54, 1980-2014

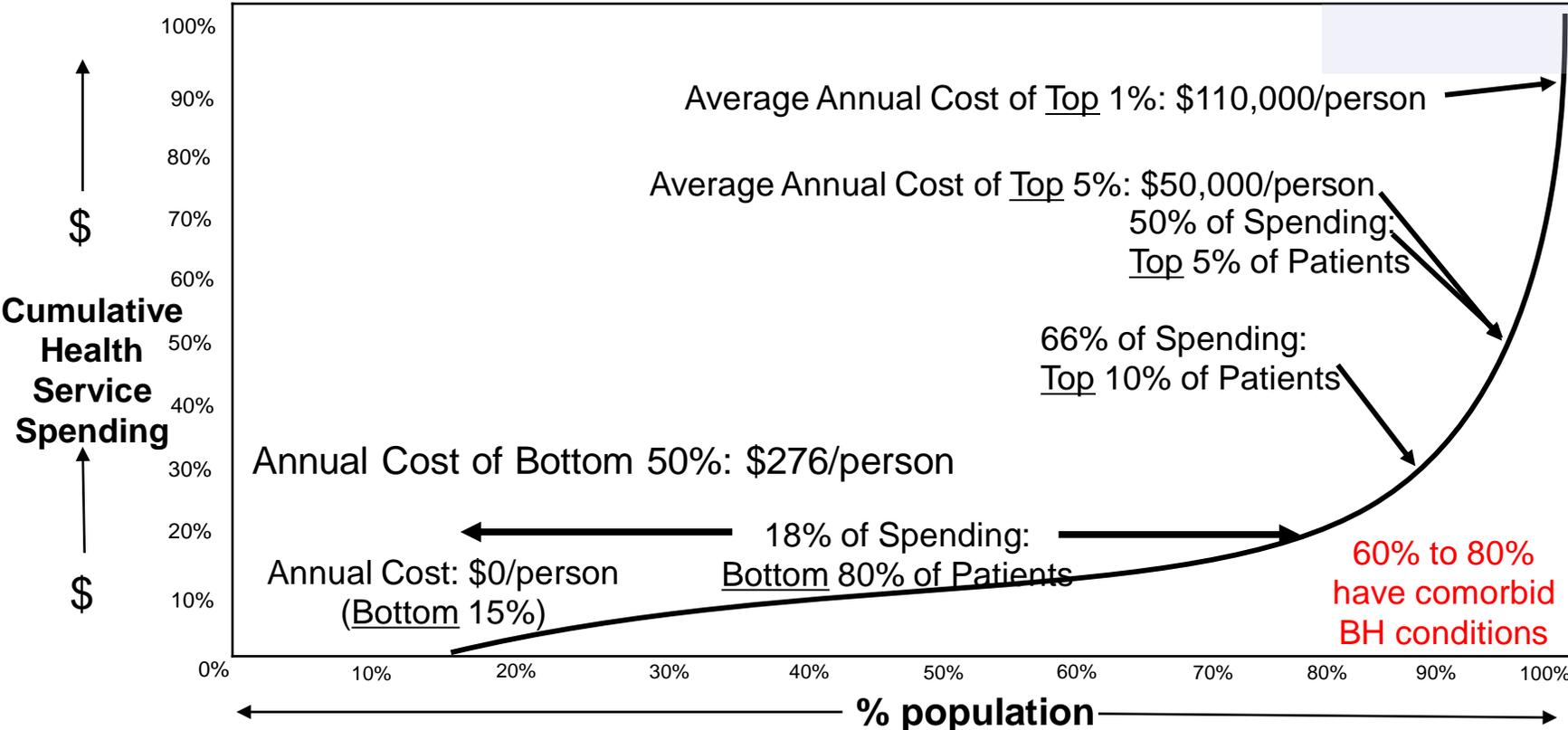


The Opportunity



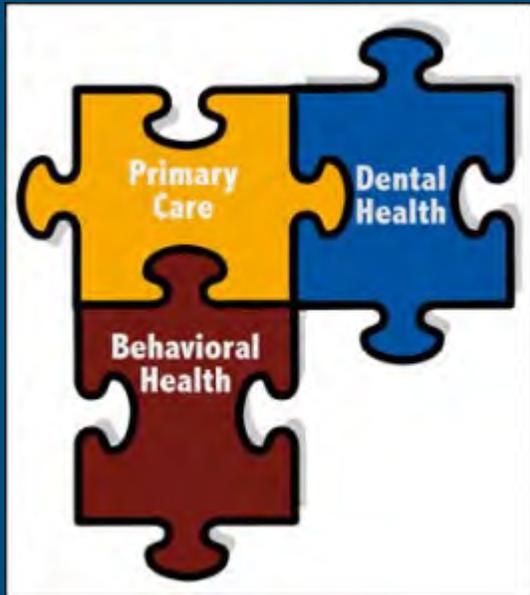
To Drive Down Costs for Complex Chronically Ill Patients

Average Annual Per Capita Health Care Costs in U.S. Dollars:
\$10,345 in 2016



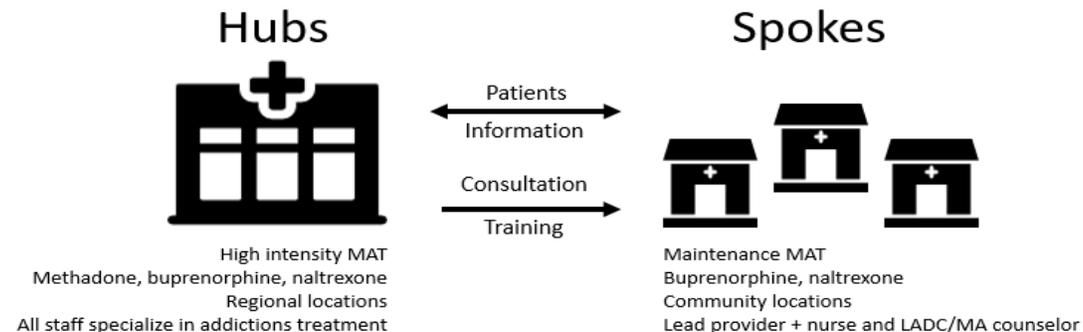
AHRQ, Statistical Brief 521, February 2019

Models of Care: Think Integration/Collaboration



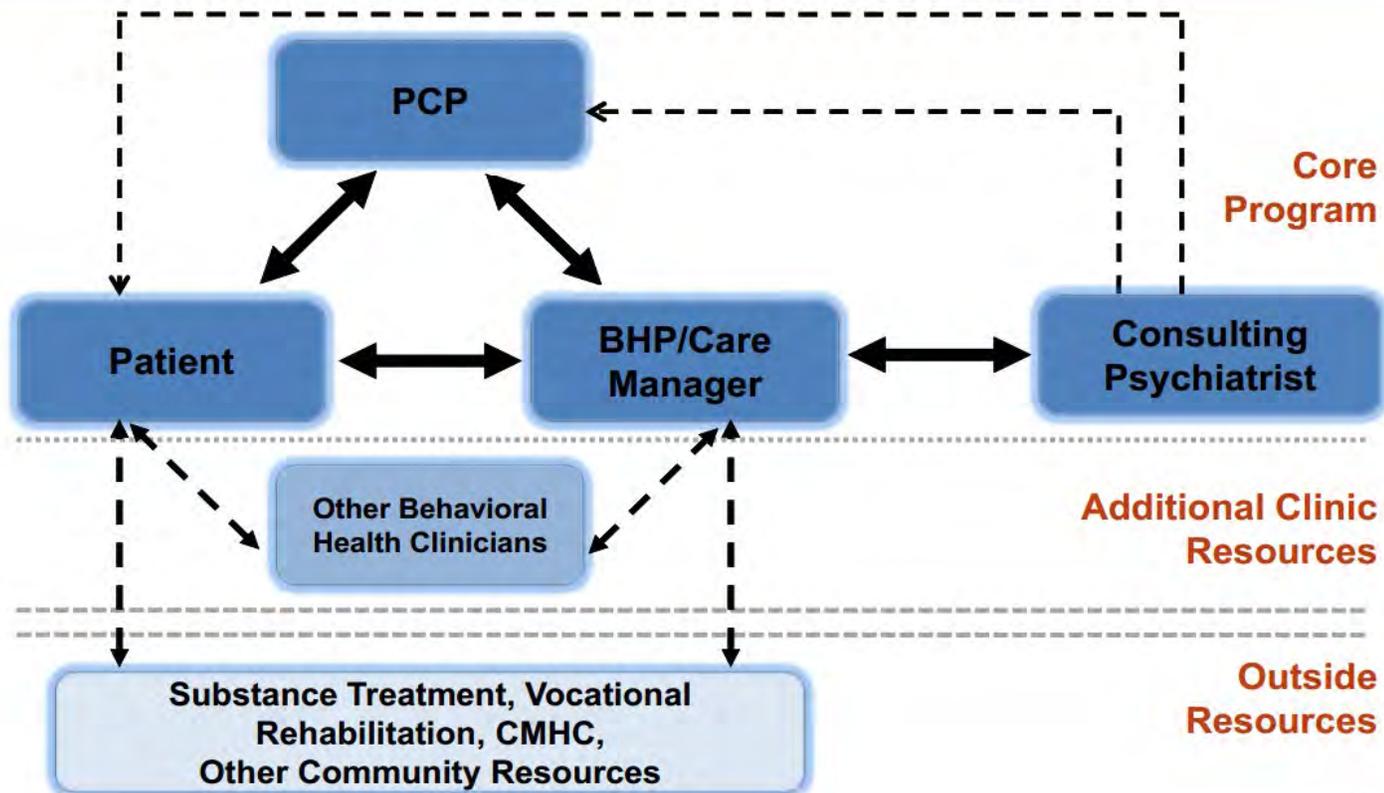
State Innovations in Treatment and Recovery: Vermont

- “Hub and Spoke” is VT’s system for delivering MAT
 - 9 Regional “Hubs” offer daily support for patients with SUDs.
 - 75 local “Spokes” include teams of doctors, nurses, and counselors who offer ongoing OUD treatment that is integrated with general healthcare services.
- Hub and Spoke system has been implemented statewide – Increased access to treatment
 - It has led to increases in VT’s OUD treatment capacity. In 2012, pre-hub & spoke, VT had 650 methadone patients and 1,837 OBOT patients, for a total of **2,487**.
 - More than 6,000 people now participating in the program (140% increase in Vermonters receiving MAT)

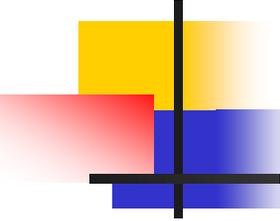


The Collaborative Care Model (CoCM)

Collaborative Team Approach



Value-Based Integrated Medical & Behavioral Health Services

- 
- Medical Setting
 - **Inpatient**, e.g., proactive psychiatric consultation; delirium prevention and treatment programs; routine “sitter” review; CIUs
 - **Outpatient**, e.g., TEAMcare/Collaborative Care; medication assisted treatment (MAT) in substance use disorder clinics; complexity clinics; LTAC & nursing home settings supported by medical and BH coverage; targeted BH interventions in medical setting, e.g., SBIRT; medical and BH prevention programs
 - **Emergency room**, e.g., medical and BH services co-evaluate patients in “medical” ERs (sunset standalone psychiatric ERs)
 - **Across treatment platform services**, e.g., value-based integrated case management for complex adults and children
 - BH Setting—selected specialty sector BH services will become part of all other medical/surgical subspecialty services in a unified medical system

URMC HRSA Grant Regional Model of Care – \$6.7 M

