DHHS Should Integrate State Substance Abuse Treatment Facilities into the Community-Based System and Improve Performance Management

A presentation to the

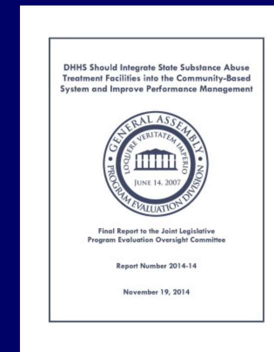
Joint Legislative Program Evaluation Oversight Committee

November 19, 2014

Jeff Grimes, Senior Program Evaluator

Handouts

- A copy of the report and presentation slides

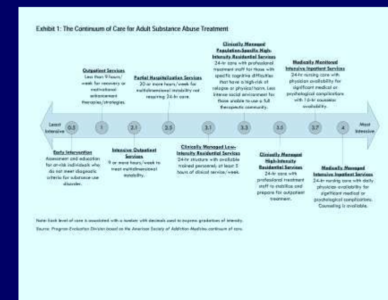

DHHS Should Integrate State Substance Abuse Treatment Facilities into the Community-Based System and Improve Performance Management

Final Report to the Joint Legislative Program Evaluation Oversight Committee

Report Number 2014-14

November 19, 2014

- Blue two-sided handout



Evaluation Team

Jeff Grimes, Evaluation Lead

Sean Hamel, Senior Evaluator

Brent Lucas, Program Evaluator

Carol Shaw, Principal Evaluator

Study Direction

- Session Law 2013-360, Section 12F.7.(b)
- Directed the Program Evaluation Division to examine the most effective and efficient ways to operate inpatient alcohol and drug abuse treatment programs

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Three Alcohol Drug Abuse Treatment Centers (ADATCs)

Julian F. Keith ADATC

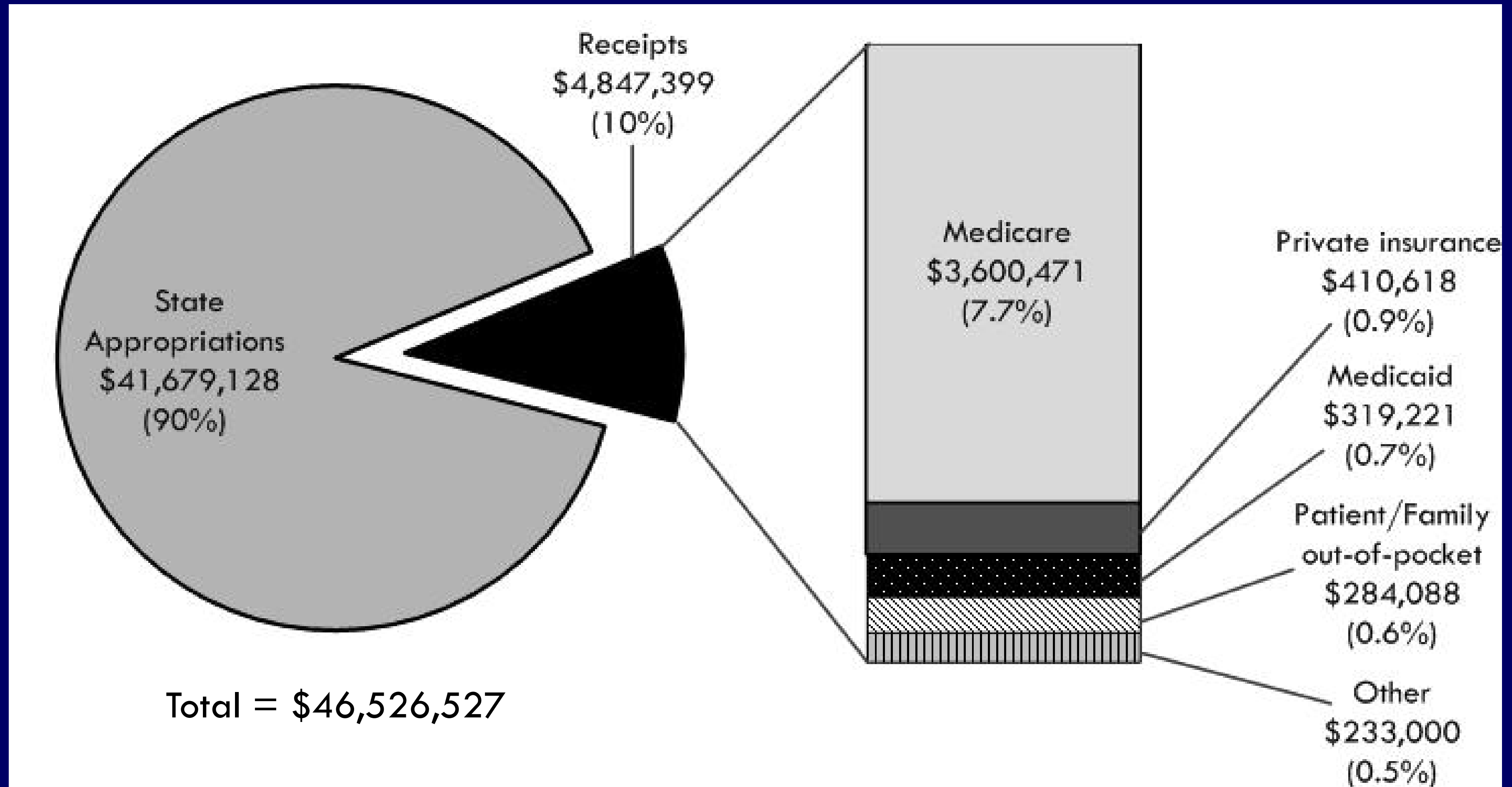
R.J. Blackley ADATC

Walter B. Jones ADATC

In Fiscal Year 2013-14 the ADATCs:

- Operated 196 beds
- Admitted 3,875 individuals
- Spent $46 million providing treatment

State Appropriations Funded 90% of ADATC Operations in Fiscal Year 2013-14



Community-Based Treatment System Local Management Entities/Managed Care Organizations (LME/MCOs)

Partners Behavioral Health Management
Pop: 909,286

CenterPoint Human Services
(Pop: 541,198)

East Carolina Behavioral Health
(Pop: 612,824)

Smoky Mountain Center
Pop: 1,089,897

Cardinal Innovations Healthcare Solutions
(Pop: 2,381,816)

Sandhills Center
(Pop: 1,067,108)

Alliance Behavioral Healthcare
(Pop: 1,727,580)

Eastpointe
(Pop: 827,734)

CoastalCare
(Pop: 633,580)

Configuration as of November 2014

Overview: Findings

1. The three Alcohol and Drug Abuse Treatment Centers operate with a high degree of autonomy, resulting in operational and treatment differences

2. Separation of the Alcohol and Drug Abuse Treatment Centers from the community-based system creates operational silos which impose challenges to utilization management, continuity of care, and information management

Overview: Findings

3. Separation of the Alcohol and Drug Abuse Treatment Centers from the community-based system limits North Carolina's ability to address service gaps and manage cost

4. North Carolina lacks a performance management system that tracks long-term outcomes of public substance abuse treatment

Overview: Recommendations

The General Assembly should

1. Integrate the Alcohol and Drug Abuse Treatment Centers into North Carolina's community-based substance abuse treatment system

2. Direct the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services to strengthen its performance management system by improving data collection and tracking long-term outcomes

American Society of Addiction Medicine (ASAM) Continuum of Care for Substance Abuse Treatment

Least Intensive → Most Intensive

0.5 — Early Intervention
Assessment and education for at-risk individuals who do not meet diagnostic criteria for substance use disorder.

1 — Outpatient Services
Less than 9 hours/ week for recovery or motivational enhancement therapies/strategies.

2.1 — Intensive Outpatient Services
9 or more hours/week to treat multidimensional instability.

2.5 — Partial Hospitalization Services
20 or more hours/week for multidimensional instability not requiring 24-hr care.

3.1 — Clinically Managed Low-Intensity Residential Services
24-hr structure with available trained personnel; at least 5 hours of clinical service/week.

3.3 — Clinically Managed Population-Specific High-Intensity Residential Services
24-hr care with professional treatment staff for those with specific cognitive difficulties that have a high risk of relapse or physical harm. Less-intense social environment for those unable to use a full therapeutic community.

3.5 — Clinically Managed High-Intensity Residential Services
24-hr care with professional treatment staff to stabilize and prepare for outpatient treatment.

3.7 — Medically Monitored Intensive Inpatient Services
24-hr nursing care with physician availability for significant medical or psychological complications with 16-hr counselor availability.

4 — Medically Managed Intensive Inpatient Services
24-hr nursing care with daily physician availability for significant medical or psychological complications. Counseling is available.

Report p. 4, Exhibit 1

Finding 1.

The three Alcohol and Drug Abuse Treatment Centers operate with a high degree of autonomy, resulting in operational and treatment differences

ADATC Admissions, Personnel, and Expenditures

ADATC Facility	Annual Admissions	Number of Personnel	2013–14 Expenditures	Average Cost Per Stay
Julian F. Keith	1,203	194	$15,212,660	$12,646
R.J. Blackley	1,291	152	$16,126,312	$12,491
Walter B. Jones	1,381	155	$15,187,556	$10,998
Total	3,875	501	$46,526,527	

Report p. 13, Exhibit 8

Over-Expenditures at ADATCs in Fiscal Year 2013-14

- **ADATCs received a $4.9 million reduction in appropriations**
- **ADATCs overspent appropriations by $5.2 million**
- **Overexpenditures covered by O'Berry Neuro-Medical Treatment Center and Murdoch Developmental Center**

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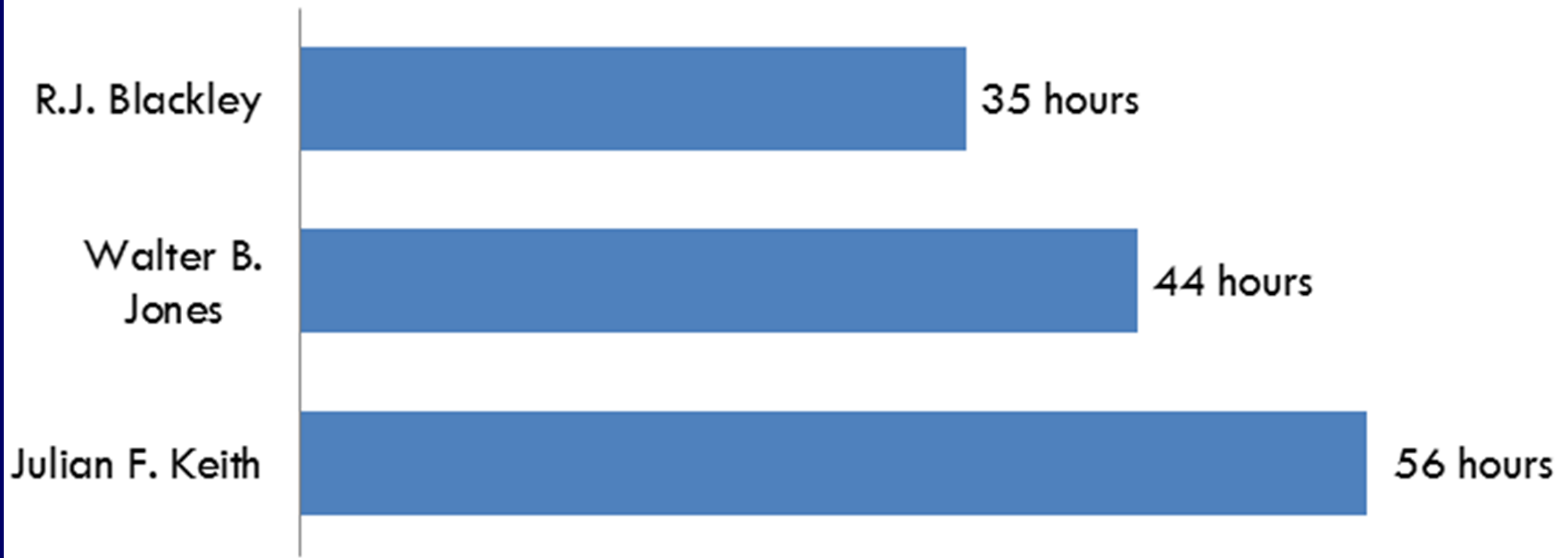
Hours of Treatment Programming Differ Among the Three ADATCs



Report p. 16, Exhibit 10

Finding 2.

Separation of the Alcohol and Drug Abuse Treatment Centers from the community-based system creates operational silos which impose challenges to utilization management, continuity of care, and information management

Structural Incentives Promote Overreliance on ADATCs

- LME/MCOs have no financial incentive to manage utilization of ADATCs
- ADATCs have limited incentive to restrict utilization
- LME/MCOs have little incentive to invest in expanded community-based treatment options that would serve as a substitute for ADATC services

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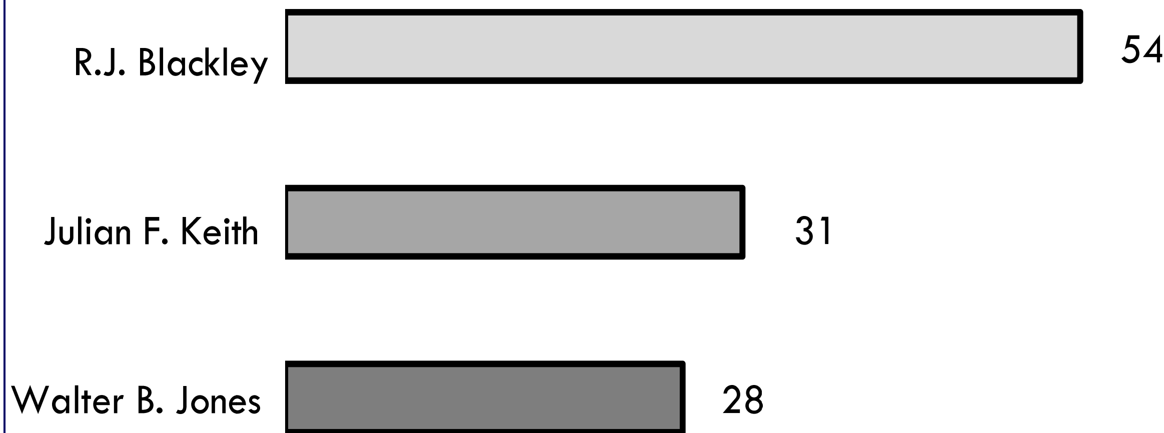
Prolonged Lengths of Stay Cost the State More Than $1.5 Million in Fiscal Years 2012-14

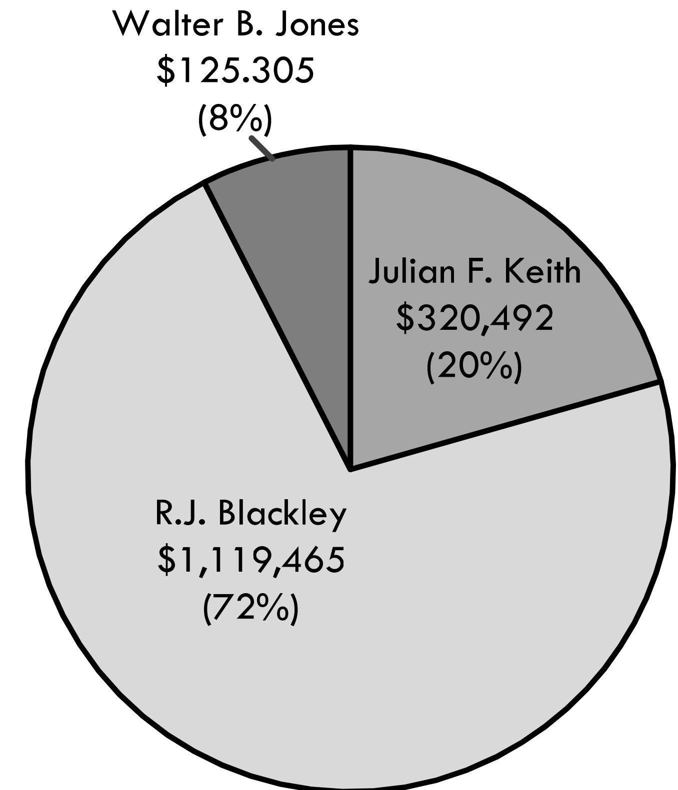
Number of Individuals Who Received Prolonged Treatment



Total = 113 Individuals

Prolonged Length of Stay = treatment days that exceeded two standard deviations from the mean number of treatment days at each facility

Cost of Prolonged Treatment



Total Cost = $1,565,262

Continuity of Care Among the ADATCs and LME/MCOs Falls Short of the Performance Target

60%
50%
40%
30%
20%
10%
0%

40% Performance Target

J. F. Keith
R. J. Blackley
W.B. Jones

FY2011-12 Q1
FY2011-12 Q2
FY2011-12 Q3
FY2011-12 Q4
FY2012-13 Q1
FY2012-13 Q2
FY2012-13 Q3

Report pp. 22-23, Exhibit 15

Finding 3.

Separation of the Alcohol and Drug Abuse Treatment Centers from the community-based system limits North Carolina's ability to address service gaps and manage cost

The Piedmont Demonstration Project

- In 2003, Piedmont Behavioral Health (PBH) began receiving a share of state institution funding from the psychiatric hospitals and ADATCs in order to expand their provider network in the community
- PBH agreed to pay ADATC when an individual from a PBH county is treated at an ADATC

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Fewer Individuals are Admitted to ADATCs from Piedmont Behavioral Health Counties

Admissions per 100,000

Fiscal Year	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Statewide Average	42	41	41	43	40	44	47	45	46	42	42
Piedmont Behavioral Health	36	24	22	11	13	9	6	3	2	1	3

Report pp. 26-27, 29-30

PBH Use of Other Services

- Two crisis/detoxification facilities that serve PBH counties
- Seven hospital detoxification providers
- 300 individuals served at medically monitored community residential treatment facility

Source: Cardinal Innovations Healthcare Solutions, Fiscal Year 2012-13

Report pp. 28-29

Medically Monitored Intensive Inpatient Services Cost Less in the Community-Based System

ADATC Treatment

ADATC Total Cost
$12,336

$771/day

Days of Treatment

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

$300/day

$273/day

Community-Based Treatment

Facility Based Crisis Services
$1,500

Medically Monitored Community Residential Treatment
$3,003

Community-Based Total Cost
$4,503

Report pp. 29-30, Exhibit 19

The Community-Based System Has Service Gaps

- Some LME/MCOs had levels of care for which they did not expend any dollars on services
- If there is a gap in services, individual may be treated at a higher level of care than necessary and at greater cost
- Separation of the ADATCs and community-based system limits the ability of LME/MCOs to address these gaps

Report pp. 31-34

Finding 4.

North Carolina lacks a performance management system that tracks long-term outcomes of public substance abuse treatment

Substance Abuse Treatment Performance Management

- North Carolina does not have reliable encounter-level data due to problems with NCTracks since July 2013
- When encounter-level data was available, performance management emphasized processes and outputs rather than outcomes

Report pp. 31-32, Exhibit 14

Measuring Long-Term Outcomes

Outcome Measure	Indicator
Reductions or abstention from substance use over time	• % of those treated who are no longer using • % of those treated who report reductions in use • % of those treated who report no use
Improvements in personal health over time	• Reductions in emergency room-related costs • Reductions in overall healthcare spending for those who received treatment
Improvements in social functioning over time	• Obtaining employment • Maintaining employment • Reduced reliance on social support programs • Stable living environment
Reductions in threats to public health and safety over time	• Reductions in criminal justice system interactions

Report pp. 31-32, Exhibit 14

Recommendations

Recommendation 1.

The General Assembly should integrate the Alcohol and Drug Abuse Treatment Centers into North Carolina's community-based substance abuse treatment system

The Process

- One year of planning for transition
- Reduce funding to ADATCs in 25% increments over a three-year transition period, while funding to LME/MCOs is increased by a corresponding amount
- By the fourth year, LME/MCOs would receive 100% of state appropriations previously going to ADATCs

Integration Process

- LME/MCOs would be able to use reallocated funding to increase capacity in the community-based system and/or purchase services from ADATCs
- By the end of the transition period, ADATCs would be providers in a LME/MCO network and would be receipt-supported based upon demand for services

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Timeline for Reporting

- Feb 1, 2016—LME/MCOs develop plans on how to use reallocated funding
- April 1, 2016—DHHS submits an ADATC business plan for the transition to the Joint Legislative Oversight Committee on Health and Human Services
- 2016 until 2020—DHHS annually submits report on integration of ADATCs into the community-based system and LME/MCO use of reallocated funding

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Recommendation 2.

The General Assembly should direct DMH/DD/SAS to strengthen its performance management system for substance abuse treatment by improving data collection and tracking long-term outcomes

Direct DMH/DD/SAS to Develop a Plan to Improve Performance Management

Plan should include:

- Specific long-term outcome measures the division will begin tracking
- Steps for incorporating outcomes into performance management system to assess the performance of providers, LME/MCOs, and the system as a whole
- Data elements to improve the process of analyzing gaps in the community-based system
- Timelines

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Plan for Improved Performance Management

- DMH/DD/SAS should submit a plan to the Joint Legislative Oversight Committee on Health and Human Services on or before January 15, 2016

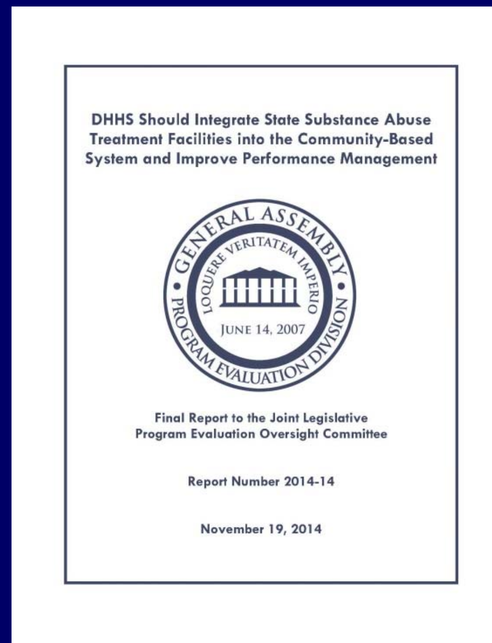
Summary

- Separation of the ADATCs from the community-based system limits North Carolina's ability to address service gaps, provide a seamless continuum of care, and manage cost
- DHHS should integrate the ADATCs into the community-based system and improve performance management by tracking long-term outcomes

Legislative Options

- Accept the report
- Refer it to any appropriate committees
- Instruct staff to draft legislation based on any of the report's recommendations

Report available online at www.ncleg.net/PED/Reports/reports.html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Jeff.grimes@ncleg.net

GENERAL ASSEMBLY • PROGRAM EVALUATION DIVISION •

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JUNE 14, 2007