

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

Meeting Summary

Attendees:

Task Force/Steering Committee: Martha Alexander, Patrice Alexander, Robert Bilbro, Dewayne Book, Barbara Boyce, Sherry Bradsher, Anthony Burnett, Chris Collins, Leah Devlin, Anne Doolen, Tony Foriest, Misty Fulk, Robert Gwyther, Carol Hoffman, Verla Insko, Larry Johnson, Robert Lamme, Jinnie Lowery, Mary McAllister, Kevin McDonald, Phillip Mooring, Mike Moseley, Paul Nagy, Martin Nesbitt, Will Neuman, William Purcell, James Ragan, Thomas Savidge, Jane Schairer, Anne Thomas, David Turpin, Michael Watson, Wendy Webster, Sonya Brown, Sara McEwen, Janice Petersen, Martin Pharr, Starleen Scott-Robbins, Flo Stein, Cynthia Widford

Interested Persons: Beverly Brookshire, Melanie Bush, Lindsey Deere, Michael Dublin, Mike Figuras, Kelly Graves, Denise Harb, Shawn Parker, Paul Savery, Wes Stewart, Dale Willetts
Staff: Kimberly Alexander-Bratcher, Thalia Fuller, Mark Holmes, Christine Nielsen, Pam Silberman, Daniel Shive

WELCOME AND INTRODUCTIONS

Dewayne Book, MD

Medical Director
Fellowship Hall

Dr. Book welcomed everyone to the third Task Force meeting and asked that we go around the room for introductions.

PREVENTION: EVIDENCE BASED STRATEGIES FOCUSED ON CHILDREN AND ADOLESCENTS

Janice Petersen, PhD

Director
Office of Prevention
NC Division of MH/DD/SAS

The Office of Prevention focuses on three aspects of prevention; mental health promotion, developmental disability support, and substance abuse prevention. Part of this perspective is focusing on what evidence-based practices (EBP) are available and where those programs are operating. Specifically, are there comprehensive prevention programs in communities and what the support for such programs exists across the state? There are many different thoughts about prevention; however, a common definition is that prevention is a proactive process that educates, support and empowers individuals, families and communities to effectively meet life's challenges and transition by creating and sustaining healthy and safe lifestyles.

The state's role in prevention was defined in the State Transformation Plan. The state plan is prevention focused and provides guidance for LMEs, providers, consumers,

advocates and other stakeholders to utilize evidence-based programs, practices and policies. The state plan allows LMEs to craft their own specific definition of prevention based on the needs of their community.

Evidence-based refers to the guidelines for documented effectiveness of a program. They should be based on a solid theory validated by research, supported by a documented body of knowledge, and judged by a consensus among informed experts.

In 2002, North Carolina received the first State Incentive Grant to work with LMEs to implement EBPs. The grant, sponsored by the Center for Substance Abuse Treatment (CSAP), was first piloted in 23 communities. Prevention professionals at LMEs and provider agencies were trained in evidence-based models approved by SAMHSA. For example, Pitt County trained teachers on the Project Alert curriculum, which dealt with workforce turnover and training issues. Another effort at the state level was the implementation of the Strengthening Families Program (SFP). The SFP showed significant results when implemented with fidelity and with periodic evaluations to assess effectiveness. Block grant funds were utilized to support the implementation and evaluation of the program. The SFP is currently working with three specific sites in Mecklenburg, Alamance, and Wake counties. These sites are considered incubator sites and need continued support. The North Carolina Institute of Medicine (NC IOM) Task Force on Child Maltreatment is considering adopting this model.

The IOM model of prevention is a viable and easy to understand prevention classification system. It was adopted by the state to help provide guidance to LMEs regarding prevention services. The IOM model is composed of three classifications: universal, selective, and indicated. These classifications are population-based, focusing on the needs of the community rather than on the level of service. Universal programs target the general public or a whole population that has not been identified on the basis of individual risk. Selective programs target a subgroup of the population whose risk of needing services is significantly higher than average. Indicated programs target individuals with detectable signs or symptoms of a problem identified as high risk or may have minimal experimentation issues. The IOM model terms are the preferred nomenclature. There is crosswalk to the older classification system (primary, secondary, tertiary), but the new model gives a better population focus. Examples of evidence-based prevention programs can be found on the National Registry of Evidence-based Programs and Practices (NREPP). The North Carolina Division of Mental Health Developmental Disabilities and Substance Abuse Services (MHDDSAS) works with LMEs to do needs assessments and implement EBPs.

The adoption of the IOM model for prevention led to the inclusion of evidence-based program language in the Substance Abuse Prevention of Treatment (SAPT) Block Grant requirements. Through the SAPT Block Grant, the LMEs are allocated funds for prevention services and report the use of EBPs on semi-annual reports to the state. These semi-annual reports feed into the LME performance reports and are subsequently sent to the federal government. SAPT Block Grant funds are awarded based on population and geography.

Another funding source for state-level prevention efforts is the Safe and Drug Free Schools (SDFS) program through the U.S. Department of Education. SDFS funds are sent to Local Education Agencies (LEA) to support school-based substance abuse and violence prevention efforts. A portion of SDFS funds (approx. \$1.3 million) are given to the Governor for community projects. In North Carolina, this portion of SDFS funds is managed by MHDDSAS. LMEs cannot directly apply for SDFS funding. Instead, an LME can apply for funding through a provider in the community. Currently 12 LMEs have SDFS contracts.

The state is divided into three prevention regions. The Division is able to track EBPs by LME; however there is no way to track EBP implementation at the provider level. LMEs can contract with many providers in multiple counties, which makes it difficult to track what specific providers are doing.

Dr. Peterson passed around materials regarding EBPs for prevention. The first is a book published by the Department of Education (2001) that contains exemplary and promising programs. The book is a bit dated but all programs are evidence-based. She also referred to the Office of Juvenile Justice and Delinquency Prevention (OJJDP) Blueprints and the SAMHSA NREPP website as important resources for evidence-based prevention programs and practices.

Effective implementation and sustainability of effective prevention programs require an understanding of community need. LMEs and communities should perform needs assessments. Prevention programs need to reflect the needs of the community. We should be careful not to dictate to LMEs what to do because the approach should be population-focused (e.g., specific to each community). Professionals and paraprofessionals need to understand the impact of what they are doing, which requires training and continuous monitoring. Train-the-trainer models could be utilized to make sure that providers are up-to-date with evidence-based programs, practices, and policies.

Program sustainability also requires evaluation. The Practice Improvement Collaborative (PIC) should be used to approve evidence-based prevention programs. Programs should also utilize the Centers for Prevention Resources (CPR) to maintain technical assistance and training efforts to local providers. Such efforts can be supported through State Prevention Incentive Grants.

Dr. Petersen identified three relevant reports that discuss the identification and implementation of EBPs:

- *Join Together Special Report: Prevention Education in America's Schools: Findings and Recommendations from a Survey of Educators.*
- *Special Report: Preventive Interventions Under Managed Care: Mental Health and Substance Abuse Services*

- *Identifying and Selective Evidence-Based Interventions—Guidance Document for the Strategic Prevention Framework State Incentive Grant. SAMHSA-Dept. of HHS*

Discussion:

- The Division tracks the use of EBPs through the semi-annual reports. The counties on the map that do not have reported data may or may not be using EBPs. The Division captures information on the use of EBPs for which the Division gives guidance. If an LME is using an EBP on which the Division does not provide guidance, then that practice would not be captured in the Division data. For instance an LME may be focused on coalition building or some other prevention practice for which the Division does not give guidance. Some LMEs may fail to complete the semi-annual report. LME funding is not entirely contingent on the use of EBPs. The state gives LMEs some flexibility. Fifty-percent of LME funding can be used for universal prevention programs, policies and/or practices. The other fifty-percent must be used for EBPs for the other indicated populations. In total, the state has about \$8.3 million for substance abuse prevention, \$7 million from the SAPT and ~\$1.3 million from SDFS.
- Since LMEs contract with numerous providers that may be geographically dispersed in their catchment area, it is difficult to pinpoint the exact location of various EBPs. The Division is able to capture the location of EBPs for specific provider agencies through the semi-annual reports.
- The state has gone through great lengths for prevention at schools and LMEs, but we are still skirting around how really to make a difference. When are we going to actually hit the problem and come to parents and change the culture? If we don't change the culture, it will not matter how much money we put into prevention. North Carolina has focused on this issue over the past two decades. The Division has a relationship with Juvenile Justice to look at binge drinking on college campuses. We are also leveraging the Partnership for a Drug Free America that targets parents, but parents cannot do it alone. The true solution rests with education. We need a consistent message that is continually reinforced through community, education, and faith-based organizations.
- This is a family disease. In many cases there is a strong family link. Children that are at highest risk often come from families with treated or untreated disease. The majority of people do not seek treatment, which breeds a cycle. How can parents address this if they have not been treated for the disease themselves? Are we really getting to the people at high risk? This is why the state adopted the IOM prevention model. The model targets populations based on behavior. The state must target prevention activities due to limited federal and state funding.
- Are all programs (on map) evidence-based? Are they all peer-reviewed? Some are scientifically evaluated and some are not. If a particular program has a strong evaluation, we do not need to evaluate again; rather, we need to concentrate on fidelity to the model. But, budgeters are very skeptical about prevention dollars. They always want to know that a particular program will *really* work. The confirmation of outcomes from the program level may not be as

important as the policy implication showing that prevention is effective. This is very important in sustaining long term success.

- Targeted prevention is crucial. Communities must look at their own population and determine what their particular needs are, and subsequently identify programs, practices, or policies that can best address these needs. At the policy level, we need to coordinate prevention dollars. Parallels need to be developed so that what is being taught in the schools is echoed in the community. There is a statewide policy to develop child and family teams of care. Durham is a good example of this. These models are very treatment focused. Maybe a next step will be to incorporate prevention.
- Much of the discussion about prevention is focused on programs and practices. There has not been much talk about prevention policies (e.g., taxes and surcharges). Successful prevention policies have been limited mainly to alcohol prevention. Overall, policies are the most difficult prevention model to implement because they require policymakers and other stakeholders to come together. There are a few examples of evidence-based policies in the NREPP book.

CONSUMER PERSPECTIVE & ENGAGEMENT

Syd Wiford, MRC, CCS, CSAS

Assistant Clinical Professor/Coordinator
Behavioral Healthcare Resource Program
Jordan Institute for Families
School of Social Work
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Addiction is very personal and to make an impact we need to keep it personal. It is easy to talk on science and research but lose the human element of addiction and its effects on individuals, families and communities.

The overarching framework for the planning, delivery, and evaluation of health programs in the public health model begins with a healthy infrastructure (planning, evaluation, workforce, laws and regulations). Upon this base, we build population-based services followed by enabling services which support direct health services. The substance abuse framework is slightly different. In substance abuse, we tend to have a broader base of enabling services (housing programs, child care, and financial assistance) that support both the population-based (school-based prevention programs, liquor outlet regulation) and direct health services (treatment and person-centered plans).

Traditionally, substance abuse consumers are only involved in decisions related to the direct use of health services. However, the basic substance abuse infrastructure is integral and dictates what services can be supported in the system. Consumer participation is needed at all levels but is rarely achieved or integrated into planning.

The initial reform effort in North Carolina was to get consumers involved in almost every aspect of care delivery. This new focus drove the Division to make changes in service

provision, particularly with a move to patient-centered planning. Research has shown that consumer and community involvement across levels of care can change the way services are delivered across a range of settings. Patient involvement at the hospital level results in higher satisfaction ratings and reduced medical errors and lengths of stay. Expanding community involvement in child mental health projects have proved successful in decreasing the overall cost of care.

Patient and family centered care models are important in garnering participation at all levels of care by fostering a sense of respect and dignity, information sharing, and collaboration. Collaboration is integral to getting patients and families involved at the system level—crafting policy and program development, implementation and evaluation as well as facility and workforce development.

In 2001, the Secretary of NC DHHS requested that a state-wide effort be made to gain input from North Carolinians who have experience with the MHDDSAS system. Part of this effort included 14 community meetings throughout the state. Many of the focus groups were held after Narcotics Anonymous (NA) or Alcoholics Anonymous (AA) meetings to talk about their experiences with the public system. Several themes emerged from these groups:

- Substance abuse consumers indicated that they have trouble accessing addiction services. There is no standard level of services available in all counties. In those counties with services, people find it hard to qualify for treatment or are faced with long waiting lists (primarily for residential treatment).
- Services are not offered in a timely manner. Many consumers face waiting lists between treatment levels.
- Needed (appropriate) care is not available
- The public sector mental health and substance abuse workforce is underdeveloped. There are not a lot of skills at the “front door” of the systems to recognize when a problem is an addiction and when it is a mental health disorder.
- Stigma of addiction

Dare County Community Needs Assessment (2006)

Substance abuse related problems were on the rise in Dare County and many in the community felt that nothing was being done to address the problem. They were very tired of the community not having a response. As such, Dare County conducted 10 focus groups to gauge the substance abuse issues throughout the county. It attempted to help the community deal with problems they already knew about. The community did not need to be told that they had a problem. Instead they wanted to know how to deal with it. Many of the same themes identified in the state wide effort in 2001 were again identified in Dare County. There was a general lack of access to needed treatment and recovery services, particularly for adolescents. The county lacked stable funding needed to support the provision of substance abuse services, and the workforce was not properly trained to identify or treat substance abuse disorders.

Dare County came to the conclusion that they needed to change their culture. They raised taxes by 1 cent and put these revenues toward an evidence-based prevention model. Several lessons can be gleaned from Dare County. More citizen involvement results in increased government buy-in. Cultural change must come from the community. The community needs to be educated and informed. There is a big difference between communities that know they have a problem and those that are not aware of the community need.

Rockingham Needs Assessment (2006)

The Annie E. Penn Trust recognized the need to conduct a county-wide substance abuse needs assessment in Rockingham County. This effort involved a diverse group of stakeholders. Substance abuse education and prevention programs ranked as the most significant need followed by treatment and intervention services. Like Dare County, Rockingham County also found that treatment services for adolescents are non-existent in the county. They also identified issues with funding and the substance abuse workforce.

The NC Commission on MHDDSAS (2006)

The Commission looked at both providers and consumers of MHDDSAS services. Although the study was not specifically focused on substance abuse, there was a large response from substance abuse providers and consumers. Many of the themes that the Commission found were identical to those found by the state in 2001 or by Dare and Rockingham counties in 2006. Many substance abuse consumers reported stigma as the greatest barrier at the “front door” of the system. They often cited that there was insufficient provider specialization or cross-training. People stayed in community support but had a hard time getting treatment. If patients did receive support services, the providers were not typically trained in substance abuse. Another common response was that DSS, the courts, and the substance abuse system do not work well together (eg, transferring records).

Across all of these efforts, we see the same themes before and after reform.

- Access
- Lack of appropriate care
- Timeliness of services
- Workforce
- Stigma

We do see that communities that get involved can make a difference; however, some communities are not aware or do not want to admit that they have a substance abuse problem to address.

Comments:

The pervasiveness of substance abuse is a function of system breakage. This could be a big part of the problem. Also, people are not addressing the problem up front. It is difficult for the average consumer to know where to go for help. The problem is not that there are not services available, rather it is teaching the community to use the system as it exists.

NETWORK FOR THE IMPROVEMENT OF ADDICTION TREATMENT (NIATX.NET)

Paul Toriello, RhD

Assistant Professor

Department of Rehabilitation Studies

College of Allied Health Sciences

East Carolina University

The NIATx model, started in 2003, focuses on improving the quality of addiction treatment.

We can all agree that substance abuse is a complex problem which requires a complex solution. It does not discriminate, and it affects a person morally, economically, and socially. The continuum of substance abuse services is complex and consists of disjointed funding streams, services, etc.

NIATX was started in 2002 by Frances Cotter from the Center for Substance Abuse Treatment (CSAT), Victor Capoccia from the Robert Wood Johnson Foundation (RWJ), and Dave Gustafson from the University of Wisconsin. There was a Request for Applications (RFA) from the RWJ that called for increased access and engagement in treatment. From this RFA, two programs were launched: STAR, which focused on performance improvement to improve substance abuse treatment, and P2R, a continuous quality improvement program. These programs evolved into NIATx.

Dr. Toriello referred to the NIATx webpage (<https://www.niatx.net>) where there are readings, data, promising practices, etc. He specifically drew our attention to the STAR SI Initiative.

The mission of NIATx is to change the way of thinking about how agencies operate. When NIATx first started, it focused on about a specific intervention and used that to improve performance. That has changed and now the focus has shifted to improvement in the following four areas:

1. Decrease wait time
2. Decrease no-show rate
3. Increase admissions
4. Increase early continuation

The NIATx model was created out of Gustafson's research. There are five principles of the NIATx model, which consistently predict performance improvement. The NIATx Principles of Performance Improvement are as follows:

1. Understand and involve the customer. Conduct focus groups and solicit feedback. Use the team to facilitate change. The team's approach should be: "We are here to serve you – how can we better do that?"
2. Fix the key problems. Ask yourselves, "Where are we struggling as an agency? What are our trendlines showing us?" The agency can pick the trendline that is going in an undesirable direction and work to change it.
3. Pick a powerful change leader. Put the leader in charge of the change process.

4. Get ideas from outside the organization or field. Think outside of the box; think outside of the agency. For example, we can learn a lot from Wal-Mart. The first thing that happens when you walk into Wal-Mart is that you get greeted; that greeting diffuses you just a little bit. There is a principle there that we can adopt into addiction treatment.
5. Use rapid-cycle testing to establish effective changes. After the first four previous steps have happened, it's time to come up with ideas, test them, and, if it holds, consider adopting appropriate policies.

How can we bridge science and service?

- Evidence-based models (EBM) are a means to an end. Using them does not guarantee outcomes, though it does increase the probability of success. How can we bridge the gap between the EBM and practice? The science-to-service gap can be bridged by performance improvement principles.
- Motivational Interviewing (MI) is an example. MI helps motivate a client past their barriers to treatment.
- What is the difference between MI in a randomized controlled trial (RCT) and in a community-based organization?
 - The clientele in the organization may not be the same as the RCT
 - There are fidelity requirements, supervision requirements, etc.
 - There are also issues concerning staff, such as reluctance to do MI
 - Thus, adopting EBP just for the sake of adopting the EBP can be a recipe for failure.

Instead of asking, "What evidence-based models should we adopt?" Ask, "How can we use evidence-based models to improve performance and outcomes?" The adoption of the EBM is a means to an end – in a way to reach mission of organizations.

Example: New Orleans (Largest residential facility in LA)

- Only 48% completed 30 days of treatment although the program was designed for a full year
- It was a 137 bed facility long term care
- We asked the clients – how can we make this more engaging and more welcoming?
- Then we asked ourselves, how can we motivate our clients to stay at least 30 days?
- The change leader was a line staff (Clinical Director) – it doesn't have to be an administrator or supervisor
- We rapid cycle tested 12 changes. Some directly related to MI, but once we started this process, the entire culture started to change and the trendline started to move in the right direction. We instituted a greeter, as well as a weekly meeting among staff to talk about the people that they thought were going to leave early. Thus, the staff started thinking about how to motivate the people that to stay.
- Clients felt that they were being treated more fairly, and have said things like, "People seem nicer," "It's a different place today."

In bridging this gap, the rallying point is the improvement, the outcome. It is important to rally around the outcome variable. Then, the agency needs to ask itself, what models have shown success and how can we implement them in our agency to improve our trendline? There is the issue of model integrity vs. adoption flexibility. These EBM are studied in controlled ways. We need to be flexible, tap into our staff's innovativeness, creativity. We need to strike a balance between the performance and the integrity. In the end, however, the rallying point should be around improvement.

Comment: Dave Gustafson is the chair of the engineering department of a major university. I say that because our field is in desperate need of outsiders. We have got to invite other industries, other fields, to help us innovate.

Response: Without a doubt. They have brought in Executives from Toyota, etc. Dave worked on software for hospitals and it turned into this. Let's be flexible, creative, and innovative.

Comment: It is interesting to talk about flexibility with models where you can see immediate results, but more questionable to talk about flexibility when you see outcomes years down the road. What you are talking about is subject to rapid response where you can see immediate results. The four aim areas have been addressed before. How can we encourage LMEs on a policy level to encourage them to do the kind of thing that you are talking about?

Response: Early continuation for 90 days is a nice threshold, but there is power in the first 30 days. It would be tempting to say LMEs need to achieve a wait time of two days. Or decrease no show rate by 10%, etc. Instead, I would ask the LMEs for a baseline. Let's have a starting point and ask for a 5% or 10% improvement. Then provide them with the models that you would like them to use. I would ask for a starting point and a plan for how they are going to use EBM in a performance improvement way to change trendline. And have them specify how they are going to do it.

Comment: One of the opportunities LMEs have is with incentive based contracts and technical assistance. I think this could help move those LMEs along. However, it is still important to set percentage improvement from baseline.

Comment: It is run sort of like a business. We need changes within the staff and within the leadership. But I think it's a great idea.

Response: I've trained a lot of people on IM, and they say that it's great, but they don't actually USE it. There's no accountability. You should be able to say, we invested in you, how did you use it?

PANEL OF PROVIDERS: WHAT'S WORKING IN NC

Misty Fulk, MEd, CSAPC, ICPS

Community Choices, Inc

Director of NC Operations

This is one of the success stories with the divesture process. Our parent agency is Community Choices, Inc (CCI). They harbor the program, but they do not interfere. Originally only located in Charlotte, now there are four locations across the state. It is a structured year long program that is apartment based. It accepts substance abuse or mental illness clients, as well as kids up to age 11. The majority of the apartments are for families. The program provides perinatal and maternal services and has had some very good outcomes.

Once the program became established, it started to expand. There are three CCI residential programs, for a total of 56 beds. They are as follows:

- Charlotte: 42 beds
- Durham: 6 beds, received a contract with the Durham Center, now called Cascade Program
- Gastonia: 8 beds (6 are dual diagnosis beds), My House program

The WISH program is an outpatient perinatal program with no residential beds; however, they are currently trying to add six beds.

The program provides gender specific treatment:

- Funding is for women and women with children
- It is based on the relational model, as this model works best with women
- Strength based, non-confrontational, non-shaming, non-guilty
- Pregnant women who use think very poorly of themselves, there is a lot of stigma against pregnant women who use, works off the idea that we “have to love them well before they can love themselves”
- A lot of the women that are served have domestic violence issues, the program does not release addresses
- The women are more than just their substance abuse problem, the program validates them as whole people
- The program is multi-cultural and family-centered. Children are central because they are moms 100% of the time.
- We teach the 16 steps, a more woman-focused version of the 12 steps
- Family drug court, many women have lost custody of their children. About half get their children back. These are women who have lost children before and have had substance abuse issues for a longtime.

The program offers integrated services, from a holistic model of care (i.e. vocational, parenting, housing, health, etc). The year long program has a treatment component of six months, and the other six months the women are working or going to school.

The continuum of care includes:

- Substance abuse education and group therapy
- Parenting skill building (many do not know how to relate to a child), bring the children in to do interactive activities, attempt to correct misconceptions regarding parenting.

- Teaching life skills
- Dialectical behavior therapy, used to develop coping skills
- Domestic violence education
- Prevocational skills: how to interview, search for a job, how to dress, etc
- We are smoke free, so we provide smoking cessation programs. We are the first program to go 100% smoke free. Provide programs and incentives.
- The goal is to reduce barriers to care (i.e. home-based assessment, etc).
- Therapeutic case management – assist with whatever they need (such as transportation services, childcare, meals, mother’s advocates, etc.)
- Services tend to be more intensive, much higher level of case management, treatment is longer, more intensive
- Long history here in NC of providing those services.

Measures of Success

- Abstinence
- Reduction in use
- Increased length of sobriety
 - Length of time connected to treatment
 - Self-esteem
 - Gage based on appearance, self upkeep
 - Participation in support

The birth outcomes are very good. Engaging and nurturing the women produces good outcomes. Early involvement with pregnant women is best.

Thomas O. Savidge, MSW

CEO

Port Human Services

Port Human Services (PHS) was established in 2004, as a comprehensive substance abuse and mental health provider. PHS contracts with LMEs in the eastern region of the state and served over 9,000 people last year.

Mr. Savidge was a member of the legislative oversight Blueprint for Change committee. PHS started organizing well before 2004. In April 2004, Pitt County put out a Request for Proposals (RFP) specifically calling for the full continuum of care and PHS was awarded that contract. PHS is not a spin off of Pitt Mental Health. They began by maxing out credit cards, getting a home equity loan, etc. One of the biggest goals on the first day of work (July 18, 2004) was to create as little disruption in the services as possible. The first priority was getting vans and trucks because three of the programs required transportation. They worked something out with Enterprise Rental Car to get free vans, but they reneged because of the “people we would be transporting”. However, transportation is essential, especially in an intensive outpatient program. So, for the first week, they used a partner’s pick up truck. They also knew someone in the public transportation system, so they got a van for \$1 a year. They loaded it up with all

of their outpatients to the NA and AA meetings. Then, one day the roof blew off while on the highway. However, since then, they have had more successes.

System of Care:

- First year of contract was an expenditure based model. They were reimbursed for costs, not the unit of service. This helped out a lot.
- Mental health trust funds, giving the opportunity to sustain service and to be creative.
- Closing the state funded provider network. When there are too many providers, it is difficult to develop a good continuum of care. A certain amount of population is necessary to support several comprehensive outpatient treatments – if not, it just waters it all down, and then no one gets good care.
- Ability to use existing facilities. Specialized care like detox – it will be hard to find willing providers to build a detox facility
- No preauthorization needed – helped people get into services. Previously an authorization was needed prior to care. Could take as long as 3 weeks – paperwork, forms, etc. They worked with one of the three LMEs that they were involved with and one eliminated this. People get into care much quicker this way.
- “One stop shop.” If people need care and want care, they have to have access to it in a one stop shop. It doesn’t work otherwise – people should not be sent all around. The people that they serve from single service companies are getting a great disservice. Sometimes they have no medical records, no background, etc. These services are not often reimbursed.
- One of the strongest things they promote is prevention. It forces collaboration with the schools. Getting a person in with the schools focuses on where a lot of our future substance abusers are.
- National accreditation. It’s painful, but necessary and helpful. Requiring providers to obtain a national accreditation helps them improve and is strongly encouraged.
- We have benefited from LMEs merging. It is difficult to work with multiple LMEs. For the most part, LMEs are trying their best, but there are so many different ways of what to do and how to do it.
- Provider involvement with committees such as this. It helps to be invited and participate.
- Collaboration with academic institutions. Rehab masters level students are the best prepared people to work with these issues.

One of the organization’s major challenges is paperwork. In order to provide services approximately 66 pages of paperwork must be completed. This issue has to be addressed. Right now what is being financed is paperwork. Clinicians have to spend at least 50% of their time on paperwork. This is an auditors dream. It is very difficult to get people into services with all of this paperwork.

Comment: There is a paperwork reduction initiative in South Carolina (they adopted it and reduced paperwork by 80%). Many organizations could benefit from that consultant.

Wes Stewart, MSW, CCJP

Region 1 Treatment Accountability for Safer Communities (TASC) Director

Mr. Stewart commented that it's nice to be on a panel of what is working and to be recognized in that arena.

North Carolina prisons continue to operate at capacity or over capacity. There is no continuum of care. This is even worse in many of the rural communities. People involved in the criminal justice system face many problems and the consequences affect HHS, DSS, courtrooms, prisons, etc.

There are eight principles for effective interventions with the substance abuse/criminal justice offender population:

1. Assess actuarial risk/needs
2. Enhance intrinsic motivation
3. Target interventions
4. Skill train with directed practice
5. Increase positive reinforcement
6. Engage ongoing support in natural communities
7. Measure relevant processes/practices
8. Provide measurement feedback

The NIDA principles for criminal justice populations reinforce the Offender Management Model (OMM) that is being used here in North Carolina. Some of the objectives were to create comprehensive and seamless care, ensure effective utilization of resources, and use evidence-based practices.

What is TASC?

TASC collaborates within the court system. They work to implement individualized care plans and to improve offenders' ability to fulfill criminal justice requirements and then to enter into treatment. TASC provides care management and communicates with treatment provider and criminal justice system. It was established in 1978 and expanded statewide in 2002. The first TASC training institute was held in 2003. TASC trained 15,000 individuals last year. The training institute provides regional assistance and continuing education statewide both in classroom settings and through distance learning.

Funding allocations are designated through three LMEs by block grants and state funds. Those funds support 130 TASC care managers in the state. Most have caseloads in an excess of 80 clients. Last year, they were given more money for additional case managers. TASC is dedicated to providing training to all staff.

Substance abuse is disproportionately needed in the offender population. Of the people served, 69% came straight from the department of corrections, and 70% have a serious risk of going to prison. The most frequent substances are cocaine, alcohol, and marijuana. They have an average of 1.3 prior arrests. At least 60% of the population is

using weekly. Average length of stay is 8.5 months. Of those clients that complete TASC, 61% have not re-offended. TASC does not provide treatment and TASC staff members are not probation officers. They supply support and continuity of care, advocate for the client, support communication throughout the system and seek to improve treatment. The main message for this committee is that treatment works.

FEEDBACK FROM THE TASK FORCE

A participant asked about what keeps people in the voluntary systems of care. One respondent noted that having good staff is key, because there is a relationship aspect to treatment and people have to trust who they are working with. Better therapists have higher retention rates. Another noted that being able to access and utilize the care systems that are in place is crucial. If an addict calls and needs treatment that day, they can't get it because of the waiting times. Meeting the client's basic needs and reducing the barriers to treatment are also important. Many people in voluntary treatment have been coerced into coming in, so it is important to be understanding and to nurture them.

A question was raised about delays in payment and the difference across specific LMEs. One program leader stated that they are always waiting on the LME payments and that they are continually struggling with all the paperwork that goes into the programs. Paperwork was cited as the biggest problem, especially when it involves the exact same issue or person. It was noted that when the only payor is the state, it's difficult. An agency provides a service, and then it takes 90 days to get paid. It is difficult to run a business that way, especially when some agencies have hundreds of thousands of dollars in that system. One of the solutions is to have multiple funding sources such as Medicaid, Medicare and private insurance, the fastest growing segment. In addition to the financial incentive that private insurance provides, an additional benefit is that "it makes the problem a little more real - it's not just the homeless, stinky people."

A discussion about paperwork ensued. Paperwork goes to the LMEs, and to the Division. It's also for internal use and for Value Options for authorizations. It would not be possible to fit it onto one page. A lot of it is necessary, such as the treatment history. But there is a lot of duplication. It would be possible to condense it into 10 pages max.

There is a huge difference among the paperwork that is required for mental health/substance abuse and for physicians – there is so much more for behavioral health. We have to figure out how to get better integrated into the healthcare system. If we put this type of paperwork onto nurses, PAs, etc – we would have a revolution. It's really putting a toll on the workforce. Practitioners love what they do, but they leave often because they just can't keep up with the paperwork. From an external point of view, you are judged by turning in your paperwork.

A suggestion was made to invite the consultant from South Carolina, who worked on the paperwork reduction program. It was noted, however, that the only place where the

paperwork reduction is possible is where the program is statewide. Otherwise, we would have to look program by program.

The discussion turned to electronic medical records and how many of the LMEs have EMRs. The task force indicated that it would be interesting to look at this from a statewide perspective and query it at a county or state level. This would provide data and would also work to reduce the paperwork. There was a strong sentiment that EMRs would help out the paperwork problem facing mental health and substance abuse providers. There are plans for an EMR SAMHSA model to be out within a year.

However, the task force agreed that there are more things to focus on, including the fact that a lot of people need services, but there are still barriers such as HIPPA and wait times. One participant noted that there is an 18 month wait period for a methadone treatment. In that “moment of truth,” we need to get those who want services into services. There is also the need to address the issue of defending whether or not patients are staying clean after treatment, program accreditation, and increasing census of programs. Accreditation was seen by one participant as important for system improvement.

There was a discussion about prioritizing the most important objectives. The group discussed whether it is more important to focus on fidelity of the intervention or on outcomes. To do it all, at all different levels, just creates chaos and more paperwork. It was suggested that the group could start with prioritizing the four indicators of quality from the NIATx presentation. One participant noted that the four aims were excellent and could be incorporated into the work culture. Furthermore, the four goals make providers more viable for pay for performance.

Additional suggestions regarding potential policy level focus areas for the state included:

- Improving retention
- Improving customer service. The system is currently not customer friendly (the client doesn't know where to go, there are wait times, etc.)
- Improve the system for providers. The system is currently not provider friendly (there is too much paperwork, there are delays in payment, etc.)
- Recognize that there are different sets of goals for those who are substance abusers, as opposed to those who have a dual diagnosis. The goal should be to get them into the LME, and assist them with getting over the hurdles.
- Reimbursement rates. Substance abuse treatment provision – in service 4 hours per day. Should re-examine the fact that the service definition is tied to how we are paid.
- Need to have a good relationship with your LME. LMEs need to understand that the organizations are doing what they can, they are committed.
- Make an effort to get enrolled in as many private insurer panels as possible.
- When the reform went into place, the state did not mandate just one computer system. I think we should do that – or at least have the computers talk to each other.
- Main issues: paperwork, inadequate levels of providers especially in rural areas.

Suggestions of focus areas for prevention money included:

- Science-based practices, such as “Reconnecting Youth.” Most of the schools will work are open to this program. It teaches life skills, problem solving, etc. This is what the good prevention models do – they teach the other things as well, not just substance abuse.
- Strengthen Families Program. It’s a long, intensive program. We don’t have enough of them in the state. We can only run 25-30 families a year in each program.
- Criminal justice system. For the most part, it’s a familial thing - you’ll see it in the whole family. We need earlier referral to treatment (offer treatment at the front end before they end up in the criminal justice system again). Also need to focus on high-risk offender. For most of the people that commit crimes, it is related to their addiction. There has been some movement around how to move people in quicker into the existing services within the criminal justice system. It is getting better. However, there are still not enough beds for the people to go into. There isn’t much money going into long-term care in the criminal justice system. This should be a high priority in prevention, given the amount of crimes that substance abusers commit.

The next meeting will be held on January 14th, from 10am-3pm, at the Hospital Association.