

**NC INSTITUTE OF MEDICINE
TASK FORCE ON SUBSTANCE ABUSE SERVICES
November 16, 2007
10:00-3:00
NC Hospital Association**

Meeting Summary

Attendees:

Task Force/Steering Committee: Martha Alexander, Patrice Alexander, Bert Bennett, Robert Bilbro, Dewayne Book, Barbara Boyce, Sherry Bradsher, Carl Britton-Watkins, Sonya Brown, Anthony Burnett, Spencer Clark, Larry Colie, Chris Collins, April Conner, Debra DeBruhl, Anne Doolen, Beverly Earle, Tony Foriest, David Friedman, Irene Godinez, Paula Harrington, Carol Hoffman, Verla Insko, Larry Johnson, Joan Kaye, Tara Larson, Kevin McDonald, Linda McEwen, Philip Mooring, Mike Moseley, Paul Nagy, Martin Nesbitt, Martin Pharr, Sharen Prevatte, William Purcell, Thomas Savidge, Jane Schairer, Starleen Scott Robbins, DeDe Severino, Flo Stein, Steve Sumerel, David Turpin, Wendy Webster.

Interested Persons: Terrill Bravender, Beverly Brookshire, Melanie Bush, Tad Clodfelter, Scarlette Gardener, Kathleen Gibson, Jason Johnson, Jeanette Jordan-Huffman, Shawn Parker, Kevin Ryan, Becky Scott, Shellie Thompson, Mike Vicario. *Staff:* Kimberly Alexander-Bratcher, Thalia Fuller, Mark Holmes, Kiernan McGorty, Pam Silberman, Daniel Shive

WELCOME AND INTRODUCTIONS

Representative Verla Insko

NC House of Representatives

Team work and consensus building will prove very important for the success of this task force. As such, it is good to see all of the Task Force members getting to know each other. Rep. Insko also pointed out the new seating configuration for the meeting and invited comments/feedback.

The notebooks that were distributed at the first meeting are yours to keep, but please bring them with you to all subsequent meetings.

Senator Martin L. Nesbitt, Jr., JD

NC Senate

Dewayne Book, MD

Medical Director

Fellowship Hall

SUMMARY OF 10-31-07 LEGISLATIVE OVERSIGHT COMMITTEE

Mark Holmes, PhD

Vice President

NC Institute of Medicine

Three addiction researchers presented at the LOC meeting; Dr. Thomas McClellan, CEO of the Treatment Research Institute, Dr. Mandy Chalk, Director of the Center for Performance Based Policy, and Kimberly Johnson of the Network for the Improvement of Addiction Treatment.

Dr. McClellan addressed the role of the state and private enterprise in improving the effectiveness and accountability of addiction treatment. The presentation builds off a four-pronged model for treatment improvement. We must increase the understanding of how addiction treatment is perceived by patients, the public and policy makers as well as how to properly pay providers for effective treatment. A primary hurdle for effective addiction treatment is counteracting the mindset that addiction treatment does not work. Perhaps it is not that addiction treatments do not work but that we are using the wrong metrics to measure their effectiveness. Substance addiction is a chronic condition and should be evaluated as such. A second barrier to effective treatment stems from a misunderstanding of why patients do not want treatment. The answers are varied but the majority of people either do not realize they have a problem, believe that they can handle the problem on their own, or find little value in the services currently available. We need to make services more valuable to patients. Computer-assisted systems for patient assessment and referral (CASPAR) work to link patient specific needs with available services in the community. Referral services would include non-treatment resources such as housing, employment or child care assistance in addition to various levels of addiction treatment. Some of these resources would help to address the common predictive factors for relapse: non-adherence to treatment plan, low socio-economic class, low family support, or presence of a co-occurring mental problem. Pay-for-performance contracting could offer a potential solution to many of these problems. Dr. McClellan used Delaware as a prototype for performance-based contracting.

Dr. Chalk discussed the pros and cons of various funding tools for addiction service systems, specifically, grants, contracts and public-private networks. Contract arrangements should be used when the funding organization would like to have greater quality and financial accountability for the contractor. Grants, on the other hand, allow for greater operational autonomy but sacrifice accountability. Public-private networks rely heavily on a strong integrator. This includes integration of organizational values and needs as well as technological integration. Dr. Chalk also discussed several questions to consider when considering a funding mechanism.

Kimberly Johnson discussed performance based contracting as experienced in Maine. Maine developed a system that concentrated on quality improvement with provider feedback. Such arrangements require extensive data collection systems, clear data definitions, explicit performance measures. To date, Maine has credited its performance-based contracting with an increased quantity and improved quality of services delivered to resident of Maine.

AMERICAN SOCIETY OF ADDICTION MEDICINE CRITERIA

Clinical Innovators Series DVD

Features David Mee-Lee, MD

Author of ASAM Criteria

The American Society of Addiction Medicine (ASAM) evolved in the 1950's as a result of the general lack of established substance abuse treatment protocols. Part of the mission of ASAM is to establish addiction treatment as a recognized primary specialty. As such, ASAM provides addiction treatment certifications. ASAM certified physicians represent the premier group of physicians treating addiction in the country. Any type of provider can become ASAM certified. There are currently about 3,000 ASAM certified physicians. This number is far below what is needed to properly treat the quantity of people in need of treatment. Most addicts are seen at off hours in the emergency room which is the worst time to encounter these patients. It is difficult to get them seen by a specialist or to help them adhere to treatment. This cycle leads us to think that addiction treatment doesn't work when in fact addiction treatment has a higher success rate than for many other chronic conditions. There is a need to have a common language in addiction treatment. The ASAM guidelines are an attempt to create a uniform standard of care in substance abuse treatment.

Before watching the ASAM Patient Placement Criteria (PPC) video, Dr. Book gave a brief overview of common terms used in the ASAM PPC.

- **Patient placement criteria** are comprehensive national guidelines for placement, continued stay, and discharge of patients with alcohol and other drug problems.
- **Levels of care** is a method of describing a range of treatment services and intensities common in mental health and substance abuse fields.
- **Dimensions** refer to the six assessment categories in which client data can be organized. The six dimensions cover key areas of a patient's life such as health, mental and emotional well-being, family, and other environmental factors.
- **Severity** is the measure of a patient's important needs as they are determined during assessment and treatment planning.
- **Acute intoxication and withdrawal potential** refers to the need to understand how the chemical works in the body in order to determine the appropriate level of care. All too frequently patients must fail at lower level of care before moving them to other levels of treatment. Instead, time should be taken on the front end to understand the complete problem and then it match to the appropriate level of care.
- **Biomedical conditions** refer to the need to understand what other medical conditions a patient may have and to understand how these conditions may impact treatment. For instance, diabetics may need to bring down their insulin in order to address the lower level of sugars in the blood as they stop drinking.
- **Emotional, behavioral or cognitive conditions** refer to the need to know whether the patient suffers from a mental or cognitive disorder that may interfere with treatment. It is also necessary to understand whether the disorder is caused by or is autonomous from the substance abuse problem.
- **Readiness to change** refers to the patient's awareness of the need for change and, more specifically, how receptive or resistant the patient is to make that change. If the patient is receptive of change then a provider works with the patient to create a recovery treatment plan that is sensitive to the needs of the patient. However, if the patient is not ready to change, the patient should be engaged into treatment using motivational enhancement strategies.
- **Relapse, continued use, or continued problem potential** assesses how likely a person is to relapse. A person must have some level of sobriety before he/she can be considered to relapse. Again, motivational enhancement strategies can be used to help the patient focus on the consequences of continued substance use.
- **Recovery environment** is a very important component of long-term recovery. The recovery environment is not just concerned with the absence of substances in the home but also about the extent of the patient's social and family supports. Ultimately, does the recovery environment have the potential to assist or hinder the recovery process?

The Task Force watched a video about ASAM criteria.

The American Society of Addiction Medicine (ASAM) has developed patient placement guidelines that identify the continuum of services needed for the lifelong treatment of substance abuse. The ASAM Patient Placement Criteria (ASAM PPC-2R) are based on a biopsychosocial model. The origins of addiction are multifaceted and require a holistic individualized treatment approach. The ASAM PPC-2R utilizes a multi-dimensional assessment to assist in matching patients with the appropriate level and modality of care.

The ASAM model is generally accepted as the standard for treatment of substance abuse. The ASAM model is based on a continuum of five basic levels of care. These levels of care are subdivided by intensity of treatment:

- Early Intervention (Level 0.5)
- Outpatient Treatment (Level I)
- Intensive Outpatient/Partial Hospitalization Treatment (Level II)
- Residential/Inpatient Treatment (Level III)

- Medically Managed Intensive Inpatient Treatment (Level IV)

These levels of care are defined by six assessment dimensions. Assessment dimensions were developed separately for adults and adolescents due to inherent differences in their stages of emotional, cognitive, physical, social, and moral development. The assessment dimensions determine a patient's mental and physical state at the time of assessment in order to better tailor the patient's placement on the continuum of services. The assessment dimensions are listed below:

- Acute Intoxication and/or Withdrawal Potential
- Biomedical Conditions and Complications
- Emotional, Behavioral, or Cognitive Conditions and Complications
- Readiness to Change
- Relapse, Continued Use, or Continued Problem Potential
- Recovery/Living Environment

As one moves to higher levels of care, the cost and intensity of the services increases.

FOLLOW-UP DISCUSSION

Flo Stein

Chief

Community Policy Management

Division MH/DD/SAS

NC Department of Health and Human Services

North Carolina adopted a modified ASAM continuum of care during the first years of reform. The ASAM PPC is similar to the DSM-4 used in psychiatry. It is used as a way to organize thinking and facilitate communication; two things that are not currently done very well. The ASAM PPC represents a system of addiction medicine. This system can be expensive, prohibiting many programs from having appropriate physician interaction.

The North Carolina Licensing Board requires that physicians know the ASAM PPC and are tested before being licensed.

The North Carolina ASAM continuum of care does not incorporate all services at each level of care; however there is at least one service within each care level to keep the continuum of services intact. Some of the higher levels of care are very expensive and have fewer people that need them. There is a need to develop local and regional capacity. For example, there are few providers of medically monitored community residential treatment in the private sector. Most of the treatment need for this level of care is absorbed by the state run Alcohol and Drug Addiction Treatment Centers (ADATC).

North Carolina ASAM Levels of Care for Adults

Detoxification Levels:

- Level I-D: Ambulatory Detoxification
- Level II-D: Social Setting Detoxification
- Level III.7-D: Non-Hospital Medical Detoxification
- Level IV-D: Medically Supervised or ADATC Detoxification/Crisis Stabilization

Treatment Levels:

- Level I
 - Diagnostic Assessment
 - Substance Abuse Community Support Services-Adult and Team
 - Mobile Crisis Management
- Level II.1: Substance Abuse Intensive Outpatient

- Level II.5: Substance Abuse Comprehensive Outpatient Treatment
- Level III.1: Substance Abuse Halfway House
- Level III.5: Substance Abuse Non-Medical Community Residential Treatment
- Level III.7: Substance Abuse Medically Monitored Community Residential Treatment
- Level IV: Inpatient Hospital Substance Abuse Treatment

North Carolina ASAM Levels of Care for Adolescents

Treatment Levels:

- Level I
 - Diagnostic Assessment
 - Substance Abuse Community Support Services-Adolescent
 - Mobile Crisis Management
 - Intensive In-home Treatment
 - Multi-Systemic Therapy (MST)
- Level II.1:
 - Child and Adolescent Day Treatment
 - Substance Abuse Intensive Outpatient
- Level III.5: Substance Abuse Non-Medical Community Residential Treatment
- Level IV: Inpatient Hospital Substance Abuse Treatment

The ASAM guidelines do not have a separate continuum of care for dually diagnosed patients. Instead, ASAM builds in dual diagnosis capacity within the adult and adolescent models through a tiered treatment plan. The ASAM guidelines define three different types of substance abuse treatment programs: 1) Dual Diagnosis Capable Programs, 2) Dual Diagnosis Enhanced Programs, and 3) Addiction-Only Programs. North Carolina does not currently distinguish between the capable and enhanced programs. Dual Diagnosis Capable Programs focus primarily on treating substance abuse conditions but are capable of handling patients with stable mental illnesses. Dual Diagnosed Enhanced Programs are geared toward patients who are more symptomatic or functionally impaired due to co-occurring mental disorders but still need primary addiction treatment. Addiction-Only Programs lack the capability to treat patients with co-occurring disabilities.

COMMENTS:

Question: How is ASAM assessment conducted in North Carolina?

Comment: The ASAM PPC is not an assessment instrument in itself. The ASAM PPC is a set of criteria that should be incorporated by individual assessment instruments. In other words, whatever assessment is used should address the six ASAM PPC dimensions. The Addiction Severity Index is a commonly used instrument. MHDDSAS currently monitors the use of these criteria in public programs.

Question: How can physicians develop an effective treatment plan if the full range of services is not available in all areas of the state?

Comment: There should be regional agreements to secure access to all levels of care through referral networks in areas where NC ASAM levels of care are not available.

Question: Are there ASAM training programs?

Comment: Yes, North Carolina is considered a leader in this area. The North Carolina Higher Education Consortiums provide coordinated substance abuse Master and Associate degree programs across the state. There are five Master programs throughout the UNC system and eight community colleges that offer Associate degrees. All of programs negotiated with the Licensing Board to make sure that all class and field placement requirements meet the licensing board standards. These are highly prescribed programs with classes ranging from 10 to 20 students per year. However, there is still a shortage in NC.

Question: Why does North Carolina not use the entire ASAM care continuum?

Comment: Providers can offer any level of care that they want; however they may not be reimbursed by Medicaid for those services outside of the NC ASAM. The current NC ASAM care continuum represents those services that are currently reimbursed by Medicaid. North Carolina has one of the most robust Medicaid substance abuse coverage of any state. Although North Carolina has an extensive array of services, we are not very good at operationalizing these services. The government is currently the only purchaser for many of these services. Local management entities (LMEs) have the money but do not have the provider base in which to spend it, which could be the primary reason for the large amount of funding that was reverted back to the state. Substance abusers are underserved in the state, particularly those individuals at the lowest levels of care. We need substance abuse parity. It is possible that substance abuse parity will be debated in the 2009 General Assembly. The success of any parity legislation will depend on how well we are able to educate the general assembly about substance abuse issues in the state, because there is currently a lack of knowledge on how to approach this issue.

Question: Aside from Medicaid will state dollars pay for other substance abuse services?

Comment: Yes, a good example of this is Triangle Residential Options for Substance Abusers (TROSA). The TROSA level of care (Therapeutic Communities) is not in the NC ASAM but is paid for with state dollars.

Question: Staffing requirements for each level of ASAM may prove difficult to meet given the shortage of substance abuse providers in the State. What options are available to help build capacity?

Comment: The entire nation is experiencing substance abuse workforce shortages. One possible solution is the use of paraprofessionals. However, paraprofessionals must be supervised by qualified professionals. It is sometimes difficult to find these professionals. Another option is to not limit positions to only those people with certain educational requirements. There is a large segment of the substance abuse workforce that has extensive on-the-job, skills-based training that could be utilized in many of these situations. We will return to this discussion at a future meeting.

Comment: We also need to be aware of the need for services in the working population. Many of these people may have insurance but are still not able to afford substance abuse treatment, or they may be hesitant to enter treatment for fear of losing their job. No one knows what the service capacity is for these people.

PREVENTION OF SUBSTANCE ABUSE

Phillip A. Mooring, MS, CSAPC, LCAS

Executive Director
Families in Action, Inc

Addiction is a disease that begins in adolescence. Research shows that early onset of drinking increases the risk of alcohol addiction. As such, substance addiction prevention should focus on delaying the onset of substance use in the adolescent population.

Key concepts of a successful prevention strategy should include recommendations for improving the accuracy of adolescent substance use data, increasing capacity through community coalitions, creating a multifaceted state prevention plan with defined and measurable outcomes, providing the necessary technical support to implement the plan, and increasing appropriations earmarked for prevention. More and accurate data is needed at the micro level (eg, counties and schools) to inform the planning processes. It is necessary to better understand where problems exist in order to better target programs.

Substance abuse impacts all aspects of society. Substance abuse diverts resources from institutions that were not designed to treat substance abuse (eg, ERs, judicial system, social services, and schools).

Substance abuse also impacts the labor supply. Of the 4,000 applications received to fill 160 positions at a Sam's Club in Rocky Mount, about 2,000 were denied due to failed drug tests. A Bridgestone-Firestone manufacturing plant in Wilson estimates that sixty percent of potential employees cannot pass a drug test. They are having difficulty filling 45 job vacancies and have entertained the notion of widening recruitment into southern Virginia.

If we are confident in the effectiveness of substance abuse prevention practices, why do we have such a gap in prevention funding? Nationally, 96% of total healthcare funding is directed to treatment services. In North Carolina, we spend about six percent of public substance abuse funds on prevention.

The five-step Strategic Prevention Framework (SPF) is a model for effective implementation of prevention practices. Underlying the SPF is the idea that prevention is an ordered set of steps and not just a one-time implementation event. Prevention is local and must involve the whole community. Boy Scouts and 4-H clubs are good ways to get community involvement. The SPF should be a part of all state, regional and local substance abuse plans. The first step of the SPF is to assess the prevention needs of the community as well as the resources the community has to address the needs. It is also important to understand the readiness of the community to address the problems and gaps in service delivery that are identified. The next step in the process is to mobilize the community. Part of mobilization is to build capacity to address the community need. The next steps are to develop and implement a comprehensive strategic plan. The final component in the SPF is to monitor the process in order to sustain effective programs and improve or replace those programs that fail.

The use of community coalitions is an effective way to garner and sustain community involvement in the prevention process. Community Anti-Drug Coalitions, for example, pool substance abuse related resources at the community level. There are currently 30 of these coalitions in North Carolina in various stages of implementation.

Mr. Mooring reviewed the use of coalitions and their fit into the principles of an ideal substance abuse system presented by Flo Stein during the previous meeting. Coalitions are consumer driven, bringing local people together to solve local problems. Grass-root efforts have historically been effective. For example, the "parent movement" of the 1980s led to decreased substance use. Coalitions are also prevention focused and outcome oriented. They use evidence-based practices that can be evaluated, and are generally cost effective. Coalition funding supports a total community effort that focuses on changing the environment and culture of a community. Examples of communities in action include coalitions in Clay County and Chapel-Hill Carrboro.

EVIDENCED-BASED PRACTICES AND THEIR IMPLEMENTATION

Sara McEwen, MD, MPH

Interim Executive Director

Governor's Institute on Alcohol and Substance Abuse

Evidence-based practices integrate the best research evidence with clinical expertise and patient values. The underutilization of evidence-based practices (EBP) is not just a problem in substance abuse treatment but for healthcare in general. When EBPs are used there is tremendous geographic variability in which practices are chosen and how those practices are implemented. The IOM, in *Crossing the Quality Chasm*, called for the use of EBPs in decisions about proper course of care. This recommendation may seem obvious; however the use of EBPs is not always the case in medicine.

The National Quality Forum (NQF) came out with a set of consensus standards on evidence-based practices for the treatment of substance abuse conditions in September of this year. The NQF standards were built on four domains (or stages) of care: identification and assessment, initiation and engagement in treatment,

intervention, and continuation of care management. Within these domains the NQF identified nine treatment practices:

- Annual screening in general and mental healthcare settings for at-risk drinking, alcohol disorders, and any tobacco use
- Providers should use systematic method to identify or screen patients
- Patients with a positive screen for a substance abuse disorder should receive further assessment; patients diagnosed with a substance abuse illness should receive a multi-dimensional, biopsychosocial assessment
- Patients identified with excess alcohol use and/or any tobacco use should receive a brief motivational intervention
- Providers should promote engagement in treatment; patients should receive supportive services
- Supportive pharmacotherapy should be available and provided to manage the symptoms and risk of serious adverse consequences related to withdrawal; withdrawal mgmt should be linked with ongoing treatment
- Empirically validated psychosocial treatment interventions should be initiated for all patients with substance use illnesses
- Pharmacotherapy should be recommended and available to all adult patients diagnosed with opioid dependence/alcohol dependence/nicotine dependence and without medical contraindications. Psychosocial treatment/support should also be provided.
- Patients should be offered long-term, coordinated management for their substance abuse illness and any co-existing conditions

To be considered an evidence-based program, the program must be based on two or more high quality research studies using randomized group designs. The studies should be done by two or more independent research groups, and be summarized in meta-analyses. Examples of evidence-based programs and practices are found in the SAMHSA's National Registry of Effective Programs and Practices (NREPP). The NREPP is a searchable database of interventions for the prevention and treatment of mental health and substance abuse disorders. All interventions listed in the registry have been reviewed and rated by independent experts based on supporting intervention outcomes and the quality and availability of training and implementation materials. SAMHSA also published six toolkits (ACT, Illness Management and Recovery, Supported Employment, Family Psychoeducation, IDDT, and Medication Management); however these toolkits are primarily focused on mental health.

So, if we know what works why are we having such a problem instituting evidence-based practice in substance abuse treatment and prevention? A primary reason stems from the fact that research is conducted under ideal circumstances with specific problems and populations. Some practices may not be generalizable to other groups or settings

The usability of a program has little to do with the quality of the evidence regarding the program. The most effective programs prove ineffective unless they are able to be successfully implemented. Part of the difficulty stems from the lack of research on how to operationalize EBPs. EBPs can be complicated, particularly when attempting to integrate them into existing processes and systems. In the real world, circumstances are constantly changing which requires flexibility and adaptability over the long-term. The implementation of EBPs takes time and requires incremental implementation. Programs should first make sure that the proper infrastructure is in place and ensure that directors, managers and funders are on board to facilitate effective practitioner practices. Then they should begin an initial product roll-out. A full practice implementation should be informed by lessons learned in the initial roll-out, and should be monitored to allow for innovation and practice sustainability.

The North Carolina Practice Improvement Collaborative (NCPIC) is comprised of mental health, developmental disability, and substance abuse educators, researchers, providers and consumers who work to connect research and practice. NC PIC meets quarterly to review and discuss relevant programs.

Annually, the group presents a report of prioritized program recommendations to the Division Director at a public forum. This forum, defined as the North Carolina Practice Improvement Congress, features brief educational descriptions of the practices being recommended by the NC PIC in its report. Currently the NC PIC is piloting three substance abuse treatment models (Matrix Model, Seeking Safety, and TELE) and two prevention models (Strengthening the Family and Project Toward No Drugs) in North Carolina. Information regarding these pilots is available at the NC PIC website: www.ncpic.net.

The NC PIC is also focused on the integration of substance abuse and primary care practice. North Carolina is advanced in its efforts to integrate behavioral health and primary care services. The CCNC co-location model is now implemented in over 40 sites across the state. The ICARE model attempts to increase communication between behavioral health and primary care providers to help facilitate better coordination of care for people with co-occurring disorders. Screening, brief intervention and referral to treatment (SBIRT) pilots are also in the planning stages.

The bottom line is that it is not the lack of evidence-based practices but rather the failed execution of these practices that has hindered widespread use of EBPs. Implementation is difficult but not impossible if programs are aware of the underlying difficulties.

COMMENTS:

Rep. Insko hopes that this presentation will carry weight as the Task Force moves forward with recommendations. The Division of Medical Assistance (DMA), in conjunction with the University of Oregon, has looked trying to tie EBPs into Medicaid funding. DMA is willing to take a more active role in integrating EBPs, but questions remain about how to move a public system to embrace EBPs.

TYPES OF DATA COLLECTED AND WHAT THE DATA SHOW

Spencer Clark, MSW

Shealy Thompson, PhD

Community Policy Management

NC Division of MH/DD/SAS

The Task Force needs to be aware of what data the state currently has and where gaps in data may exist. The MHDDSAS data system is comprised of central client data warehouse that is populated with internal and external sources.

Data source within MHDDSAS:

- The **client data warehouse** is the hub of MHDDSAS data for the State. It captures individual consumer demographics, financial eligibility and family information, and drug(s) of choice. Data is submitted by LMEs on a monthly basis. The warehouse can be linked to the other MHDDSAS data systems (IPRS/Medicaid claims data, HEARTS, NC TOPPS, NC-DETECT, and consumer surveys) as well as other external data systems (DSS, DPH on special project basis). The data warehouse is the basis for the annual MHDDSAS statistical reports.
- **Integrated Payment and Reporting System (IPRS)** is the behavioral health claims system for LMEs. It captures information on individual consumer diagnostic information, the type, date and volume of services rendered, and the cost of services. The IPRS captures state dollar expenditures (including Medicaid), but is not able to capture grant data. The IPRS will be able to report county level expenditures starting January 2008.
- **Healthcare Enterprise Accounts Receivable Tracking System (HEARTS)** is a complement to the IPRS that captures information on individual consumer diagnostic information, the type, date and volume of services rendered, and the cost of services for state institutions. HEARTS is an accounting based system with great detail, but it is very difficult to analyze.
- **North Carolina Treatment Outcomes and Program Performance System (NCTOPPS)** is a

web-based performance and outcomes database. It captures information on individual consumer treatment outcomes, functional areas, service needs, and perceived barriers to care for individuals aged six and older who received services through an LME. NCTOPPS can be used by providers for patient-specific, local, regional or state planning. MHDDSAS generates bi-annual reports for State and LMEs. Reports can also be run for specific providers upon request. The quality of the data depends on the accuracy and timeliness of the data submitted by providers.

- **NC Disease Event Tracking and Epidemiological Collection Tool (NC-DETECT)** is a collaboration between MHDDSAS and the North Carolina Hospital Association. It captures admissions data from community hospital emergency departments. There is reasonable participation by community hospital, but participation is not at 100 percent. Access to the data is restricted and data can only be reported in the aggregate. The data may underestimate substance abuse in emergency department due to fee driven diagnoses.
- The Division also conducts **Consumer Surveys** for both mental health and substance abuse patients. These surveys offer patients the opportunity to confidentially evaluate service quality based on overall satisfaction, access, appropriateness, participation in treatment, and outcomes. The surveys are infrequent and are not able to track patients who drop out of treatment. The Division is currently reevaluating the survey methodology.

MHDDSAS also has access to several datasets that are managed outside of the Division. The use of these data sets requires upfront user agreements. The NC Data Warehouse has the capacity to link with these data sets; however data matching is time consuming.

- **Behavioral Risk Factor Surveillance Survey (BRFSS)** is sponsored by the CDC and managed locally by the NC Center for Health Statistics. The BRFSS measures the medical and behavioral health needs of the adult population by state.
- **Child Health Assessment Monitoring Program (CHAMP)** is the non-adult version of the BRFSS. CHAMP is managed locally by the Department of Public Health.
- **Youth Risk Behavior Survey (YRBS)** is a school-based survey sponsored by the Department of Public Instruction. The YRBS monitors selected risk behaviors among youth and young adults. School participation is voluntary in North Carolina.

MHDDSAS produces many reports using the dataset and surveys discussed above.

- **Community System Progress Reports** look at LME-specific substance abuse performance measures on a quarterly basis. The outcome measures are tied to performance contracts which are used to direct local and state planning. There is considerable variability in LMEs, particularly with regard to provider supply and patient engagement. North Carolina is one of a few states that have integrated the Washington Circle standards into state performance measures.
- **Statewide System Performance Reports** are published in October and April of each year. They look at statewide performance domains such as access to services, use of person-center planning and other evidence-based practices, consumer outcomes, and prevention and early intervention services. The critical domains are updated every six months. Previously reports were generated with LME reported data. This data is now being migrated to the Data Warehouse which will allow for more specific reports in the future.
- **Quality quick facts** are constantly updated on the MHDDSAS website.

The prevalence of substance abuse in North Carolina (8.6 percent) is lower than national average but has increased in recent years. We are currently serving less than 10% of need through the MHDDSAS system and we have seen substance abuse admissions into the public system decline for past 7-8 years. This is a big source of concern as this trend may be tied to system Transformation.

Mental Health and substance abuse admissions into the private system are generally underrepresented due to poor payment for behavioral health conditions. Many admissions have underlying substance abuse

problems that are not coded due to reimbursement.

The MHDDSAS system is trying to reduce the number of substance abuse patient that are treated in the mental health setting. About 45 percent of state hospital admissions have a substance abuse or substance abuse/mental health diagnosis. A more appropriate level of care for many of these people would be through the ADATCs. MHDDSAS would like to move 13 percent of the substance abuse only admissions to the state-run ADACTs.

Geographic provider and services disparities are common. There are fewer providers and services available in the eastern and western parts of the state, particularly for detoxification services. However, the LMEs that are good at getting treatment to adults are also good at getting services to adolescents.

COMMENTS FROM THE TASK FORCE

Dr. Silberman began the discussion by asking what types of information would be useful in moving forward with the Task Force.

- We need to know what level of ASAM services are provided at each LME. Is it possible to put a chart together that arrays what LMEs are doing by level of ASAM? It would also be helpful if we knew what prevention and treatment EBPs are being used by LMEs.
- In order to get the General Assembly to pay attention to substance abuse, we need to show how substance abuse impacts the state. We need to be able to show how substance abuse impacts hospitals, schools, families and the justice system at the state and local level. Do we have this data at the county or LME level? The Department of Corrections just finished an epidemiological profile of substance abuse with RTI that looked at the impact of substance abuse on the state and local justice system (courts and corrections) at the county level. Data may or may be available for hospitals and schools at the county level
- Substance abuse has a tremendous impact on families. The foster care system in North Carolina is inundated with cases involving parents with significant substance use disorders. In fact, substance abuse impacts about 80 percent of all foster care children. A troubling trend with substance abusing parents is that many of them are not trying to reunite with their children, a fact that is really testing the limits of the foster care system. We need to better understand the relationship between substance abuse and foster care. Is there data that look at the contributing factors that lead to Social Service involvement in cases involving substance abusing parents?
- There was much interest in the Delaware and Maine performance-based contracting models at the LOC meeting. Has anyone looked at the feasibility of bringing these models into North Carolina? Also, how are these models funded?
- If everyone in the state that needs substance abuse treatment ended up seeking care the system would be overwhelmed. There is barely enough capacity in the current system (providers and services) to offer care to the 10 percent of substance users currently in the public treatment system. There is speculation that the need for services will increase especially among the veteran population. We need to look at what would be an appropriate level of growth for the system.
- Reimbursement for substance abuse screening is non-existent. Codes have been developed but they are not currently funded. Much of the money in the public system is tied to target populations but significant numbers of people that need treatment are not part of these populations.
- There is a lack of two-way communication between primary care physicians and substance abuse

specialists. Are there any examples of integration efforts that have successfully dealt with these turf issues? The Asheville integrated care model and Medicaid specialty care pilots are good examples of successful integration efforts. The Medicaid model is a case management approach that emphasizes communication between providers, specialists, and patients.

- Many people with chronic conditions abuse substances as a way to manage pain. This is commonly seen in the primary care setting. Is there data that looks at the relationship between self-medication and the primary care setting?
- The Task Force needs to look at barriers to service. What is it about the current system that only draws in 8 percent of substance abusers? Are there specific barriers to care or is the current system only able to treat 8 percent of the needs?