Approved: March 4, 2008
Date

MINUTES OF THE JOINT MEETING OF SENATE WAYS AND MEANS AND HOUSE APPROPRIATIONS COMMITTEES

The Joint Meeting of Senate Ways and Means and House Appropriations Committees was called to order by Chairwoman Sharon Schwartz and Chairman Dwayne Umbarger at 11:30 a.m. on January 17, 2008, in Room 313-S of the Capitol.

All members were present except.
Senator Jay Emler - excused
Senator Steve Morris - excused
Senator David Wysong - excused

Committee staff present:
Kristen Clarke Kellems, Assistant Revisor of Statutes
Amy Deckard, Kansas Legislative Research Department
Audrey Dunkel, Kansas Legislative Research Department
Cody Gorges, Kansas Legislative Research Department
Reed Holwegner, Kansas Legislative Research Department
Heather O'Hara, Kansas Legislative Research Department
J. G. Scott, Kansas Legislative Research Department
Jarod Waltner, Kansas Legislative Research Department
Melinda Gaul, Chief of Staff, Senate Ways & Means
Mary Shaw, Committee Assistant

Conferees appearing before the committee:
Mady Chalk, Ph.D., Director, Center for Policy Analysis and Research, Treatment Research Institute

Chairwoman Sharon Schwartz, House Appropriations Committee, invited the Senate Ways and Means Committee to a Joint Meeting where Mady Chalk, Ph.D., Director, Center for Policy Analysis and Research, Treatment Research Institute, on Outcomes of Addiction Treatment and Approaches to Measuring Performance (Attachment 1).

The meeting adjourned at 1:00 p.m. The next meeting of Senate Ways and Means was scheduled for January 18, 2008.

Senate Ways and Means
1-17-08
Attachment 1

PUBLIC RESPONSIBILITY and ADDICTION TREATMENT

Mady Chalk, Ph.D.

A Briefing for the Kansas Legislature

January, 2008

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Performance Measurement in Addictions Treatment Programs

- ***A series of briefings offered to state legislatures through a collaborative effort of the State Associations of Addiction Services, National Conference of State Legislatures, and the Treatment Research Institute. Funded by the Substance Abuse and Mental Health Services Association (SAMHSA) under the Partners for Recovery Initiative through a contract with Abt Associates Incorporated.***

SAAS
STATE ASSOCIATIONS OF ADDICTION SERVICES

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NATIONAL CONFERENCE of STATE LEGISLATURES

THE PRESENTATION

I. Public and Private Financing of Treatment

II. Proven Practices

III. Using Outcome and Performance Measures for Quality Improvement and Accountability

IV. Purchasing Alternatives for Publicly Funded Systems of Care

What Are We Talking About?

- About 22 million Americans age 12 or older or 9.4 percent of the population are classified as having substance use disorders.
- Only a small proportion are treated (1.5 percent of the population).
- Substance use disorders, if not treated very early, become chronic, relapsing conditions that require continuous monitoring and often multiple treatment episodes.

What Are We Talking About?

- In the current treatment system care is limited and much of it is outdated despite scientific advances.

- The treatment workforce is in a critical state and needs significant attention. Many staff lack the credentials to implement science-based treatments.

Why Are We Talking About It?

- The recent IOM Report on Improving Quality in Treatment of Mental and Substance Use Disorders
- Treatment Pays Dividends
- Rapid Advances in Neuroscience, Evidence-based Practices, and Medications Development
- The Long-term High Cost of Untreated Illness

Why Are We Talking About It?

- Failure to provide ***effective*** care has serious personal and societal consequences: crime, accidents, disability, and death.

- With assistance from the legislature Kansas can improve its capacity to address treatment of substance use disorders.

The Dividends of Treatment

- In Washington State, medical expenses were cut in half for individuals who received treatment compared to those who did not.
- In Minnesota, 80% of treatment costs were offset in the first year alone by reductions in medical costs and hospitalizations.
- In California, criminal activity declined by 66 percent; for every dollar invested in treatment there was a $7 return.

The Dividends of Treatment

- Ohio realized $11 in savings on health care costs for every dollar spent on treatment.
- In Oregon, taxpayers saved $5.60 for every dollar spent on those who completed treatment.
- In federally-funded programs, $4 was saved for every dollar spent on treatment in health care and criminal justice costs.

The Dividends of Treatment

Pregnant Cocaine Users in Prenatal Care

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What Does the Research Say?

Assessing Costs and the Complications of Delivery

Svikis, et al. Johns Hopkins

146 Cocaine Abusing, Pregnant Women Seeking Pre-Natal Care – Not Treatment

100 Received -1 Week Residential Treatment

46 Received - Standard Pre-Natal Care

Cocaine and Urine at Delivery

100 Treated Women	46 Control Women
*37%	63%

Weight and Gestational Age

100 Treated Women	46 Control Women
*2939 gms	2534 gms
*39 wks	34 wks

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N-ICU Stay and Costs

100 Treated Women	46 Control Women
*7 days	39 days
*$14,500	$46,700

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What About Cost offsets?

- Cost offset studies are being conducted by a number of States

- These studies assess how alcohol and drug treatment can offset costs in other areas of health care, criminal justice costs, general assistance costs etc.

Cost Offsets- State of Washington

Results for SSI Clients – Health Indicators:

- $296 per client per month net cost offsets (after alcohol/drug treatment costs deducted) – methamphetamine.
- $267 per client per month net cost offsets (after alcohol/drug treatment costs deducted) – all other drugs/alcohol.
- Cost offsets higher for clients completing 90 days of alcohol/drug treatment or more.
- Cost offsets highest for treatment completers, regardless of length of stay.

Cost Offsets - State of Washington

Health Indicators (con't):

- 35% reduction in average monthly emergency room costs for alcohol/drug treated group versus non-treated persons (represents $154 per client per month reduction in costs).
- 29% decline in cost of an emergency room visit for treated versus non-treated persons; 20% decline in number of subsequent emergency room visits
- 42-64% reduction in subsequent emergency room visits for persons with primary mental illness who received (42%) or completed (64%) alcohol/drug treatment versus those that needed but didn't receive such care.

Cost Offsets-State of Washington

Criminal Justice Costs:

- 16% reduction in arrests for those entering treatment.
- 30% reduction in arrests for those receiving 90 days or more of treatment.
- 43% reduction in arrests for those completing treatment.
- Methamphetamine clients tend to have slightly better outcomes (higher reduction in arrests).

Who is Paying for Treatment?

- About 80% of expenditures for treatment for substance use disorders is made by public sources (Mark et al., 2005). We expect this to rise to 90% by 2010. Over two-thirds of spending is on direct government grants and contracts.

- Only 1.5% of Medicaid expenditures are for treatment of substance use disorders.

Who is Paying for Treatment?

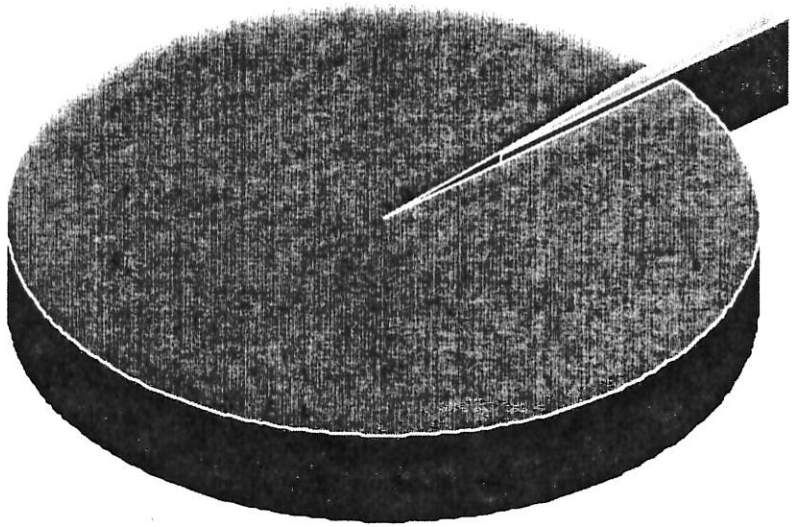
- Three-quarters of covered employees have limits on outpatient visits and two-thirds have limits on inpatient days.

- Private insurance spending for addiction treatment services declined from 22 percent in 1991 to 10 percent in 2003 (Gabel et al. Health Affairs, 2007)

Medical Spending is a Tiny Portion of All Health Spending, 2003

SA = $20.7 B

1.3%



All Health = $1.6 T

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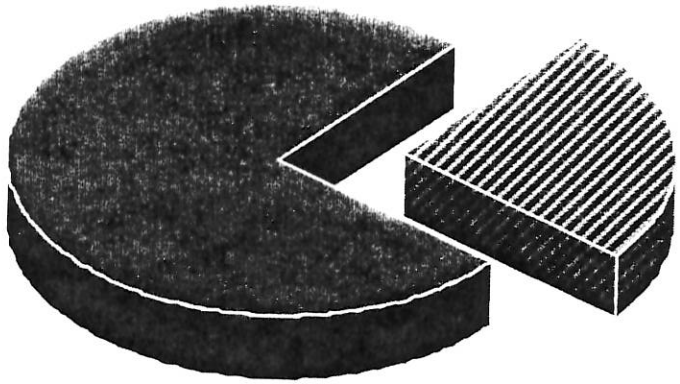
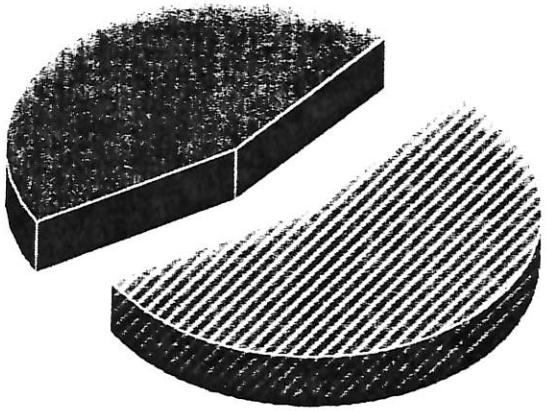
Public Expenditures Are Much Greater for Treatment of Substance Use Disorders Than for Health Care, 2001

All SA
Public, 76%



2001, All SA = $18.3 B
Public = $13.8 B
Private = $4.5 B

All Health
Public, 45%



2001, All Health = $1,372.5 B
Public = $613.1 B
Private = $759.4 B

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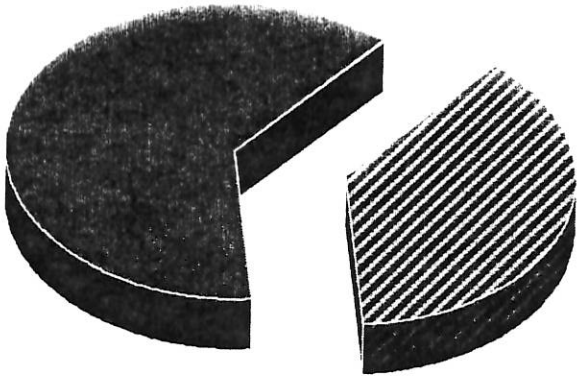
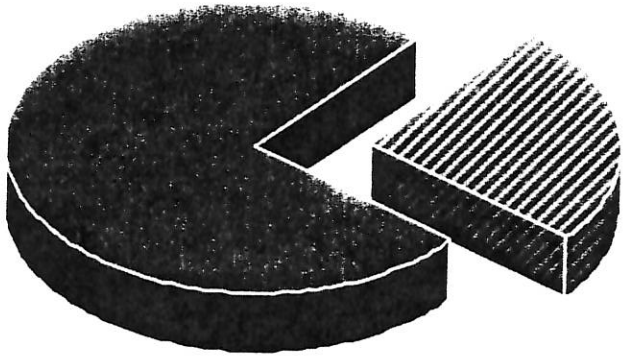
Public Spending is a Growing Proportion of Expenditures Between 1991 and 2001, in billions

All SA, 1991:
Public, 62%



All SA, 2001:
Public, 76%



1991, All SA = $11,436 B
Public = $7,142 B
Private = $4,295 B

2001, All SA = $18,264 B
Public = $13,794 B
Private = $4,470 B

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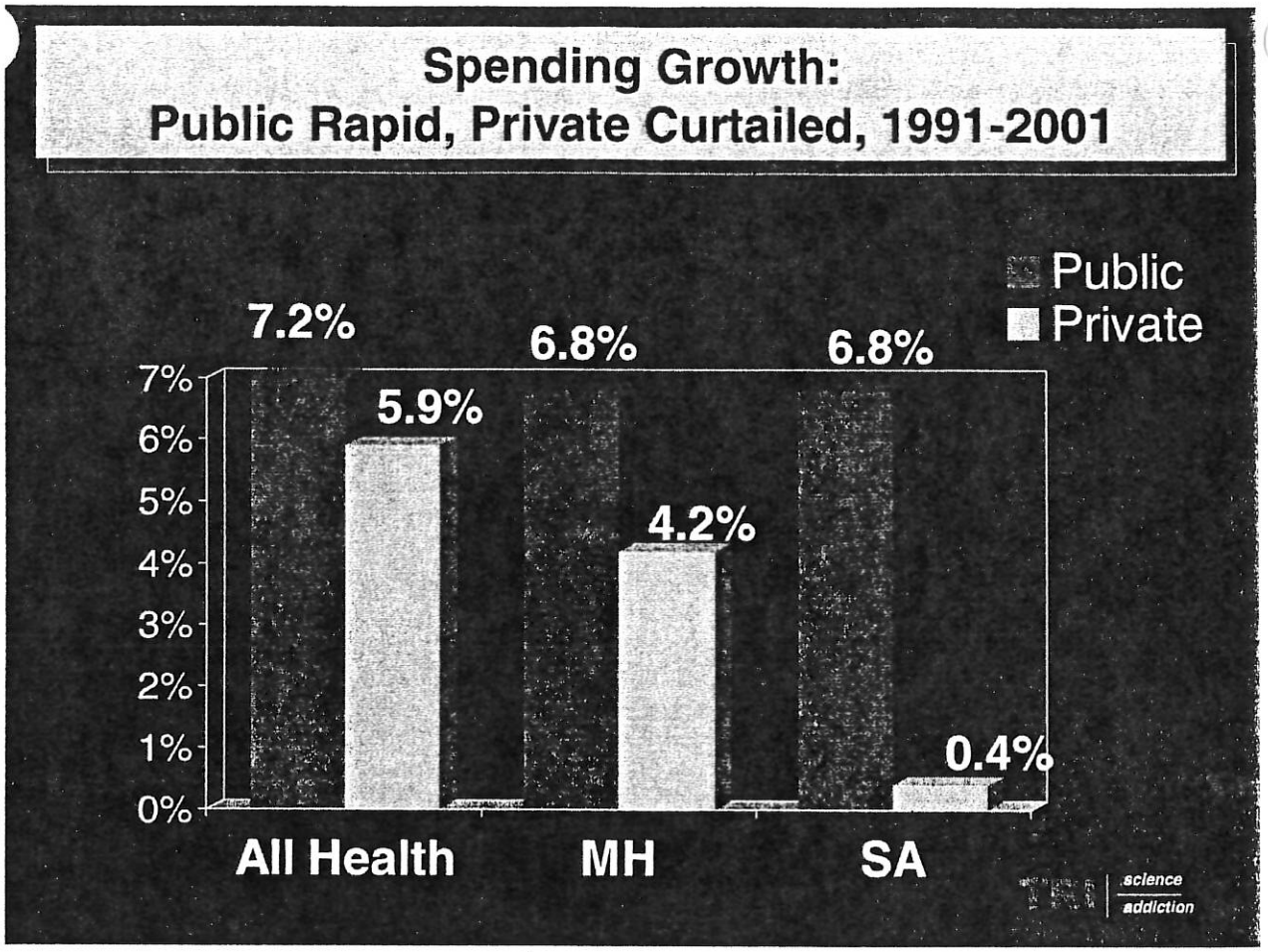
Spending Growth:
Public Rapid, Private Curtailed, 1991-2001
Public
Private
7.2%
5.9%
6.8%
4.2%
6.8%
0.4%
7%
6%
5%
4%
3%
2%
1%
0%
All Health
MH
SA
science
addiction

The Treatment System

- There are about 13,000 addiction specialty treatment programs in the US.
- About 80% of them are outpatient, and government funded.
- Of the outpatient programs, 75% see less than 300 admissions per year.
- Two-thirds are private, not for profit programs (D'Aunno, 2004).

The Public Treatment System: What Does It Look Like?

- Typically well-established nonprofit agencies with exclusive responsibility for providing treatment for low-income, uninsured populations.

- Public providers have fixed budgets, excess demand for services (as evidenced by waiting lists), and no competition.

The Public Treatment System: What Does It Look Like?

- Counselor turnover is about 50% per year and over half of Directors of treatment programs have been in their jobs for less than 1 year.

- The large majority of treatment program Directors (75%) have a Bachelor's Degree or less.

Who Are the Patients?

- Patients whose treatment is funded by State substance abuse agencies are also clients of ***many*** other State, county, and local agencies.

- Most of those in treatment have multiple medical illnesses and lack housing supports. Yet, about ¾ of those with addictions were employed full or part time in 2005 (Gabel et al., Health Affairs, 2007)

Chronic Illness and Continuing Care

- For many, if not most in the public sector, substance use disorders are chronic illnesses.

- And, as in other chronic illnesses, there is no cure but effective treatments are available.

Chronic Illness and Continuing Care

- The effects of treatment do not last very long ***after treatment stops***.

- Patients who are out of contact are at elevated risk for relapse; retention is essential.

How Does Treatment Look for Most Chronic Illnesses?

- Early, intensive stages of treatment prepare patients for later, less intensive care: the goal is self-management.

- Symptoms and function determine care intensity.

How Does Treatment Look for Most Chronic Illnesses?

- Evaluation is a ***clinical duty during treatment:***
  - Good function = continue care
  - Bad function = change care

How Does Treatment Look for Substance Use Disorders?

- Some ***fixed amount*** or duration of treatment is believed to ***resolve*** the problem.
- Goal is to get patients to ***complete*** treatment.
- Evaluation is a research responsibility done ***following the conclusion of treatment***.
- Poor outcome = failure.

What Do We Need to Do?

Implement a Continuing Care Model:

Primary Care – Identification, Brief Intervention

Referral

Specialty Care –

Initiation of Treatment

Duration Determined by

Symptoms and Function

Primary Continuing Care –

Continuous Recovery Monitoring

Long-Term Management Support

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Proven and Promising Practices

- There are now purchasing and administrative, promising practices that can encourage adoption of new treatment technologies.
- Implementing these promising practices may require some shift in regulations or new legislation, and a willingness by legislators to support experimentation in purchasing by the State.

What Are The Promising Practices?

- **State Level**
  - Braided funding.
  - Purchasing networks or multiple levels of care, ensuring diversity in provider networks.
  - Standardized definitions, rates, and performance criteria across state purchasing units.
  - Removing regulatory practices that present barriers to implementation of proven practices by providers.

What Are the Promising Practices?

- **Provider Level**
  - Strengthening business and clinical systems.
  - Developing inter-systems linkages.
  - Introducing new technology or employing technology in new roles to improve results.
  - Embracing the value of the customer as a key partner in shaping organizational change.

What Are Proven Clinical Treatment Practices?

- Availability and use of medications.
- Screening and brief interventions in primary and other health care settings.
- Standardized clinical assessments and specific psychosocial clinical interventions
- Recovery support services and concurrent recovery monitoring
- Care management and wraparound services.

(NQF, 2007)

What Is Concurrent Recovery Monitoring?

- Monitoring Care During Outpatient Treatment:
  - Identify and Reduce Threats to Progress
  - Teach Self-Management Skills
- Monitoring in Continuing Care:
  - Support Abstinence
  - Encourage Self-Monitoring
  - Intervene Upon Threats to Relapse

Using Performance Measures To Improve Treatment Quality

- Washington Circle Group measures of identification, initiation, and engagement currently being used by NCQA.

- New measure development: screening and brief interventions, recovery management support, medication-assisted treatment.

Performance-Based Contracting

- Contracting for reduced "time to treatment" and increased retention – the Delaware example
- Contracting for public health value: eliminating "detox-only" services and contracting for continuity – the Philadelphia example
- Contracting for post acute treatment recovery management – the Hazelton and Betty Ford examples

Implementing Recovery Management Support

- Provide telephone follow-up by specialty providers.
- Assure that patients receive check-ups with primary care clinicians and that clinicians intervene if threats to relapse are apparent.
- Provide access to recovery support services.

Using the NOMS for Accountability

- What are the NOMS: the NOMS use public health and public safety outcomes.
  - Abstinence
  - Increased employment/education
  - Decreased crime/criminal justice involvement
  - Increased in stability of housing
  - Social connectedness (under development)
  - Client perception of care (consumer survey under development by the Forum on Performance Measurement)
  - Increased access to services
  - Increased retention in treatment

The Future: Public Responsibility

- State and county public officials and legislatures who purchase care bear much of the burden and the responsibility for introducing change into public systems of care (despite its difficulty).
- The basic economics of the public system are at odds with shifts from well-established (entrenched) practices, yet shifts need to occur.
- Legislatures need to pay attention to the strategic location of their Substance Abuse State Agencies and to creating incentives for change.

Legislators Can Change the Treatment System

- Use performance incentives to leverage change
- Increase the use of technology in service delivery and reporting: management information systems
- Increase the focus on the need to improve the workforce
- Support collaborative planning and treatment at the State level
- Experiment with purchasing alternatives and mechanisms in the public sector
- Implement a continuing care model of treatment.

Legislators Means You!

- You need to have a Substance Abuse Treatment Strategic Plan to improve the quality of treatment services in Kansas.

- You need to see to it that your strategic plan becomes operational.