Whitepaper

Substance Use Disorder & Addiction Treatment Innovators' Playbook

An in-depth look at the state of addiction and insight into the future from our panel of experts

SUNWAVE

Table of Contents

The State of Addiction Treatment

An estimated 109,680 individuals in the United States died from a drug overdose last year, according to the most recent Centers for Disease Control and Prevention (CDC) data. Although deaths due to prescription opioids decreased, fatalities from synthetic opioids, such as fentanyl, surged, reaching about 75,000. While adolescent substance use in 2022 remained similar to previous years, the numbers belie the near doubling of drug overdose deaths among those between 12 and 17.

Substance Use Disorder (SUD) and addiction treatment innovation continue to lag despite a clear need. A recent trade report found that venture capital invests little in new addiction treatments—an anomalous trend compared to other complex diseases and disorders. For instance, cancer treatments have attracted nearly 270 times more funding than addiction, despite having similar prevalence rates.

Policy and provider support, including incentives and reimbursement parity, have not kept pace with the rising need. Advancements have been made, such as expanded access to opioid use disorder (OUD) medications, including buprenorphine and naloxone. Insurers are showing signs of compliance with The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), designed to ensure coverage for mental health treatment. And industry stakeholders continue to push for health information technology adoption in behavioral health—a gap that has hamstrung the industry in accessing the data, insights, and interoperability advancements seen in other areas of healthcare. But continued underfunding, the slow pace of regulatory change, and the fragmented healthcare ecosystem hinder the speed of transformation needed to address the addiction crisis.

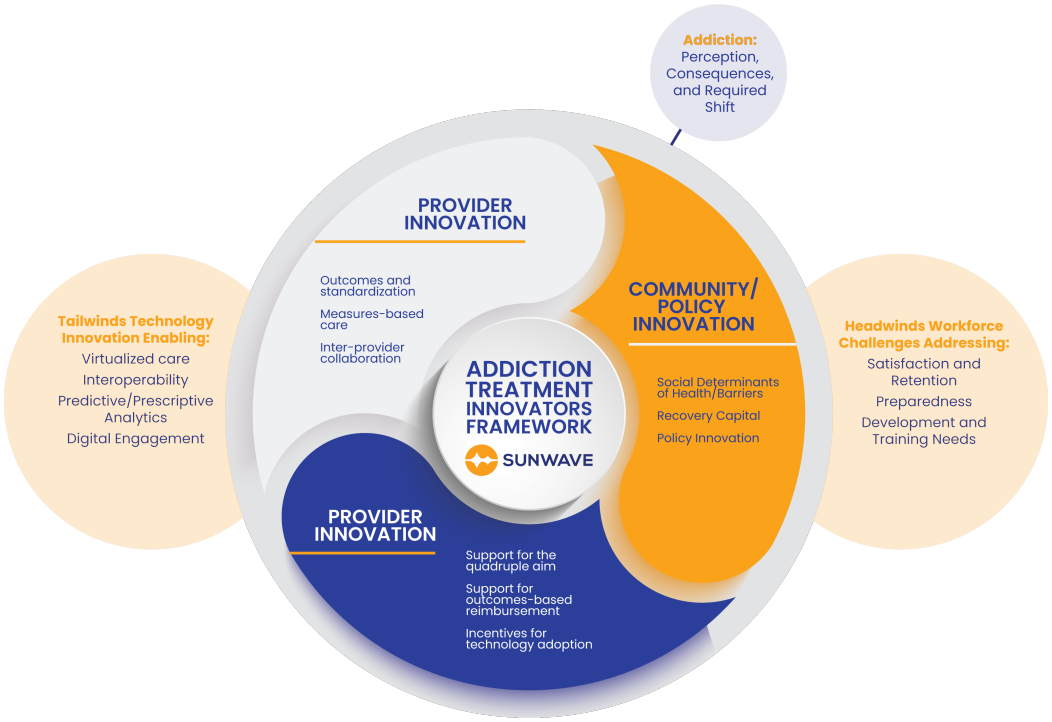
The stigma of those suffering from a SUD persists. According to a recent Journal of Substance Abuse study, people with SUD experience a community-wide stigma that is instilled into the healthcare system. This stigma manifests as barriers to care, including a lack of education, limited resources, and fewer recovery options. Moreover, this stigma fuels the criminalization of addicts, exacerbating health inequities that impede marginalized groups and result in poor health outcomes and increased mortality.

Against this backdrop of need and stigma, we asked, “What innovation—across treatment, policy, perception, payment, and technology—will change the course of addiction treatment in the U.S.?”

The answers we collected spanned the industry. Voices from providers, payers, policy advocates, and those in recovery came together to inform and shape how we understand the path toward a solution. While the challenges are complex, we heard a distinct commitment to and renewed interest in finding innovative solutions.

To organize these insights, we developed an **Innovation Framework**. The circle's center comprises the major stakeholder groups and innovation activities, including providers, payers, and community/policy organizations. The outside of the circle is the state of addiction treatment today—it represents the context within which the major stakeholder groups exist. Broader external forces and areas of innovation need were identified. Staffing shortages and workforce challenges continue to pose major headwinds; technology advancements and adoption serve as tailwinds.

This framework embodies the thoughts and insights gathered over in-depth interviews with eight experts in the field of addiction. And while not exhaustive, it represents overarching themes that we believe shape the future of addiction treatment.



Executive Summary—Innovation at the Front Lines

Providers—Navigating the Path to Better Outcomes

Currently, providers are bearing the brunt of the burden when it comes to addiction treatment. While they sit on the front lines of the crisis, they carry an undue administrative workload that distracts from patient care. Providers describe a constant battle for treatment authorizations and reimbursements that consumes resources and limits their autonomy in determining the best course of treatment.

Providers highlight the importance of measuring outcomes in mitigating the uneven burden of care. Without measurable outcomes, providers face challenges negotiating with payers, innovating treatment protocols, and managing the overall patient journey. The need for standardization and consensus on what constitutes successful addiction treatment is emphasized, along with a demand for data-driven methods.

Providers also discuss the need for measures-based care to support quality and performance targets, and the ability to compare patient outcomes against the larger industry. Many interviewees talk at length about the need for collaboration among providers. They emphasize the need to understand addiction as a complex, chronic disorder and to treat it with the same multidisciplinary approach seen in other chronic conditions, such as diabetes and cancer.

Community and Policy Organizations—Lowering Barriers and Increasing Connection

Family, housing status, socioeconomic, provider access, rural location, and insurance coverage are significant barriers to initiating and maintaining addiction treatment. These factors sit within a dysfunctional system, restricting care access, prioritizing short-term fixes over long-term gain, and stymieing the transformation needed to address addiction's complexities.

Across our interviews, experts point to the concept of Recovery Capital to sustain healthy outcomes for SUD patients. The American Society of Addiction Medicine's (ASAM's) Recovery Capital definition is cited as a good baseline:

> The breadth and depth of internal and external resources that can be drawn upon to initiate and sustain recovery from alcohol and other drug problems. It can be found at the personal, social, community and cultural levels.

And interviewees highlight the importance of community resource engagement to help bridge transportation, childcare, and housing gaps that impede ongoing access and treatment.

Major changes to policy, including expanded access to buprenorphine, over-the-counter naloxone, and COVID-era flexibilities allowing for the prescription of controlled substances over telehealth, are lowering barriers to medication-assisted therapies proven to reduce relapse rates. But with the end of the public health emergency, some of the changes that improved access are already being phased out—such as open Medicaid enrollment—or face an uncertain future—such as the DEA's telemedicine prescribing policies. And these policies do little to empower providers with the funding needed to drive technology and innovation adoption, mitigate payer influence over treatment duration, or improve collaboration across community resources and addiction treatment stakeholders. And while there is an acknowledgment that reforms move slowly, our experts emphasize how this crisis demands the same swift action and coordination seen during the pandemic.

Payers—Ensuring Care Access

The concept of "value-based care" is often batted around in SUD and addiction treatment conversations. Our experts quickly point out that value-based and at-risk reimbursement models are a distant reality from where we are today. Innovation starts with parity—access to and the cost of care must be the same across physical and mental care. And while most of our interviewees acknowledge progress toward parity across commercial and public payers, examples including excessive re-authorizations and limitations on length of stay are highlighted as undermining parity gains.

Financial limitations across the uninsured and underinsured populations are mentioned as major barriers to treatment initiation. Once in treatment, the constant battle over treatment duration and length of stay lower the likelihood of success. Nearly every expert, including payer representatives, underscore the importance of longer stays in seeing better results.

Experts point to the mainstream medical community for other innovation frameworks, including the Quadruple Aim. Supported by the Institute for Healthcare Improvement,

the Quadruple Aim framework helps organizations shift from a fee-for-service focus to an outcome focus. The goal is to improve health, enhance the patient experience, reduce costs, and minimize clinician burnout. This framework guides and sets measures of success and best practices across providers and, ultimately, drives outcomes-based reimbursement and innovative models of care such as Accountable Care Organizations.

But addiction treatment is far behind the rest of the industry when it comes to the data sharing and transparency required to support the Quadruple Aim framework. Much of this stems from behavioral health's exclusion from the Health Information Technology for Economic and Clinical Health Act (HITECH Act) of 2009, which provided billions of dollars to medical providers to purchase and maintain electronic health records. Without access to incentives and compliance driving technology adoption, addiction treatment providers lack the necessary tools to collect patient data, drive interoperability, and track long-term outcomes, all of which are critical to value-based care models. Our experts echo calls for immediate funding and guidance to help bridge the technology divide.

Headwinds—Workforce Challenges

According to a 2015 Pew Charitable Trusts report, the average number of addiction specialists was 32 for every 10,000 patients. And while the report didn't specify the ideal ratio, it did label the shortage as "severe." Fast forward to the post-pandemic world, and the problem is worse. With overdose deaths nearing 110,000 annually, scaling up an already dwindling workforce has become a national emergency.

To call workforce challenges a headwind doesn't fully capture the magnitude of the problem or the needed innovation to drive a solution. And our experts speak to the complex reality they face on the ground. Increasing the number of treatment providers hinges on:

- Improving satisfaction and retention of current talent
- Growing a diverse and prepared pipeline of new clinicians
- Enhancing training and mentorship
- Integrating addiction treatment into the mainstream medical community

As with all addiction treatment, there is no cure-all to the workforce shortage. From compassion fatigue to the draw of remote work options, multiple factors push and pull the workforce out of addiction treatment. Finding near-term solutions that don't

place more onus on providers to fill gaps is paramount to lowering overdose rates and improving outcomes.

Tailwinds—Technology Advancements

Technology tends to create opportunity. This rings true for our experts, though their excitement stems more from increased access to proven technology and processes over new advancements like generative AI and virtual reality -- at least for now.

Data accessibility garners the most enthusiasm. Getting access to standardized, usable, and complete data is the lynchpin for many of the innovations mentioned by stakeholders. And with data access comes the opportunity to share data across providers, payers, and the larger community. Interoperability continues to pose challenges within healthcare, however. There is hope that we can fast-track collaboration among addiction specialists by leveraging years of real-world data and evidence from mainstream medical communities.

With access to data comes the opportunity for predictive and prescriptive analytics, and advanced data science algorithms can correct systematic errors in SUD and mental health data. We also have access to demographic data, including the social vulnerability index that enriches patient-level information. By marrying data from addiction providers with the massive data assets curated by the broader medical community, we can quickly address gaps and uncover insights to pinpoint rising-risk patients before they have an overdose or high acuity event.

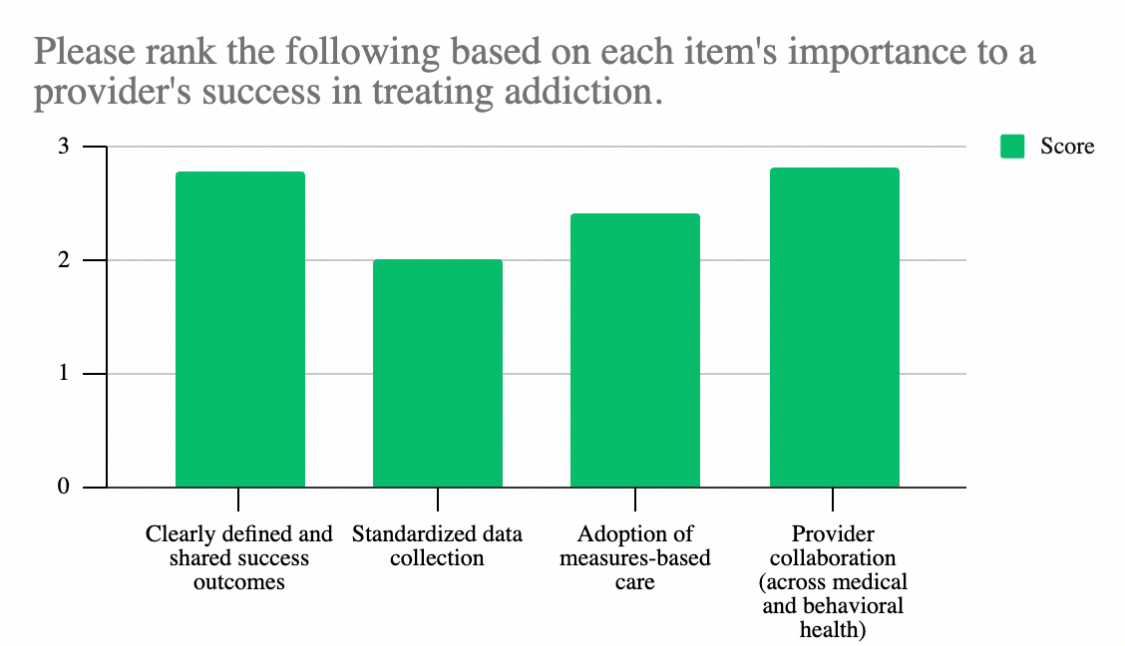
Given our point in post-pandemic history, we'd be amissif we didn't touch on virtualized care. COVID taught us we can connect with patients, prescribe medication, and manage addiction treatment virtually. It also highlighted the work needed to ensure digital engagement and the effectiveness of virtual care options. Virtualized care isn't going away. In fact, many of our experts are excited about new digital therapeutics that help complete the biosocial picture of a patient through wearable devices. And as we continue to struggle with workforce shortages and ongoing barriers to care, telehealth/telemedicine will remain a critical lifeline for many patients entering treatment or maintaining recovery.

How to Use This Report

This report offers an in-depth analysis of the state of addiction treatment, innovation drivers and barriers by stakeholder group, and the industry's headwinds and tailwinds. The insights we present are derived from comments made by our interviewees during

comprehensive interviews, each lasting between 30 and 60 minutes, conducted in the spring of 2023. Insights from a survey of 71 addiction treatment professionals are provided for additional insight into innovation drivers and the factors that are most important for success. Brief biographies of each expert and any supplementary references used in the report are included at the end of this document.

Providers—Innovating for Better Patient Outcomes



Survey respondents ranked clearly defined outcomes and provider collaboration as most important to a provider's success in treating addiction.

Addiction treatment providers sit at the intersection of increased demand for services, a patient population that is more complex and acute, and higher levels of scrutiny and data demands. At the center of this intersection are patient outcomes. This is the focus of so many of our conversations, including defining outcomes, measuring care, and collaborating across providers.

Outcomes and Standardization

Annie Peters, Ph.D., the executive director for the National Association of Addiction Treatment Providers (NAATP)'s Foundation for Recovery Science and Education

(FoRSE) program, explains the problem: “The biggest obstacle to innovation is that we don't agree on objective outcomes of addiction healthcare. We need to build a culture of measurement, a culture of data, a culture of technology, and a culture of collaboration.”

Siobhan Morse, MHSA, CRC, CAI, MAC, division director of clinical services for Universal Health Services (UHS), connects the lack of consensus to data: “Data has no value and no meaning until you ask it questions. It's the questions we can't agree on. Because we can't agree on what an outcome is.”

Getting to an agreed-on outcome and standardizing how we measure the patient journey is not only foundational to innovation, but critical to reducing stigma and reframing our understanding of addiction. Morse continues, “We need to change (the) paradigm to move us into the thought process that this is a chronic care disease.”

Work is underway across addiction treatment professionals to define outcomes and standardize data capture throughout patient treatment. The FoRSE program, in particular, is driving efforts at standardization and benchmarking. Through this work, we gain industry-wide insights into the patients served and treatment progress against key indicators for a diverse set of addiction treatment providers. But what the final agreed-to outcome is—and how to measure it—is still a challenge that the medical community at large needs to address. As Peters explains:

“A lot of the focus, as it rightly should be, is on preventing death. There is also the aspect of promoting health—not just preventing death. How do we promote wellness, health, quality of life, fulfillment, and hope? Those things are harder to measure.”

Michael Walsh, a long-time industry expert and consultant, frames the problem this way based on conversations with people looking to get their loved ones into treatment: “They often ask what my success rate is or what the programs I’m recommending success rates are and I ask a question, I say, ‘What's your idea of success?’ Because I have families that want their son or daughter to stop getting arrested, and others want abstinence and a spiritual awakening. And there's a lot of real estate between those two outcomes.”

Measures-based Care

Defining a successful outcome requires a systematic way of measuring and monitoring progress. While there is consensus that measures-based care—an approach that relies on measuring and monitoring specific clinical metrics associated with better patient outcomes—is critical to driving clinical performance,

adoption is low. Less than 20 percent of behavioral health providers incorporate measures-based care into their practices.

Pete Nielsen, chief executive officer for the California Consortium of Addiction Programs and Professionals (CCAPP), explains the challenge this way: “What are the criteria for how (a patient is) really doing emotionally, physically, spiritually? Where's the measure that we're using? I think we can get there by figuring out how we know if a treatment is working and effective.”

For Nielsen, who works with providers across California and nationwide, the lack of a scientific approach for capturing and reporting treatment progress creates confusion and leaves many without the insights needed to understand if a program is a right fit. He states: “How do we know that the money being spent is well spent towards an individual? We have no idea what gives us the best outcome.”

Other experts highlight the need to incorporate a multidisciplinary approach to the science of addiction treatment and measurement. Tiffany Naumann, PsyD, chief clinical officer at Montare Behavioral Health, emphasizes the importance of individualized care plans.

Naumann explains, “There are a lot of nuances when it comes to addiction or substance use issues, and not everyone has the same outcome. Outcomes can be vastly different. Different types of abuse, misuse, addiction, and problematic behavior around substances have different needs, different outcomes, and require different treatment plans.”

For Naumann, there is tremendous potential for better patient outcomes within the operationalization of research and literature inside addiction treatment facilities.

“I think it takes people taking what we know from research and literature and putting it into practical application,” she continued. “The exciting thing is creating models of care that are integrative of evidence-based modalities we know work, combined with new researched-based concepts. I get excited about working on something that in the next five years can be a modality or a manualized curriculum that can then be plugged into different treatment programs.”

Provider Collaboration

Integrated behavioral health, also referred to as Primary Care Behavioral Health, drives cross-disciplinary collaboration and ensures that behavioral health expertise is represented within a patient’s care team. According to the American Psychological

Association, integrated behavioral health yields improvements across the experience of care, outcomes, cost, and provider satisfaction. But realizing the benefits of integrated behavioral health is difficult, largely because of the historical separation between the medical care system and behavioral health.

A renewed effort to advance integrated behavioral health is underway. Driven in large part by the explosive growth in mental health needs over the pandemic, the Department of Health and Human Services (HHS) is calling for integrated care as a core component to the HHS roadmap. And this focus is echoed by our experts.

Morse of UHS describes the collaboration that she and her colleagues are driving to bring addiction expertise into the Emergency Department (ED): "The lens through which we see this disease (of addiction) is really where we need to be strategically moving. For example, in Washington, D.C., we have stations and peer navigators in the emergency room. For anybody who may have an issue, we're screening for substance use disorder. We're using a referral-to-treatment type model to move patients through, so they're not utilizing expensive resources but are gaining access to the most appropriate care."

CCAPP's Nielsen also speaks to the need for collaboration and visibility: "There will be some silo-busting. And recovery outcomes will not be based on abstinence. Instead, we will start looking at the individual's recovery over time, longitudinally."

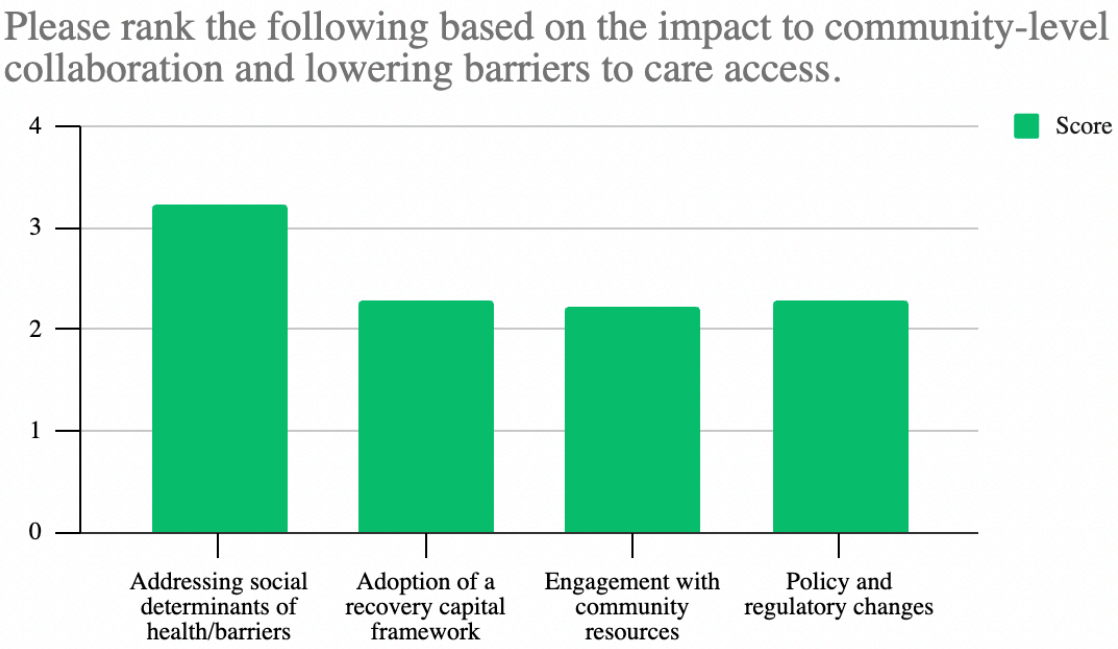
Persistent stigma, reflected in the medical community, was mentioned by nearly every participant as a mediating factor to poor recovery outcomes.

Brett McGennis, chief executive officer for Regard Recovery and Journey Pure, explains stigma's impact this way: "The reality around the addicted population is that when they've been looking for treatment, there's a lot of bias that goes around. The removal of stigma and bias presents a whole lot of opportunities."

NAATP's Peters explains how that stigma manifests in treatment: "We know there are racial disparities in who gets treatment and who is incarcerated. There are also disparities in who responds well to treatment because historically, treatment was designed for a White cisgender male population. We have to figure out how to drive destigmatization in all communities and provide services that people relate to and are attracted to."

Payers are also thinking about stigma, its impacts on outcomes, and the link between stigma and parity. Eric Bailly, senior director at Third Horizon Strategies, explains, "What people don't pay enough attention to is how stigma, especially in SUD, impacts a person's experience with the healthcare system. I've heard some terrible stories about how people have been treated when seeking out services for an SUD, but the work done around mental health and addiction parity has helped tremendously. As a practicing clinician in the early 2000's, there were circumstances I encountered in which individuals may have one visit (with a clinician) per calendar year, and they worked for a great company. At the time, I thought, how do you get away with this? We don't do that anymore. What happens in medicine should be commensurate with behavioral health, and vice versa."

Community and Policy Organizations—Innovating for Resilience



Close to 50% of survey respondents ranked addressing social determinants of health as the most important factor in driving collaboration and lowering barriers to care.

Social Determinants of Health (SDoH) comprise the "conditions in the environments where people are born, live, learn, work, play, worship, and age" that impact health, functioning, and outcomes. In the context of substance use and overdose prevention, programs that engage patients across multiple levels of their physical and social environment are more likely to be successful. Our experts highlight the need for innovation and change across SDoH to drive addiction treatment success—topics centered on reducing barriers to care, increasing Recovery Capital, and driving policy innovation.

Barriers to Care

> A core tenet across interviews is the need to "meet patients where they are." This statement carries with it the weight of understanding where someone is in their treatment journey, the family and economic barriers that stand in the way of recovery, and the idea that engagement can happen in multiple ways and at different levels of acuity.

As Elevance's Bailly explains, "Any organization working on a digital front door that recognizes the many pathways to condition care management, engagement, and services look very different for each individual depending on their circumstance. In essence, meeting people where they're at and with what they're ready and willing to do."

Barriers to care comprise a wide scope of topics. The complexity of the care system, transportation challenges, financial limitations, housing instability, and motivation all impact an individual's ability to access care and maintain recovery once treatment is complete. Walsh describes the problem this way: "We have to broaden the tent; we need it to be a lot bigger in the United States and abroad, in order to really make movement addressing the issue."

Walsh's calls for "more people under the tent" go beyond providers to the agencies, lawyers, social workers, hospital personnel, and community. "We need to educate and utilize all these potential partners and social capital levers to help build Recovery Capital that ensures long-term recovery." He explains, "If I'm 20 years old, and I've completed a program, and now I've got 10 interviews with these really cool companies, I've got this light at the end of the tunnel. I'm a lot more likely to stay clean and change my life."

But transformation has been slow for addiction treatment. While the mainstream medical community is taking steps to overcome barriers related to outcomes and reimbursement, behavioral health is still far behind. Walsh further explains: "The internal structure of our healthcare system, our legal system, and social justice system hasn't really changed a whole lot since the Affordable Care Act. We talk a lot more about wellness and long-term recovery. But the practical programs that achieve those goals and bring down the cost on society to help people live better lives and be more productive—those things have not caught up yet."

Recovery Capital

A repeated framework to address barriers to care and improve treatment success is Recovery Capital. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), Recovery Capital comprises the "internal and external resources a person draws on to begin and sustain recovery." CCAPP's Nielsen describes Recovery Capital as measurable: "You can measure Recovery Capital in two ways. You can measure people's internal capital by what they say, and you can identify the different resources in their life. It is about answering the important questions. Really, how are you doing? Where's your social capital, your community capital, your personal capital? Because if you have more capital, you're going to need fewer services."

Nielsen and Walsh point to Recovery Capital as a way to drive personal accountability and engagement.

Nielsen states: "I think that at some point, individuals will adopt Recovery Capital as a way to measure their own recovery. Just like you measure your own blood pressure and insulin, (people in recovery) will have their own personal responsibility. I really envision that Recovery Capital and outcome measurement will be something owned by the patient, and that will continue over time. It will break down silos. It will follow them from harm reduction, prevention, and treatment into long-term recovery and across community organizations, medication-assisted recovery, and medication-assisted treatment."

Walsh states: "It is about changing the mindset from putting it on other people or a facility or a type of program and instead taking personal responsibility. Putting an action plan in place over a long period of time is how you change, whether you're an addict, you want to get in shape, you want to pursue education, or be successful in business."

The future lies in our ability to measure the effectiveness of Recovery Capital and ensure that what we measure and how we understand the concept of recovery is culturally competent. The innovation efforts around Recovery Capital reflect the need to reach agreed-to outcome measures and to understand it within the broader community context.

Nielsen and his team are helping bridge these gaps through collaborations with other industry experts. He explains, "We have a national Recovery Capital conference we do every year. And through that work, we are really fine-tuning the process of defining outcomes. We map all the Recovery Capital (parameters) to Z-codes (a set of ICD-10-CM codes used to report social, economic, and environmental determinants). The idea is to come out with a screener for Recovery Capital called the R1 36 item Recovery Capital Screener and a Recovery Capital Planner that we can start beta testing in treatment facilities."

Policy Innovation

At the societal level, our experts point to policy change—both current and needed—as a major accelerator to innovation. Federal efforts are underway to address gaps in capacity and barriers to substance use and addiction treatment. This includes momentum by HHS to advance equitable access and increase visibility into patient outcomes.

But local efforts, including Medicaid, hold some of the biggest potential to lower rates of substance use disorder, cost, and mortality. These programs vary widely by state and include varying degrees of social and community-level resources. This is in spite of strong data pointing to lower rates of hospitalizations and longer-term recovery associated with Medicaid expansion.

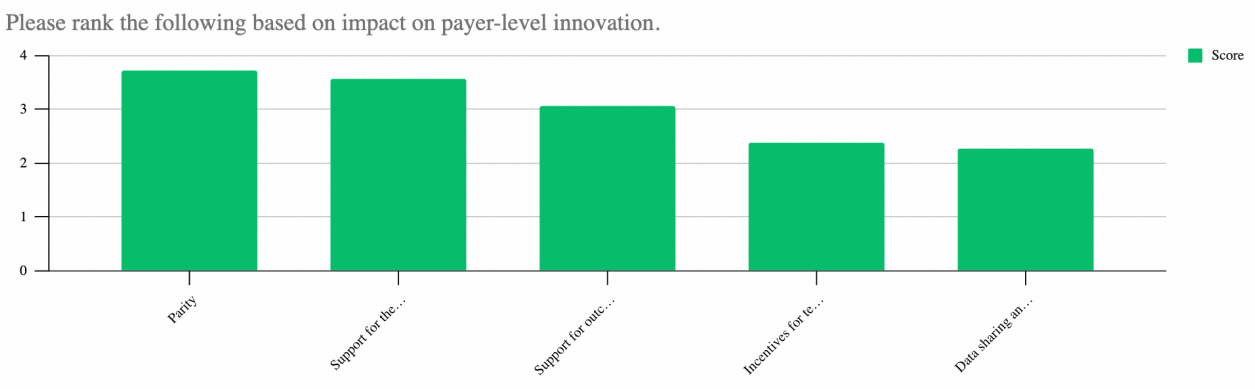
Montare's Naumann sheds light on the intersection of addiction and community-level need: "This ties a lot into the co-occurrence of addiction and homelessness. I spent many years in Southern California, specifically in Los Angeles. And anyone who's been following California public issues understands that there is a crisis with homelessness. If you were to poll all those people who are homeless, you're going to recognize that there is a very strong issue of addiction tied to that, along with mental illness. So, what on the surface looks like a housing or a homeless issue really is an addiction issue and a mental health crisis."

Naumann also touches on the community- and policy-level responsibility to help direct people into treatment: "We have to use points of leverage to get (people) into

treatment. There's some debate and maybe some controversy on what those points of leverage are. But we have to get everybody to recognize that you're asking somebody to make a sound decision who isn't capable of making a sound decision."

Policy changes across all levels are needed to ensure access to addiction and substance use disorder treatment. States, in particular, have the power to drive community-level connections and resources to those who face the biggest barriers to care. And local governments are in the best position to create incentive vehicles to guide people to care and fill the gaps in Recovery Capital to reduce the risk of relapse. While federal efforts point light and heat on integrated mental and physical care, more needs to be done to make the mainstream medical community accountable for behavioral health outcomes. It is worth noting that all of this work is contingent on a workforce that meets the increased demand–a topic we tackle later in this report.

Payers—Innovating for Access



Parity tops the list of factors impacting payer-level innovation, according to our survey respondents.

In the United States, payers dictate value. By owning reimbursement vehicles and patient risk, payers determine what services are approved and how much they cost. Since the 2008 passing of the Mental Health Parity and Addiction Equity Act (MHPAEA), the federal government has tried to prevent "group health plans and health insurance issuers that provide mental health or substance use disorder (MH/SUD) benefits from imposing less favorable benefit limitations on those benefits than on medical/surgical benefits." Often shorthanded to the umbrella term of "parity," the MHPAEA is achieving inconsistent success largely due to the lack of consensus around outcomes and quality measures.

Our experts point to the real-world impacts that lack of parity has on SUD and addiction treatment. While recent policies driving better federal and state-level enforcement of the law are helping move reimbursement in the right direction, gaps still exist.

Parity dominates our conversations around payer innovation, but our experts also highlight the length of treatment duration, adoption of the Quadruple Aim framework, and support for technology adoption as major areas of innovation opportunity.

Parity

Third Horizon Strategies' Bailly describes the ongoing battle for parity with a current example:

"Methadone, which is an extremely effective and lifesaving medication for the treatment of opioid use disorder, has been federally regulated to the point where there are access issues and low utilization across the board for those diagnosed with Opioid Use Disorder. Insulin, which is a lifesaving medication for the treatment of diabetes, another chronic health condition, is not subject to commensurate regulations. As a society, we wouldn't stand for the kinds of regulations that methadone is subjected to when it comes to the treatment of diabetes."

The lack of parity is driven in large part by a lack of outcomes data. Because the industry still struggles with measuring and monitoring treatment outcomes and cost, payers continue to dictate the types and duration of care delivered. Without insights that prove the effectiveness and necessity of treatments, providers have little leverage in the parity conversation, and politics may continue to define dosages.

Bailly continues, "Why is there such stringent regulation on a medication which is a healthcare decision? SUD and mental health are healthcare conditions; they do not belong in a political argument. (Treatment) should be driven by evidence. It should be driven by data and professionals in the field who have dedicated their lives to this work."

McGennis of Regard Recovery and Journey Pure sees the impact of benefits limitations at his facilities. In describing the necessity for change, he also reflects on the reality of addiction treatment compared to his own experience with the mainstream medical community:

"Substance abuse treatment is no different from any other type of treatment. You know, I'm on blood pressure medication, but I don't walk into my doctor's office and get grilled on how many cheeseburgers I ate in the last six months to determine whether he's going to leave me on or take me off my medication. And yet we do that in the substance abuse field. The payer requests a toxicology test, and if people test positive, they end up in a penal kind
of system."

For McGennis, the problems that underlie parity also undermine the movement toward value-based care:

"In October, I met with four heads of insurance companies who wanted to talk about how to get to a value-based care system. And I said, we won't get to a value-based care system until we agree on what the value is. Treatment and insurance companies are extremely far apart on what the value is
in treatment."

Progress to support parity has been made in recent years. CMS's Behavioral Health Strategy is driving coverage for behavioral health services and opioid use disorder. And the Fiscal Year 2023 Omnibus Appropriations Bill expands access and enforce and ensure parity compliance. But more work needs to be done to bring these efforts to the front-line providers who are treating a patient population that continues
to grow.

Optimizing Length of Stay

Length of Stay (LOS) is intrinsically tied to parity and data gaps. Our experts cite it often enough as a separate topic that we want to highlight these insights.

Walsh, an industry consultant and SME, explains treatment duration as one of the most critical components to success: "Good treatment is great, but there's no substitute for time when you're talking about mental health and substance use disorder. And for those who have families and jobs that they can't leave, the question is how do we get them more than a Band-Aid on a hemorrhage? Because we know that for long-term sustainable recovery, they need so much more than is available today."

Decades of research point to longer treatment as the most significant predictor of addiction treatment outcomes. According to the National Institutes on Drug Abuse Principles of Drug Addiction Treatment: A Research-Based Guide (Third Edition),

treatment duration needs to fit the individualized needs of the patient, with most addicted individuals needing at least three months of treatment.

McGennis points to his organization's own patient populations for proof points that link treatment duration to better outcomes:

> "There are some states that have a limit on the number of times that you can admit over the course of a year. Well, there's an easy way to solve that: don't send them home after 14 days. There are winds of change that, while not necessarily (technology) innovations, are innovations of thought. If we invest the time properly in a patient's stay, in getting the person out of the fog of their addiction and really dealing with the underlying issues, that pays huge benefits for the patient, for the treatment center, and for the insurance company."

This innovation of thought is heavily dependent on proof points gathered at the patient level and tracked longitudinally to prove the value of longer treatment durations. But this data, and the infrastructure required to meet analytic demands, does not exist for most SUD and addiction treatment providers. To address this gap, a number of our experts point to the Quadruple Aim—a long-held framework used to guide outcomes-focused care and reimbursement within the mainstream medical community—as a pathway to accelerate insight and iterate innovation.

The Quadruple Aim

The Institute for Healthcare Improvement's Quadruple Aim framework provides strategies to improve the patient experience of care, improve the health of the population, lower cost, and drive workforce satisfaction (although some organizations elect a different fourth aim such as health equity or readiness).

Third Horizon Strategies' Bailly points to the framework as a major innovation driver and path to alternative payment models: "What's going to drive innovation, particularly in addiction treatment, is the Quadruple Aim. It helps frame access to quality and cost-effective SUD care that enhances the member and provider experience on all levels."

The Quadruple Aim defines quality from the perspective of the patient. And the framework is used to strengthen alternative payment models and payer innovation, including accountable care organizations, bundled payments, and new models of care delivery. Bailly explains its application in practice: "We have the ability to test out some of (these innovation models). Using the Quadruple Aim, we can balance cost, member experience, provider experience, and quality."

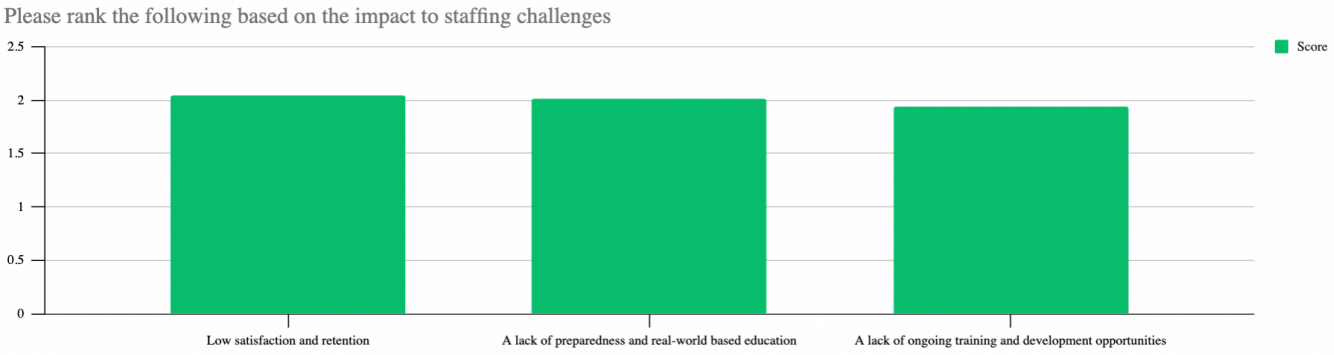
Technology Adoption

The Quadruple Aim, as well as parity and increased treatment duration, relies on insights and outcome measures. But behavioral health is excluded from the financial support and incentives that drive technology adoption across the mainstream medical community. As a result, SUD and addiction providers lag behind their medical peers in core technology, such as electronic medical records adoption.

NAATP's Peters echoes the call, saying: "We know we need widespread screening and assessment, as well as collaboration and knowledge of who is served well in each setting, and with each type of service. We need data to determine all of that. We all should be collecting data using standardized measures on who we serve, what we do, and how it affects people."

Recently, the Medicaid and CHIP Payment and Access Commission (MACPAC) urged state and federal agencies to address technology adoption gaps by promoting IT adoption and interoperability. Critical to their recommendations are Medicaid programs that play a fundamental role in incentivizing adoption and providing adoption guidance. However, the pace of change is glacially slow compared to the need for certified health IT and the kind of interoperability that provides a complete, longitudinal picture of addiction treatment outcomes.

Headwinds—Innovating for a Strong Workforce



Low satisfaction levels are the top concern when it comes to staffing challenges, according to survey respondents.

A recent survey reveals that 91% of behavioral health providers face significant staffing shortages, with 75% stating that these shortages critically affect patient care. The 2023 Medicare Physician Fee Schedule somewhat alleviates the issue by easing supervisory regulations for care provided by licensed counselors and therapists. However, surging patient demand, competition for skilled professionals, and an ongoing scarcity of practitioners continue to burden mental health and SUD treatment.

According to the Health Resources and Services Administration (HRSA), by 2030, there will be a critical shortage of psychiatry and addiction treatment specialists. This supply crisis exists even if there is no change in demand for services or care utilization. And today, many providers struggle to find and retain workers across all levels of clinical care. The result is decreased access and increased wait times for patients seeking SUD and addiction treatment.

Drivers behind the SUD and addiction treatment shortage vary by location and provider type. However, three barriers contribute to most of the strain:

- **Staff turnover:** The SUD workforce faces a 32% turnover rate, roughly five times the rate seen in other medical specialties.
- **Burnout:** More than half of behavioral health providers report symptoms of burnout. While this is in line with general healthcare trends, this is likely to escalate as the demand for behavioral healthcare continues to grow in conjunction with staffing and retention challenges.
- **Lack of parity:** Lower reimbursement rates translate into lower salaries across SUD and addiction treatment roles. For instance, the average salary for social workers in addiction is $38,600 compared to $47,230 in the broader healthcare industry. If pay and benefits are inconsistently or inequitably distributed, it affects staff retention.

Our experts highlight the need for workforce innovation to help fill gaps that limit access to care and ensure the skills and acumen needed to support a more complex patient population.

Marlon Rollins, Ph.D., chief operating officer for Renewal Health Group, explains the workforce challenges he faces within his organization: “I think that, especially in healthcare, we tend to look past the workforce. What is going to drive innovation (includes) a meaningful investment in training and development.”

Training and education need to align with the challenges of substances like fentanyl, emerging treatment modalities, and more complex patients. Rollins continues:

"What do (new treatments like ketamine) mean for the experience of trauma? Recognizing that people are using much more complicated substances—things like fentanyl–we have a changing client base in their drug of choice and poly-substance use. What will drive innovation is the chronic disease itself and how acute it becomes. Staff need to understand the complexity of clients as they come in and understand what trauma looks like."

Rollins points to the role of the education system in preparing clinicians across levels of care delivery for the challenges of SUD and addiction treatment. He explains, "I think it's a matter of making sure that the schools themselves understand who is coming into our treatment centers. Educators may not know what (a patient population) is dealing with unless they are highly skilled and have the resources to provide a curriculum that's really meaningful to what a clinician sees once they graduate."

This gap between the education curriculum and a clinician's real-world experience exacerbates workforce challenges by leaving skills gaps that employers are left to close. And the criticality of SUD and addiction treatment workforce shortages fosters an environment focused on filling open positions over skill and acumen. Rollins describes the problem:

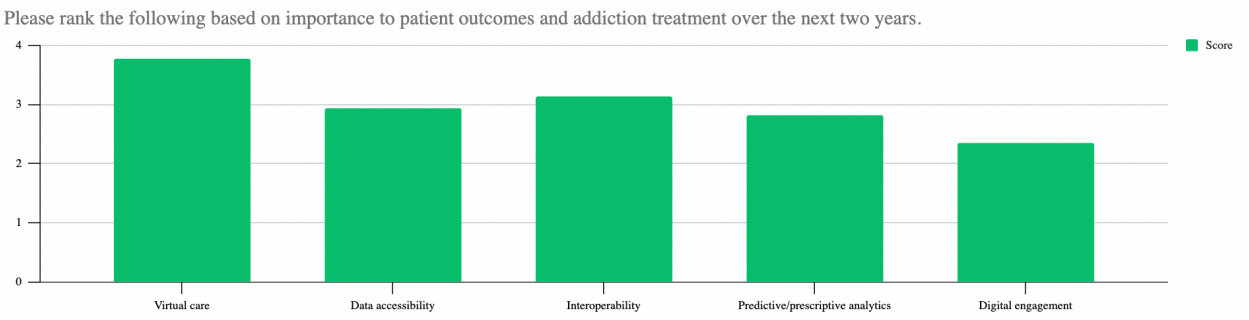
"A lot of times, people say, 'We need a position—get in and go.' They just need to get somebody in the role even if they aren't properly prepared out of school to treat the complex patients we see. It is left to the employer to train clinicians. And I don't mean simply the duties of the job; they need to understand the patient experience, the complexity of trauma, and how that intersects with (a patient's) culture and background."

For Rollins and other SUD and addiction treatment leaders, workforce innovation comes back to patient outcomes. While the education system works to prepare the next generation of SUD and addiction specialists, providers must invest in their workforce to ensure that the best care possible is provided for complex clients. This requires regulatory support, such as the revisions to the 2023 Medicare Physician Fee Schedule introducing flexibility to allow more behavioral health clinicians to bill for services, and increased funding opportunities to bolster provider education and training programs.

Rollins summarizes the need this way: "If (educational institutions) provide onsite training for (clinicians) that's coordinated with the provider, you gain a pipeline of

people who have the experience and the classwork integrated together. Providers gain a better pipeline of talent informed through a combined approach, whereby the practice is informed by the educational curriculum and the educational curriculum is informed by the practice."

Tailwinds—Innovating for Impact



"Survey respondents ranked virtual care and interoperability as the top two innovation trends with the greatest potential positive impact on patient outcomes."

Technology is not a panacea. But it does hold the key to accessing better insights and enabling faster connections between providers, patients, and community organizations. Behavioral health is an outcast in health IT and, as a result, has limited access to the money and momentum seen across other healthcare sectors. But that is finally changing.

Driven in large part by the need to define, understand, and capture patient outcomes, SUD and addiction treatment providers are forging ahead. They are looking to the successes and failures of the mainstream medical community to fast-track innovation. And they are building on the grassroots momentum created by patients and providers who are working tirelessly to lower barriers to care, increase connection across patient populations, and address the growing complexity of our addiction crisis.

Data Accessibility

Our experts point to data accessibility as one of the most exciting and fundamental areas of innovation. NAATP's Peters explains the impact of data access this way: "As providers, having access to the most current data on an individual and their background at our fingertips drives clinical decision-making. We can say that this person has these symptoms and resources; we know what is likely to be helpful for

them, we know what they can afford, we understand their community, we know what local resources and community supports they have."

Walsh, a noted industry expert, echoes Peters' sentiment. He describes how data and outcome measurements are crucial, but with a lack of trustworthy and reliable data, there is a need to measure success within the context of the community and the individual's needs:

"We haven't been privy to the clinical data. But if we come together, we can drive real insight that shows if you do this—these are the impacts on the patient."

> "It is in the data that maybe we can change the whole conversation."

Predictive and Prescriptive Analytics

With better data comes the opportunity to operationalize predictive and prescriptive analytics. This includes the ability to identify rising-risk patients earlier and at lower acuity levels to drive more individualized care and interventions. Across our experts, the promise of advanced insights unlocked by data accessibility holds a critical role in lowering mortality and improving patient outcomes.

Third Horizon Strategies' Bailly explains the opportunity to intervene earlier and with better insights:

"I think the key is to individualize outreach—like an email or a text for (lower-risk and lower-acuity individuals) who could benefit from a combination of asynchronous and synchronous conversations. And you have the top set that needs some formalized treatment, which looks really different depending on the individual. We've built a system that is so reactionary and doesn't think far enough ahead before these issues become an inpatient ER visit. But predictive analytics certainly can accelerate moving away from the reactionary-based care without having to wait for an adverse event."

Individualized care depends on a complete understanding of the patient, including the external forces impacting risk. CCAPP's Nielsen sees data as a way to realize true individualized care and correct some of the misconceptions propagated by the SUD and addiction treatment industry: "What we have today is not individualized care; we are still putting patients in boxes. With better data, we can determine if what is

prescribed is really what a patient needs. And we can truly assess the potential effectiveness of what we have available."

Montare's Naumann echoes Nielsen's sentiment: "With different types of use, abuse, misuse, and addiction, problematic behaviors around substances have different needs and different outcomes and different treatment plans. I think that the industry as a whole needs to take a really strong look at how we craft individual plans for clients rather than everybody getting the same thing."

For Nielsen and Naumann, the prescriptive capabilities that come with better data accessibility and technology culminate in lower risk and a greater likelihood of long-term success. Nearly every one of our experts emphasized the complexity and chronic nature of addiction. And, as with other complex diseases, tailoring treatment, outreach, and predictive insights rely on rich data from the patient and health-related social variables that drive Recovery Capital and care utilization.

UHS's Morse summarizes the potential this way:

"When you ask me what the most important innovation in treatment for this population is, it is looking at them as people—at their whole person needs. This includes everything from their healthcare needs, their medical, their behavioral, and their substance use needs, looking at their social determinants. And we need to do this in partnership with the payer organizations and local communities to create a system and a network to help patients enter care, remain in care, and receive the care that they need over extended periods
of time."

Virtual Care

The pandemic was the mother of necessity for virtual care adoption across behavioral health. For SUD and addiction treatment providers, COVID forced a tremendous leap forward in the use of technology to ensure access and improve care quality.

While in-person groups and individual sessions remain the gold standard, evidence points to the safety and effectiveness of virtual, synchronous SUD-focused care. And asynchronous modalities are demonstrating therapeutic opportunities to augment traditional treatments.

Regard Recovery and Journey Pure's McGennis specifically speaks to the pandemic's impact on telehealth adoption and its potential to lower care and access barriers:

"There are things that have come out of the COVID-era that are definitely driving innovation. On the outpatient side, telehealth is here to stay. The necessity for patients to see a clinician in-person or get to a place of treatment is certainly less burdensome. And so, if you were trying to get better, you were trying to fight your addiction, and yet you were told you had to be in an office three days a week for a couple of hours to do that—it's very difficult for people who have jobs, especially single parents who are balancing childcare, their job, their addiction, everything. "

"If we are going to treat the disease and treat it effectively, then we as an industry have to understand that telehealth delivers a great opportunity. It brings the patient closer to care."

Renewal Health Group's Rollins frames our current environment as a sort of tipping point: "The fact that we're comfortable with technology, it makes me excited about the idea of integrating that into the experiences of the brain for healing and transformation. Integrating technology into the treatment of some of these diseases, the underlying trauma, how the brain works, getting better sleep, et cetera. I am excited that those are coming together, and in a positive way, pushing people to overcome their fear and stigma of the use of technology in these spaces."

Beyond telehealth, the virtual world provides opportunities for connection to expanded communities that drive more individualized support for people in treatment and recovery. Peters talks about the emergence of grassroots recovery communities online during the height of stay-at-home orders: "Being a person in recovery, I was losing my community and my connections. It's not just virtualization. It's also recognizing that there are nuanced and different needs across communities, whether that be for BIPOC, LGBTQ+, or whatever your community. Policy and culture change move painfully slowly, and in the meantime, there are people who are in need of help now. Communities are working to leverage technology to fill some of those gaps."

Connecting a patient to the resources, communities, and care that lower barriers and the risk of relapse are game-changers in the fight to curb substance abuse.

For decades, SUD and behavioral health data existed in siloes. And payment incentives still are not aligned to outcomes. It's a disconnected system that contributes to inconsistent results.

But there is promise and momentum, driven in large part by providers and patients. There is a collective optimism that sees the light at the end of the tunnel for the addiction crisis. And at the heart of this movement is the patient and an understanding that the complexity of addiction requires the same kind of individualized, nuanced understanding that we see in other chronic conditions and complex diseases. The hope is that innovation across treatment, ongoing care, connection, and recovery is accelerated by the groundswell of data, insights, and technology, all of which point to better outcomes.

Our Innovators

Eric Bailly, LPC, LADC

Senior Director at Third Horizon Strategies

As a person in long term recovery, Eric has vested interest in working with the treatment of substance use disorders. Through a blend of clinical expertise and a comprehensive understanding of managed healthcare, Eric has been able to work effectively with multidisciplinary teams to consistently drive for excellence.

Brett McGennis

CEO Regard Recovery

Brett is an executive leader in the Behavioral Health space since 2017. Focused on providing the highest quality of care for those suffering from SUD antenatal Health Disease.

Tiffany Naumann, PsyD, LMFT

Chief Clinical Officer at Montare Behavioral Health

Dr. Tiffany Naumann, PsyD, LMFT has been a clinician, supervisor, and executive leader in the behavioral health space for close to 20 years, focusing on complex trauma, severe mental illness, and chemical dependency. She has dedicated the past 10 years to growing, developing, and enhancing clinical treatment programs across the spectrum of care; with an emphasis on clinical quality and integrity, compliance, and outcomes.

Pete Nielson

President & Chief Executive Officer for the California Consortium of Addiction Programs and Professionals (CCAPP)

Mr. Nielsen has worked in the substance use disorders field for 20 years. In addition to association management, he brings to the table experience as an interventionist, family recovery specialist, counselor, administrator, and educator, with positions including campus director, academic dean, and instructor.

Annie Peters, PhD

Director of Research and Education at NAATP/Executive Director of FoRSE

Dr. Annie Peters is a licensed clinical psychologist who has been working in the behavioral health field since 2006, with experience in psychotherapy, counselor education, and executive leadership. She currently leads the NAATP Foundation's Addiction Treatment Outcomes Program to examine and improve the quality of and access to services for Substance Use Disorders.

Marlon Rollins, PhD

President and COO of Renewal Health Group

Marlon Rollins, PhD, LPCC, LMHC, is the President and COO of Renewal Health Group. He has over 15 years of leadership experience in the behavioral health and addication treatment fields, having served as CEO and COO with Universal Health Services, American Addiction Centers, and Acadia Healthcare. He is a licensed mental health counselor, and a licensed professional clinical counselor, holding a master's degree in Counseling Psychology and a PhD in Educational Psychology.

Michael Walsh

Senior Interventionist at Crisis Case Management, Podcast Host, Special Projects Consultant and Director of Clinical Outreach at Landmark Recovery.

Michael Walsh is a skilled interventionist with 20-plus years of industry experience in a multitude of settings that include many of the country's premier treatment facilities. The former President & CEO of The National Association of Addiction Treatment Providers (NAATP) also served as a liaison to the American Society of Addiction Medicine. He has played a key role in shaping policy on the national level, and in developing strategies for innovation in the burgeoning Behavioral Health & Recovery industry.

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About Sunwave

Sunwave Health drives healthy results for behavioral health and SUD providers through a unified platform that eases documentation and answers clinical and operational questions, leading to better outcomes. Sunwave provides client and referral tracking, electronic medical records, billing, patient engagement tools, and an advanced analytic engine to deliver immediate visibility into performance and risk. As a result, providers can better manage increased demand, improve clinical and non-clinical resource utilization, increase patient retention, and optimize reimbursement. Sunwave Health–driving healthy results.

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