

**PLAN TO EXPAND ACCESS TO SUBSTANCE ABUSE SERVICES
IN MARYLAND BY 25% BY 2012**

**Maryland Department of Health and Mental Hygiene
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Executive Summary

Providing treatment and support services to those diagnosed with substance use disorders is effective in improving their lives. The benefits to citizens include substantial cost savings and enhancement of public health and safety. Maryland's publicly funded treatment system exceeds the national average on increasing illicit drug abstinence, increasing alcohol abstinence, increasing employment and decreasing arrest rates and homelessness among participants in treatment, yet is unable to meet the need for treatment that exists. The Governor's Strategic Goal is to expand access to substance abuse services in Maryland by 25% by 2012.

The strategic approach to achieving this goal focuses both on expanding the capacity of the service system and improving the quality and efficiency of the current system. Expansion of capacity will be accomplished by increasing provider capability to obtain Medicaid reimbursement for outpatient and intensive outpatient treatment, drawing federal matching funds which will enable the use of grant funded treatment slots to treat new patients. Improving the quality and efficiency of the current system will open treatment slots to new patients by reducing patient relapse and subsequent re-admission, and by increasing treatment slot turnover rates. These strategies will result in a capacity expansion of 8705 new patients by 2012.

Background

Substance abuse is both a public health and a public safety problem. It is a significant contributor to high-cost medical, legal, and social interventions.

Substantial research has demonstrated the effectiveness of substance abuse treatment in improving the lives of addicted and abusing individuals and enhancing the public health and safety of citizens. Treatment reduces crime, homelessness, and use of dangerous and illicit substances. Treatment increases employment and school enrollment and builds stronger and healthier communities. People with addictive disorders can and do recover, and treatment and recovery support services form the clearest path to that objective.

Research shows that each dollar spent on treatment saves approximately seven dollars in the costs of criminal justice, healthcare and lost productivity. Recent research by the Justice Policy Institute concluded that treatment is far more effective than incarceration for reducing both crime and substance abuse. Treating non-violent offenders is also far more cost-effective than incarcerating them. A 2001 study in Maryland by the Alcohol and Drug Abuse Administration (ADAA) and the Center for Substance Abuse Research demonstrated that the positive effects of treatment were evident in the year following discharge, and that treatment completion was associated with the best long-term results. The study showed that patient employment rates were higher in the year after treatment than in the year before treatment, and arrest rates were lower. Further, for those who completed treatment, the predicted probability of employment was higher and arrest lower than for non-completers during the year following discharge from treatment. Also, adjusted mean wages in the year after treatment were over \$1400 higher for those who completed treatment than for those who failed to complete treatment.

The Fiscal Year 2008 ADAA Outlook and Outcomes report shows that the Maryland treatment network exceeded national averages on increasing illicit drug abstinence, increasing alcohol abstinence, and increasing employment. The Maryland treatment network also exceeded the national average in decreasing arrests and decreasing homelessness.

It has been estimated that as many as one in ten individuals over the age of 12 is in need of substance abuse services. The State can address some of its most pressing problems through increasing access and availability of substance abuse treatment as well as ensuring that other recovery support services are available.

Goal

The Governor's overall Strategic Goal is to expand access to substance abuse services in Maryland by 25% by 2012. As baseline, the State will use the unduplicated number of individuals admitted to ADAA-funded substance abuse treatment in 2008: 34,823 individuals. Achieving a 25% increase in substance abuse services by the end of 2012 will require that 43,528 unduplicated individuals will be admitted to publicly funded treatment and recovery support services, an increase of 8705 individuals.

The estimated need for addiction treatment substantially exceeds the availability of treatment services in every jurisdiction in the State.

Maryland State Drug and Alcohol Abuse Council Strategic Plan

The Maryland State Drug and Alcohol Abuse Council (SDAAC) Strategic Plan, submitted on August 1, 2009, contains the following goals:

- Goal 1: Facilitate establishment and maintenance of a statewide structure that shares resources and accountability in the coordination of, and access to, comprehensive recovery-oriented services.
- Goal 2: Improve the quality of services provided to individuals (youth and adults) in the criminal justice and juvenile justice systems who present with substance use conditions.
- Goal 3: Improve the quality of services provided to individuals with co-occurring substance abuse and mental health problems.
- Goal 4: Codify the State Drug and Alcohol Abuse Council to assure a sustained focus on the impact of substance abuse.

These goals and related objectives emphasize improvement in the quality of care provided to individuals with substance use conditions, and are complimentary to the approach outlined below designed to expand access to services. The Department of Health and Mental Hygiene has incorporated the SDAAC's recovery-oriented systems of care recommendations into the strategic plan for achieving a 25% expansion in substance abuse services, outlined below.

Strategic Approach

The strategic approach to achieving the goal of expanding access to services focuses both on expanding the capacity of the service system and improving the quality and efficiency of the current system.

Expansion of capacity will be accomplished by increasing provider capability to obtain Medicaid reimbursement for outpatient and intensive outpatient treatment services. Medicaid spending will draw federal matching funds, thus enabling the use of grant funded treatment slots to treat new patients.

Improving the quality and efficiency of the current system will open treatment slots to new patients by reducing patient relapses and subsequent re-admission, and by increasing treatment slot turnover rates.

The current system of care delivery concentrates resources on treating the acute symptoms of a chronic illness. Patients enter treatment in the public system when their disease has progressed to the point where they are experiencing multiple complications (involvement with the criminal justice system, loss of employment, deteriorating family relationships) and co-morbid medical and psychiatric conditions. Treatment is focused on interrupting the patient's use of substances and initiating the recovery process. Interventions may include residential treatment to address chronic patterns of heavy substance use.

Patients in Maryland's system of care improve while in treatment and maintain many of those gains after discharge from treatment. However, patient lifetime re-admission rates, both in Maryland and nationwide, underscore the chronic nature of addiction and call into question the model being used to treat patients with substance use disorders. Multiple re-

admissions to treatment are the norm for many patients. Factors known to contribute to relapse and re-admission to treatment include:

- Inadequate Dosage of Care
- Lack of Evidence Based Treatment Interventions
- Inadequate Scope of Care
- Lack of Post-Discharge Continuing Care

System improvements that target the quality of treatment and adjust the mix of services toward offering more continuous recovery support will align addiction services more fully with a chronic disease management model of care. Offering continuous recovery support will reduce the use of high-intensity high-cost residential treatment.

Specific Interventions

A specific intervention that will expand the capacity of the system to treat more patients is to redirect payment for outpatient care from state funded grants to Medicaid payments.

Medicaid reimbursement: The advent of improved reimbursement rates for outpatient and methadone maintenance treatment for substance use disorders, and the determination to include intensive outpatient treatment as a reimbursable service under Medicaid and Primary Adult Care (PAC) improved the feasibility of redirecting ADAA grant funds to Medicaid, so that portions of the care of Medicaid and PAC eligible patients in the service system would be funded through this mechanism. The benefit comes from the potential of the Medicaid program to draw Federal matching funds, so that more funds will be available to pay for covered addiction treatment services. Grant funds currently being used to fund services for Medicaid and PAC eligible patients could then potentially be used to fund new patients, creating expanded capacity.

Three interventions that will expand access within the current system include expanding patient access to buprenorphine treatment, increasing efficiencies within the existing system of care and developing a recovery oriented system of care model.

Buprenorphine treatment is an evidence based practice that targets patients who are addicted to opioids. Treatment begins when patients are evaluated by a physician and prescribed buprenorphine. Once the patient is stabilized on a dose sufficient to prevent craving for opioids, psychosocial interventions are provided to help the patient develop and maintain recovery from addiction. Once the patient has become medically stable and initiated positive lifestyle changes, responsibility for maintenance of the medication can be transferred from the treatment program to a physician in the community. This ability to transfer the patient allows a treatment program to “turn over” the treatment slot – to begin treatment with a new patient.

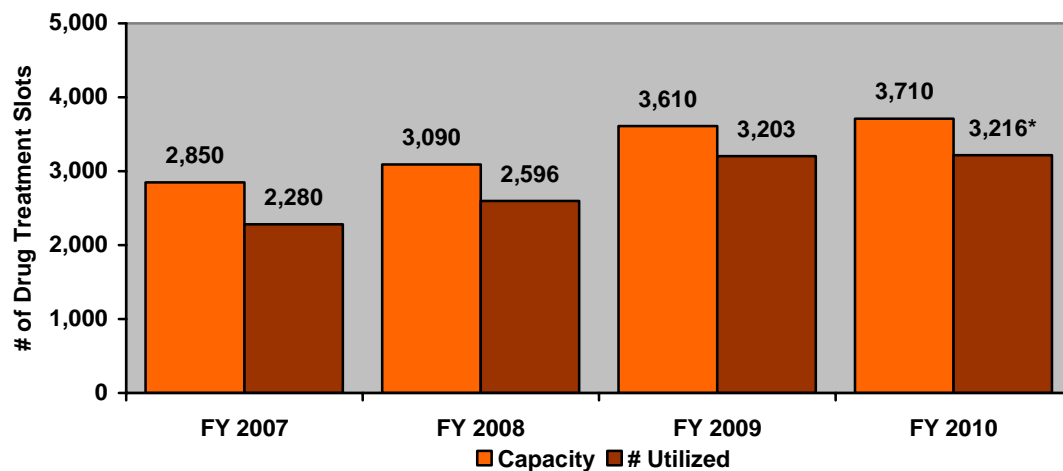
Efficiencies: In a system where patients who have completed treatment are monitored and provided with ongoing support and where recovery support services such as sober housing and employment readiness programs are easily accessible, the use of intensive residential treatment can be reduced. Patients often stay in intensive residential services longer than is medically necessary because they need the 24-hour-a-day support this level of care offers. Purchasing more low intensity residential services such as halfway houses and sober housing will provide the appropriate level of services these patients need, reducing the need for higher intensity care and opening more treatment capacity to new patients. Funds redirected from the purchase of high intensity treatment bed days will be used to purchase lower intensity residential services.

Two other efficiency measures include requiring that treatment programs increase their capacities to provide services to adults in outpatient settings, from caseloads of 30 patients per counselor to 40 per counselor, and insuring accountability by providing regular feedback to providers on performance and outcome measures.

Outpatient care is currently purchased at the rate of a caseload of 30 patients for each full time counselor. The average frequency with which counselors see patients is once per week, but there is typically variability in an outpatient counselor's caseload, with some patients being seen more often, and some seen as infrequently as once per month. In addition, a substantial number of patients occasionally no-show for their appointed counseling sessions. Increasing the caseload assignment from 30 patients to 40 patients for each full-time counselor is a reasonable capacity that recognizes the real world conditions in outpatient treatment programs and does not compromise the quality of care.

Department of Public Safety and Correctional Services: The number of treatment slots for prisoners during their incarceration has risen dramatically during the O'Malley Administration. Likewise, the prison system is doing a much better job at ensuring that the slots stay filled.

**Drug Treatment, Capacity and Utilization in State Prisons,
by fiscal year, FY 2007 through FY2010**



The community treatment system can improve efficiency in the utilization of community treatment opportunities by building upon the treatment rendered "behind the wire." If a more efficient "hand off" can be developed, released prisoners may not need the same level of intensity as they would if they "de-compensated" following release and had to begin treatment anew.

The Department of Public Safety and Correctional Services is developing a system to follow and identify appropriate offenders for aftercare groups as they are transferred between correctional institutions. This will ensure continuity of care in the prison system and improve connections to programs in the community upon release.

The Department of Public Safety and Correctional Services has committed to working with its vendors who have programs in the community to ensure appropriate continuity of care and further will work with other local programs to maximize immediate program placement. The Public Safety Compact is a partnership with community organizations to provide case management and treatment in the community for offenders from Baltimore City who complete substance abuse treatment while incarcerated.

Additionally, DPSCS has committed to utilizing SMART for monitoring the substance abuse treatment delivered to its inmates and tracking those inmates into community treatment to manage this continuity program through real time data. DPSCS is working with ADAA information services to set up training of DPSCS substance abuse counselors for access and utilization of the SMART data system.

In addition to efficiency in use of resources, continuation in community treatment programs upon release increases the probability that an offender will remain drug free. Offenders who complete prison-based substance abuse treatment plus aftercare in the community are less likely to have a new arrest or lapse into drug use at three and five years post release compared to offenders who complete prison-based treatment with no community aftercare. (*Inciardi, Martin, and Butzin, 2004; Prendergast, Hall, Wexler, Melnick & Cao, 2004*)

Recovery Oriented System of Care (ROSC): This model is comprised of a network of treatment and recovery support services mobilized to provide comprehensive care to individuals with severe substance use disorders and their families. The model is aligned with chronic care disease management principles, emphasizing earlier intervention in the progression of addictive illness, and the development and coordination of services that provide long-term support for maintenance of recovery.

Critical elements of the model include providing evidence-based treatment, providing clinical care to address co-morbid physical and mental health conditions, providing continuing care monitoring, and offering recovery support services. ROSC models are being implemented in many areas across the country, most notably in Connecticut and Philadelphia, in response to compelling research that points to the need to transform the prevalent model of addressing substance use disorders.

Implementation of this model results in increased rates of recovery, reduced rates of re-admission to intensive treatment, decreased lengths of stay in intensive treatment, and reduced complications from both the progression of the illness and from co-morbid conditions. All of these outcomes result in reduced costs to provide care. The cost savings can be redirected to purchase increased system capacity.

The anticipated outcome of the Maryland State Drug and Alcohol Abuse Council's Strategic Plan is a coordinated, state-mandated recovery-oriented system of care for Maryland citizens. The following objectives detail the Council's ROSC recommendations:

- Involve all relevant agencies in developing a ROSC;
- Improve coordination and collaboration among agencies that provide services to individuals with substance use conditions;
- Promote the use of substance use prevention best practices;
- Explore funding strategies that reduce service capacity deficits;
- Improve data sharing capabilities within and among partnering agencies; and
- Ameliorate the workforce shortage.

Strategy 1: Expand Buprenorphine Treatment Access

The buprenorphine treatment delivery model that maximizes efficiency of the treatment system relies upon the availability of physicians who are trained and certified to prescribe buprenorphine in communities across Maryland. The provision of statewide face-to-face and online physician trainings is a key element to implementation of this strategy. The training will be followed up with practice based workshops for physicians and their office staff.

In addition to physician training and support, the ADAA will provide technical assistance and training in best practices to all 24 jurisdictions, thus enabling them to improve their buprenorphine service delivery systems.

An innovative practice that holds great promise for increasing access to buprenorphine treatment, particularly in more rural areas of the State, is mobile opioid treatment delivered via a customized RV. The ADAA is committed to exploring this treatment option wherever feasible, and will implement mobile services in at least one rural region of the State.

Progress will be measured by evaluating increases in patients served.

Strategy 2: Redirect Payment for Outpatient Care from State-funded Grants to Medicaid Payments

The initial activity required to implement this strategy focuses on helping grant-funded certified addiction treatment programs develop billing and collections capacity and improve their business management practices. There are two phases to this initiative. In Phase I, the ADAA, with a consultant, will meet with four jurisdictions and their identified treatment programs for direct, hands-on assistance with reshaping program practices. The four jurisdictions, Baltimore City, Baltimore County, Montgomery County, and Prince George's County, were selected because they have the greatest numbers of MA/PAC patients in the state and, therefore, the most opportunity to maximize reimbursement. Phase I includes technical assistance provided to seven programs, four from Baltimore City and one from each of the other jurisdictions. ADAA staff, jurisdiction staff, and the consultant will meet with identified programs and their staff to establish or enhance management, clinical, and administrative activities for successful billing and collections. Phase II will be implemented using the ADAA and jurisdictional leaders to provide technical assistance to the rest of the programs in the four jurisdictions. The ADAA will also meet with the remaining jurisdictions to provide technical assistance using materials developed in Phase I. A User Group will be created to discuss and improve strategies for billing and collections. Ongoing technical assistance will be provided as necessary. Billing operations will be monitored and numbers of patients served will be compared to numbers served in 2008 to evaluate increases.

Strategy 3: Increase Efficiencies in Existing System of Care

Initially, the ADAA will increase the slot assignment for Level I adult standard outpatient treatment from 30 slots per counselor to 40 slots per counselor. Once this change goes into full effect in July 2010, utilization of the slots will be monitored, with an expected increase in patients served.

The ADAA plans to gather cost data on more intensive levels of residential treatment (Level III.7) and provide technical assistance to ADAA funded residential treatment programs to encourage them to obtain certifications for additional levels of lower intensity treatment (Levels III.5 and III.1). This activity will serve as the foundation for encouraging higher intensity programs to transfer patients to lower intensity treatment when clinically appropriate. The cost savings will then be used to purchase additional lower intensity treatment that can serve new patients.

Monitoring of performance and outcome measures will be critical to evaluating the success of the efficiency measures – utilization of capacity, appropriate transfer of patients to other levels of care based on clinical readiness, length of stay in treatment, decreases in substance use and arrest rates, and increases in employment. The ADAA plans to gather statewide and local data on these measures, and schedule monthly meetings with jurisdictions to review their data. Progress will be evaluated by measuring the increase in patients served.

Strategy 4: Develop a Recovery Oriented System of Care Model in Maryland

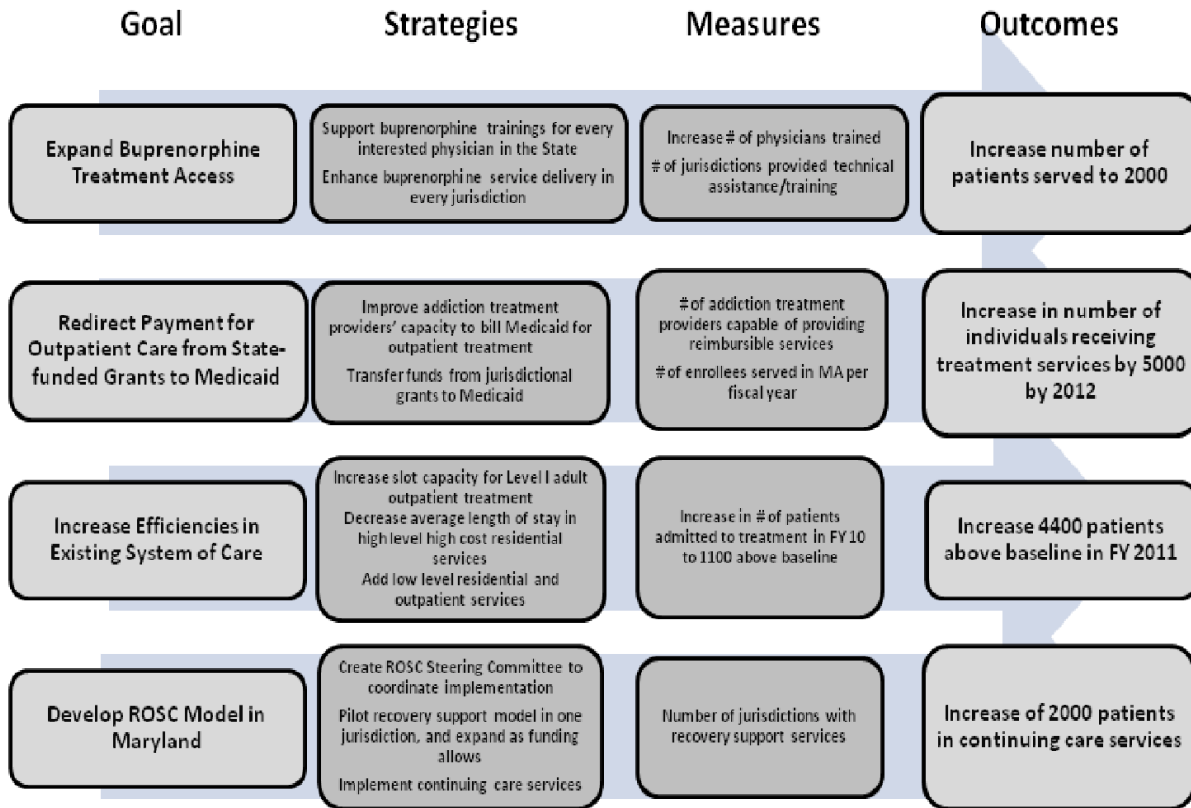
Initially, the ADAA will create a ROSC Steering Committee to determine the implementation process in Maryland, to include the involvement of stakeholders in the planning process, development of clinical standards for treatment and recovery support services, development of funding strategies, technology transfer planning, establishment of outcome measures, and selection of priority recovery support services. The Committee will also determine regulatory and policy barriers to the implementation of ROSC in Maryland, and develop plans to address them.

As part of the implementation process, the Committee will identify change agents in each jurisdiction to lay the groundwork for expansion of the model into every jurisdiction in Maryland. To facilitate the transformation process, the Committee will establish a Learning Collaborative comprised of the change agents from each jurisdiction that will meet monthly to participate in training and receive guidance regarding implementing elements of ROSC within their jurisdictions.

The Steering Committee will explore models of peer recovery support that can be implemented in Maryland, and develop a priority list of selected models. One model will be selected to implement as a pilot project, funding permitting. The Committee will explore establishing a revolving loan fund to support the development of sober housing options as a recovery support service. The Committee will also develop protocols, outcome measures, and funding strategies for the rollout of continuing care activities in all jurisdictions. An evaluation plan will be established that identifies benchmarks and timelines for the implementation process. One measure of success will be the number of patients enrolled in continuing care and recovery support activities.

The chart and timeline of the following pages provide a visual representation of the strategic plan to expand access to substance abuse services in Maryland.

Expanding Access to Substance Abuse Services Plan Summary



Timeline

Strategy	Jul-Sep 2009	Oct-Dec 2009	Jan-Mar 2010	Apr-Jun 2010
Expand Buprenorphine Treatment Access	Provide technical assistance in service delivery model to most jurisdictions	Provide physician certification training and follow up in Hagerstown and Annapolis	Pursue development of mobile opioid services in rural jurisdictions as funding allows	Provide physician certification training and follow up in Waldorf and Frederick
Redirect Payment for Outpatient Care to Medicaid	Provide technical assistance to jurisdictional staff to develop billing capacity	Provide technical assistance to jurisdictional staff to develop billing capacity	Transfer funds; begin billing; hold User Groups to troubleshoot issues	Monitor billing operations; provide ongoing technical assistance
Increase Efficiencies in Existing System of Care		Change slot capacity assignments for outpatient care from 30/1 to 40/1	Provide technical assistance to residential programs to increase flexibility in levels of care provided	Provide technical assistance to jurisdictions to purchase more low intensity services
Develop a Recovery Oriented System of Care Model in Maryland	Establish Recovery Oriented System of Care Steering Committee	Develop jurisdictional assessment of ROSC elements; Develop priority list of recovery support models	Pilot recovery support model; Establish Learning collaborative for change agents in jurisdictions	Develop ROSC implementation plans for each jurisdiction