

Rewarding Results

Improving the Quality of Treatment for People with Alcohol and Drug Problems

Recommendations from a National Policy Panel

2003

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Join Together is a project of the Boston University School of Public Health.

About this Report

Join Together, a project of the Boston University School of Public Health, formed a national policy panel in the summer of 2002 to address the quality of treatment for substance use disorders. The panel members developed the principles and recommendations contained in this report, drawing upon commissioned background papers, and written and oral testimony.

Members of the Treatment Quality Panel

- **Jerome H. Jaffe, M.D. (Chair)** – Clinical Professor of Psychiatry, University of Maryland School of Medicine; Former Special Consultant to the President for Narcotics and Dangerous Drugs and first Director of the Special Action Office for Drug Abuse Prevention
- **Sheila Blume, M.D.** – Clinical Professor of Psychiatry, State University of New York at Stony Brook
- **Lee P. Brown, Ph.D.** – Mayor of Houston, Texas
- **Ronald P. Corbett, Ed.D.** – Executive Director, Massachusetts Supreme Judicial Court
- **Gloria DeRobles** – Associate Executive Director, East Bay Community Recovery Project
- **Saul Feldman, Ph.D.** – Chairman and CEO, United Behavioral Health
- **Martin Iguchi, Ph.D.** – Director, Drug Policy Research Center, Rand Corporation
- **Michael Massing** – School of Journalism, Columbia University
- **Dennis McCarty, Ph.D.** – Professor, Department of Public Health and Preventative Medicine, Oregon Health Sciences University
- **Tara Wooldridge, LCSW** – Manager, Employee Assistance and Work/Life, Delta Air Lines

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Join Together and the panel members wish to thank the following individuals who contributed papers on the treatment system for the panel's consideration:

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Executive Summary

In December 2002, Join Together, a project of Boston University School of Public Health, convened a national, non-partisan panel of experts and asked them to develop specific recommendations to improve the treatment of substance use disorders.

Jerome Jaffe, M.D., a clinical professor of psychiatry and the nation's first "drug czar," chaired the panel, which included physicians and researchers, treatment providers, and representatives from sectors that purchase treatment services, including employee assistance, managed care, and criminal justice. The panel commissioned original research papers on the state of the treatment system, held a public hearing in Houston, Texas, and received written or oral testimony and suggestions from more than 60 individuals and institutions.

*Purchasers of
treatment services
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Many panel members had participated in past national efforts to improve treatment quality. They approached this assignment in the context of other efforts currently underway to address quality issues throughout the health care system. The panel reviewed many existing approaches to improving quality, including improvements in training and credentialing, state licensing requirements for treatment practitioners, and service integration. The panel's report concludes that while these efforts were laudable, none of the current approaches was likely to lead to sustained quality improvement and better treatment outcomes without stronger incentives for change.

The panel's primary recommendation is that **purchasers of treatment services should reward results** — an idea that is very consistent with other leading edge efforts to improve the quality of health care for other diseases. The report outlines the reasoning behind this recommendation and the changes in measurement and accountability that will need to be established to implement a results-based reimbursement system.

The panel makes specific recommendations to payers and providers about the steps they should take to shift to a system that recognizes and rewards the providers who consistently deliver better treatment outcomes. These include:

- The federal government, the single largest purchaser of treatment services, should drive the expansion of systems for measuring performance and outcomes of individual treatment programs.
- Other purchasers — such as state and local governments, public welfare agencies, the criminal justice system, and employers — should not wait for the federal government, but should start to use the tools they already have to manage for results. They should examine existing performance data, and use external care management to increase the availability of such data. They should meet with providers to establish appropriate expectations for results, and develop pay-for-performance contracts with incentives to meet the desired results.
- Foundations and agencies that fund research should support the development of improved case-mix adjustment models and demonstrations of purchaser-provider relationships that manage for results.
- Community leaders should advocate for the development of comprehensive results-oriented treatment systems by holding institutions accountable for improving treatment quality and assuring collection of local data to feed the results management systems.

The panel members recognize in the report that treatment resources are inadequate, and that treating people with substance use disorders with such inadequate support is often challenging, frustrating, and unfair. The report describes the prospect of short term dislocations of some treatment providers and patients as the system shifts to measure and reward results. Nevertheless, the panel believes and argues strongly that rewarding results will provide the basis for improvement, which will lead to the evolution of a more stable treatment system that is capable of responding to more traditional quality improvement strategies.

Members of the Treatment Quality Panel

- **Jerome H. Jaffe, M.D. (Chair)** – Clinical Professor of Psychiatry, University of Maryland School of Medicine; Former Special Consultant to the President for Narcotics and Dangerous Drugs and first Director of the Special Action Office for Drug Abuse Prevention
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Letter from the Director of Join Together

For the past decade, Join Together has convened leaders from throughout the country to address major policy challenges and opportunities associated with the prevention and treatment of substance use disorders. Our first panel, chaired by Thomas Brennan, former governor of Maine, focused on underage drinking. The panel members recommended that no person under 21 should be allowed to drive with any measurable alcohol in his or her blood. That is now the law in every state.

The panel on treatment quality, whose report you are about to read, was asked to address a very difficult issue. Treatment for substance use disorders is woefully inadequate and underfunded. Advocates press for additional resources, and try hard to protect existing providers. They do so, knowing that there are quality problems throughout the treatment system, just as there are in other areas of health care that have significantly more resources. We have all been slow and reluctant to focus on quality issues, in fear of making the situation even worse. However, when patients get poor results, in part because they got poor care, arguments for expanded resources are undermined, no matter how unfair that may be.

The panel was chaired by Jerome Jaffe, M.D., one of the founders of the modern treatment system. Its members included some of the most experienced treatment experts, providers, and payers in the country. We could not have assembled a more knowledgeable or committed group. They were passionate in their desire to make recommendations that would help many more people get well, and frustrated by their experiences with past quality improvement efforts.

As a result, they made a bold recommendation that has major consequences for the entire treatment system — that **purchasers of treatment services should reward results**. This strategy may cause a significant realignment of specialized treatment providers; some will prosper, and others will disappear. The panel members grappled with the implications of what they were suggesting, but decided that the present course was worse for both patients and providers than the potential good that could come from rewarding results. We all hope this report will spark a substantial debate about the best ways to improve drug and alcohol treatment. If a system of financial rewards and punishments will not effect improvement, what will?

Ultimately, change in the treatment system will occur at the community level. We hope the recommendations of this panel will help community leaders develop and implement strategies for quality improvement that meet local needs and opportunities.

I thank the members of the panel for undertaking this challenging work, and to the Join Together staff members who worked hard to organize and support their effort.

Sincerely,

David L. Rosenbloom, Ph.D.
Director, Join Together

Letter from the Chair

Join Together convened this panel to develop strategies for improving the quality of treatment for substance use disorders. The panel was to approach the issue of quality broadly, in the context of efforts to reduce errors and increase the quality of services throughout the entire health care system. We were to consider both publicly and privately funded treatment and to address “wrap-around” services, including mental health care, job training and housing placement.

When we first convened as a panel in December 2002, we found ourselves united by experience indicating that the quality of treatment for substance use disorders is a very serious issue in many communities, often as serious as or more serious than treatment access. Quality is an especially important concern in areas where the criminal justice system or the welfare system is coercing persons to participate in treatment. Nothing could be more futile than to make treatment participation a condition of liberty or of economic support but offer only inadequate and unhelpfully aversive treatment.

We also found ourselves united by a commitment to develop recommendations that reflected the truth of our experience and the available evidence. We found that our concerns went beyond traditional quality issues like training and credentialing, service integration, and transfer of new treatment methods. We found ourselves focused on creating incentives for quality improvement.

We met again in February 2003, and heard testimony from a broad group of experts and practitioners. Their input solidified our collective view that to achieve continuous quality improvement, buyers and funders of treatment should reward results. We believe this theme is very consistent with emerging ideas about how to improve the quality of health care in general.¹

We acknowledge that in emphasizing results, buyers may ask for more than some providers can provide. A sustained emphasis on results may cause some treatment system restructuring. While we believe that restructuring may well be necessary, we share the belief that adequate resources are also essential. Treating persons with substance use disorders is always emotionally challenging, and often profoundly frustrating and alienating. Those on the front line deserve our unequivocal support and our profound gratitude for their service. In many areas, they need significantly expanded resources.

On behalf of the panel,

Jerome H. Jaffe, M.D.
Panel Chair

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The Panel's Perspective: Reward Results

We endorse previous efforts to improve treatment quality, but believe that they lack necessary force.

As individuals, we have participated in all of the major treatment quality improvement initiatives undertaken nationally over the past few decades. We believe that two major federal consensus documents express many ideas that can help improve quality.

- The National Institute on Drug Abuse's (NIDA) *Principles of Drug Addiction Treatment* (1999) highlight the importance of addressing multiple needs of patients, including social, physical,² and mental health needs, and the importance of continuing care beyond initial detoxification through treatment and self-help support programs (see appendix I).
- *Changing the Conversation*, the Center for Substance Abuse Treatment's (CSAT) National Treatment Plan Initiative (2001), speaks to the need to invest in treatment to improve results and advocates work force development, best practice dissemination, evidence-based standards for quality of care, and strengthening of training and credentialing of treatment professionals (see appendix II).

However, recent national treatment quality improvement efforts share a fundamental strategic weakness: They are largely exhortations. To quote one federal official who testified on the need to increase accountability, "standards and guidelines, if they are promulgated by the federal government, will probably never see the light of day."³

We believe that buyers and funders of treatment should reward results.

Professionals and organizations respond to incentives. Incentives for good treatment results will drive other elements needed to improve quality, such as training and credentialing, expanded use of evidence-based best practices, and better information systems.

While our purpose is not to define what results should be rewarded, we do have a pragmatic view that we believe patients, employers, and legislators generally share:

- Reduction or cessation of substance use, reduction of health care utilization, getting or keeping a job, abandoning crime, and stabilizing a family are all positive developments during and following treatment for substance use disorders.
- Programs that succeed in bringing these developments about — whatever their clinical philosophy — are better than programs (with a comparable clientele) that do not.
- Substance use disorders are often chronic and relapsing, and treatment is often a lengthy process, so improvements that take place during treatment are of value, whether or not they endure.
- Good treatment for substance use disorders is sometimes perceived by patients in early recovery as unpleasant or overly demanding. However, patients can and should give feedback on waiting times, staff attitudes, safety, the physical condition of facility, and other important organizational issues.

The Washington Circle Group, a leadership group of treatment researchers and professionals, has developed one well-considered approach to measuring results. Direct results measurement is often difficult, because patients are not always candid and may be hard to reach for follow-up. Therefore, the group recommends indirect measures – measures that are not outcomes in themselves, but have been shown to correlate with outcomes (see table 1). The National Committee for Quality Assurance recently added two of these measures to the Health Plan Employer Data and Information Set that it advocates for use when evaluating managed health plans. These well-designed measures rely on data that providers should naturally capture as part of their records.

Table 1: General Population Performance Measures from the Washington Circle Group

(Defined as measures for a general population managed care plan)

- Percentage of adult patients with primary care visits who are advised or given information about alcohol and other drugs (AOD) disorders
- Number of cases per 1,000 members who were diagnosed with AOD abuse or dependence or who received AOD-related plan services on an annual basis
- Percentage of individuals with an index diagnosis of AOD abuse or dependence who receive any additional AOD services within 14 days
- Percentage of patients with an index detoxification who initiated AOD plan services within 14 days following detoxification
- Percentage of clients diagnosed with AOD disorders that receive three plan-provided AOD services within 30 days of the initiation of care
- Percentage of survey respondents who report using AOD services and who also report that their family member/significant other received preventive interventions
- Percentage of clients who report specific services provided and/or monitored by the plan to promote and sustain positive treatment outcomes post-discharge

From McCorry F, Garnick D, Bartlett J, Cotter F, Chalk M. "Developing Performance Measures for Alcohol and Other Drug Services in Managed Care Plans." *Journal on Quality Improvement*, 26(11):633-643, 2000.

Incentives for chosen results can range from publicly posting results (an extremely powerful motivator); to administrative sanctions, such as increasing or decreasing level of supervision; to a variety of financial incentives.⁴ Performance-based contracting is one approach; payers pay for services in the traditional way, but grant higher compensation for good outcomes or channel more patients to high-performing providers (perhaps refusing to renew contracts for low performing providers). Other approaches include reimbursement of effective quality improvement investments and outcome-based contracting, in which providers do not bill for specific services, but contract to achieve defined outcomes.

Program evaluators with a broad base of qualitative information to supplement direct and indirect measures are essential to a system designed to reward treatment results. Raw measurements often fail to reflect complex realities. A treatment facility that has a low rate of program completion may be a poor facility that patients are eager to escape. Or, it may be an excellent facility that accepts many severely addicted persons who are not committed to treatment. These realities require a sophisticated synthesis of field visit results, raw data, case mix adjustment⁵, and a range of qualitative considerations. We believe that experienced program evaluators can prevent the “cherry-picking” of low risk clients that a mechanical reliance on results measures can encourage.⁶

An emphasis on results will lead to a more stable treatment system, a system more capable of quality improvement.

While many programs are well run and provide high quality care, too many are fiscally weak and unstable. Only in a more stable treatment system can we hope to use training to achieve significant increments in quality. Rewarding those programs with good results will mean taking patients and funds from programs with consistently poor results. The weaker programs are likely to close or consolidate with other programs.

Weak infrastructure dramatically limits the effectiveness of many basic quality improvement strategies.

The survey of treatment facilities by Thomas McLellan, Deni Carise, and Herbert Kleber (see table 2), quantifies a reality we all suspected but were still unhappy to see. Many facilities have high turnover of both counselors and administrators. Excessive caseloads, relatively modest compensation, inadequate training, unclear treatment objectives, and the lack of data and criteria to measure and reward successful

results all undermine the motivation of treatment professionals. Facility administrators are often counselors with little formal management training. Treatment facilities are frequently small stand-alone entities that exist precariously, under severe financial pressure.

It is self-evident that the weak infrastructure dramatically limits the effectiveness of many basic quality improvement strategies. Because most treatment “technology” consists of concepts and procedures resident in the minds of treatment providers, staff turnover reduces the value of training and best practice dissemination. Weak and unstable management prevents the sustained implementation of practice standards. Fragmentation further hampers supervision. Financial constraints and facility instability especially curb the implementation of management information systems and treatment improvements based on information system findings.

We recognize the risk that incentives, if implemented suddenly and inflexibly, could decrease treatment availability as treatment programs close. However, if incentives are phased in and if smaller, unstable providers are encouraged to combine with larger entities, availability can be preserved. New partnerships should evolve among providers that help them preserve their viability without total merger – for example, arrangements that allow them to share specialized personnel and administrative or technology costs.

Table 2: Instability in the Treatment Infrastructure – Results from a Survey of 125 Facilities

Instability of Facilities

- Of 125 programs contacted from a list compiled 18-21 months earlier, a total of 52 (42%) had either closed, changed mission, or were under new ownership.
- This list was a nationally representative sample from the National Survey of Substance Abuse Treatment Services in 2000. N-SSATS is an exhaustive survey of all specialty sector treatment programs, including government owned, private not-for-profit, and private-for-profit programs. Excluded from the sample were very small programs, adolescent-only programs, prison programs and private office practices. In the sample, 76% were outpatient, abstinence oriented programs, 13% were inpatient/residential, and 11% were methadone maintenance.

High Turnover of Program Directors

- 51% of the program directors had been on the job for less than one year.
- 17% of the program directors contacted had no college degree. 58% had bachelor's degrees, and 20% had master's degrees (MA or MSW). One program was under the direction of a physician.
- 72% of the directors were working full-time in that capacity; 28% were funded for part-time positions only.
- Most had never had formal instruction in program direction.
- Conversations with program directors generally and with the most recently appointed directors in particular, were marked by feelings of being overwhelmed by the responsibilities.

Limited Training of Treatment Staff

- "Counselor" is the primary job title, but training is variable and many have little post-graduate training in specific therapeutic techniques and interventions.
- Less than half of the programs had a full or part-time physician on staff to address the needs of persons with co-morbid infectious diseases or mental illnesses.
- Professional staff, other than counselors, were very rare and, if they were present at all, were typically there in an administrative role.

Minimal Clinical Information Technology

- There was no standard set of clinical information among the sample programs.
- Even when computers were available for clinical staff, there was little availability of clinical management software.

From McLellan AT, Carise D, Kleber H. "Can the National Addiction Treatment Infrastructure Support the Public's Demand for Quality Care?" *Journal of Substance Abuse Treatment*, 25(2): 117-121, 2003.

The findings of this survey are broadly consistent with prior survey results, including:

- Gallon S, Gabriel R, Knudsen JRW. "The Toughest Job You'll Ever Love: A Pacific Northwest Treatment Workforce Survey." *Journal of Substance Abuse Treatment*, 24(3): 183-196, 2003.
- Johnson AJ, Roman PM. "Predicting Closure of Private Substance Abuse Treatment Facilities." *Journal of Behavioral Health Services & Research*, 29(2): 115-125, 2002.
- Mulvey KP, Hubbard S, Hayashi S. "A National Study of the Substance Abuse Treatment Workforce." *Journal of Substance Abuse Treatment*, 24(1): 51-57, 2003.

Another reason that we advocate rewarding results is the lack of public consensus as to the most effective approaches to creating durable recovery.

A focus on results makes unnecessary a premature choice among competing schools of thought about how to facilitate recovery.

The research community has made enormous progress in documenting improvement and recovery following treatment over the past decade. There is substantial consensus in the community of treatment scholars about how to improve treatment quality. However, it does not extend to the entire community involved in recovery from substance use disorders. Some put a primary importance on persons in recovery helping each other, as in Alcoholics Anonymous. Others put a greater emphasis on the role of trained professionals. Among the background papers commissioned for our panel was a review of the literature on the effects of training, which showed a striking lack of research on the question of whether or not counselors with more academic training do, in fact, achieve better results.

We believe that in the national debate about how to improve treatment for substance use disorders, differences have hampered forceful implementation of quality standards. It is always difficult for local or state regulators to impose standards on politically active providers, and essentially impossible when there is a lack of public consensus as to the legitimacy of the standards.

A final fundamental reason to focus on rewarding results is to strengthen the credibility of treatment as it competes with other priorities for funding.

Our emphasis on rewarding results should not be interpreted as denigrating efforts to improve quality through training and credentialing, best practice dissemination, service integration and other measures. Most of the panel members have participated in those efforts.

Stronger financial incentives are necessary to make efforts successful and self-sustaining.

We believe, however, that stronger financial incentives are necessary to make those efforts successful and self-sustaining. Legislators are more likely to protect or expand social investments that offer clear results for the clients and society as a whole. Similarly, employers are more likely to fund treatments that strengthen their work force. CSAT and others have spent enormous resources demonstrating the feasibility of recovery. However, it is our collective experience that some treatment programs are more effective than others. Even among the most ardent advocates of treatment, we find grave concerns over the unevenness of treatment quality. The more confidence decision makers can have that their funds will be managed to maximize results, the more willing they will be to invest.

We believe it is essential that we define rewarding results as a national goal and begin moving towards it.

As we recognize at many points in this report, a system that rewards results is a long-term goal, not a “quick fix.” There are high logistical and political barriers to achieving that goal. Yet, for too long, the treatment system for substance use disorders has been undervalued and under-funded. At the same time, it has been asked to tackle a broad range of social problems — employment, housing, family stability — that general medicine has not been required to address. A systemic focus on results, should, over time, improve the system’s quality and stability, and build greater public respect for its work.

For too long, the treatment system for substance use disorders has been undervalued and under-funded.



Recommendations

➤ **The federal government should drive expansion of systems for measuring performance and outcomes of individual treatment programs.**

Recommended Actions:

- The Substance Abuse and Mental Health Services Administration (SAMHSA) should, with Congressional support, encourage development of performance and outcome measurement systems by states on a pilot and volunteer basis by offering incentive grants for those that move forward early.
- When several states have implemented successful systems, Congress should authorize SAMHSA to define binding milestones in a multi-year program for all states that receive a Substance Abuse Block Grant to develop performance and outcome measurements systems.
- The milestones need not encourage national standardization on issues like data collection cycles and items. Although collaboration on management systems could reduce overall costs, the goal is that each state has a results management system in place, not that they have the same management system. The milestones should be defined to encourage coordination with requirements of Medicaid programs.
- The President's proposed voucher program may be useful, but only if the administration follows through on initial proposals to define accountability requirements for voucher funds *at the program level*.
- SAMHSA should impose strong performance requirements for its targeted capacity expansion grants and use them to create management models for the states.

It is clear to us, based on our familiarity with systems across the country, that most state agencies must significantly improve their management information systems to support effective measurement of performance and outcomes at the program level. We believe that the federal government must use its funding leverage to accelerate development of the information infrastructure necessary to reward results. However, our specific recommendations for the federal government are modest because we understand the limits on federal political power to mandate change for the states. The federal government should articulate a national goal and use its limited political and financial resources as effectively as possible to further that goal.

*Federal funding agencies
are not using
results-based management.*

The federal government accounted for roughly one-third of the nation's spending on treatment for substance use disorders in 1997, and its share has been increasing since then (see table 3). Yet, despite its enormous potential funding leverage, the federal government has limited its efforts on quality improvement to advocacy and research leadership. As described previously in this report, NIDA and CSAT have made valuable contributions towards *defining* quality standards and measures, as has the National Institute for Alcohol Abuse and Alcoholism. However, federal funding agencies are not using results-based management to implement those guidelines.

Although CSAT oversees the single largest treatment funding program — the Substance Abuse Block Grant — it imposes essentially no requirement for measurement of performance or results by providers. Funds may be withheld only if program spending rules are violated.⁷ Perhaps the only requirement of management discipline applied to individual providers funded by the grant is a requirement that not less than five percent of the providers in the state be subject to independent peer review annually⁸ — and in a recent proposal, SAMHSA proposed to eliminate this minimal requirement.⁹

Table 3: Estimated Expenditures for Substance Abuse Treatment in 1997 (millions of \$)

Private Total	4,545	38%
Out-of-Pocket	1,252	11%
Private Insurance	2,875	24%
Other Private	417	4%
Public Total	7,345	62%
Medicare	914	8%
Medicaid (State and Federal)	2,268	19%
Other Federal	1,851	16%
Other State and Local	2,313	19%
Total	\$11,890	100%

The dominant role of public funding, federal funding in particular, has probably increased since this 1997 estimate. From 1997 to the 2004 Presidential Budget Request, federal treatment funding increased 34 percent, or five percent per year. According to a 2002 survey, even excluding the funds it spends through general medical care programs (Medicare, Medicaid, Veteran’s Health Administration), the federal government accounted for 40 percent of public funds spent on treatment.

Sources: Join Together analysis of Table D-4 in Coffey RM, Mark T, King E, Harwood H, McKusick D, Genuardi J, Dilonardo J, Buck JA. *National Estimates of Expenditures for Mental Health and Substance Abuse Treatment, 1997* (SMA -00-3499), 2000; National Drug Control Strategy FY2004 budget summary: www.whitehousedrugpolicy.gov/publications/policy/04budget/index.html; and FY2004 SAMHSA budget submission: www.samhsa.gov/budget/content/2004/2004budget-13.htm

Even the newly proposed shift from the block grant to a “performance partnership” grant will do little to strengthen provider obligations to implement measurement because it speaks to the issue of results at the state population level, not the program level. Population rates of substance use disorders that reflect many factors other than treatment interventions are difficult to measure accurately. Accountability at this level is all but meaningless. Even further diluting accountability, the performance partnership proposal makes clear that states can choose their own measures, will not be compared with each other, will submit only as much data as they are able (no binding mandate), and, most importantly, that funding will not be affected by the measurement.¹⁰

We believe that a federal push for greater accountability is especially appropriate for the Substance Abuse Block Grant. State governments lack adequate political incentive to manage treatment programs for results. In other joint federal-state efforts, states have much greater incentives to assure the effective use of funds either, because entitlements drive rapidly rising state program costs (as in Medicaid), or because there is great demand for the program funds by communities so that the allocation of funds is highly visible and competitive (as in highway programs). States can control the costs of treatment for substance use disorders by limiting access — when demand exceeds funded supply, persons with addictions simply do not get treatment. And the process of funds allocation to individual programs is much less visible than the allocation of funds, for example, to highway projects.

We believe the federal initiative to encourage more effective measurement of results should require state and local adoption of results measurement, but need not require systems standardization per se. One of the fundamental challenges in implementing any information system that spans facilities is standardization of data definitions. Some treatment facilities and agencies have already made significant investments in systems and in training personnel to use them — for example, Maryland is planning a five-year process to implement performance measurement.¹¹ To change data definitions would require a significant additional investment. We see no *management* need for program data to be standardized nationally.

CSAT will best serve its goals of expanding access and improving quality if it demands results from each grantee.

While small compared to the block grant and still undefined, the President's treatment voucher proposal¹² makes a commitment to accountability based on outcomes. The proposal states that, "The key to accountability in this program will be the system of reimbursement. Payment to providers will be linked to demonstration of treatment effectiveness measured by such indicators as client substance use following discharge."¹³ If this language is fully implemented, this program may be consistent with the recommendations of this panel. However, there is still considerable need for further definition; and, as a panel, we do not take a position on the voucher program.

Most of the rest of the non-block-grant federal funds for treatment (outside of health care programs) are disbursed through hundreds of grants targeting specific subpopulations, under CSAT's Targeted Capacity Expansion program. Referring generally to the targeted grants managed by CSAT, the Office of Management and Budget recently commented, "Neither managers nor partners are held directly accountable for program outcomes. Performance data are not used in employee evaluations. Grantees compete for funds initially, but only lose funding for poor performance in extreme cases..."¹⁴ The OMB report goes on to acknowledge agency intentions to improve accountability. We believe that, over the long term, CSAT will best serve its goals of expanding access and improving quality if it demands results from each grantee.

➔ **State and local treatment agencies should not wait for federal leadership on measurement issues, but should use the tools they have in place to manage for results.**

Recommended Actions:

- Where a state or local treatment agency is the dominant funder of services, it should begin to manage for results using existing data supplemented by regular evaluative conversations with providers.
- State and local treatment agencies should consider the use of external care management to further strengthen management for results.
- State and local treatment agencies should review their powers under provider contracts to assure that they have the flexibility to reward results, and if necessary migrate to more flexible contracting.

When a public agency controls a large share of provider funding and possesses a base of management information to work from, it has enormous power to motivate results. Especially in high poverty areas, a state or local government agency is often the dominant funder of treatment services, paying private facilities to provide treatment to those who lack health insurance and have limited income. The agency may possess administrative data on admissions and discharges sufficient to provide indicators of program performance or capable of being enhanced for that purpose.

The most practical initial approach to results management for a state or local treatment agency may be to assemble available performance data and meet with providers jointly on a regular basis to praise apparent good performance and discuss apparent poor performance. If evaluations are conducted in a visible process involving discussion with the provider executives, the executives have the opportunity to explain numbers that may be misleading and at the same time may develop a stronger personal motivation to improve performance. The agency also builds a credible public foundation for both rewards for good performers and reduced funding for poor performers.

Baltimore has developed such a process called “DrugStat,” mirroring the “CrimeStat” process used to motivate police managers in New York City. A DrugStat-like process provides a starting model for results-oriented management. It allows agencies and providers to develop a shared understanding of performance measures. Over time, the conversations may become repetitive and the weakest providers may be eliminated. The management process may evolve towards more routine, lower profile communications with a more stable group of consistently performing providers, perhaps returning to a DrugStat-like process periodically to maintain continued improvement.

The quest for quality in public treatment for substance use disorders depends on committed political leadership.

External care management can support further evolution towards management for results. In this model, individual treatment plans are monitored to assure that an individual patient’s treatment needs are identified, that appropriate services are offered in proper progression, and that the patient is able to take advantage of those services. The external care manager is independent of any provider, and so is unbiased when evaluating the patient’s needs and choosing care that will provide the best results in the most cost-effective manner.

An external care management group that follows a large number of patients has a strong base of information about facility performance. The experience of the external care manager will give strong support for actions to reward results either by the external care manager or the primary funding agency. Thus, while external care management may or may not, in itself, improve patient care (the evidence on this issue is still thin), we believe that external care management can help support efforts to reward results.

Some managed care organizations have moved beyond cost-oriented utilization management and are practicing true external care management. These managed care organizations may be appropriate partners for public treatment agencies. In many states, Medicaid purchases behavioral health care through managed care organizations. In these states, coordination with the Medicaid managed care provider may be an important consideration or even an opportunity for the public treatment purchaser.¹⁵

Flexible control of the funding stream for providers is essential to meaningful results-oriented management. Public treatment services that directly control referrals through a central intake have the greatest ability to create immediate performance incentives. But even agencies that have no role in referrals can create significant economic incentives. For example, agencies that simply fund treatment capacity in programs can, subject to contractual terms, regulate the number of funded treatment slots, having the same economic effect as regulating the flow of referrals. Similarly, agencies that reimburse episodes of care for patients can set and regulate ceilings on the number of patients for individual providers or otherwise vary payments to reflect performance. Or, agencies may hold back a percentage of payments from all providers to be redistributed to providers that achieve performance objectives.¹⁶ In every instance, however, the public agency must start by developing contracts that give necessary flexibility to vary the payments for providers based on performance.

In order for any of the measures discussed above to succeed, the public treatment agency must possess the political independence to take appropriate actions that may affect provider interests. In many jurisdictions, the treatment agency is as dependent on the providers for political support as the providers are on it for financial support. As a result, it may not be willing to displease providers. Ultimately, the quest for quality in public treatment for substance use disorders depends on committed political leadership.

➤ Public welfare, social service and criminal justice agencies that refer clients for treatment should seek effective care management for results.

Recommended Actions:

- Agencies referring clients for treatment should partner with the public treatment agency to manage for results.
- Absent that, referring agencies should purchase external care management to manage for results.
- Referring agencies should pool their referrals from different offices within their agency and also should partner with other referring agencies to create a flow of referrals large enough to assure that they have adequate bargaining power and management resources in approaching treatment providers.

Extensive research shows that untreated substance use disorders contribute substantially to crime, welfare dependency, and child abuse and neglect. Many agencies addressing these problems have sought to control substance use disorders among their clients. Criminal

justice agencies condition probationary liberty on abstinence (as proven by drug testing) or on participation in treatment, as in many “drug courts.”¹⁷ Similarly, welfare agencies may condition benefits and social service agencies may condition child custody. In some areas, these agencies together control a huge share of the referrals to treatment.

These agencies can and should motivate treatment providers to deliver results consistent with their social objectives — reduction of crime, welfare dependency and child neglect. Where there is a public treatment services agency that is effectively managing by rewarding results, other public agencies should partner with it. They should work with the treatment services agency to develop program performance criteria that include their objectives.

In the absence of strong results-oriented management by a treatment service agency, other agencies should make use of external care management or invest in the development of comparable staff expertise. Far too often, social agencies, lacking expertise, assume that providers are delivering quality care. They take at face value provider explanations for client failure that blame the client, when in fact, poor treatment quality may have failed to meet the client’s needs.

These agencies can and should motivate treatment providers to deliver results consistent with their social objectives.

Funding may be a barrier to the use of external care management. The social agency may have no funding of its own dedicated to treatment. It may depend on clients either having private insurance or, more typically, meeting eligibility criteria for publicly funded treatment. Yet, external care management will spare agency staff the labor of placing clients and may increase the impact of treatment. Moreover, given the severe consequences that they may impose when clients relapse or leave treatment, social agencies have a high duty to focus on quality.

Social agencies are at a special disadvantage when they interact in a fragmented way with treatment providers, as, for example, when local court probation departments or local welfare offices place their own clients. They are often too small to effectively influence providers. Lacking both financial leverage and a statistical base of outcome comparisons, and often desperate to place clients in need of treatment, they are entirely incapable of managing for results. It is essential that senior agency managers exert leadership to pool together referrals from offices within their agency and from other social service agencies. Senior managers should seek to aggregate control of a significant flow of referrals that can support either an allocation of funds for external care management or, at a minimum, a dedication of agency staff to the management of outcomes — collection of necessary performance data, managerial compilation and evaluation of that data and direction of referrals toward better performing providers.

➔ **Employers should work together and with managed care organizations to strengthen management for results in managed behavioral health care.**

Recommended Actions:

- Employers and managed care organizations should collaborate to define minimum acceptable standards for management of providers.
- Employers should insist on comparative performance measures for the managed care organizations themselves.

We believe that high quality behavioral health services have a positive net impact on an employer's bottom line. Even when performance impairment is serious, treatment may restore an employee's productivity and preserve the employer's investment in the employee. Employers should seek high quality screening and early intervention to prevent progression to more serious and costly illness. They must also ensure adequate aftercare services that target relapse prevention.

The same basic strategies that apply to public treatment agencies — collection of performance data, managerial compilation and evaluation of that data and direction of referrals and other rewards towards better performing providers — apply equally to private care purchasers. However, there is one fundamental difference: Employers already rely predominantly on managed care to deliver behavioral health services to employees.¹⁸ Thus, managed care operators are necessarily central to active management for results in the private sector.

Managed care organizations are in a good position to improve quality because they aggregate the purchasing power of employers in local areas. Larger organizations have the leverage to collect data necessary to evaluate performance and to reward results. Additionally, they have the potential to develop the expertise to fairly evaluate performance because they manage a large flow of patients.

This expertise becomes even more important when evaluating outcomes of treatment by independent practitioners operating outside supervising treatment facilities.

Moreover, managed care organizations often are at risk for the costs of providing care and may therefore recognize the need to identify and treat substance use disorders that might otherwise lead to expensive physical and mental health problems. They may initiate screening and early intervention. However, under some contracts, they may not have the incentives that would lead them to maximize the bottom-line benefits of treating substance use disorders, since they are not at risk for the costs of non-behavioral medical problems. For example, some behavioral health carve-outs may lack incentives to collaborate with primary care and work toward mitigation of overall health care costs.

Employers should work together to encourage expansion of results management by managed care providers. Employers can develop significant market power by forming alliances with each other to seek quality improvements. The Leapfrog Group, created by the Business Roundtable of Fortune 500 employers, represents the purchasers of care for 33 million persons and is successfully urging specific quality improvements in hospitals.¹⁹

We recommend that large employers similarly define basic standards for results management for behavioral health by managed care providers (see "Proposed Standards"

High quality behavioral health services have a positive net impact on an employer's bottom line.

on page 15 as one example). They can then make compliance with these standards a consideration or even a condition for managed care providers seeking to do business with them. If the group controls a large enough pool of employed lives, they will be able to move managed care providers towards their standards. The Leapfrog Group, or a group like it, could implement this approach nationally. Or, in a local market with dominant employers, a similar local group could be successful. This process need not be adversarial — many managed care organizations will be eager to support the development of appropriate management standards and should be invited to participate.

Employers should also insist that managed care organizations provide standardized comparison data about their own performance, which will increase competition among managed care organizations on the basis of quality and will, in the long run, support performance-based contracting between managed care organizations and employers.

Alcoholism Treatment Pays For Itself In Healthcare Cost Reductions Alone

In the largest study of its kind, researchers tracked for 14 years the healthcare utilization of nearly 4,000 white- and blue-collar employees (or their family members) with alcoholism at a large Midwest manufacturing plant. They were enrolled in either a fee-for-service healthcare plan or a health maintenance organization. The study compared the medical costs of people who received treatment for their alcoholism with those of people who needed treatment but were not treated.

The study demonstrated that after six months, treatment had begun to reduce healthcare costs by as much as 55 percent from their highest pre-treatment levels, even when the cost of treatment was included, while the healthcare costs of people with alcoholism who were not treated continued to rise.

Three years later, the employers continued to see a substantial return on their investment in treatment: The healthcare costs of people who received treatment were still 24 percent lower than those who did not.

This landmark study analyzed healthcare costs only; it did not measure the productivity benefits to employers or possible reductions in health care costs of dependents. Similar studies about the economic impact of alcohol on healthcare costs demonstrate that:

- People with drinking problems use healthcare at twice the rate of people without drinking problems;
- Alcoholism treatment helps reduce healthcare costs as soon it is initiated; and
- Although alcoholism treatment reduces healthcare costs for most problem drinkers, it results in higher savings among younger problem drinkers.

From: Ensuring Solutions to Alcohol Problems, George Washington University. "Primer 3: A Sound Investment: Identifying and Treating Alcohol Problems," 2003: www.ensuringsolutions.org/pages/primer/primer3/primer3.html

Proposed Standards for Managed Behavioral Health Care for Employers

We recommend that employers work together and with managed care organizations to require that managed care organizations manage for results, adopting principles like the following:

The managed care organization (MCO) provides a managed continuum of care:

1. As a routine component of primary health care encounters, primary care providers use brief screening instruments to identify potential substance use disorders.
2. Persons identified as having substance use disorders receive brief interventions, and, if necessary, more significant treatment.
3. All those possibly requiring more significant treatment receive full assessments and an individual treatment plan reflecting their particular needs.
4. Care managers follow up with providers to assure that patient needs are being met and with patients to assure that they are connecting with treatment.

The managed care organization measures its own and provider performance:

1. The MCO provides basic administrative performance measures which allow comparisons to other MCOs, as suggested by the Washington Circle Group and the National Committee for Quality Assurance.
2. The MCO collects provider performance and outcome measures from the care management process suggested above.
3. The MCO solicits customer feedback on provider quality.
4. The MCO directly tests performance with site visits, phone calls and other measures to verify safety, cleanliness, convenience, and responsiveness.
5. The MCO communicates to providers the employers' fundamental priority – the timely return to work of productive employees – and measures provider performance on this dimension.

The managed care organization rewards provider performance:

1. The MCO uses economic incentives to reward good performance.
2. The MCO drops from its network poor performers.

The central goal of employers is employee productivity. Panel member Tara Wooldridge, Employee Assistance Program Manager, Delta Air Lines, told the panel: “Our goal is to make sure our employees have access to quality treatment, that access is timely, that there is an understanding of the relationship between work and health. And that's a battle that may never be won because there are too many providers that don't understand you cannot treat people in a vacuum, and that signing them out of work for months at a time is not in their best interest. However, it is essential that we appropriately address safety concerns before we return employees to work.” Clearly, one of the most important measures of performance that providers need to accept for employees is timely return to work.

MCOs serving Medicaid and Medicare clients should be held to essentially the same performance standards, perhaps, excepting the return-to-work criterion, at least for elderly clients.

➤ **Foundations and agencies that fund research should support the development of results-oriented systems.**

Recommended Actions:

- Funders should support the development of systems that provide information to providers, clinicians, care managers, and administrators.
- Funders should support continued research to understand the factors predicting outcomes and to improve case-mix adjustment.
- Funders should also support demonstrations by public agencies and others seeking to manage results more actively.

Measurement, based primarily on provider data, is the foundation for results management. Data collection is most accurate when the care providers entering the data benefit from its accuracy. Audit sanctions are a remote threat; so in order to motivate accuracy, data collection must support the provision of patient care. With emerging information technology, patient record-keeping can generate suggestions for improved care and timely feedback on results for both counselors and program administrators. We feel that development of this technology is an important priority for continued investment.

Different facilities take on different clients, some of whom have much poorer prognoses. Rewarding results fairly depends on recognizing and adjusting for this reality. Case-mix adjustment is still an approximate science. Certainly, individual treatment outcomes may depend on characteristics of the client and the quality of the facility. However, they also depend on a host of unpredictable influences from outside the treatment environment and, perhaps, on the mix of other patients in the same program. Funders should invest in research designed to strengthen our ability to predict treatment outcomes and to identify unpredictable factors that can, in retrospect, explain outcomes. Improved case-mix adjustment will advance efforts to reward results.

In addition to funding research to build a stronger technical foundation for rewarding results, funders should support demonstrations of active management for results. As discussed above, there are many possible models. Many of them may require a small investment to demonstrate their feasibility to local authorities in particular local conditions. In evaluating proposals for these investments, grantmakers should give attention to the political ability of the agencies involved to enforce active management in the face of possible provider resistance.

➤ **Community leaders should advocate for the development of comprehensive results-oriented treatment systems.**

Recommended Actions:

- Community leaders should survey the components of the treatment network to identify missing services, and should advocate to make these services available.
- Community leaders should work with both buyers and providers of services to adopt the recommendations of this report and manage for results.
- Community leaders should collect local data to measure the overall effectiveness of their strategies to control substance use disorders.

Leaders are those who take action to make a difference in their communities. We do not presume to recommend political strategies or choices among competing political priorities

for community leaders. However, we suggest in this section some goals, broadly consistent with our more specific recommendations, which community leaders may wish consider.

Community leaders concerned about substance use disorders should strive to ensure that citizens have access to the full continuum of necessary care from screening and brief interventions through after care. Inpatient, outpatient, and pharmacological treatments should all be readily available. Community leaders must begin by negating the stigma against substance use disorders that often discourages persons from seeking treatment and also tends to make employers and governments less willing to fund appropriate treatment.

The component of the continuum that is most often lacking is broad screening and brief intervention. Too often, problems go unrecognized until patients have badly damaged their lives and reputations. All institutions in the community have a responsibility to help recognize emerging disorders among those they care for, and encourage participation in treatment. The highest priorities for improved screening and intervention are in the health care and criminal justice systems where persons with substance use disorders frequently appear.

Community leaders should also advocate for results-oriented management. They should seek to hold institutions accountable for improving treatment quality, asking whether they can illustrate effective identification of persons in need of treatment and appropriate referrals. Leaders should ask whether institutions are adopting the recommendations of this report or are undertaking other measures to reward results.

Finally, community leaders should assure the collection of local data on the prevalence and severity of substance use disorders and related problems. Without such data, leaders have no way to measure the overall success of their portfolio of treatment, prevention, and law enforcement efforts. Local data focus community attention on the problem of substance use disorders and generally help to build support for stronger interventions, including expansion and improvement of treatment.

*“Substance Abuse: Improving the Quality of Treatment”
provides a useful tool for community members to
assess the quality of their local treatment system.
Available at: www.jointogether.org/sa/qualityactionkit*

Summary

Substance use disorders are the nation's number one health problem and lie at the root of many public safety and workplace issues. Improving quality of treatment is as important as improving access to treatment. Leadership for improvement must come from many sources — Congress; the Substance Abuse and Mental Health Services Administration; state legislatures; state and local treatment agencies; criminal justice; welfare and other public agencies; employers and managed care organizations; providers; and community leaders. We hope that our report helps leaders see ways to improve treatment quality.

Our recommendations sum to a single phrase: reward results. We recognize that there are many avenues for treatment quality improvement, including training, credentialing, best practice dissemination, work force development, facility licensing standards, improvement and implementation of new models for treatment of dual diagnosis patients. We believe, however, that rewarding results is essential to motivating action for improvement. We also believe that if providers receive rewards for improved results, they will creatively open new avenues for improvement — a focus on results gives greater freedom than more detailed mandates for change. Finally, we believe that rewards for results may lead to a restructured treatment system with greater stability and correspondingly greater capacity to improve.

While we have placed central emphasis on the role of institutional buyers and managers of care in demanding results, we believe that the voices of patients and families must be heard. People who have progressed to the stage of recovery, and their families, often have essential insight into what did and did not work for them — their personal stories are frequently compelling and persuasive. We also believe that providers of treatment for substance use disorders are profoundly committed to serving their patients and often have great understanding of what works. Wise managers will listen very carefully and systematically to the voices of consumers, their families, and their providers.

We have advocated that buyers reward results as a central strategy for improving quality. We believe that this strategy is the best long-term, not only to effect quality improvement, but also to end stigmatization and increase resources. We wish, in closing, to reemphasize our shared beliefs that adequate resources are essential, that treating persons with substance use disorders is always emotionally challenging and often profoundly frustrating and alienating, and that those on the front line deserve our unequivocal support and our profound gratitude for their service. Legislators should fund public treatment adequately and mandate parity in insurance reimbursement for treatment for substance use disorders.



Appendix I: NIDA'S Principles of Effective Treatment_____

- No single treatment is appropriate for all individuals.
- Treatment needs to be readily available.
- Effective treatment attends to multiple needs of the individual, not just his or her drug use.
- An individual's treatment and services plan must be assessed continually and modified as necessary to ensure that the plan meets the person's changing needs.
- Remaining in treatment for an adequate period of time is critical for treatment effectiveness.
- Counseling (individual and/or group) and other behavioral therapies are critical components of effective treatment for addiction.
- Medications are an important element of treatment for many patients, especially when combined with counseling and other behavioral therapies.
- Addicted or drug-abusing individuals with coexisting mental disorders should have both disorders treated in an integrated way.
- Medical detoxification is only the first stage of addiction treatment and by itself does little to change long-term drug use.
- Treatment does not need to be voluntary to be effective.
- Possible drug use during treatment must be monitored continuously.
- Treatment programs should provide assessment for HIV/AIDS, hepatitis B and C, tuberculosis and other infectious diseases, and counseling to help patients modify or change behaviors that place themselves or others at risk of infection.
- Recovery from drug addiction can be a long-term process and frequently requires multiple episodes of treatment.

From: *Principles of Drug Addiction Treatment: A Research Based Guide*. National Institute on Drug Abuse. 1999. Available at: www.nida.nih.gov/PODAT/PODAT1.html

Appendix II: CSAT's National Treatment Plan Initiative

Invest for Results

- Close serious gaps in treatment capacity to reduce associated health, economic and social costs.
- Establish standard insurance benefits that provide coverage for substance abuse and dependence.
- Set reimbursement rates and funding levels to cover reasonable costs of providing care.

"No Wrong Door" to Treatment

- Require appropriate assessment, referral, and treatment in all systems serving people with substance abuse and dependence problems, including the human services and justice systems.
- Ensure that in all systems individuals enter and become engaged in the most appropriate type and level of substance abuse treatment, and that they receive continuing services at the level needed.

Commit to Quality

- Establish a system that more effectively connects services and research (CSR), with the goal of providing treatment based on the best scientific evidence.
- Utilizing the CSR system, develop evidence-based standards for quality of care, achieve consensus on data elements to measure quality of care and treatment outcomes for payors, establish standards for training and credentialing of treatment professionals and adopt best business management.
- Attract and maintain a high quality, diverse workforce, responsive to the client population.

Change Attitudes

- Engage the recovery community in all levels of discussion.
- Conduct research to better understand stigma and discrimination against people in recovery.
- Conduct educational initiatives to reduce stigma and discrimination against people in recovery.

Build Partnerships

- Form groups that will unite people and systems responsible for various dimensions of the problem.
- Create forums where government agencies and private organizations can collaborate.
- Establish a Partnership Support Program that provides support to collaborative projects.
- Establish "partnership-building" as a priority objective in all activities.

From: National Treatment Plan Initiative Fact Sheet. Available at:
www.samhsa.gov/centers/csat/content/ntpfact.htm

Witnesses

The panel thanks the following individuals who gave written or oral testimony for the panel to consider:

- **Tammy V. Acevedo**, person in recovery
- **Gordi Albi**, Interventions NorthWest, Inc., Eugene, OR
- **Anonymous**, mother of heroin addict, WI
- **American Society of Addiction Medicine**
- **Susan Avery**, mother of daughter with substance use disorder, Brattleboro, VT
- **Marguerite Babcock, M.Ed., LPC, MAC, NCC**, consultant, Pittsburgh, PA
- **Alice Baer**, person in recovery, Denver, CO
- **Stephanie Bailey, M.D.**, Director of Health, Health Department of Nashville & Davidson County, Nashville, TN
- **Cody Barrett**, Director of Training, Community Release Corrections, NJ
- **Mark R. Bencivengo, M.A.**, Assistant Commissioner, Coordinating Office for Drug and Alcohol Abuse Program, Philadelphia, PA
- **Kerry Broderick, M.D.**, Physician, Denver Health, Denver, CO
- **Jack Buehler**, Clinical Director, ANTLERS Center, Inc., Lincoln, NE
- **John Carnevale Ph.D. and Amelia Arria Ph.D.**, Carnevale Associates, Darnestown, MD
- **Mady Chalk, Ph.D.**, Director, Office of Quality Improvement and Financing, Center for Substance Abuse Treatment, Rockville, MD
- **Teresa Descilo**, Executive Director, Victim Services Center, Miami, FL
- **Dick Dillon, CAC**, Vice President, Preferred Family Healthcare, Inc., St. Louis, MO
- **Bruce Ednie**, Certified Alcohol and Drug Counselor, Bonners Ferry, ID
- **David Elliott, M.F.T., LADC**, Program Supervisor, Reno-Sparks Health & Human Services, Reno, NV
- **J. David Else**, Center for Spirituality in Twelve Step Recovery, Pittsburgh, PA
- **Brian Fingerson**, Pharmacist, LaGrange, KY
- **Bethany Gadzinski**, Project Director, City of Boise Methamphetamine Clinic, Boise, ID
- **Larry Hames**, Executive Director, Your Choice, Inc., Hallowell, ME
- **Joseph Harding**, Executive Director, Friends of Recovery New Hampshire, Manchester, NH
- **Marcy Hoerster**, Project Coordinator, Employee & Family Resources, Des Moines, IA
- **Constance Horgan, Ph.D.**, Brandeis University, Schneider Institute for Health Policy, Waltham, MA
- **Joyce Ingram-Chinn**, Behavioral Health, Kailua, HI

- **Jeremiah S. Jeremiah, Jr.**, Chief Judge, Rhode Island Family Court, Providence, RI
- **Thomas T. Johnson, CEAP, CCDC, III E**
- **Richard Juman, Psy.D.**, Executive Clinical Director, Bridge Back to Life Center, New York, NY
- **LeeAnn Kahlor**, Communications Officer, Paths to Recovery, Madison, WI
- **Chris Kelly**, Director, Advocates for Recovery Through Medicine, Washington, DC
- **Toni Krupski, Ph.D.**, Chief, Division of Research and Evaluation, Division of Alcohol and Substance Abuse, State of Washington, Olympia, WA
- **N. William Layfield**, Drug Education Council, Mobile, AL
- **George Linn**, certified alcohol and drug counselor, Columbus, OH
- **Lynn**, recovering alcoholic, Queens, NY
- **Tanya Magness, RNC**, Director, Substance Abuse Services, Baptist Hospital, Knoxville, TN
- **Marianne Marcus, Ed.D., RN, FAAN**, Professor and Chair, Department for Nursing Services, University of Texas, Houston, TX
- **Peter McLenighan**, Executive Director, Stepping Stones, Joliet, IL
- **Joan McNamara**, Chief Executive Officer, Compass Health Care, Tucson, AZ
- **Ken Minkoff, M.D.**, Clinical Assistant Professor of Psychiatry, Harvard Medical School, Cambridge, MA
- **Lupe and Roger Morin**, Center for Health Care Services, NAMI Board, San Antonio, TX
- **Charles Morimoto, M.Ed.**, Assistant to Deputy Director, San Francisco Department of Public Health, San Francisco, CA
- **NAADAC - The Association for Addiction Professionals**
- **Kimber Paschall Richter, Ph.D., M.P.H.**, Assistant Professor, Preventive Medicine and Public Health, University of Kansas Medical Center, Kansas City, KS
- **George Perkins**, Board Member, Intervention Resource Center, Inc., Louisville, KY
- **John T. Pichot, M.D.**, Member of the Board, American Academy of Addiction Psychiatry, TX
- **Beny Primm, M.D.**, Executive Director, Addiction Research and Treatment Corporation, Brooklyn, NY
- **Harlen Pruden and Mary Downs**, SpeakOUT! LGBT Voices for Recovery, New York, NY
- **Carolyn Reuben, LAC**, President, Community Addiction Recovery Association, Sacramento, CA
- **Rush Russell**, President, Children's Futures, Trenton, NJ
- **Stan Sacks**, National Development & Research Institutes, New York, NY
- **Jeffrey Shelton**, A Step Higher, Chesapeake, VA
- **Thelma Simon, LADC/BSW**, Director, Substance Abuse Program, State of Nevada, Reno, NV

- **Jennifer Smith, M.D.**, Physician, Cook County Bureau of Health Services, Chicago, IL
- **Richard Spence, Ph.D.**, Research Scientist and Director, Gulf Coast Addiction Technology Transfer Center and University of Texas, Austin, TX
- **J. Ward**, disability advocate, Kenton, OH
- **Julie Wilson**, sober person, Wilmington, DE
- **Wayne Wirta**, President/CEO, NCADD New Jersey
- **Tracey Wright Lee**, person in recovery, Vacaville, CA
- **Brian Young**, Director, Wisconsin Recovery Advocacy Partnership, Waukesha, WI

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About Join Together

Join Together, founded in 1991 by a grant from The Robert Wood Johnson Foundation to the Boston University School of Public Health, supports community-based efforts to reduce substance use disorders and gun violence.

In 2000, Join Together launched Demand Treatment!, a national initiative to drive up the demand for treatment through community partnerships, technical assistance, and alliances with public and private organizations. Improving the quality of treatment for substance use disorders is one of the program's four priority areas.

Other Join Together policy panel reports focusing on treatment include *Treatment for Addiction: Advancing the Common Good* (1998) and *Ending Discrimination Against People with Alcohol and Drug Problems* (2003).

Individuals interested in quality improvement may also want to read Join Together's action kit, *Substance Abuse: Improving the Quality of Treatment* (2002).

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Endnotes

¹ See, for example, National Business Coalition on Health, “Changes in How Employers Buy Healthcare – Rewarding Results,” National Health Leadership Council Meeting, July 31- August 2, 2002. Available at: www.nbch.org/rewardingresults.pdf

² Among physical needs, we recognize the importance of addressing the needs of persons with co-occurring physical disabilities. See www.naadd.org to gain a broader understanding of this issue.

³ Testimony of Mady Chalk, Division of Services Improvement, Center for Substance Abuse Treatment, before the Treatment Quality Improvement Panel, February 4, 2003.

⁴ See endnote 1.

⁵ “Case-mix adjustment” means the application of statistical methods to develop a predicted set of outcomes based on incoming characteristics of patients – history of use, employment status, etc. Facilities are deemed to be performing well if they deliver better outcomes than expected based on their patient mix. While case-mix adjustment provides valuable information, no adjustment algorithm is perfect. In fact, treatment results are hard enough to predict that even adjusted results measures cannot be relied upon in isolation.

⁶ By “cherry-picking” we refer to the avoidance of high-risk clients to optimize results – taking the easy cases. Many quite defensible policies can, in effect, amount to cherry-picking. For example, a facility for treatment of substance use disorders may refuse to accept persons receiving psychiatric medications. The presence of medications in the hands of clients may create a management challenge that the facility may legitimately wish to avoid or be ill-equipped to handle. But, the policy serves to exclude a great many higher risk patients.

⁷ 42 U.S.C. § 300x-55.

⁸ 42 U.S.C. § 300x-53.

⁹ “SAMHSA has monitored the usefulness of the requirement and believes that it has not achieved the purpose for which it was included in statute largely because the States, while they fulfilled their obligation under the provision, did not use it to improve performance.” Request for comments by SAMHSA, 67 FR 78496, 78502-3 (December 24, 2002).

¹⁰ *Id.*, 67 FR at 78497, 78501-3.

¹¹ Testimony of John Carnevale and Amelia Arria before the Treatment Quality Improvement Panel, February 3, 2003: “Using Performance Measurement to Improve Treatment Effectiveness: Maryland’s Approach.”

¹² “[W]e will launch a new program, funded with \$600 million over three years, that will expand access to substance abuse treatment while encouraging accountability in the treatment system. For those without private treatment coverage, we will make sure that medical professionals in emergency rooms, health clinics, the criminal justice system, schools, and private practice will be able to evaluate their treatment need and at the same time issue a voucher good for the cost of providing that treatment. Treatment vouchers will be redeemable on a sliding scale that rewards the provider for treatment effectiveness. Services can range from interventions designed for young substance abusers before they progress deeper into dependency, to outpatient services, to intensive residential treatment. For the first time, we will provide a consumer-driven path to treatment. ... The path to help will be direct, appropriate, and open on a non-discriminatory basis to all treatment programs that save lives, including programs run by faith-based organizations. For many Americans, the transforming powers of faith are resources in overcoming dependency. Through this new program, we will ensure that treatment vouchers are available to those individuals who choose to turn to faith-based treatment organizations for help. Our goal is to make recovery the future for all those struggling with substance abuse.” The National Drug Control Strategy, February 2003, pp. 19-20 at: www.whitehousedrugpolicy.gov/publications/pdf/strategy2003.pdf

¹³ President’s National Drug Control Strategy, FY2004, Budget Summary, p. 33 at: www.whitehousedrugpolicy.gov/publications/policy/04budget/fy04budgetsum.pdf

¹⁴ Office of Management and Budget, FY2004 Performance and Management Assessment of the Substance Abuse Treatment Programs of Regional and National Significance as available at: www.whitehouse.gov/omb/budget/fy2004/pma/substanceabusereat.xls

¹⁵ Data are fragmentary, but it appears that very few states are using a managed care operator to control non-Medicaid public substance abuse treatment. By contrast, of course, managed care is becoming the rule for Medicaid programs. See, e.g., U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, "Medicaid Managed Care State Enrollment as of June 30, 2002," at: cms.hhs.gov/medicaid/managedcare/mcsten00.pdf

¹⁶ New Mexico has used a hold back approach to increase the identification of patients with co-occurring disorders – holding back a percentage of payments to providers and distributing them to the facilities most effective on this dimension. See Cline, C. and Minkoff, K. "A Strength-Based Systems Approach to Creating Integrated Services for Individuals with Co-occurring Psychiatric and Substance Use Disorders." Draft Technical Assistance Document Prepared for the Substance Abuse and Mental Health Services Administration, December 2002.

¹⁷ For more information on drug courts, see: www.nadcp.org/whatis

¹⁸ Studies indicate that 80 to 90% of employees who have coverage for substance use disorders receive their coverage through some form of managed care, and that over 90% of private industry employees that have health insurance have some form of managed care coverage. See Table 4 in Bureau of Labor Statistics *National Compensation Survey: Employee Benefits in Private Industry in the United States, 2000* at: www.bls.gov/ncs/ebs/sp/ebbl0019.pdf. Note that 94% of all private industry employees' benefit plans cover inpatient detoxification, approximately 80% cover inpatient rehabilitation, and approximately 85% cover outpatient rehabilitation for substance use disorders. See Table 7.

Managed care penetration was 75% among state and local government full-time employees with health benefits in 1998. See Table 46 in Bureau of Labor Statistics *National Compensation Survey: Employee Benefits in State and Local Governments, 1998* at: www.bls.gov/ncs/ebs/sp/ebbl0018.pdf

¹⁹ See: www.leapfroggroup.org