

# Evaluating Quality of Care for Employees With Opioid and Alcohol Use Disorders

A Q&A With Mohannad Kusti, MD



**MOHANNAD KUSTI, MD**

Medical Director

United States Steel Corporation  
Pittsburgh, Pennsylvania

*The opinions and conclusions expressed in this interview are those of the interviewee only and do not necessarily represent the official position of United States Steel Corporation (U.S. Steel). Mention of any company name, products or procedures does not constitute endorsement by the mentioned organizations. In addition, citations to any references including external web sites, books or articles do not constitute an organizational endorsement of the sponsoring organizations or their program or products. Furthermore, U.S. Steel Corporation is not responsible for the content of these websites.*

**AJMC®: What are the current challenges with substance or drug rehabilitation for employers? And what solutions or services have you put into place?**

**KUSTI:** One of the challenges that many encounter is finding high-quality treatment programs in certain locations. It is difficult to find high-quality providers that are covered in-network to meet the demand that we have. Another challenge, obviously, is managing the cost associated with treatment. The cost of treatment and health care costs in general is a considerable challenge, especially for self-insured companies who want to take care of its employees and family members by providing access to high quality health care while managing the costs. This goes for Substance Use Disorder treatment just as much as other disease and illnesses. Then there is the challenge that current treatment programs do not distinguish between jobs, it seems like almost everybody is treated the same way under the same protocol in a one-size fits all model. I am advocating for personalized medicine and treating every individual differently to provide the best care for that specific individual.

**AJMC®: What are the tenets that make up a good rehabilitation program?**

**KUSTI:** The main principle is how SUD providers approach this disease. Substance use disorder has been, for the past decades, treated as an acute event or an acute episode, when in fact, it should be treated as a chronic illness. When you go in-depth and talk to the SUD specialists and go into the pathology in the brain that is associated with addiction and substance use disorder, there are multiple indicators that it should be treated as a chronic condition. It should not be treated as an acute incident.

We need to use the chronic disease terminology: such as disease relapse and remission. I look at substance use disorder as any other chronic illness such as cancer, epilepsy, diabetes, coronary artery disease and it must be treated as such. Having somebody go through 21-day or 28-day residential or inpatient treatment followed by 8 to 10 weeks of some type of outpatient program—and then telling them, “OK, just go do AA or NA and you should be good to go”—is not the right approach for this disease and will not be sufficient to eliminate or try to control this pathology in the brain. Providers have been trying that and so far, results are not great, as you can see in the news with all these SUD-related deaths. There has to be behavioral modifications associated with the treatment and as science has shown, behavioral changes takes a long time. There must be constant points of contact and communication and we need to have

accountability on both sides—the patient and the provider, and that is the one of the main parts of the program I am proposing. This program is long-term and will last for up to 3 years, with option of annual checkups after that for the life of the individual, because we all know that the disease has the potential for relapse.

**AJMC®: Who is involved in supporting employees in organizations who are being treated for opioid use disorder? What is the role of the pharmacy benefits manager?**

**KUSTI:** In any large organization, the benefits team has the duty to do plan design while working with the health plan or third party administrator. You have to work with the PBM team to make sure that the medications are covered in the outpatient setting—especially all medication-assisted treatment drugs (MAT) used to treat SUD. A key component of the program I am advocating—and I did not mention this earlier, is to make sure that all MATs are provided and discussed with the patient. In particular, an opioid-free MAT option for individuals who work in a safety-sensitive position should be discussed, which from my experience, is not always the case. A lot of time this treatment option is not even brought up or discussed with the patient. Furthermore and unfortunately, sometimes the MAT choices that are being offered are directly related to profit generated for the treating organization and not if they are indicated for that patient or not. I have seen MAT choices based on whatever the practice, or provider is accustomed to using.

People are different—again, we talk about customized medicine—some individuals may not qualify for a certain opioid-free MAT or may have a contraindication for a certain treatment. The SUD specialist may offer the opioid MAT treatment option or the partial opioid option. But at least we are making sure that the discussion is occurring, and that all options are presented to the patient, which, currently, is not always the case.

**AJMC®: It sounds like it's the provider's responsibility to explain the MAT therapy and the differences between them. But do you think the people who are designing benefit plans understand the difference between the MAT options?**

**KUSTI:** Large organizations have experienced teams that have ongoing internal discussions on the topic and I am grateful to have been working with such a team here at my company. Many employers, however, do not have medical expertise in-house, so they either rely on their health plan or they rely on their consultants. Depending on how knowledgeable those consultants are, they may or may not be as informed about these different MAT options and understand the differences between them. It is also difficult

and challenging to solely depend on the health plan to make those decisions for you, particularly for employers without medical expertise and employers who are fully insured. They must depend on the health plan 100% of the time to make plan design changes. These employers manage their plans and benefits differently than those who are self-insured. Depending on the health plans, they may or may not have the same knowledge and expertise about SUD and treatment recommendations, which is why it is a good practice to have reliable medical expertise, whether it is in-house or provided by a reliable consultant. In my opinion, particularly when you are dealing with large populations, you need to have that medical expertise to assist and guide self-insured employers and fully insured employers, so they know what to ask about SUD and they know what to expect.

“ **An opioid-free MAT option for individuals who work in a safety-sensitive position should be discussed.** ”

**AJMC®: Are there any ways that you can think of that you could improve access for your employee-assistance programs (EAPs)? MATs?**

**KUSTI:** The employee-assistance program is a separate program. Most employers actually work very hard to promote their EAP programs. EAP provides a valid recourse for employees and members covered under the plan. It is a confidential venue where people who have concerns, or any life-issues can utilize and get direction. EAP can refer people to get treatment and depending on the level of knowledge of the EAP specialist, they could even discuss MATs options, but will not recommend one treatment versus another because that will usually be left to the clinicians evaluating the patient. Members have access to EAP 24/7 all days of the year.

As for the MAT access and options, this program that I am working on has it embedded as a requirement for the provider. They are obligated to have the discussion about MATs as soon as the initial day of treatment, whether they

are admitted to an in-patient treatment program or intensive outpatient program, as opposed to waiting until they are about to be discharged and then having that conversation. I want to make sure that this specific conversation is ongoing and starts early on and make sure that all options are presented, not limit it to options that are financially beneficial for the provider or the preferred treatment method for the provider. After all options are presented, then a discussion should occur to determine which MAT choice is best for that individual based on their own case, and it must be a case-by-case basis. The goal is to provide the individuals who are struggling with this disease all the tools available to them when they are being discharged from acute care. The pathway to recovery is a difficult one and challenging for most individuals, and it is up to the provider to make sure that all resources and tools are being provided and recovering person is equipped with everything they need to stay in remission and prevent relapsing.

**AJMC®: What are the other organizational, personal and family impacts of your desired SUD treatment program?**

**KUSTI:** The program I am describing also targets a faster return to work so that we do not have people staying off work on disability for long periods of time. It is ideal to get them back to a functional life and a functional routine as productive part of the community safely but as soon as possible. That is part of the treatment.

Another point that I talk about is the burden on the caregivers. People who are typically taking care of individuals with substance use disorder have a lot of burden on themselves, also. It may affect their job, it may affect their entire life. This program involves the caregivers and the family members and offers them a little bit of respite, as they feel a little bit safer knowing that their loved one is being taken

care of. It not only touches the patients, it also touches the employer, the payer, the caregivers and the family members. It's a holistic program with a holistic approach.

**AJMC®: If new treatment options become available, what is the process to change treatment?**

**KUSTI:** Employers who are self-insured, usually depend on their PBMs and/or their own research internally. We do both. We talk to our PBM and our pharmacy benefits consultants and do our own research, and we are engaged on what new MAT medications have been approved by the FDA or what is coming through the approval pipelines. We try to cover new medications that have good outcomes, high efficacy, and provide them under our covered formulary. We almost always cover them and add them to our formulary once we have evidence that they are effective and they are a good option for our covered lives.

**AJMC®: It sounds like you're very active in evaluating your health programs and policies to make sure that they're working for your employees. How often do you revisit your health policies to see how effective they are?**

**KUSTI:** Like many large self-insured employers, we have regular touch-base meetings with our health plan and PBM, but recently we are doing it a lot more. We are constantly touching on one topic or another with the different benefit programs that we have. This is due to how the health care system is designed, how complex it is, and how expensive it is. Self-insured employers must stay on top of it. But again, that's works better when the organization has what we do. We have the in-house expertise and utilize pharmacy benefits consultants, and all of us work together. However, we realize that might not be the case for many other employers. ♦