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HEALTH

1401 WEWATTA ST. SUITE 103 DENVER, CO 80202 PH 303.928.8511

October 7, 2022

Kari White
Director of Community Health Equity at Northern Counties Health Care
Northeast Kingdom of Vermont

RE: RFP–Mapping the Mental Health and Substance Use System of Care in the Northeast Kingdom of Vermont

Dear Ms. White:

I am pleased to present this Mapping the Mental Health and Substance Use System of Care in the Northeast Kingdom of Vermont RFP on behalf of Initium Health, a public benefit company, whose mission is using innovation to improve human health. We are a technology-enabled consulting firm with a diverse team that brings years of experience in the healthcare ecosystem spanning public health, health systems, community engagement, branding and marketing, and health promotion. Our clients include municipalities, government agencies, health systems, universities, and behavioral health providers.

As a team of former hospital executives and public health professionals we bring a nuanced understanding of the challenges and opportunities in behavioral health. With a mission of improving human health and current projects underway in Massachusetts and New Hampshire and past experience in Maine, we believe we are ideologically aligned and uniquely qualified to determine the best public health approach while leveraging the latest research in the field. In addition, principal James Corbett recently published the Business case for mental health equity in the North American Journal of Psychiatry which highlights that Initium has Academic and practical credentials in mental health and substance use disorder (SUD).

Thank you for the opportunity to submit this proposal. The accompanying materials detail deliverables in a potential engagement. If you have any questions, please contact me at james@initiumhealth.org and 303-928- 8511 ext. 702.

Sincerely,

James Corbett, MDiv, JD
Principal, Initium Health

## Interest and ability to meet described steps and deliverables

Initium is Latin for "origin" or "beginning." Initium was founded in 2018 by seasoned healthcare executives with decades of experience in hospital administration, process improvement, and healthcare. We are a public benefit corporation (PBC) with the mission to use innovation to improve human health. A PBC is a relatively new corporate designation which allows benefit to be a charter purpose of an organization and differentiates it from a traditional for-profit organization. As a PBC, we do not exist for financial gain alone and we firmly believe that enhanced care for all populations across the socio-economic and cultural spectrum is critical.

The focus of our work is to reduce the impact of mental health and Substance Use Disorder (SUD) on individuals, families, and communities. We believe all people deserve wellness and recovery, and that we share a responsibility to ensure a full continuum of culturally responsive services and supports are available to safely achieve this.

Initium has a proven track record in behavioral health. We understand the multiple entities involved in this ecosystem and have successfully coordinated efforts across multiple stakeholders to forge strategic partnerships to address the unmet behavioral health needs of communities. This helps us to promote improved health outcomes of the vulnerable populations suffering from homelessness, substance use disorder, mental health disorders, and the co-occurring disorders. We gather insight from multiple perspectives of those experiencing behavioral health conditions and those providing care for this population. As healthcare insiders, our experience working with hospitals, providers, and clinical staff provides a streamlined and thoughtful approach to engagement.

As a company with experience across the United States and particularly in the New England states of Maine, Masschussets and New Hampshire, Initium is well positioned to advance the aims of the Vibrant ONE (Orleans/Northern Essex) Accountable Health Community partnership in Vermont. As consultants with skilled team members certified as Black Belt Lean Six Sigma and certified project managers (PMP), Initium has vast experience in creating both process and asset mapping that documents the strengths and gaps in a commmunity's behavioral health ecosystem.

Biographies for our leadership who would be directly involved in supporting Vibrant ONE are attached.

## Proposed strategies and processes for stakeholder engagement and mapping

Understanding the patient journey is crucial to ensuring patients have their health needs addressed and a positive experience of care. Initium has experience in dissecting the behavioral health ecosystem and highlighting challenges and opportunities within the

ecosystem. While quantitative data is of great value, we know that qualitative data gathered by interviews of affected parties offers keen insight of individual experiences and provides invaluable texture to the quantitative data to create a more complete and accurate picture of the experience of community members in accessing behavioral health care.

Initium is also quite skilled at process mapping which is a valuable tool that allows us to communicate how a process works in a concise and straightforward way. This is of tremendous value in what is many times an unstructured behavioral health care framework as it clarifies gaps in the process and illuminates potential intercept points. Our approach would also allow for a "dream big" approach which is prerequisite to aspire more deeply without constraints as to what intervention can enhance care and what the impact of such changes would be.

Initium has vast experience in discerning, unpacking and developing an optimal care coordination process which accounts for multiple stakeholders and touchpoints in community based and institution based care. Data collection and closed loop referrals which illustrate the impact of social and medical referrals is a hallmark of our custom approach. Central to this is a "no wrong door" approach which seeks to ensure that needs are addressed at multiple touchpoints.

There is increasing and strong evidence that a person's wellbeing, inclusive of behavioral health, is predominantly impacted through social determinants of health (SDOH), which are conditions in the environments where people live, learn, work, and play that affect a wide range of health and quality-of-life-risks and outcomes. SDOH are often mapped using a social ecological model, which conceptualizes health broadly and focuses on the complex interplay between factors that might affect health, as well as the success or failure of attempts to address these problems. Additionally, it can bring to light some of the root causes of health disparities.

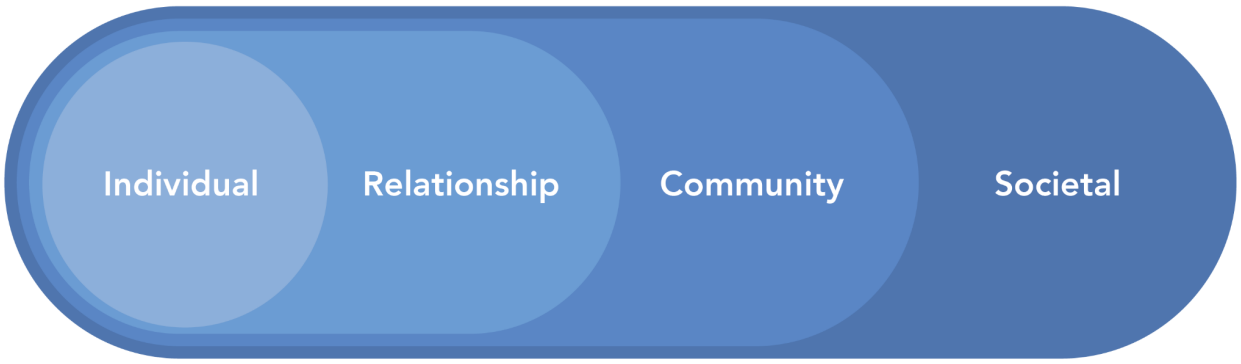


Figure 1: The Social Ecological Model

Due to the interactions and influence between these health determinants (individual, intrapersonal, community, and societal), it is necessary to address all levels of the model at the same time and barriers that exist that prevent individuals from accessing appropriate treatment. Initium's will use this public health approach as a framework for the

behavioral health feasibility study and assessment for a triage center to emphasize health-enhancing changes in both social and community environments.

## STAKEHOLDER ENGAGEMENT PROCESS

Our approach to an effective stakeholder engagement originates from a dynamic, collaborative, and equitable strategy that satisfies the needs and values of the community. In collaboration with VibrantONE, Initium Health's engagement approach will be tailored uniquely to the community and will outline a set of specific outreach and public participation strategies. The engagement process will follow the roadmap below:


1.) Define the Engagement Aim

This delineates the overall mission, objectives, achievements, and impact of the community engagement process. Our considerations include:

- Outcomes and lessons learned from past community engagement efforts in the Northern Kingdom
- Timeline to best accommodate a stakeholder engagement process
- Data collection plan and interview / survey questions on topics such as behavioral health services available, current gaps in care, barriers to treatment, stigma, etc.
- The key performance indicators (KPIs) of a successful stakeholder engagement plan

2.) Identify Stakeholders and Develop Engagement Strategy

Determining the correct target audiences is critical for an effective strategy. With insight from VibrantONE, Initium will:

- Specify stakeholders/groups who influence or are influenced by behavioral health care in the region
- Maximize involvement of stakeholders with due focus on specific groups and geographical areas that are highly impacted
- Determine which groups have a high influence on the patient outcomes and who may need to be empowered to have greater influence

We envision key stakeholders may include:

| Healthcare | Government | Community |
| --- | --- | --- |
| • Hospital Administration<br>• Frontline staff<br>• Community behavioral health providers | • EMS<br>• Sheriff Department<br>• Police<br>• State Patrol<br>• Detention facilities<br>• Elected officials<br>• Educational institutions | • Neighborhood associations<br>• Business/landowners<br>• Faith based organizations<br>• Advocates for underserved and/or hard to reach populations<br>• Individuals with lived experiences<br>• Philanthropic entities<br>• Community Service Agencies |

3.) Engage

This phase includes the execution of the stakeholder engagement strategy.

- Reach the identified stakeholders and community members through varied methods
    - Curated introductions from trusted liaisons
    - Phone calls and virtual meetings
    - Web-based surveys and emails
    - In-person meetings
    - Social media promotion
- Develop rapid micro-process maps and validate with stakeholders

## MAPPING AND RECOMMENDATIONS

We will map the patient journey and data flow using the micro-process maps developed in conjunction with and validated by stakeholders across the region and care continuum. We will also request, collect, and analyze quantitative data wherever possible to further validate the process and journey maps or illustrate where they differ. Finally, we will used the narratives from those with lived experiences of behavioral health care and their family members, providers, clinical staff, and others, to more fully develop the maps so they reflect real world practices.

Using the data outlined above, we will evaluate current services in light of best practices, including from the following sources:

- Substance Abuse and Mental Health Services Administration's (SAMHSA) "National Guidelines for Behavioral Health Crisis Care"
- The National Council for Wellbeing's "Behavioral Health Roadmap to the Ideal Crisis System"
- The McKinsey Health Institute Crisis Now Crisis System Calculator

- SAMHSA past funded care coordination and regional collaboration projects with exceptional results and leading models

We will develop our recommendations in concert with Vibrant ONE, providing additional time for input and feedback throughout the process. Our final report will include narrative, data visualizations, and presentations along with compelling imagery and stories which will support any efforts toward changing the status quo.

## RELEVANT EXPERIENCE WITH SIMILAR PROJECTS

### City of Clovis, New Mexico- Regional Mental Health Facility Feasibility Study

Initium Health engaged with the Cities of Clovis and Portales; the Village of Fort Sumner; Curry County, DeBaca County, Quay County, and Roosevelt County in New Mexico to complete a feasibility study for a regional behavioral health facility. Eastern New Mexico is a rural, culturally diverse area with disadvantaged communities that have very limited access to mental health and substance use services across the continuum of crisis care. We conducted over 70 interviews with key stakeholders across city and county staff, sheriff's offices, detention centers, schools, nonprofit agencies, fire departments and EMS, hospitals, outpatient behavioral health providers, and others who informed our gap analysis, needs assessment, and ultimately, the recommendations we provided.

Components of the engagement included:

Gap Analysis

- Assess the community's current mental health care service delivery model's ability to meet current and future needs
- Compare current service levels against state/national service benchmarks
- Provide examples of working models of regional mental health facilities including innovative models
- Collect and analyze behavioral health data from existing publications; statewide research; and local hospitals, EMS, law enforcement, and healthcare providers
- Host regional community charrette/listening session and one-on-one interviews with key stakeholders
- Present findings at city, county, and state meetings and to elected officials

Feasibility Study

- Determine licensing and regulatory requirements for a regional facility
- Generate a business plan and pro forma that details land, construction, and operational costs
- Recommend staff recruitment and employee retention strategies
- Research applicable grants, private/public sector investment, public funding sources, and income
- Assess potential sites including development of site criteria and site analysis
- Develop preliminary floors plans and building design utilizing the architecture of recovery in the design

## City of Santa Monica, California - Behavioral Health Strategy Development and Feasibility Study

Initium Health is currently working with the City of Santa Monica, California, to develop a comprehensive behavioral health strategy inclusive of a feasibility study for a behavioral health center. This engagement includes broad community engagement with stakeholder and group interviews, community listening sessions, and media outreach to reach residents and understand their needs and desires with regard to behavioral health services.

| | |
|---|---|
| Community Engagement | • Interviews<br>• Community Listening Sessions<br>• Broad Reach Marketing Campaign |
| Behavioral Health Strategy & Feasibility Assessment for Behavioral Health Center | • Needs Assessment & Gap Analysis<br>• Phased Strategy for Access to Care<br>• Operational/Financial Feasibility for a Behavioral Health Center |
| Behavioral Health Center Site Assessment | • Assessment of up to 5 sites<br>• Programmatic, Operational, and Financial Adjustments for each site |

## UC San Diego Health, CA

Initium was contracted to do a cost study analysis and strategic plan to enhance care for the large Medicaid population served by this health system across the two-hospital campus. We worked closely with physicians, administrators, and staff to provide an assessment of current practices related to the care of Medicaid patients, including behavioral healthcare, access to affordable housing, and other community based services that improve health. Our analysis spanned multiple communities in the two hospital campuses catchment area.

Our team discovered opportunities to drive value across the health system using key performance indicators, such as inpatient length of stay, non-emergent ER visits, and community factors that impacted health spend and outcomes. Our analysis of the financial impact unearthed a significant opportunity to improve net revenues, providing new impetus for health system leadership and initiatives for increased efficiencies across the system and deepen its community engagement and impact.

## Availability and ability to meet timeline

Our team has the capacity and capability to complete this project within the given timeframe. We thoughtfully choose the type of projects we bid on and work on. Our organizational philosophy is to focus on the quality of the work we provide and not quantity, and consequently we have the organization readiness to choose projects such as this that are fully aligned with our vision and capabilities. We currently have 15 full or part time employees, and additional contractors and consultants who lend their expertise as needed, to our engagements.

## Anticipated cost

Stakeholder Engagement: $12,000

Process / Journey Mapping: $7,000

Recommendations and Final Report: $7,000

Total: $26,000

## Whether the organization/consultant firm is BIPOC or women-owned and/or led.

Initium is led by James Corbett and is a BIPOC-led organization as James is African American.

A single community hospital in Kansas looked to strategically align with its local FQHC in order to improve patient outcomes and reduce costs of care in a non-Medicaid expansion state.

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# CASE STUDY

## FQHC AFFILIATION STRATEGY

### THE CHALLENGE

A community hospital in Kansas entered the planning stages of a new state-of-the-art recovery campus and sought to align and strengthen the community's behavioral health ecosystem to ensure that it would be positioned to succeed given the multiple entities involved. At the same time, the hospital had a new opportunity to collaborate on care of the underserved in partnership with a local Federally Qualified Health Center (FQHC) that recently experienced a major organizational overhaul. The two entities were aligned in the need to partner but were very siloed with differing visions of how and to what degree they could align. The hospital sought our support to develop an FQHC affiliation model that would optimize care and reimbursement for Medicaid patients and the uninsured.

## OUR APPROACH

### Health Ecosystem

The Initium team conducted a series of interviews with hospital and FQHC stakeholders, analyzed financial and operational data, and reviewed successful hospital-FQHC partnerships in similar markets across the country. We paid particular attention to improving health information transfer so that patients could be cared for more effectively and efficiently. We examined scheduling challenges at the FQHC and made recommendations to generate additional capacity. We also established workflows to shift patients who presented in the hospital ER with low-acuity issues to the FQHC, aligning care coordination resources to ensure effective transitions of care.

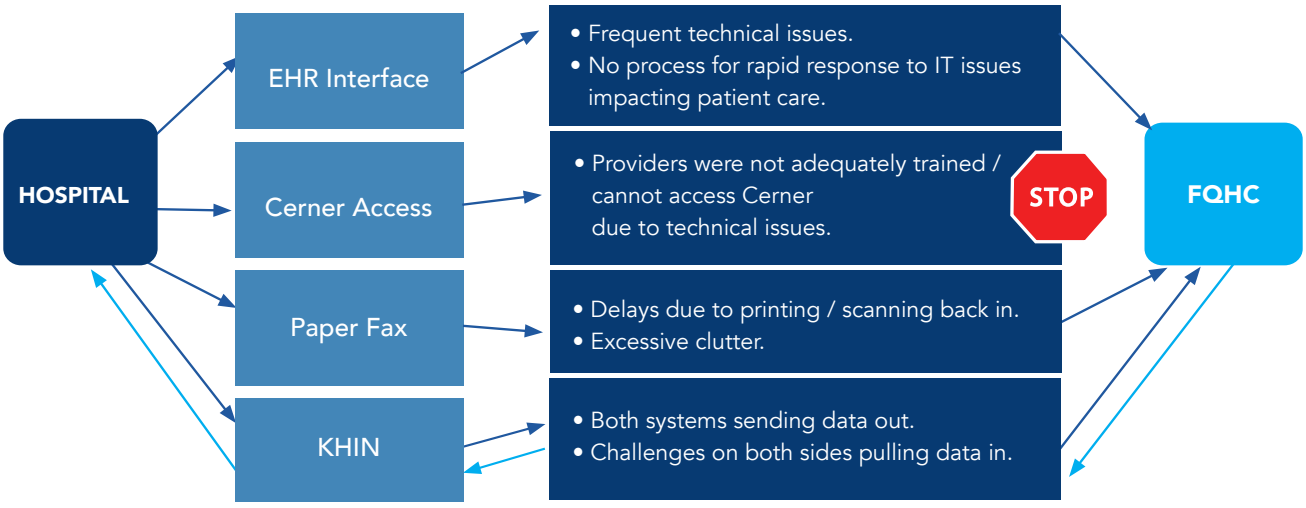
Our team developed a shared framework for joint population health management strategies, along with an assessment of technological solutions, with an emphasis on supporting new care pathways and alignment options within the market. By examining each area of care delivery, we made recommendations for identified priority areas that were directly tied to key indicators of success.

## OUR RESULTS

### Aligned Incentives

- Established plans for an in-house retail pharmacy at the FQHC to capitalize on its 340B drug discount program participation, a solution that was mutually beneficial for both organizations.
- Developed strategy to optimize care delivery for Medicaid-covered and uninsured individuals while reducing overall healthcare costs by transferring select clinics from the hospital to the FQHC.
- Advanced the organization's strategic alignment through board-level collaboration, joint strategic planning, and a memorandum of understanding to formally agree on the details of a mutually beneficial plan.
- Provided a roadmap to align ER behavioral health care with multiple community-based providers, including plans to advance communication and coordination and reduce ER visits.

## HEALTH INFORMATION TRANSFER: THE PRIMARY CHALLENGE TO CARE COORDINATION



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## JAMES CORBETT, MDiv, JD
**Principal, Initium Health**

James Corbett is a seasoned healthcare executive bringing over a decade of c-level leadership experience from both the for-profit and the non-profit sectors of the industry. James has served as a Fellow at Harvard Medical School, Harvard's Safra Center for Ethics and the Nashville Healthcare Council. In addition, he served a 4-year term on the National Institute of Health's National Advisory Council for Nursing Research; having been honored to receive the appointment from former Health and Human Services Secretary, Kathleen Sebellius. He was recently appointed as an Expert Advisor to The Agency for Healthcare Research and Quality (AHRQ).

James' experience comes from serving in four health systems, providing strategic and operational leadership for behavioral health, FQHC affiliations, population health, research operations, global health, advocacy, and ethics. Currently, James works with health systems, health plans, physician groups, and technology companies across the country on strategic and operational goals. He speaks nationally giving keynote presentations on a variety of topics including Medicaid strategies, behavioral health, social determinants of health, and ethics.

### FOCUS AREAS

Medicaid Strategy
FQHC Affiliation Models
Advocacy/Government Relations
Behavioral Health
Population Health
Research/Clinical Trials
Research Operations
Community Health
Community Partnerships
Free Clinics
Recovery Housing
Real World Evidence Trials
Substance Use Disorders
Global Health
Ethics

### EXPERIENCE

2018 — **Initium Health**
Principal
Denver, CO

2018 - 2013 — **Centura Health**
Senior Vice President
Denver, CO

2013 - 2010 — **Steward Health**
System Vice President
Boston, MA

2010 - 2007 — **Mercy Hospital**
Vice President
Portland, ME

### EDUCATION

**Bioethics Fellow**
Harvard School of Medicine

**Master of Divinity**
Duke University

**Juris Doctor**
Saint John's Law School

**Bachelor of Arts, International Relations**
Syracuse University

**Lean Six Sigma, Green Belt Certification**
Villanova University

### EXTERNAL LEADERSHIP

- Keynote, John Hopkins School of Medicine, 2019
- Keynote, Ohio State Mgmt Institute, 2018
- Keynote, World Congress: Integrating BH & Primary Care Models, 2018
- NIH Nursing Research Council, 2014-2018
- Fellow, Nashville Health Care Council, 2018
- Thought Leader, Denver Business Journal, 2017
- Keynote, Iowa Primary Care Assoc., 2017
- Keynote, Harvard Medical School, 2016
- Fellow, Harvard Medical School, 2011-2014

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## KATE BAILEY, MPH
**Senior Consultant, Initium Health**

Kate Bailey, MPH, brings a depth of experience designing, implementing, and evaluating new initiatives in healthcare and public health. She has a track record of process redesign in hospital and ambulatory care settings, and working closely with providers to ensure changes are sustainable. Kate provides project management expertise along with the development of indicators and dashboards to monitor progress.

As a consultant, Kate has worked with established health care systems and community health centers to develop strategies in the areas of behavioral health, pharmacy, population health and addressing social determinants. She worked with a large health system to develop a comprehensive Medicaid strategy in a complex reimbursement environment, and with regional health systems to design behavioral health care pathways and clinical-community partnerships. She has also secured state, federal and private foundation funding to support new initiatives. Kate holds a Bachelor of Science degree from Gordon College and a Master of Public Health from Boston University, along with a Black Belt in Lean Six Sigma from Villanova University.

### FOCUS AREAS

340B Auditing

Lab Integration

Project Management

Quality & Process Improvement

Clinical-Community Partnerships

Ambulatory Care

Behavioral Health

Care Coordination

Patient Experience

Social Determinants of Health

Health Insurance Access

Community Health Workers

Pragmatic Trials

### EXPERIENCE

2018

**Initium Health**
Consultant
Boston, MA

2015 – 2012

**Steward Health**
Performance Director
Boston, MA

2011– 2006

**Boston University Medical Center**
Research Technician
Boston, MA

### EDUCATION

**Master of Public Health, International Health**
Boston University

**Bachelor of Science, Biology, Mathematics**
Gordon College

**Lean Six Sigma, Black Belt Certification**
Villanova University

### EXTERNAL LEADERSHIP

- Board of Directors, Somebody Cares New England, 2018
- Advisory Committee, Massachusetts Department of Public Health, 2013
- Program Manager, LifeGivers International Ministries, 2013
- Board of Directors, Haverhill Community Violence Prevention Coalition, 2013

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## SAMANTHA LIPPOLIS, MPA

**Director of Virtual Care, Initium Health**

Sam Lippolis is a telehealth expert and trainer specializing in video visits, remote patient monitoring, eConsults and all aspects of virtual care. When she isn't training groups of clinicians for organizations, she's coaching one-on-one with providers to redesign their practice for a virtual first model.

After 12 years of telehealth planning and implementation with academic and large health systems, Sam's real world knowledge makes her highly sought after as an advisor and trainer. Her unique view on telehealth is focused on human connection, exceptional clinical care and a better lifestyle for providers. Sam is known for having fun while conveying complex information that everyone can understand and put into action. Her enthusiasm is infectious and her clients realize an immediate improvement in their virtual interactions with patients.

Sam has contributed to Modern Healthcare, Healthcare Informatics, MGMA and SG2 Healthcare Intelligence.

### FOCUS AREAS

Telehealth

Virtual Care

Digital Health Companies

Policy Analysis & Advocacy

Reimbursement Policy for Virtual Care

Global Health

Workflow Redesign

Clinical Training for Virtual Care

Implementation

Technology Selection

### EXPERIENCE

Present - 2022
**Initium Health**
Director of Virtual Care
Denver, CO

Present - 2019
**Sam Lippolis, LLC**
CEO
Denver, CO

2020 - 2018
**UC Health**
Connected Care Director
Cincinnati, OH

2017 - 2015
**Centura Health**
Telehealth Director & Manager
Englewood, CO

### EDUCATION

**Master of Public Administration**
University of Colorado

**Bachelor of Arts - Geography**
University of Colorado

### EXTERNAL LEADERSHIP

- Big Dogs Huge Paws, Volunteer, Colorado
- Camp to Belong, Director of Counselors and Councelor (Volunteer) Colorado, Maine, Washington.
- Goodwill Industries and Boys and Girls Club, Group Mentor (Volunteer) Denver, Colorado

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## LAUREN LE
**Consultant**

Lauren Le, MPH, has a wide variety of experiences rooted in education in community health and health systems. Her experience in community health and health education began with her undergraduate degree, where she focused on health promotion and health behavior theory. Lauren transferred this knowledge to practice when working on the community health team at her local health department and then on the health education team at the Brain Injury Association. Her education continued with a focus on health systems and health policy, which led to her experience in quality and process improvement within a large hospital.

In her professional career, Lauren has worked with a wide variety of stakeholders to conduct surveillance on drug and poison exposures. She has experience in applying for, receiving, and managing grant funding for research ranging from clinical trials to secondary data analysis, and employs health behavior theory to inform best practices in her work.

### FOCUS AREAS

- Health Behavior Theory
- Health Promotion
- Program Planning
- Program Evaluation
- Epidemiology
- Drug Surveillance
- Adolescent Drug Exposures
- Drug and Poison Safety
- Health Policy
- Health Systems
- Healthcare Economics

### EXPERIENCE

Present - 2022
**Initium Health**
Proposal Writer
Denver, CO

2022 - 2017
**Rocky Mountain Poison and Drug Safety**
Researcher
Denver, CO

2015
**Intern**
University of Colorado Hospital- Process/Quality Departments
Aurora, CO

### EDUCATION

**Master of Public Health: Health Systems, Management and Policy**
Colorado School of Public Health
Aurora, CO

**Bachelor of Science in Education: Community Health**
University of Kansas
Lawrence, KS

# The Business Case for Mental Health Equity

James Corbett, MDiv, JD[a], Temi Olafunmiloye[b,1], Joseph R. Betancourt, MD, MPH[c,*]

**KEYWORDS**

• Mental health • Substance use disorder • Opioids • Disparities • Business case

**KEY POINTS**

- Racial and ethnic disparities persist in mental health and substance use disorders, as minorities face greater challenges accessing mental health and substance use disorder services and receive a lower quality of care.
- Mental health expenditure exceeds that of other medical conditions, increases the costs of addressing physical health, and is exacerbated by health disparities.
- Real-world evidence trials account for strategic and operational concerns along with the disparate financial incentives of multiple stakeholders.
- Real-world evidence trials offer great promise to solidify the business case for equity, reduce disparities, and combat the major challenge of mental health and substance use disorders.

## INTRODUCTION

Mental health has garnered increased attention in recent years as more than 47 million Americans experience mental illness each year, and 9.2 million Americans suffer from mental health and substance use disorders (SUD).[1] The need for services to address this growing epidemic has become a public health and policy priority; more than 60% of adults with mental illness and 81% of those with SUD do not receive treatment.[1,2] Nevertheless, health system investment in mental health and SUD services remains challenging for multiple reasons, including low reimbursement and low return on investment as compared with more profitable health system services. At the same

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psych.theclinics.com

| Abbreviations | |
|---|---|
| MAT | Medications for addiction treatment |
| OUD | Opioid use disorder |
| SUD | Substance use disorders |

time, payors historically have carved out mental health and SUD from physical health and reimbursed less for these services, and regulators have not appropriately monitored or enforced policies such as the Mental Health Parity and Addiction Equity Act. As the monetary and human costs from our nation's mental health and SUD burden escalate, however, strong business and ethical cases arise to better address this crisis in a meaningful and sustainable manner. This need is further magnified as our nation pushes toward value-based care and population health management, where improving outcomes and performance in physical health requires concomitant treatment of mental illness and SUD. This article describes the root causes and cost of disparities in mental health and SUD and offers an innovative perspective on aligning stakeholders to make the business case for equity in mental health and SUD treatment and outcomes.

A deeper exploration of the mental health and SUD crisis demonstrates that racial and ethnic disparities persist. For instance, minority populations tend to have limited access to health care, and receive lower quality care, than their white counterparts. Although research shows that minorities have a lower or equivalent prevalence of mental illnesses as whites, mental health services are more likely to be used by those that are white, high income, and living in urban areas.[3,4] Black and Latinx populations are less likely to receive mental health services and receive adequate quality care.[5–8] For example, between 2008 and 2012, whites had the highest average use of mental health services at 16.6%, followed by American Indian/Alaskan Natives (15.6%), African Americans (8.6%), Latinos (7.3%), and Asians (4.9%).[9] Further, the mental health needs of patients with limited English proficiency are dramatically unmet, with research revealing that only 8% of patients with limited English proficiency who express a need for services receive them.[10] Given that these minority and populations with limited English proficiency also disproportionately suffer from and receive lower quality care for chronic conditions such as heart disease, asthma, and diabetes, and because physical health outcomes worsen and costs increase by inadequate treatment of mental illness, an even stronger business case is evolving for mental health equity.

## BACKGROUND ON MENTAL HEALTH AND SUBSTANCE USE DISORDERS

### *Disparities in Mental Health*

Mental health disparities describe the unequal access to mental health services, lower quality of care, and decreased probability of favorable risk-adjusted health outcomes that minority groups experience.[11] Although mental health services use has generally increased in the United States over time, minority populations have faced greater challenges accessing them, for both historical and structural reasons. Mental health disparities are impacted by social and physical stressors that impact minority populations at greater rates.[12] These include racial discrimination and social exclusion; adverse early life experiences; poor education; unemployment, underemployment, and job insecurity; poverty, income inequality, and neighborhood deprivation; poor access to sufficient healthy food; poor housing quality and housing instability; adverse features of the built environment; and poor access to health care.[13] Generally,

the greater the social inequality, the higher the risk of developing a mental health disorder.

Barriers to receiving mental health care are extensive. Research demonstrates that high cost and limited insurance coverage are the highest reported barriers to using mental health services among all racial and ethnic minority groups. Other barriers include stigma, negative experiences with providers, perceived ineffectiveness of treatment, and structural barriers such as limited appointment availability and lack of transportation.[14] For example, research has shown that black, Latinx, and Asian populations are more likely to report prejudice, discrimination, and a lack of confidence that the services would help as reasons for not seeking treatment.[9] The burden of mental health disparities is further exacerbated by the political climate. For example, 1 study showed that lesbian, gay, and bisexual populations living in states with bans on same-sex marriage had higher rates of psychological distress as compared with lesbian, gay, and bisexual populations living in states without these bans.[15] In another study that compared rigid immigration policies and mental health in the Latinx community, Latinx people residing in states with stringent immigration policies experienced a greater number of poorer mental health days.[16] In summary, mental health disparities are longstanding, widely prevalent, and deeply problematic.

### *Disparities in Substance Use Disorders*

Addiction to drugs or alcohol comprises a mental illness known as SUD. SUD is defined as a problematic pattern of substance use that causes significant impairment or distress.[17] SUD are shaped by genetic, environmental, and developmental factors, leading to an array of mental, physical, and behavioral symptoms.[18] A subset of SUD is opioid use disorder (OUD). The term opioid is used to describe a class of drugs that includes prescription pain relievers, synthetic opioids, and heroin.[19] OUD carries a great possibility of developing a physical dependence in a short timeframe, sometimes as little as 4 weeks—and abruptly stopping opioid use can lead to severe withdrawal symptoms.[20] Because mental health and SUD are closely tied together, similar disparities exist among minority populations. African Americans and Latinx populations are less likely to complete treatment for SUD, because psychosocial stressors and the severity of drug use are cited as influences on the completion of treatment.[21] Compared with whites, Latinx populations have a 92% likelihood of completing treatment for substance abuse and African Americans have a 69% likelihood.[8] African Americans are also less likely to complete treatment across several substances, including alcohol, cocaine, marijuana, heroin, and methamphetamine compared with whites.[8]

Not only do minority groups have lower rates of treatment completion, but they are also less likely to receive treatment at all. OUD is now considered a public health emergency as more than 130 Americans die daily as a result of this crisis.[22] One of the most beneficial evidence-based treatments for OUD involves medications for addiction treatment (MAT). MAT is the use of medications in combination with counseling and behavioral therapies; it is proven to be effective in the treatment of opioid use and in helping to sustain recovery.[23] Buprenorphine, methadone, and naltrexone are the 3 drugs that have been approved by the US Food and Drug Administration to fight opioid dependence.[23] Typically, these treatments have been most effective when combined with counseling and psychosocial support.[23] From 2004 to 2015, buprenorphine was more likely to be provided to patients that were white, had private insurance, and/or could self-pay.[4] Research shows that, between 2012 and 2015, there were a total of 13.4 million patient visits that resulted in a buprenorphine prescription; white patients accounted for 95% of those visits and minority patients accounted for

only about 3%.[24] Further, for every 35 white patients who received a buprenorphine prescription, 1 minority patient did, with an overall 77% lower odds of having an office visit that included a buprenorphine prescription.[24] Race and class are inextricably linked, making race, ethnicity, and income defining aspects of access. Between 2012 and 2015, approximately 40% of outpatient visits involving buprenorphine prescriptions were paid for by the patient outside of insurance, with private insurance covering only 34% of these costs, and only 19% were paid for by either Medicare or Medicaid.[24] Although 69% of counties in the United States have at least 1 SUD facility, about 40% do not have at least 1 outpatient SUD facility that accepts Medicaid.[25] Counties in the South and Midwest, as well as those with higher proportions of African American and/or Latinx residents, were less likely to have SUD outpatient facilities that accept Medicaid.[25]

Amid the OUD epidemic, several barriers hinder treatment for co-occurring disorders, including personal beliefs (ie, perceived stigma, cultural attitudes) and structural barriers (ie, insurance coverage, service availability and location, disorder identification, and lack of provider training to identify the disorders).[26] There is a lack of specialized services for treatment for substance abuse and mental health, particularly in rural areas.[26] Further, research suggests that negative stereotypes may contribute to the underdiagnoses and misdiagnoses of racial, ethnic, gender, and sexual minorities.[26] As the number of Americans with SUD grows, there is a pressing need to increase access to treatment for black, Latinx, and low-income populations to ensure all who could benefit from this treatment are provided appropriate access.

## THE COST OF MENTAL HEALTH AND SUBSTANCE USE DISORDERS

Mental health care costs the United States about $300 billion annually, including $100 billion in health care expenditures.[27,28] Mental disorders are considered some of the highest cost medical conditions, with spending having increased by 5.6% between 1996 and 2013.[28] When substance use is taken into account, mental health and SUD services combined account for 7% of overall health care spending in 2014.[29] Medicare and Medicaid covered more than one-half of all spending on mental health care and SUD services, totaling $110 billion and $22 billion, respectively.[29] Early recognition and treatment of mental illness can lead to a decreased number of medical visits, ultimately decreasing costs. Further, mental illness increases the likelihood of morbidity for several chronic diseases, including cardiovascular diseases, obesity, diabetes, and cancer.[27] This finding suggests that providing accessible and high-quality treatments has the potential to improve outcomes for chronic diseases, further decreasing health care expenditures.[27] Eliminating mental health disparities by providing additional care can lead to the United States saving up to $38 million in emergency room expenditures and $833 million in inpatient expenditures for black and Latinx populations.[30] These significant cost decreases indicate an urgency to promote mental health and SUD equity. The World Health Organization states that investing in mental health is key to the advancement of and well-being of populations and improves economic efficiency.[31] The World Health Organization lists 4 ways to begin this investment:

1. Increase awareness and education about mental health and illness.
2. Provide better quality health and social care services for underserved populations with unmet needs.
3. Provide better social and financial protection for persons with mental disorders, particularly those in socially disadvantaged groups.

4. Provide better legislative protection and social support for persons, families, and communities adversely affected by mental disorders.[31]

These investment areas highlight the need for interventions that address equity not only at the individual and community level, but the structural level as well.

## MENTAL HEALTH PARITY AND SUBSTANCE USE DISORDER EQUITY

The Mental Health Parity and Addiction Equity Act, which was enacted in 2008, requires that, when mental health or SUD benefits are covered, they are covered equally with physical health services.[32] SUD treatment is an essential health benefit for individual and small group coverage under the Affordable Care Act.[33] Although the passing of this landmark law helped to ameliorate the bifurcation of mental health and physical health, mental health and SUD parity compliance remains a work in progress across public and commercial payers, despite having been the law for more than a decade.

Meaningful oversight and enforcement of mental health and SUD parity are critical to reversing the current opioid epidemic, yet legislation alone is not the solution. In addition to enforcement, the removal of barriers such as prior authorization for MAT services, ensuring that MAT is affordable, and that health insurance companies have an adequate network of addiction medicine and mental health physicians are also crucial to addressing disparities in treatment. The business case has to be made at the intersection of regulators, payers, and providers who need appropriate incentives for investment. Both payers and health systems have become adept at adhering to the letter of the law, balancing regulatory requirements with financial restraints in deciding how to respond to shifts in regulations. Consequently, an ecosystem approach that accounts for the multiple and varied incentives of key stakeholders to address mental health and SUD is required and tangible; meaningful data must be acquired and disseminated.

## MAKING THE BUSINESS CASE: REAL-WORLD EVIDENCE TRIALS

Traditional clinical trials, although of great value, are costly and time consuming, often spanning multiple years in development and navigating the complex approval process. Moreover, clinical trials are often conducted with specific populations, controlled in certain environments that do not reflect clinical or community realities.[34] Historically, clinical trials have struggled to have diverse participants and have, at times, increased disparities by focusing their studies on discrete populations.[34] Real-world evidence trials have the potential to compensate for the limitations of traditional clinical trials, improving the ability to generalize findings to be more inclusive of diverse populations.[34] This allows researchers to answer questions that better pertain to these populations, gaining a deeper understanding of how clinical settings, providers, and health systems affect treatments and outcomes. Real-world evidence trials involve information gathered beyond typical clinical research settings (ie, electronic health records, claims and billing data, disease registries, data from health informatics, personal devices, and health applications).[34] Thus, although efficacy trials aim to understand whether an intervention leads to a certain result under ideal conditions, effectiveness trials seek to assess the degree of effect under real-world clinical settings that are often impacted by factors such as patient preference, organization culture, administrative decisions, and organizational structure of the entities involved.[35] Real-world evidence trials, which embrace a health ecosystem approach and account for multiple entities and diverse incentives, could uncover financial,

operational, and strategic factors required to enhance the business case for meaningful investment in mental health and SUD.

Enhancing the business case using real-world evidence trials in mental health and SUD would best be served by incorporating a health ecosystem approach and collaborating with appropriate payers, health systems, and related parties in the recovery ecosystem, including those involved in outpatient care, inpatient care, housing, and social support services. Collecting and analyzing patient outcomes and financial outcomes could offer a data-driven and strategic opportunity to compel investment in mental health and SUD. For example, regarding OUD, strategic questions to answer would include the following: Does reducing the barriers to access, such as prior authorization of MAT, lead to fewer overdose deaths? Does reducing barriers save payers and health systems money when compared with the cost of overdose in the emergency room and other high-cost settings? Does the costlier injectable extended-release version of buprenorphine lead to fewer hospitalizations and emergency room admissions than the less expensive oral buprenorphine, and ultimately save more despite the higher upfront costs of injectable medications? Providing the answers to such trenchant questions in a real-world setting with a lens toward operational, financial, and patient outcomes could form a cogent argument for investing in OUD, and mental health and SUD more broadly, in minority communities.

## MAKING THE BUSINESS CASE: MEDICAID AND REAL-WORLD EVIDENCE

Medicaid is both a federal and state program that provides health insurance for low-income individuals, and is one of the largest purchasers of health care services in the United States, providing coverage for more than 70 million people at an annual cost of more than $460 billion.[36] Medicaid is also the largest payer for mental health services in the United States and generally the first or second largest item in every state budget.[37] Given that Medicaid is a program for the poor and largely serves Latinx and black populations, Medicaid could act as the epicenter for rapidly addressing disparities in mental health and SUD access and treatment. Medicaid's size, scope, and centrality in the health insurance market make it a viable opportunity. Historically, for Medicaid, cost containment has meant imposing arbitrary across-the-board rate cuts or cutting eligibility, but the time is ripe for state Medicaid agencies to leverage real-world evidence trials.

Unlike Medicare, which is managed across the country under central administration, each state Medicaid office has latitude regarding how they administer the program. This latitude presents both a challenge and an opportunity. Coverage policy, in its broadest sense, is intended to promote value in medical care by using reimbursement to favor the use of effective care and avoid payment for ineffective care.[38]

Ways in which Medicaid can address disparities become apparent when exploring mental health and OUD treatment. For example, all state Medicaid offices are required to pay for mental health inpatient stays, but optional benefit categories include effective evidence-based nonclinical services such as peer support and community residential services and vary greatly by state.[37] On a more granular level, although all state Medicaid offices offer coverage for buprenorphine, which is used in MAT, 40 states require prior authorization for its use.[39] In a similar vein, Medicaid coverage for extended-release injectable buprenorphine is covered by 33 state Medicaid offices but only 7 do not require prior authorization.[40] Prior authorization is an effective tactic to prevent overuse and manage costs, but it has also been proven to be a barrier to care particularly for minority communities.[4] Real-world evidence trials could be a powerful tool to study financial and patient data, connecting the decrease of prior

authorization requirements to the decrease in overdose deaths and expensive emergency room visits associated with overdose. Similarly, real-world evidence trials could determine the impact of oral buprenorphine and the extended-release injectable buprenorphine and analyze cost differentials and overdose rates based on geography, health system characteristics, and race and ethnicity. Data-driven decision making based on patient and financial data in real-world settings could positively impact the opioid crisis, decrease costs, and meaningfully address disparities in mental health and SUD.

## PRIVATE SECTOR INVESTMENT

There are instances of local communities across the country taking this leap; communities in Kansas and Colorado have now passed local taxes to build their capacity to address mental health and SUD.[41,42] In private industry, the Google affiliate, Verily, in Dayton, Ohio—considered the epicenter of the OUD crisis—established a nonprofit organization called OneFifteen to highlight and address the 115 people who die daily from OUD.[43] Additionally, private foundations in different states, including the Colorado Health Foundation, are now offering zero interest loans to inspire investment in mental health as well as in mental health innovation and technologies.[44,45] Although community investment in mental health and OUD is promising, more remains to be done at the payor, provider, state, and federal levels to address the OUD epidemic and decrease disparities in access and treatment to mental health and SUD services more broadly.

## SUMMARY

The cost of our nation's mental health and SUD burden continues to escalate and is further exacerbated by health disparities that impact minority and low-income populations. Acknowledging the business case for addressing our mental health and SUD crisis is of vital importance. Although there are no easy answers, it is incumbent upon health systems, policymakers, and payers to address the human and financial cost of this crisis. A health ecosystem approach that aligns disparate incentives and accounts for financial, operational, and strategic concerns of payers and health systems is needed to inspire investment in mental health and SUD in underserved communities across the country. Although the human cost of the mental health and SUD epidemic is clear, navigating the "whose pockets" issue of cost decreases associated with these investments remains a challenge. Real-world evidence trials, which account for strategic and operational concerns along with the disparate financial incentives of multiple stakeholders, offer great promise to reduce disparities and combat this major challenge of our generation.

## DISCLOSURE

The authors have nothing to disclose.

## REFERENCES

1. National Alliance on Mental Illness. Mental health by the numbers. 2019. Available at: https://www.nami.org/learn-more/mental-health-by-the-numbers. Accessed December 23, 2019.
2. American Addiction Centers. Alcohol and drug abuse statistics. 2020. Available at: https://americanaddictioncenters.org/rehab-guide/addiction-statistics. Accessed December 28, 2019.

3. Wang PS, Lane M, Olfson M, et al. Twelve-month use of mental health services in the United States: results from the national comorbidity survey replication. Arch Gen Psychiatry 2005;62(6):629–40.
4. Lagisetty P, Ross R, Bohnert A. Buprenorphine treatment divide by race/ethnicity and payment. JAMA Psychiatry 2019;76(9):979–81.
5. Cook BL, Zuvekas SH, Carson N, et al. Assessing racial/ethnic disparities in treatment across episodes of mental health care. Health Serv Res 2014;49(1):206–29.
6. Alegria M, Page JB, Hansen H, et al. Improving drug treatment services for Hispanics: research gaps and scientific opportunities. Drug and Alcohol Depend 2006;84S:S76–84.
7. Guerrero EG, Marsh JC, Khachikian T, et al. Disparities in Latino substance use, service use, and treatment: implications for culturally and evidence-based interventions under health care reform. Drug and Alcohol Depend 2013;133:805–13.
8. Mennis J, Stahler GJ. Racial and ethnic disparities in outpatient substance use disorder treatment episode completion for different substances. J Subst Abuse Treat 2016;63:25–33.
9. Substance Abuse and Mental Health Services Administration. Racial/ethnic differences in mental health service use among adults. Rockville (MD): Substance Abuse and Mental Health Services Administration; 2015.
10. Sentell T, Shumway M, Snowden L. Access to mental health treatment by English language proficiency and race/ethnicity. J Gen Intern Med 2007;22:289–93.
11. Safran MA, Mays RA Jr, Huang LN, et al. Mental health disparities. Am J Public Health 2009;99(11):1962–6.
12. Institute of Medicine. Unequal treatment: confronting racial and ethnic disparities in health care. Washington, DC: The National Academies Press; 2003.
13. Compton MT, Shim RS. The social determinants of mental health focus. J Lifelong Learn Psychiatry 2015;13(4):419–25.
14. Mojtabai R, Olfson M, Sampson NA, et al. Barriers to mental health treatment: results from the national comorbidity survey replication (NCS-R). Psychol Med 2011;41(8):1751–61.
15. Hatzenbuehler ML, McLaughlin KA, Keyes KM, et al. The impact of institutional discrimination on psychiatric disorders in lesbian, gay, and bisexual populations: a prospective study. Am J Public Health 2010;100(3):452–9.
16. Hatzenbuehler ML, Prins S, Flake M, et al. Immigration policies and mental health morbidity among Latinos: a state-level analysis. Soc Sci Med 2017;174:169–78.
17. Center for Disease Control and Prevention. CDC guideline for prescribing opioids for chronic pain — United States. Atlanta, GA: CDC; 2016. p. 2016.
18. Volkow ND, Koob GF, McLellan AT. Neurobiologic advances from the brain disease model of addiction. N Engl J Med 2016;374(4):363–71.
19. National Institute on Drug Abuse. Opioids. Available at: https://www.drugabuse.gov/drugs-abuse/opioids. Accessed December 26, 2019.
20. American Psychiatric Association. Opioid use disorder. 2018. Available at: https://www.psychiatry.org/patients-families/addiction/opioid-use-disorder/opioid-use-disorder. Accessed December 20, 2019.
21. Guerrero EG, Marsh JC, Duan L, et al. Disparities in completion of substance abuse treatment between and within racial and ethnic groups. Health Serv Res 2013;48(4):1450–67.
22. National Institute on Drug Abuse. Opioid overdose crisis. 2019. Available at: https://www.drugabuse.gov/drugs-abuse/opioids/opioid-overdose-crisis. Accessed January 2, 2020.

23. US Food & Drug Administration. Information about Medication-Assisted Treatment (MAT). Information about Medication-Assisted Treatment (MAT). 2019. Available at: https://www.fda.gov/drugs/information-drug-class/information-about-medication-assisted-treatment-mat. Accessed January, 2020.
24. Robeznieks A. Black patients less likely to get treatment for opioid-use disorder. Chicago, IL: American Medical Association; 2019.
25. Cummings JR, Wen H, Ko M, et al. Race/ethnicity and geographic access to Medicaid substance use disorder treatment facilities in the United States. JAMA Psychiatry 2014;71(2):190–6.
26. Priester MA, Browne T, Iachini A, et al. Treatment access barriers and disparities among individuals with co-occurring mental health and substance use disorders: an integrative literature review. J Subst Abuse Treat 2015;61:47–59.
27. Reeves WC, Strine TW, Pratt LA, et al. Mental illness surveillance among adults in the United States. Atlanta (GA): Office of Surveillance, Epidemiology, and Laboratory Services, Centers for Disease Control and Prevention, U.S. Department of Health and Human Services; 2011.
28. Roehrig C. Mental disorders top the list of the most costly conditions in The United States: $201 Billion. Health Aff 2016;35(6):1130–5.
29. National Conference of State Legislatures. The costs and consequences of disparities in behavioral health care. 2018. Available at: http://www.ncsl.org/Portals/1/HTML_LargeReports/DisparitiesBehHealth_Final.htm. Accessed December 27, 2019.
30. Cook BL, Liu Z, Lessios AS, et al. The costs and benefits of reducing racial-ethnic disparities in mental health care. Psychiatr Serv 2015;66(4):389–96.
31. Chisholm D. Investing in mental health: evidence for action. Switzerland: World Health Organization; 2013.
32. Creedon TB, Cook BL. Access to mental health care increased but not for substance use, while disparities remain. Health Aff 2016;35(6):1017–21.
33. The Center for Consumer Information & Insurance Oversight. Information on Essential Health Benefits (EHB) benchmark plans. Available at: https://www.cms.gov/CCIIO/Resources/Data-Resources/ehb. Accessed January 3, 2020.
34. Sherman R, Anderson S, Pan GD, et al. Real-world evidence — what is it and what can it tell us? N Engl J Med 2016;375(23):2293–7.
35. Gartlehner G, Hansen RA, Nissman D, et al. Criteria for distinguishing effectiveness from efficacy trials in systematic reviews. Rockville (MD): Agency for Healthcare Research and Quality (US); 2006.
36. Clemans-Cope L, Holahan J, Garfield R. Medicaid spending growth compared to other payers: a look at the evidence. San Francisco, CA: Kaiser Commission on Medicaid and the Uninsured; 2016.
37. Musumeci M, Chidambaram P, Orgera K. State options for Medicaid coverage of inpatient behavioral health services. San Francisco, CA: Kaiser Family Foundation; 2019.
38. Garber AM. Evidence-based coverage policy. Health Aff (Millwood) 2001;20(5):62–82.
39. Weber E, Gupta A. State Medicaid programs should follow the “Medicare model”: remove prior authorization requirements for buprenorphine and other medications to treat opioid use disorders. Washington, DC: Legal Action Center; 2019.
40. Substance Abuse and Mental Health Services Administration. Medicaid coverage of medication-assisted treatment for alcohol and opioid use disorders and of medication for the reversal of opioid overdose. Rockville (MD): Substance Abuse and Mental Health Services Administration; 2018.

41. Jones E. Voters overwhelmingly approve sales tax to fund behavioral health campus, services. 2018. Available at: https://www2.ljworld.com/news/county-government/2018/nov/06/voters-overwhelmingly-approve-sales-tax-to-fund-behavioral-health-campus-services/. Accessed January, 2020.
42. Benzel L. Local voters could hold key in Colorado's mental health crisis. The Gazette. Mental Health: A Crisis in Colorado Web site. 2019. Available at: https://gazette.com/premium/local-voters-could-hold-key-in-colorado-s-mental-health/article_98d74afa-16d9-11ea-b3b8-0f4a2928a97e.html. Accessed January, 2020.
43. Lester N. OneFifteen opens the first of its state-of-the-art facilities for the treatment of opioid use disorder in Dayton, Ohio. 2019. Available at: https://onefifteen.org/press/. Accessed January 3, 2020.
44. The Colorado Health Foundation. Funding opportunity: strengthening primary care. Available at: https://www.coloradohealth.org/funding-opportunities/funding-opportunity-strengthening-primary-care. Accessed March 31, 2020.
45. The Colorado Health Foundation. Colorado Health Foundation Announces groundbreaking investment with Denver-based, for-profit behavioral health app developer. Available at: https://coloradohealth.org/news/colorado-health-foundation-announces-groundbreaking-investment-denver-based-profit-behavioral. Accessed March 31, 2020.