

Part I - Reasons for Proposal by MCPAC

Revised by SOCR X-Tech Committee

Mission, Vision, Goal and Objectives for Change

Mission

To provide quality alcohol and other drug (AOD) prevention, early intervention and recovery/treatment services to individuals, families and communities and to improve outcomes through leadership, partnership and collaboration.

Vision

A system of care for AOD services is a planned, comprehensive approach with attention to our rich cultural diversity, providing a model for the delivery of prevention, early intervention and recovery/treatment services enabling individuals, families and communities to access appropriate services within an integrated, coordinated, and seamless system. Individual providers would be linked together into a system that would identify and utilize client outcome measurements, formalize provider relationships and bring them together under a formal, contractual arrangement. Provider agreements would cover provider fees, indicate how practice management should be conducted, what steps are to be taken to measure and evaluate quality, and how client satisfaction would be determined. This outcome-driven service system would formally establish collaborative relationships and comprehensive service agreements with other public and private human and community service systems to ensure that ancillary and inter-connected services are provided and matched to client needs.

Goals of the California AOD system include:

- ◆ Provide California communities with timely access to quality alcohol and other drug services.
- ◆ Establish strong community-based prevention efforts along with individual prevention and early intervention strategies.
- ◆ Provide leadership in developing and actively participating in cooperative and collaborative “client oriented” service delivery partnerships with other public and private sector service systems and communities.
- ◆ Eliminate or reduce alcohol and other drug abuse.
- ◆ Reduce social services involvement with individuals related to alcohol and other drug usage.

- ◆ Reduce criminal activity relating to alcohol and other drug usage.
- ◆ Reduce the amount of physical and mental suffering associated with alcohol and other drug usage.
- ◆ Enhance the stability of the individual through alcohol and other drug services, which may encourage education and employability.

Objectives

1. Enhance coordination linkages and timely access with schools, drug courts, Department of Correction, CalWORKs, Department of Social Services, Department of Developmental Services, Department of Mental Health and other ancillary service systems.
2. Ensure “client oriented” alcohol and other drug service system accountability and continued quality improvement.
3. Enhance and ensure timely access to alcohol and other drug prevention, intervention, treatment and recovery services by all eligible populations.
4. Enhance the quality and effectiveness of alcohol and other drug services.
5. Review client/participant outcome measurements.

PRINCIPLES OF CHANGE

Our design of an AOD **California system of care** is committed to the following principles:

1. To promote, advocate and support alcohol and other drug services as a unique, distinct and organized service specialty that reduces the level of alcohol and other drug-related problems of individuals, communities and society.
2. To promote, advocate and support alcohol and other drug services/programs that provide high quality and culturally competent prevention, treatment and recovery services that result in positive client/family/community outcomes and client/participation satisfaction. In particular, the role of community-based prevention strategies in stopping AOD abuse before individualized AOD services are required should be promoted.
3. To increase access to a full array of cost effective and efficient alcohol and other drug services/programs. Employ creative funding strategies for maximum revenue generation. Promote improved treatment and recovery outcomes through better communication, coordination, cooperation and collaboration with other service systems.

RATIONALE FOR CHANGE

Assessment of the Current Environment

The need for AOD services continues to grow, while the ability to deliver the publicly funded services often struggles to keep pace. The Managed Care Policy Advisory Committee (MCPAC) considered the following factors in assessing the current environment:

Continued Demand for AOD Services

In California, as elsewhere, the demand for publicly funded alcohol and drug treatment currently exceeds the available publicly funded capacity. This demand is demonstrated most clearly in the Drug and Alcohol Treatment Access Report (DATAR), which reports on provider waiting lists. The DATAR recorded in excess of 11,000 clients waiting for AOD treatment at the end of May 1999, the most recent month for which totals are available.

Moreover, this demand will continue to increase as alcohol and drug abuse issues are identified as fundamental barriers to progress in dealing with clients in other public service systems, such as welfare, criminal justice, children and family services, mental health and education. The demand will increase as those other systems seek publicly funded AOD services for their clients, as already seen in initiatives for welfare reform, perinatal care and criminal justice. (As an aside, MCPAC considered modification to existing data collection systems to be a vital step, so that the impact of AOD abuse on other public systems can be adequately assessed and anticipated.)

In addition, the demand is expected to continue increasing because a growing body of research has documented the effectiveness of alcohol and drug treatment/recovery services in reducing the negative impact of AOD abuse in people's lives, and the resulting reduction in overall public expenditures for clients who have utilized AOD services. The 1994 CALDATA study demonstrated publicly funded savings in a ratio of 7:1 to costs. Awareness of demonstrated effectiveness as well as continued improvements in techniques of assessing and treating AOD abuse will result in increased referrals for services.

Finally, the demand for AOD services continues even when public policy decisions are made to reduce services in other areas. For example, the recently enacted federal welfare reform legislation allows the States to deny certain benefits to some convicted felons; however, drug treatment is specifically excluded from the list of benefits that can be denied. For these

reasons, the AOD field projects increasing demand for publicly funded AOD services.

Current Efforts to Increase Access

The Department's proposed budget for FY 2000-01 is currently \$448,128,000, of which \$325,025,000 is specifically dedicated for treatment/recovery services. This amount has not been sufficient to reduce the unmet need as indicated by DATAR data, even though considerable efficiencies were made in the Drug Medi-Cal (DMC) program rates and practices. Prevalence and use trends continue to indicate long-term unmet AOD service needs. Recent increases in the rates of AOD use by youth have also indicated a potential demand for services.

However, the environment in which public services are delivered is also changing in the following ways:

- **Outcome Accountability**

Public sector services are increasingly expected to demonstrate measurable outcomes. In the AOD field, formalized outcome measurement is relatively new and, as in any behavior-involved service, somewhat controversial and difficult to define. However, many AOD programs and other States' AOD agencies are starting to define the expected outcome for treatment/recovery services as improved levels of functioning for AOD clients. Increasingly, public AOD agencies are viewing their role as the purchaser of improved levels of functioning on behalf of a defined group of beneficiaries with a documented alcohol or other drug problem that can be reduced by use of an AOD service. Under this concept, clients are seen as entering AOD programs when AOD abuse is causing varying degrees of dysfunction in medical, mental, family, social, legal, employment/education and housing domains of functioning. When the client enters an AOD program, the AOD program can assess that level of functioning using various available assessment tools, assign a descriptive indicator and record that indicator. The measures of success are that the client leaves the program at a higher level of functioning in the various domains and is no longer actively abusing alcohol or other drugs. Various tools for placement and outcome measurement have been reviewed and developed by MCPAC workgroups, and are included in this report.

AOD Services in California

To envision the impact of moving the current publicly funded AOD system in California to a California system of care, as the MCPAC prefers to term it, the MCPAC found the following observations important in forming the recommendations found in Part II of this document:

Managing Access: In general, a major criticism of the current AOD system is the largely unmanaged access to treatment/recovery services. In most counties, provider capacity, and the provider's willingness to accept a client as appropriate to the particular program drive the current access process. There is no process or incentive at present for providers to assess and refer clients to greater or lesser levels of care, based on the client's level of functioning. Often this results in decisions to accept a client for residential services, for instance, when the client's issue is more a lack of housing, as opposed to the need for the full-time support system offered by a residential program during a client's initial recovery period.

The MCPAC discussed the need to move from purchasing capacity in the AOD system to purchasing outcomes through the use of tools proposed in this report, and placing clients in the least restrictive setting, as methods of managing access and thereby increasing capacity and access to the AOD system.

Uniform Assessment Tool: As initial steps, the MCPAC's Briefing Paper recommended that the field move toward a uniform access tool. These tools improved the efficiency and effectiveness of treatment placement, planning, and outcome measurement. A MCPAC subcommittee developed recommendations on appropriate assessment tools, placement criteria and outcome data. The field is beginning to test these recommended tools in CalTOP. In fact, several counties have moved forward on their own and are already experimenting with standardized assessments and client treatment/recovery matching.

To transition the current system to an AOD California system of care, as assessed by the MCPAC, will require extensive efforts at standardizing assessments, implementing data systems, developing acceptable placement criteria, and systematically recording and reviewing outcomes to improve program practices. This fundamental infrastructure must be in place before the fiscal impacts are assessed and any change in existing financial systems is implemented.

The MCPAC developed several recommendations to begin this transition. Cross-system screening tools were reviewed and recommended (Appendix E). The California Treatment/Recovery Placement Indicators (Appendix F) was developed by MCPAC as a tool that reflects California adaptation of the American Society of Addiction Medicine (ASAM) Patient Placement Criteria, establishing a common structure to describe a client's level of care placement. Above all, data collection systems need to be modified in order to collect this more outcome-based data. Prior to use in CalTOP, a statewide survey was completed to look at the most commonly used and accepted screening and assessment tools in California. The ASI was found to be both the gold standard and the most commonly used assessment tool. Presently, CalTOP is automating the use of the ASI Lite and these other assessment tools.

Savings Issue: While the MCPAC looked at savings to be achieved using capitation techniques and managed care, it found that the usual managed care savings strategies of using fewer high-end costly services, such as hospitalization, or of managing repeat visits, would not produce savings in California. First, there are very few high-end hospitalization services in the current AOD service system; second, when repeat visits do occur, do so in less costly services and third, addiction is a chronic, lifetime disease which does not lend itself to capitation or other financially driven systems.

However, the MCPAC has come to believe that many of the salient managed care techniques could be applied to a client driven service system and achieve some efficiency. Therefore, this proposal incorporates some of those concepts, such as standardized assessment and placement matching. Moreover, documented linkages of clients to other public systems would allow those systems to achieve savings by investing resources in AOD services.

Fiscal Transition: The MCPAC has reviewed managed care and capitation and has found that it is not a viable funding mechanism for the alcohol and drug field, financially driven systems use the acute disease model while a chronic disease model needs the system of care continuum of services. A move to capitated rates for the AOD publicly funded system should not be undertaken in California.

The MCPAC also studied the issue of risk assumption in traditional managed care systems. It concluded that the current AOD service provider network has little experience in managing at-risk contracts,

and MCPAC does not recommend risk assumption that jeopardizes the business viability of providers.

Given these conclusions, the MCPAC is recommending a phased-in fiscal migration plan. This plan would first develop a service code billing structure, built from components of the larger program modalities currently in place. Definitions would be established for services, such as counseling sessions, dosage, education, and aftercare visits. After running a system to gather data on utilization under this service code structure for a period of time, the State could then choose to consider appropriate changes to the financial system. The long-term structure must recognize alcohol and drug addiction as a chronic relapsing disease, support local priority setting and rely on performance outcomes that employ realistic measures of effectiveness.

Cultural Competency: The MCPAC believes that cultural competency is not simply a part of provider readiness but is crucial to successful outcomes and needs to be built into all mechanisms of the system, including technical assistance and Director's Advisory Council contracts, data collection, financing (as requirements placed on plan/brokers), assessment, governance, and outcomes. The Cultural Competency Work Teams recommendations for ensuring that a culturally competent system is developed can be found in the workgroup reports section (Report 3).

In Summary

Because these changes are complex, the MCPAC offers its recommendations with the service provider's challenge for the future: outcome system based on client needs, integration of systems while retaining specialization of AOD experts. The MCPAC advises those who would engage in the subsequent policy discussions of this paper to first take time to define their terms when speaking about managed care. Managed care has many concepts and many meanings. It has been implemented too quickly and worked poorly for AOD services in many states.

Above all, it is important to recognize that we have the ability in California to use the more successful parts of managed care, to design a **California system of care**, and to build safeguards into the law to protect against managed care abuses. The AOD field should not be wedded to other systems definitions or solutions. We have the opportunity in California to construct beneficial changes to the existing AOD system, preserving its strengths, highlighting prevention services and, at the same time, increasing access to useful, necessary public services.

