Innovation in Human Services

December 10, 2024

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The Big Picture

- None of what I'll discuss is as important as building state capacity and developing an experimentalist mindset in gov't
- Reasonable people can disagree about right size of gov't, but we should want highest quality of public employee for any level of spending
- State and local gov't is the *"laboratory of democracy"*
- Big lesson: we won't get better at things we don't get feedback on

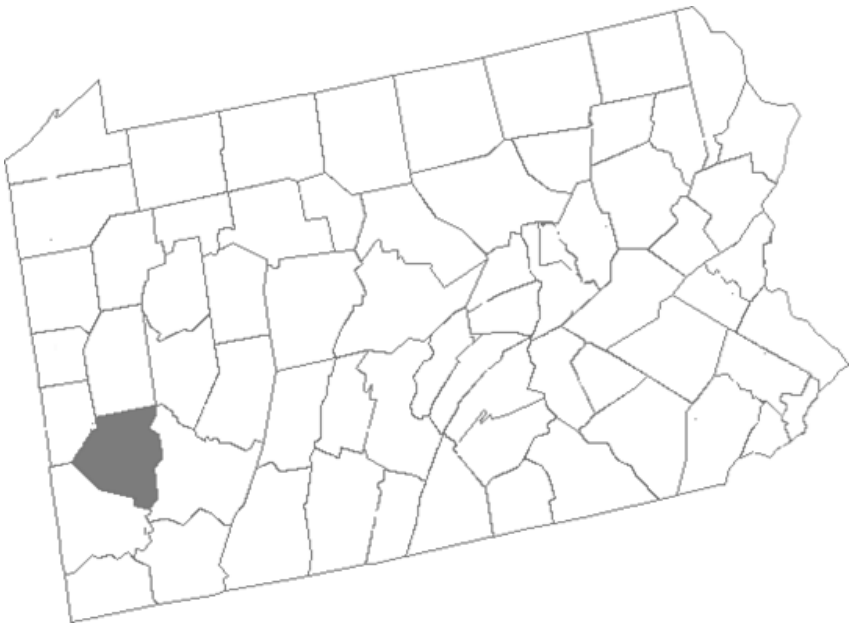
What we'll discuss

- **Pricing and capacity problems** in serving high-acuity youth
- **Innovation on Treatment Engagement:** Lessons from Involuntary Hospitalizations
- **Innovation on Treatment Efficacy:** The Case of GLP-1s

Section 1

Pricing and capacity problems in serving high-acuity youth

Allegheny County Overview



- Population: 1.25 Million
- Federal-State-Local Funding
- \$1.4 billion budget; 1,000+ employees
- Integrated department: child welfare, behavioral health, intellectual disabilities, homeless housing, family strengthening and community supports, aging

Many child welfare and human service problems feature common pricing and capacity challenges

- A bad combination:
  - Demand for services exceeds capacity
  - Provider reimbursements are similar for all clients
  - Clients differ in costs to serve and acuity
  - Providers have discretion on which clients to serve

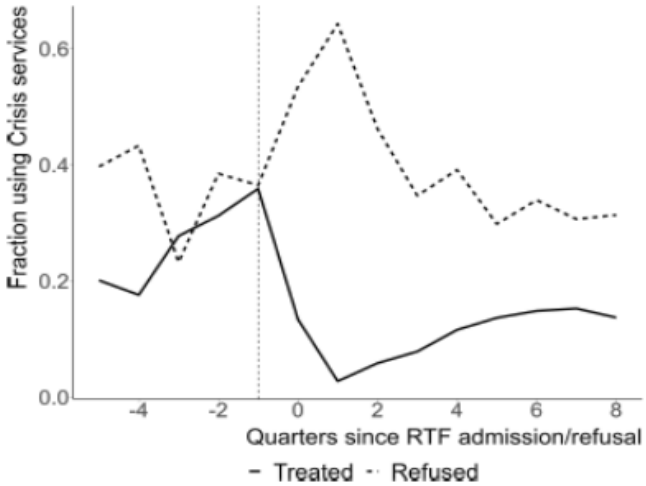
→ Higher needs, expensive to serve children are denied for services

→ Placements to recommended levels of care fail, children languish, system spends resources in crisis mode for a tiny subset of clients

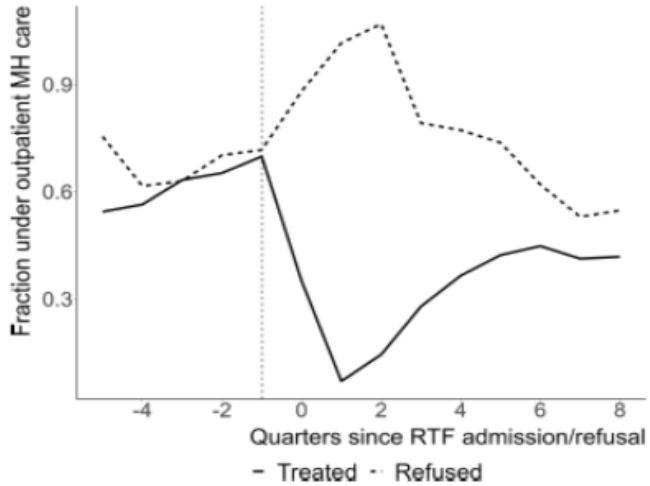
Youth recommended for residential treatment facilities have high needs

Outpatient mental health	0.95
Intensive behavioral health	0.12
Family-based mental health	0.73
Inpatient mental health	0.77
Partial hospitalization	0.51
Crisis	0.81
CYF Investigation	0.23
Juvenile probation	0.21

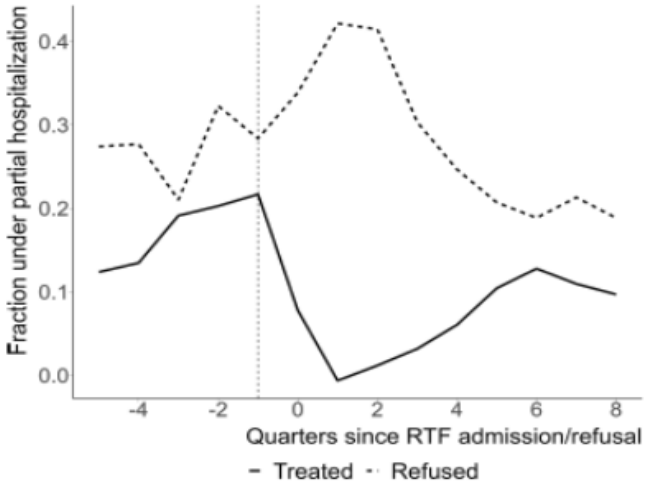
When matchmaking fails, youth access many other services instead



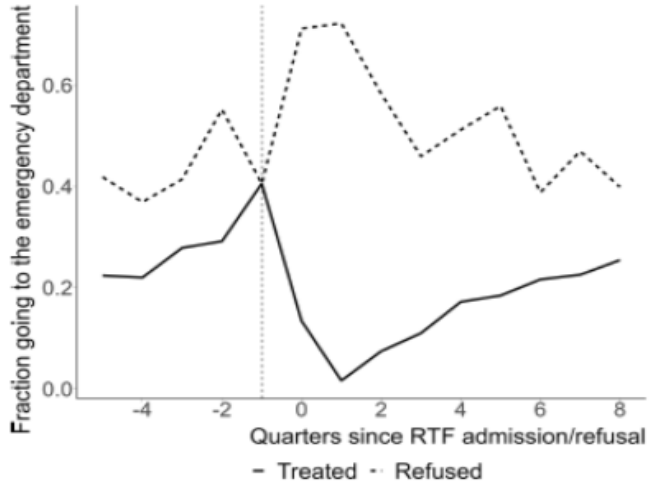
(a) MH Crisis



(b) Outpatient MH



(c) MH Partial Hospitalization



(d) ED Visits

How can we solve this problem?

- Potential reactions:
  - "No eject, no reject" clauses and similar mandates
  - More provider TA
  - Share burden with providers (service coordination, supports)
- **What if we took the signal that people weren't willing to serve at that price and increased rates instead?**

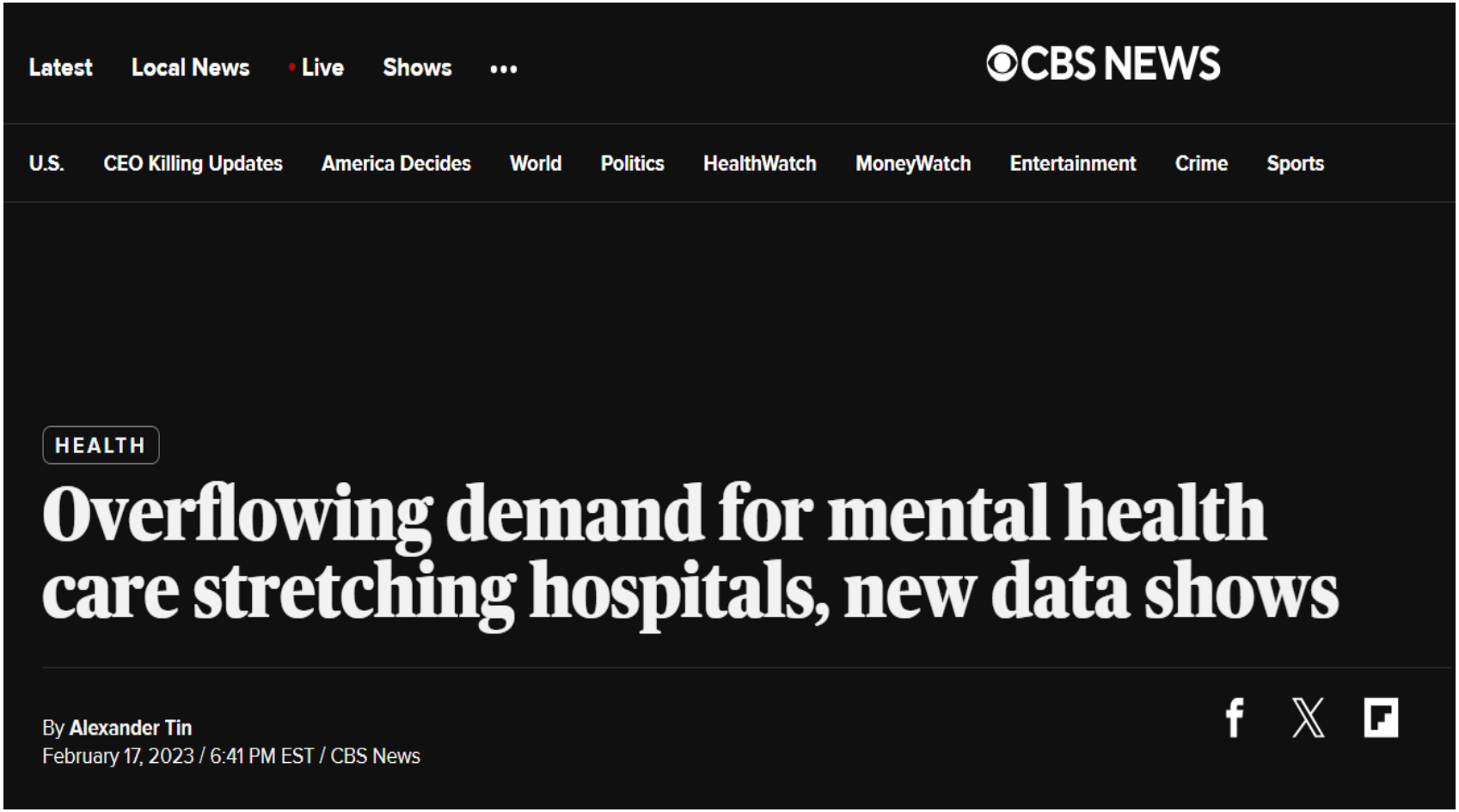
Solution: Dynamic pricing of services

- Solicit reimbursement rates from providers that would enable them to serve rejected high-acuity youth
  - Ideal to have many providers for competitive bidding
- Select lowest cost offer (allowing for client discretion)
- Early stage results look promising: flexibly setting rates to adjust to different situations allows youth to connect to services
- Interest in expanding this for similar situations (e.g., foster placements) where price discovery is hard and youth have very different levels of need

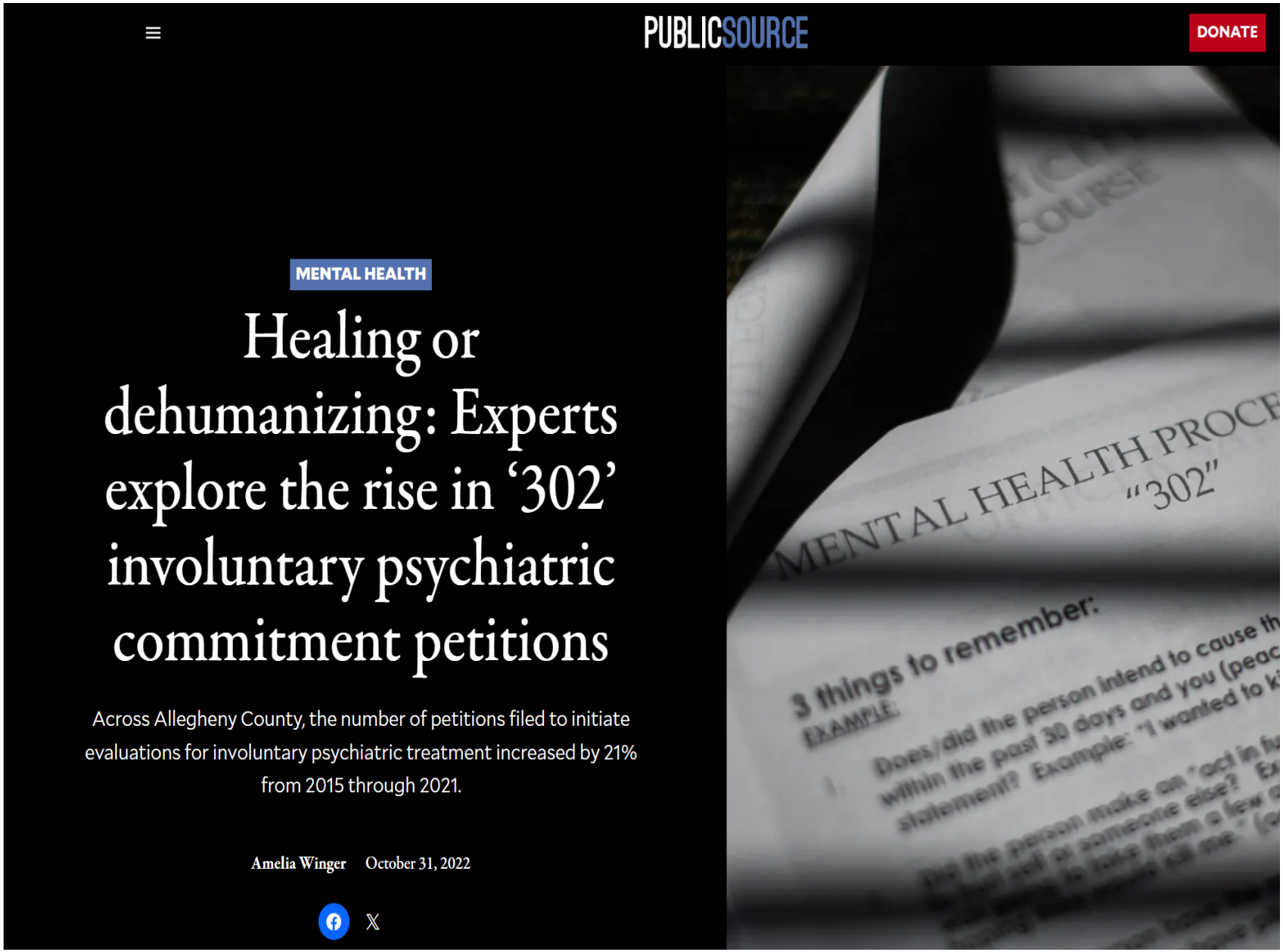
Section 2

Innovation on Treatment Engagement: Lessons from Involuntary Hospitalizations

Mental Illness on the Rise



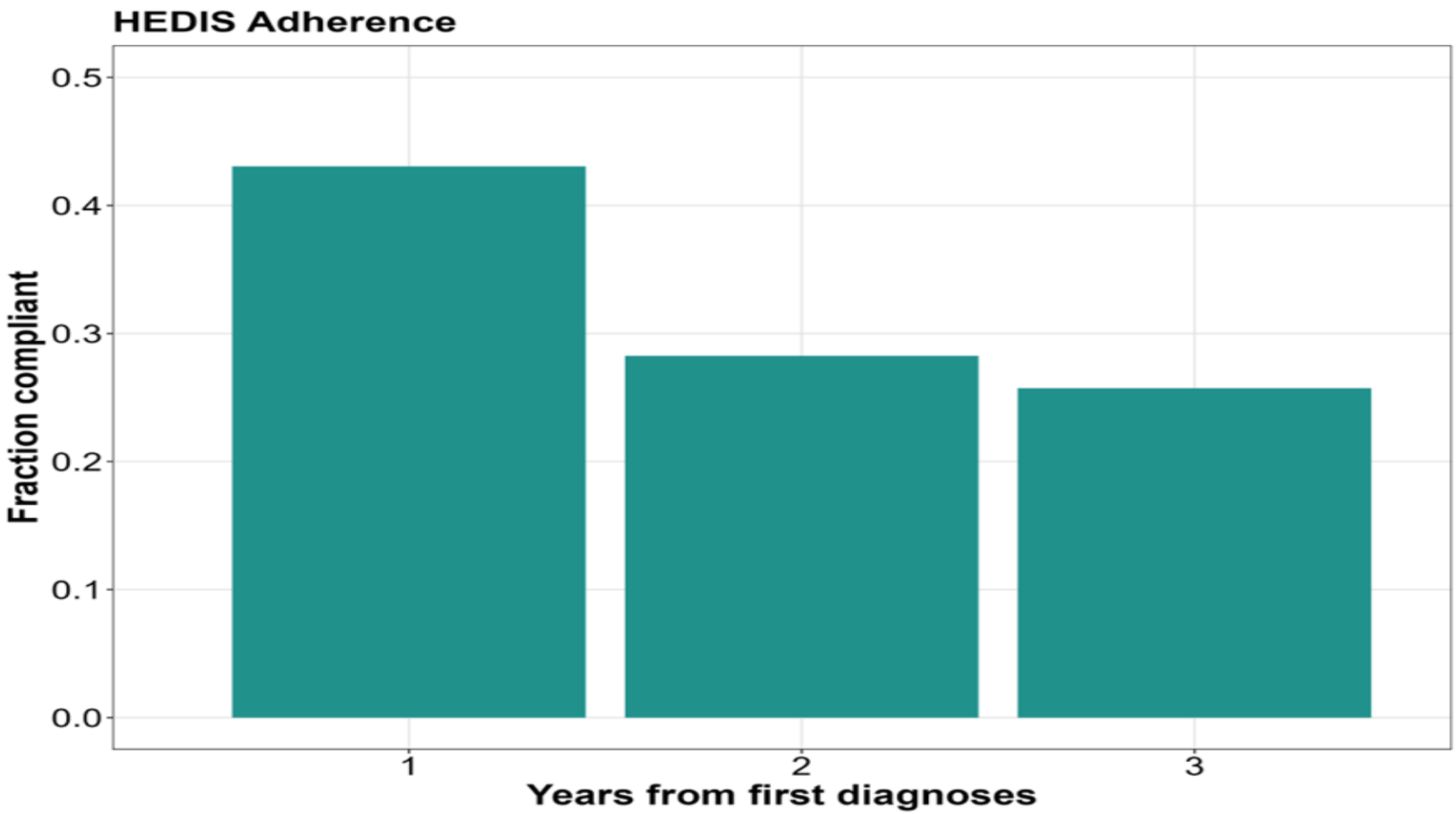
Involuntary Hospitalization on the Rise Too



Why care about involuntary hospitalization?

- Pain and suffering in this population are high
  - Death risk relative to general population:
    - Suicide - 33X
    - Overdose - 15X
    - Homicide - 5X
    - 1 year after evaluation, 8% have died (20% in 5 years)
  - Relevant: Every state has an involuntary hospitalization law
  - Prevalent: Occurs at rate of imprisonment at federal & state level
  - Costly: $<$2% of Medicaid enrollees, 25% of Medicaid BH costs

Most individuals with schizophrenia are not adherent to medication



How can we improve outcomes for this group?

- Adherence strategies are highly context dependent
- Consistent evidence on financial incentives

→ Can we pay people to take long-acting meds to mitigate risk after hospitalization?

  - 1st trial in US to test this (Jan. '25 launch)

- AOT - intervene with legal options mandating treatment before meeting "harm to self or others" threshold is met
  - High potential for use after hospitalization

Section 3

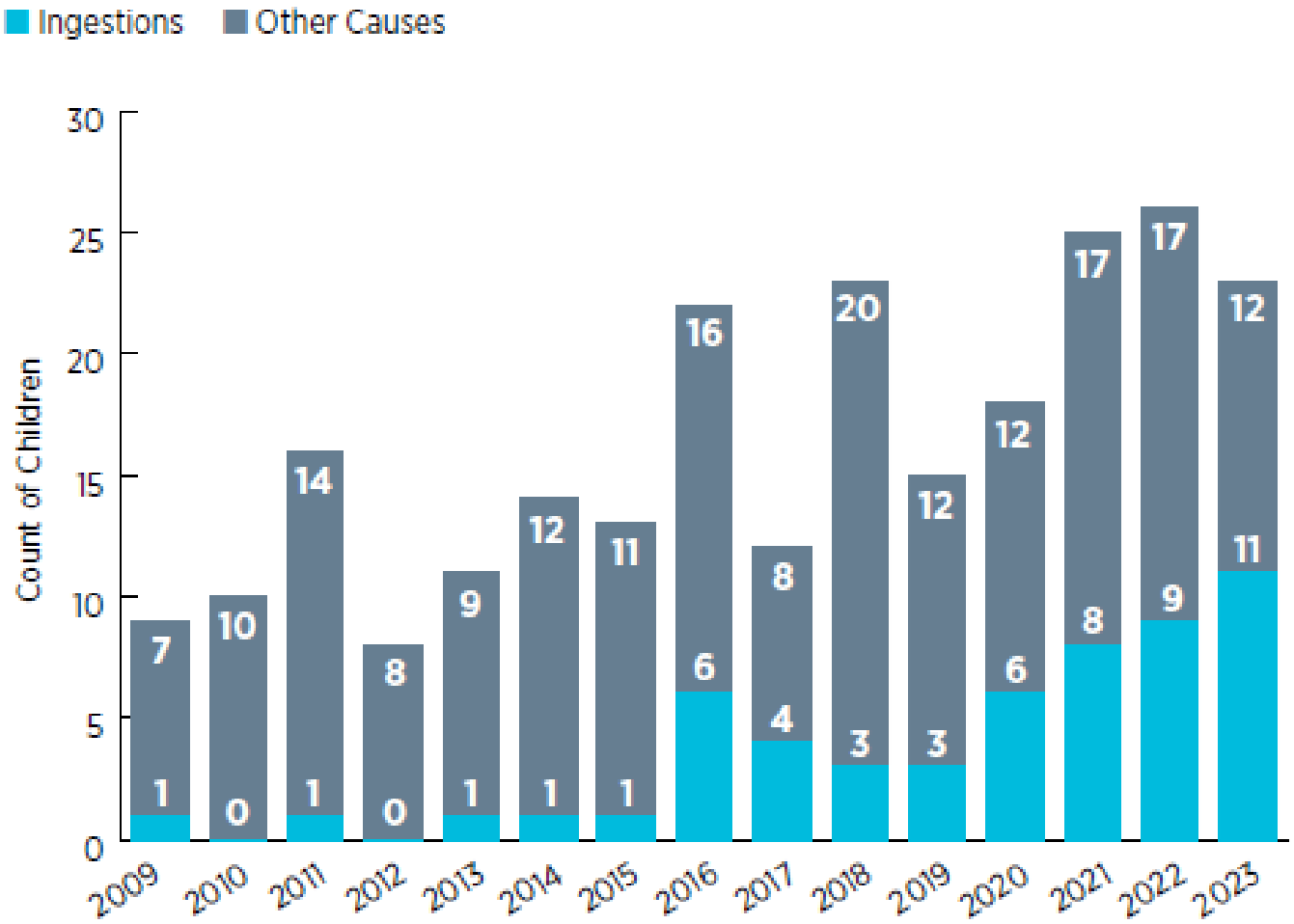
Innovation on Treatment Efficacy: The Case of GLP-1s

Opioid use and concerns are prevalent in Child Welfare

Table: Percent of Child Welfare-Involved Parents with Opioid Use Disorder or References

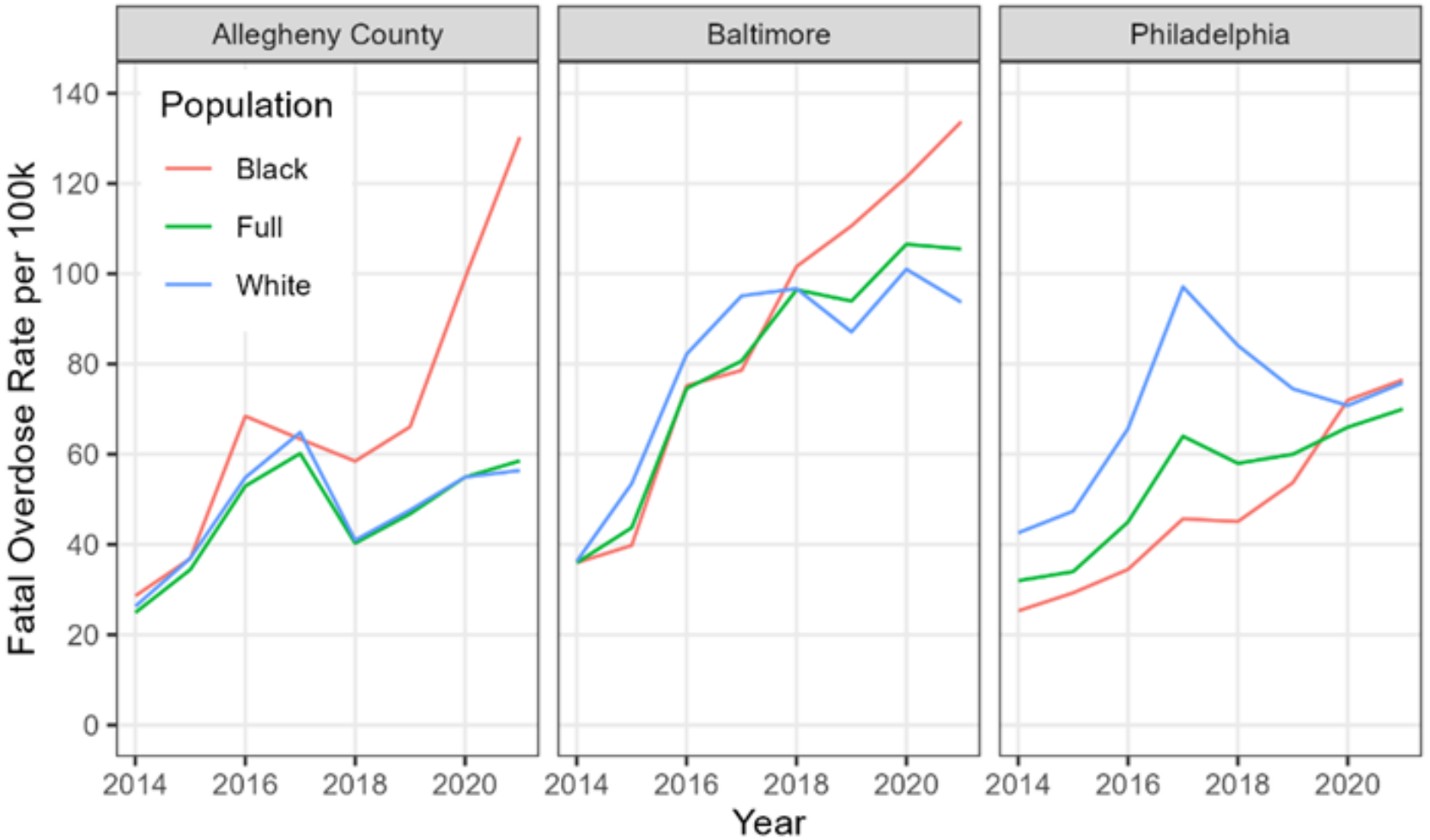
CYF Parent Condition	Case Opening	Dependency Decision	Home Removal
Has Opioid Use Disorder Diagnosis	21.0%	25.3%	22.3%
Used Medication for Opioid Use Disorder	17.4%	21.6%	18.2%
Case Notes Mention Opioids	66.2%	77.6%	76.9%

Child fatalities and near fatalities from drug ingestion have increased since the pandemic



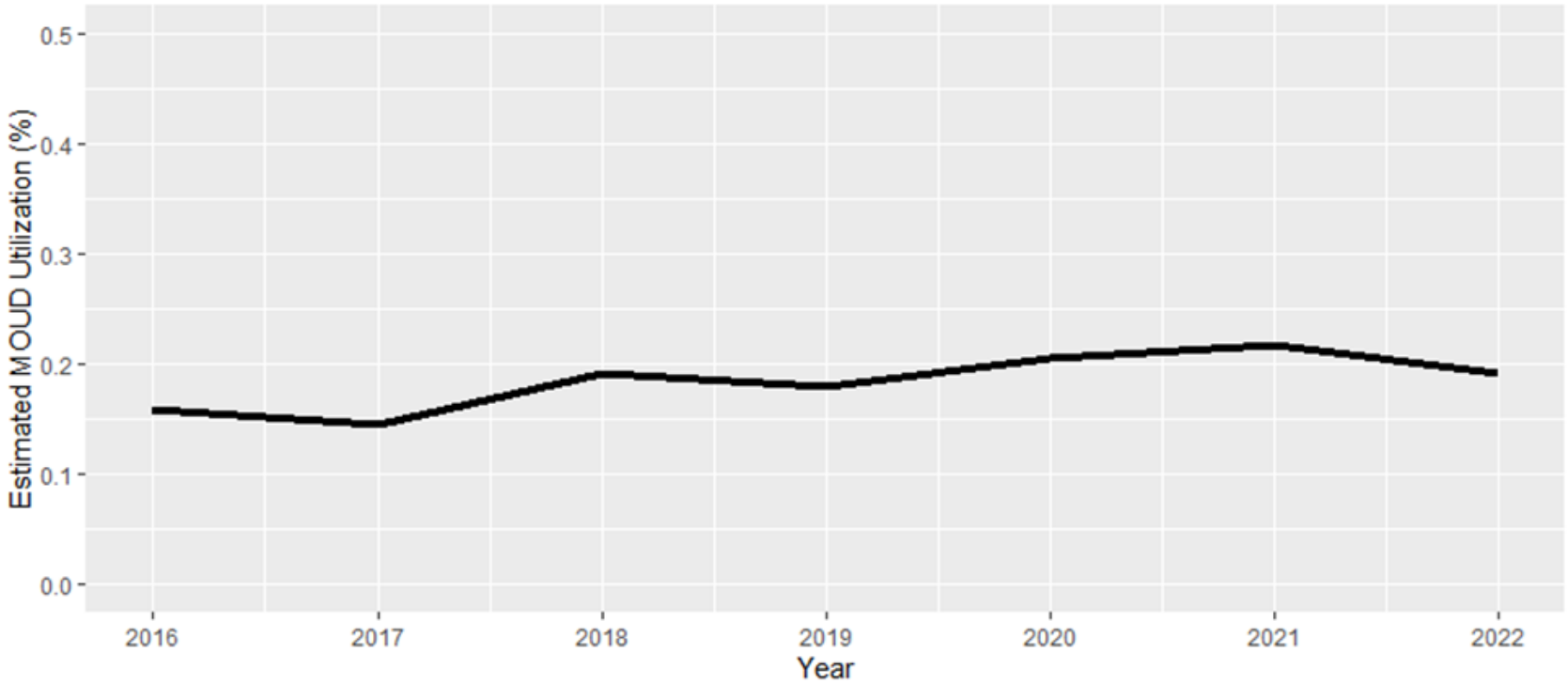
*Note: Other leading causes include abusive head trauma, blunt force or penetrating trauma, and gunshots.

Allegheny County faces similar trends on fatal overdoses to peer jurisdictions

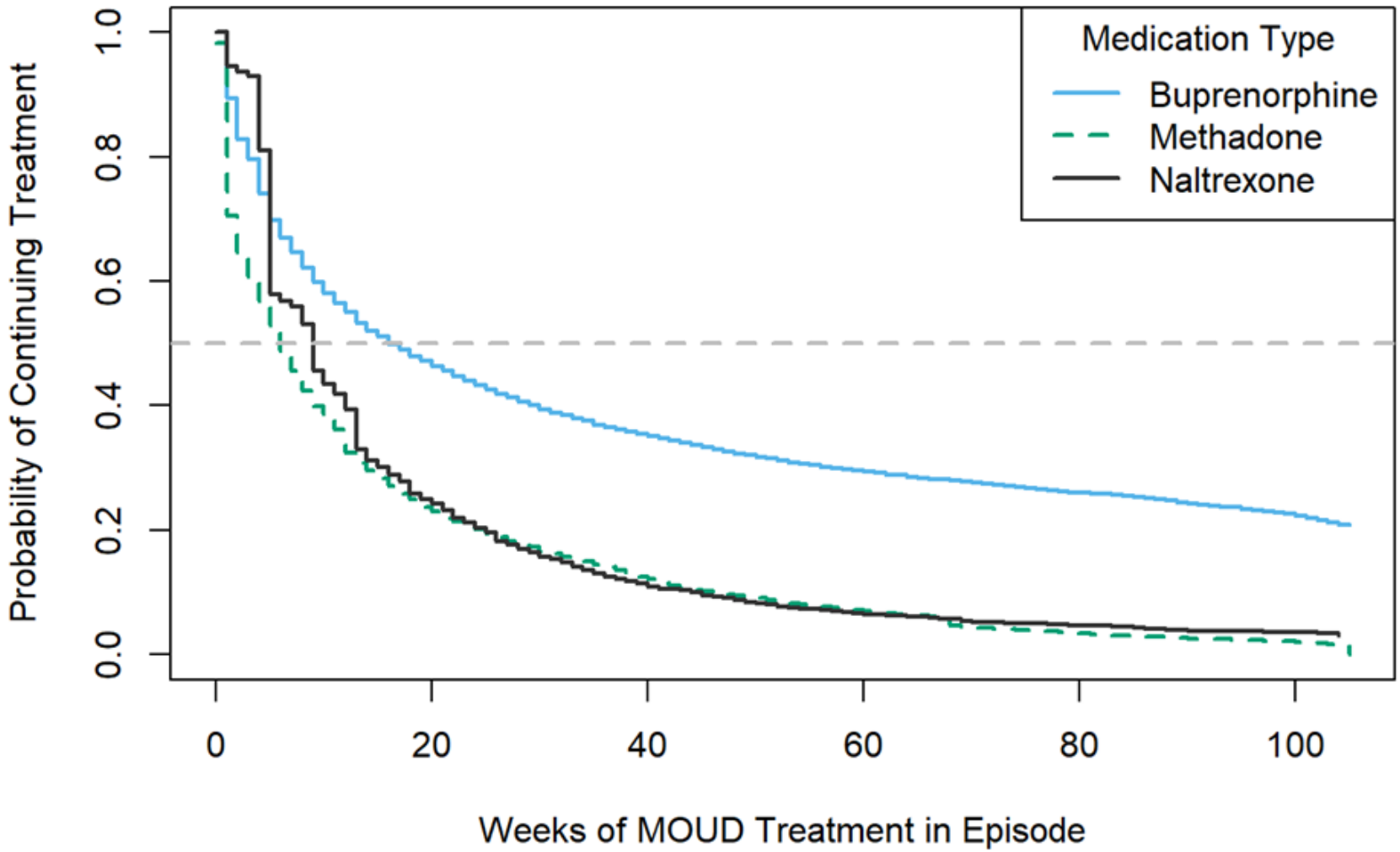


Despite investments expanding access to treatment, take-up of gold standard medication remains a challenge

Figure. Buprenorphine Use among Individuals with Opioid Use Disorder in Allegheny County



Discontinuation of medications for opioid use disorder is swift and common



Three Potential Paths Forward

- **Innovation on treatment efficacy**
- **Innovation on treatment engagement**
- **Addiction "burns out"**

Our best solutions to the opioid epidemic aren't good enough

- NIDA-funded Healing Communities Study - evidence-based, community-chosen interventions across 67 communities in 4 states
- Major initiative: $343.7 million budget
- **Results:** "During the comparison period...the population-averaged rates of opioid-related overdose deaths were similar in the intervention group and the control group"

Medical innovation for addiction has stagnated

Table: Novel Treatments Approved by FDA Since 2000 by Condition

Condition	**Number of Approvals**	**Medication, Year**
Opioid use disorder	1	Suboxone, 2002
Alcohol use disorder	1	Acamprosate, 2004
Stimulant use disorder	0	

GLP-1 drugs like Ozempic are the most significant recent medical advance in the field of addiction

- Recent small-scale randomized trials have shown strong reductions in craving and consumption of alcohol and opioids
- Retrospective study in *Addiction* found decreases in overdose and alcohol intoxication risk
- Patient anecdotes are overwhelming: "My AA program friends say it's 'my higher power at work.' That may be true, but I also believe that it's the drug. ...I am an average woman that has seen an improvement in all my cravings through the use of this drug!"
- Patient appeal
  - low side effects, high efficacy, unrestricted access, no abuse risk, no stigma

We have an opportunity to test and scale these medications for national impact

- Developing and executing a Phase 3 pivotal trial for GLP-1s and opioid/alcohol addiction is a key step to unlocking payer coverage
- Work in progress with VA to design and execute this
- Study population health in settings like homelessness, post-incarceration, and child welfare to measure how medication impact downstream system involvement

Recapping today

- **Addiction and serious mental illness are persistent challenges in human services**
- **Medication utilization** is a tractable path to better outcomes
- **Experimenting with new delivery models** is especially promising:
  - Financial incentives
  - Involuntary care
- **Investment in service access** is unlikely to be a major driver of better outcomes in well-resourced jurisdictions
- No new medications for addiction in 20 years **can and must change.**
- **Attracting the best talent possible** into government and allowing them to tackle hard problem should be a major priority