Report
to
The LEGISLATIVE FINANCE COMMITTEE

Department of Health
Review of Substance Abuse Program
August 9, 2005

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DAVID ABBEY
DIRECTOR

August 9, 2005

Michelle Luhan Grisham, Secretary
Department of Health
1190 St. Francis, Harold Runnels Building
Santa Fe, New Mexico 87504

Dear Secretary Grisham:

On behalf of the Legislative Finance Committee (committee), I am pleased to transmit the review of statewide substance abuse treatment and prevention.

The audit team reviewed major substance abuse programs statewide, compiled appropriations and costs, evaluated outcome data, analyzed populations served and funding equity, and prepared this report. It will be presented to the committee on August 9, 2005. We very much appreciate you and your staff for the cooperation and assistance we received. An exit conference was conducted on July 18, 2005, to discuss the report.

We believe that this report addresses issues the committee asked us to review and hope the New Mexico Department of Health will benefit from our efforts. Thank you for your cooperation and assistance.

Sincerely,

David Abbey
Director

DA/SF:lg

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The Legislative Finance Committee (committee) requested a review of issues relating to substance abuse treatment. The committee's primary concerns were the measurability and accountability of the statewide substance abuse initiatives, costs, and program outcomes. The focus of this review was to

- Identify all substance abuse programs,
- Determine total dollars appropriated and how funding is disbursed,
- Determine measurable outcomes,
- Determine how the population to be served is identified and how many clients are being or have been served,
- Determine administrative costs associated with substance abuse programs, and
- Determine funding equity among programs and regions.

Public expectations of treatment must be met.

Among individuals receiving addiction treatment, the public expects safe, complete detoxification; reduced use of medical services; elimination of crime; return to employment and self support; elimination of family disruption and no return to drug use. Prevention services are the first line of defense against substance abuse. Although substance abuse prevention was not a primary focus, a cursory review of substance abuse prevention activities at the Department of Health (DOH) revealed they are very well planned and managed.

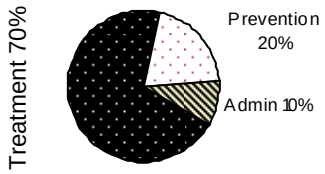
Incompatible data systems limited analysis.

The majority of substance abuse treatment and prevention activity and funding is spread across six agencies, requiring substantial data analysis. Data incompleteness and incompatibility among different state substance-abuse-related programs were obstacles to analysis of statewide substance abuse treatment cost and effectiveness. DOH receives the most funding and is the only agency that attempts to systematically track client outcomes. Therefore, the review focused on DOH treatment activities. Activities of other agencies' programs were examined to obtain a general understanding.

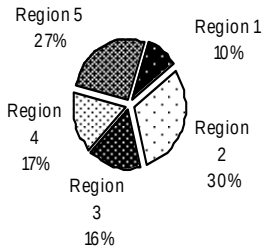
Services provided under phase 1 of the contract are transitional.

During this review, the state's mental health and substance abuse programs were being substantially reorganized. In fall 2003, the Interagency Behavioral Health Purchasing Collaborative (collaborative) was formed to create a single entity to manage the funds and delivery of behavioral health care. In April 2005, ValueOptions New Mexico was selected to manage the publicly funded mental health system. The first phase of the three-phase contract, July 1, 2005 to June 30, 2006, is considered a transition and implementation year and the current system will not be changed except for the elimination of the regional care coordinators (RCCs) that formerly managed the DOH regional mental health and substance abuse network.

FY05 Statewide Substance Abuse Budget by Activity

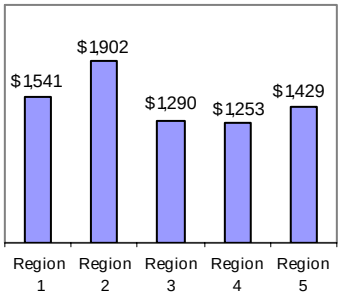


FY05 Substance Abuse Budget By Region



Note: FY05 Statewide cost ($12.3 million) excluded

Average Cost Per DOH Client By Region FY04



ASI outcome data is limited.

Findings. The following items include information and findings relating to the issues included in the review objectives.

- Although drug- and alcohol-abuse trends in New Mexico appear to have worsened from 1999 through 2003, in 2004 drug-caused deaths statewide declined 18 percent. Future trends will show whether it is a mere aberration or a true turnaround of a progressively worsening situation. From 1999 through 2003, illicit drug overdoses were the predominant manner of drug-caused deaths in New Mexico. Rio Arriba county's drug-caused death rate (proportionate to population) far exceeds all other counties in the state.

- The impact of publicly funded treatment efforts in New Mexico is virtually unnoticeable to the public due to the large substance-abuse population, the limited number of persons who need and seek treatment, and the undeterminable treatment success rates.

- FY04 expenditures and FY05 budget for substance abuse treatment and prevention are $64.2 million and $80.6 million, respectively. FY05 administrative costs of $7.7 million were 10 percent of total budget. DOH FY04 expenditures and FY05 budget are $35.8 million and $49.5 million, respectively.

- Equitable distribution of DOH funds throughout the various regions in the state cannot be determined due to the lack of adequate documentation.

- Average cost per DOH client served by the RCC network in FY04 was $1,517. The highest average cost was in the region that includes Santa Fe, Sandoval, Rio Arriba, San Miguel and Taos counties and the lowest average was in the southeastern part of the state. It is not possible to compare New Mexico's cost with other states' cost per client using National Outcome Measure data because DOH does not break down cost per client by treatment type.

- Substance abuse treatment outcomes cannot be adequately measured due to non-existent post-treatment follow up and insufficient outcome data.

- Providers are not conducting follow-up administrations of the addiction severity index (ASI), a nationally accepted instrument, to assess substance abuse clients.

- Sixteen percent of DOH substance abuse clients treated by RCC network providers from 2000 through 2004 registered more than once. Of these, 85 percent registered twice and 15 percent registered more than two times.

- DOH cannot provide adequate oversight of RCCs and their subcontractors with only three program managers.

Adequate program oversight cannot be provided.

- The current methods used for measuring and monitoring utilization and cost of provider services are inefficient, ineffective, and an open invitation for abuse and possibly fraud.

    - DOH failed to reconcile provider utilization rates to eliminate encounter data paid for by other funding sources.
    - Inadequate oversight of the Recovery from Addictions Program allowed incidences of fiduciary negligence, reporting deficiencies, and other egregious activities.
    - Providers billed both DOH and the Human Services Department for the same Medicaid-funded services.

Utilization and cost measurement monitoring is ineffective.

- Funds withheld from two providers for nonperformance were subsequently returned without adequate explanation or justification, a possible violation of the Anti-Donation Clause of Article IX of the New Mexico Constitution.

- The collaborative's request for proposals and resulting contract are not specific with regard to performance outcomes, utilization rates, contract oversight, data ownership, incentives and sanctions for provider and ValueOptions New Mexico .

ValueOptions is responsible for mental health system implementation.

- Best practices identified during this review include federally required National Outcome Measures; an emerging expert consensus on Concurrent Recovery Monitoring (developed specifically for outpatient substance abuse treatment); and linking payment to performance outcomes.

- The National Conference of State Legislatures, the State Associations of Addiction Services and the Philadelphia-based Treatment Research Institute are conducting a year-long national benchmarking project regarding addiction treatment programs.

- A report by Inflexxion on state ASI data, produced under contract with DOH, is misleading to the uninformed reader due to data limitations.

Recommendations. To help determine whether substance abuse treatment is producing the desired outcomes, whether tax dollars are being used effectively, and whether relevant indicators of success are being used, measured, and reported affordably, DOH should take the following steps:

- Develop and maintain a methodology that ensures equitable funding distribution to substance abuse providers throughout the state. Maintain adequate documentation that justifies distributions.

Continue to enhance treatment measurement.

- Continue to use the ASI for follow-up assessment with consideration given to all 10 national outcome measure domains. Consider using the Concurrent Recovery Model for outpatient treatment, as well as post-treatment follow-up assessment for residential and inpatient clients. Determine and report annually the effectiveness of existing services as required by Section 43-3-13-A-5, NMSA 1978.

Pay providers only for services provided.

- Consider a fee-for-service or other type of contractual arrangement with pay-for-performance provisions to ensure that providers are paid only for the services provided. Until an alternative system is established, perform formal, well-documented utilization reviews and reconciliation of medical loss ratios (MLR).

Reallocate funding based on performance.

- Reallocate funding based on provider performance to avoid violating the anti-donation clause.

Develop adequate oversight methodologies.

- Develop an oversight methodology that will ensure compliance with all standards; systematically test for internal controls and fiscal accountability; and amend contracts to allow firm enforcement of provider sanctions.

- Follow the Attorney General's suggestion and refer the Recovery from Addictions Program matter to one of the recommended investigative/prosecutorial agencies.

Resolve double billing issues.

- Analyze instances of apparent double billing during FY04 and prior years. If warranted, demand reimbursement or refer matter to the appropriate law enforcement or prosecutorial agency.

- Use the Inflexxion report as a starting point for future efforts, but do not attempt to draw broad conclusions. Accept the report's recommendations and urge the collaborative to consider them in their future monitoring efforts.

The collaborative is encouraged to review this report to ensure that issues identified will be addressed in the new mental health and substance abuse treatment delivery system. For example, a comprehensive database should be developed that will track statewide costs per client by type of treatment and effectiveness by program. The ValueOptions New Mexico contract should be amended to address the following items:

- Best practices,
- Best ASI applications for initial and follow-up assessments,
- ASI assessment intervals,
- Utilization rates or range,
- Collaborative oversight activities,
- Data ownership,
- Application of incentives and sanctions for ValueOptions New Mexico and providers, and
- Specific requirements for payment and related justification by agency.

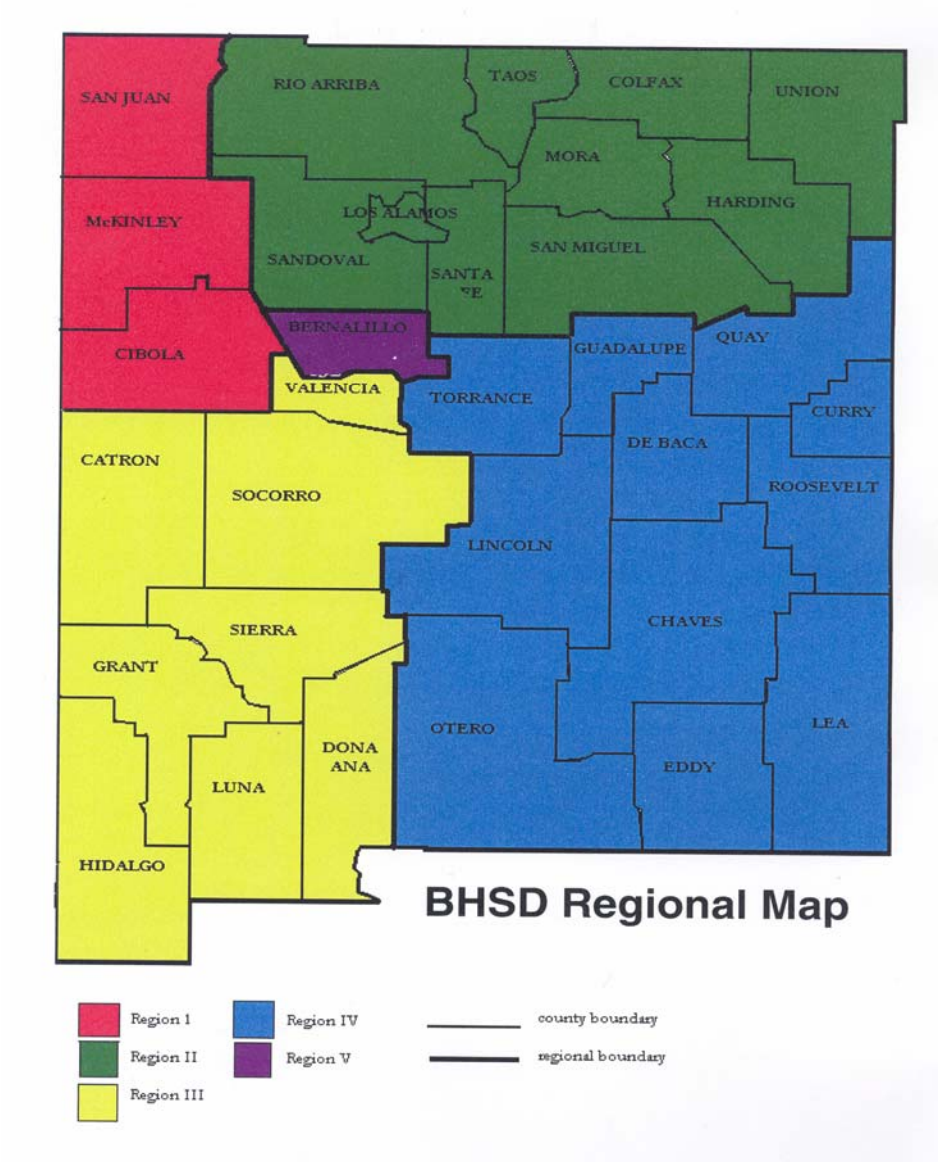
Collaborative should address issues in this report.

ValueOptions was selected to effectively administer the program.

Background. In July 1997 the Legislature enacted the merger of the DOH Mental Health and Substance Abuse divisons, resulting in the Behavioral Health Services Division (BHSD). Although other agencies provide limited substance abuse services, BHSD has been delegated the primary responsibility for administering publicly funded substance abuse services to New Mexico citizens who seek such treatment.

From FY02 through FY05, BHSD contracted with three regional care coordinators (RCCs) that managed most substance abuse providers in New Mexico. The 33 counties are divided into five regions managed by the three RCCs. The following map displays the counties, regions, and related RCCs.

Graph 1. Map of Counties, Regions and Related RCCs



Presbyterian Medical Services -Regions 1 & 5

Rio Grande Behavioral Health Services, Inc-Regions 3 & 4

Region 2 Behavioral Health Providers, Inc-Region 2

The RCCs provide a variety of treatment services including detoxification, inpatient, short- and long-term residential, intensive outpatient, outpatient, and follow-up services via contracts with individual subcontractors. A BHSD program manager assigned to each region is responsible for the coordination and general oversight of RCC and sub-provider activities. The DOH Division of Health Improvement (DHI) performs onsite reviews of the RCCs and some sub-contractors. The DHI onsite activities include policy and procedure reviews to assess managerial adequacy and contract compliance, personnel file reviews to ensure adherence to licensure requirements, and chart audits of services provided to verify that services reported were actually performed and to ensure the sufficiency and quality of services provided to clients. RCCs monitor sub-contractors for the same purposes.

Program managers also oversee many providers outside the RCC system. A few of these providers serve the state's Native American population and submit data into BHIS. They represent less than one percent of the overall clients and costs in BHIS. The non-RCC providers that do not enter data into BHIS are excluded from the RCC system for various reasons. In some instances, the types of services provided are not treatment services; for example, services not entering the BHIS system include prevention, which is not an individualized service, or forensic evaluations. In other cases, a new provider may not have completely or adequately established its operations to conform to RCC-required standards.

Because many tables and graphs in this report are from BHIS data only, they are not intended to be representative of the true overall volume of statewide substance abuse-related activities. They do, however, show reasonable comparisons between statewide regions and support the overall conclusions. The tables and graphs in this report whose source is the BHIS or the Human Services Management Information System include both substance abuse and co-occurring clients. Co-occurring clients include persons that are being treated for substance abuse as well as another mental health condition.

Single Behavioral Health Delivery System. In 2004, the legislature passed House Bill 271, which was signed by the governor. This bill established the Interagency Behavioral Health Purchasing Collaborative made up of 15 state agencies to create a single behavioral health delivery system that braids and blends the behavioral health funds of multiple state agencies into a unified network of services. More specifically, the single health delivery system would manage funds, promote mental health, prevent and/or reduce mental illness and substance abuse, and promote participation by mental health and substance abuse clients in their communities.

A request for proposals (RFP) was issued in November 2004 (about four months after the initial target date for its release), and a behavioral health contractor (ValueOptions New Mexico) was selected in April 2005. The contract is divided into three phases:

- Phase 1 - July 1, 2005, through June 30, 2006 - The contractor must be fully operational in supporting the state's management of the new behavioral health system on July 1, 2005. The following specific activities are included:
  - Provide services, pay providers, and report data;
  - Continue transition;
  - Refine expectations;
  - Refine data systems;
  - Identify ways to maximize funding;
  - Develop local systems of care;
  - Implement statewide plan; and
  - Establish goals for Phase 2.

- Phase 2 – July 1, 2006, through June 30, 2008 – Phase 2 activities include the following:
  - Establish greater blending and flexibility of funding;
  - Establish additional funding streams;
  - Refine local systems of care;
  - Develop additional evidence-based and promising best practices;
  - Support additional consumer- and family-operated services;
  - Refine performance expectations and consumer and family outcomes, measures, and reports;
  - Seek additional resources (e.g., grants); and
  - Establish goals for Phase 3.

- Phase 3 – July 1, 2008 through June 30, 2009, or an earlier date to be determined by the parties – Phase 3 activities include the following:
  - System maturation,
  - Increased program and service development,
  - Improved performance and outcomes, and
  - Increased coordination among local and statewide systems.

As evident from Phase 1 activities, the majority of the single behavioral health delivery system remains to be conceptualized and/or implemented. Although the responsibility for such rests with the collaborative, it has been contractually delegated to ValueOptions New Mexico. The collaborative's role will be oversight, as well as policy and programmatic development, activities to enhance the behavioral health workforce and to seek additional resources for the system.

Objective and Scope. The review period included data FY00 through FY05. The review was conducted to assess the measurability and accountability of the statewide substance abuse initiatives, related costs, and program outcomes. Specific tests were performed to

- Identify all substance abuse programs,
- Determine total dollars appropriated and how funding is disbursed,
- Determine measurable outcomes,
- Determine how the population to be served is identified and how many clients are being or have been served,
- Determine administrative costs associated with substance abuse programs, and
- Determine funding equity among programs and regions.

Procedures. Review procedures include the following:
- Review DOH substance abuse program requirements;
- Obtain substance abuse financial information from DOH and other agencies and analyze for statewide regional allocation and administrative and direct program cost distribution;
- Analyze BHIS database for adequacy and completeness of treatment service and cost reporting, outcome-related data gathering and monitoring, and comparison of regions by costs and services;
- Review RCC and sub-provider contracts;
- Visit with DOH, RCCs, and sub-contractors and review organization and program documentation;
- Examine provider case files, payroll, and billing records;

- Review substance abuse programs of other agencies; and
- Examine other relevant data.

Authority for Review. The Legislative Finance Committee (committee) has the statutory authority under Section 2-5-3 NMSA 1978 to examine laws governing the finances and operations of departments, agencies and institutions of New Mexico and all of its political subdivisions, the effects of laws on the proper functioning of these governmental units, and the policies and costs. The committee is also authorized to make recommendations for change to the Legislature. In furtherance of its statutory responsibility, the committee may conduct inquiries into specific transactions affecting the operating policies and cost of governmental units and their compliance with state law.

Review Team.

G. Christine Chavez, Deputy Director for Performance Audit
Susan Fleischmann, Senior Performance Auditor
Lorenzo Garcia, Senior Performance Auditor
Scott Roybal, Performance Auditor

Exit Conference. The contents of this report were discussed on July 18, 2005, with Jessica Sutin, deputy secretary, DOH; Karen Meador, BHSD director, DOH; Mat Onstott, Medical Assistance Division, deputy director, HSD; Rich Tavares, BHSD deputy director, DOH; Elaine Benavidez, Bureau Chief, BHSD Community-Programs Bureau, DOH; Charles Jaramillo, BHSD chief financial officer, DOH; and Betty Downes, BHSD systems consultant, DOH.

Report Distribution. This report is intended for the information of the Office of the Governor, Department of Health, Human Services Department, Department of Finance and Administration, Office of the State Auditor, and the Legislative Finance Committee. This restriction is not intended to limit distribution of this report, which is a matter of public record.

G. Christine Chavez
Deputy Director Performance Audit
Legislative Finance Committee

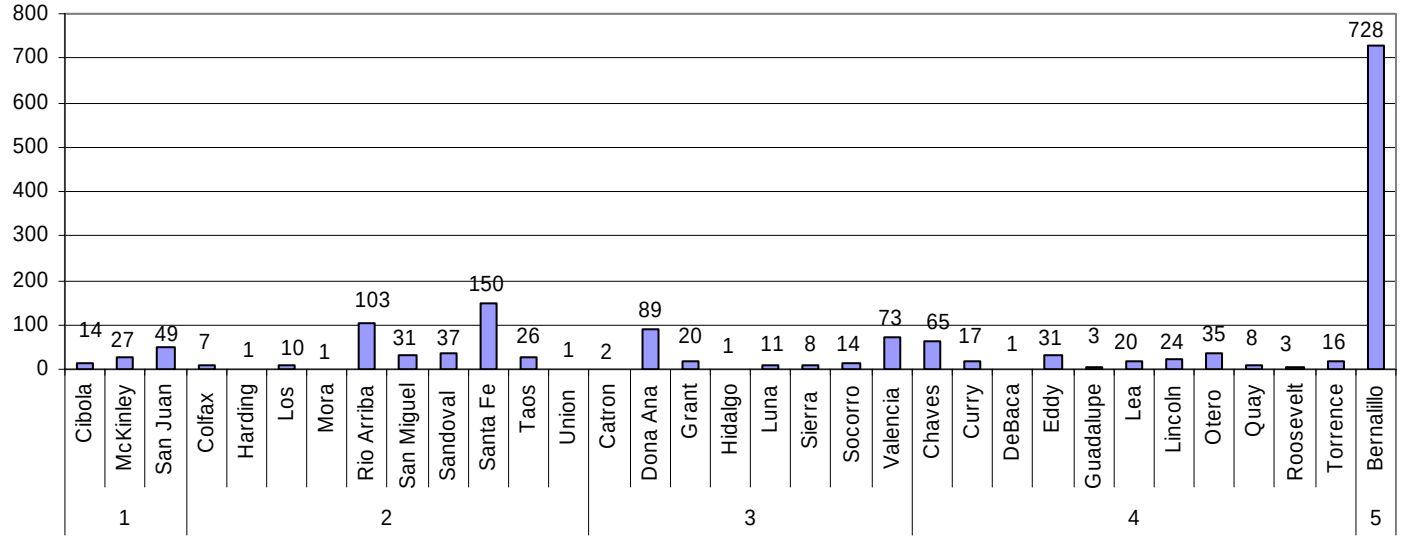
Substance Abuse Trends in New Mexico. As reflected in Table 1, drug-caused death trends in New Mexico have progressively worsened from 1999 through 2003. In 2004, however, drug-caused deaths statewide declined 18 percent from 342 in 2003 to 279 in 2004. The reason for the decline can not be currently determined. Future trends will show whether it is a mere aberration or a true turnaround of a progressively worsening situation. Graph 2 shows the distribution of drug-caused deaths from 1999 through 2004 by county and region. Graph 2a is an analysis of drug caused deaths rate (proportionate to county population) from 1999 through 2004. Harding county, for example, had only one drug-caused death (graph 2), but because of its minimal population (less than 1,000) the projected death rate per 100,000 people would be 132 (graph 2a). Rio Arriba county's drug-caused death rate (proportionate to population) far exceeds all other counties in the state.

Table 1. Drug-Caused Deaths in New Mexico—1999 through 2004

	Region						
Calendar Year	1	2	3	4	5	Unk	Total
1999	15	63	33	26	113	11	261
2000	14	55	35	35	115	10	264
2001	9	58	31	30	106	28	262
2002	18	68	32	28	135	10	291
2003	20	66	44	60	139	13	342
2004	14	57	43	44	120	1	279
Grand Total	90	367	218	223	728	73	1,699

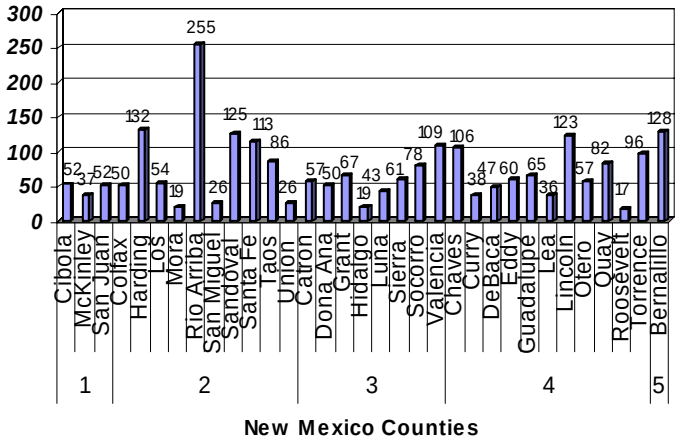
Source: Office of Medical Investigator 1999 through 2004 Annual Reports

Graph 2. Drug-Caused Deaths by County and Region
1999 through 2004



Source: Office of Medical Investigator 1999 through 2004 Annual Reports

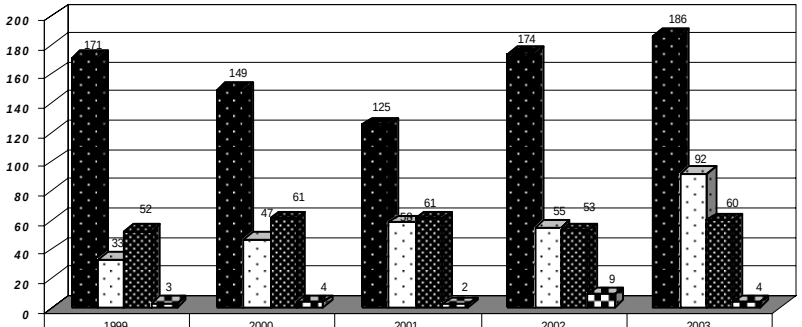
Graph 2a. Drug-Caused Deaths Per 100,000 Population by County
1999 through 2004



Source: Office of Medical Investigor 1999 through 2004 Annual Reports

The predominant manner of drug-caused deaths from 1999 through 2003 is overdose from illicit drugs with prescription drug overdoses trailing a distant second.

Graph 3. Drug-Caused Deaths - Manner of Death
1999 through 2003

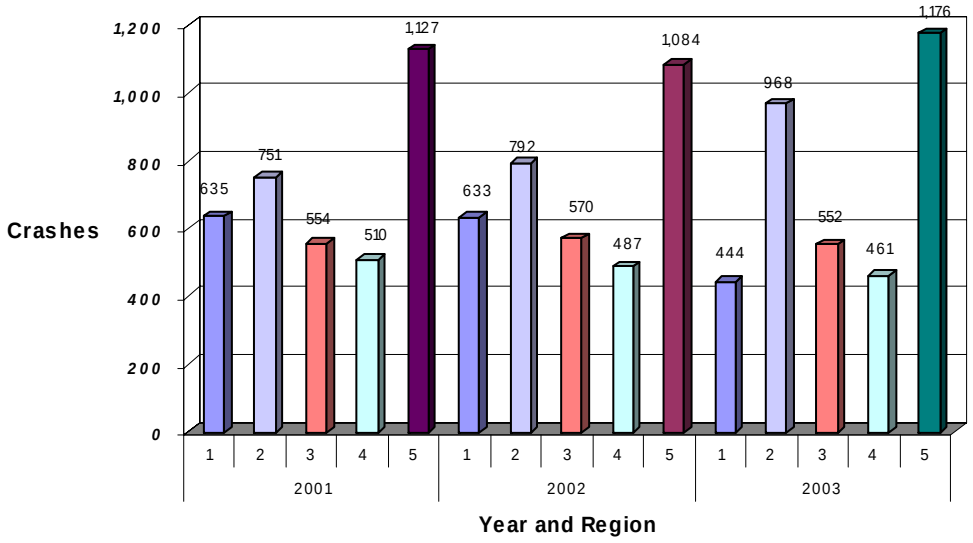


	1999	2000	2001	2002	2003
Illicit drug(s)	171	149	125	174	186
prescription meds	33	47	58	55	92
Homicides and Other	52	61	61	53	60
Other Accidents	3	4	2	9	4

Source: Office of Medical Investigator 1999 through 2003 Annual Reports

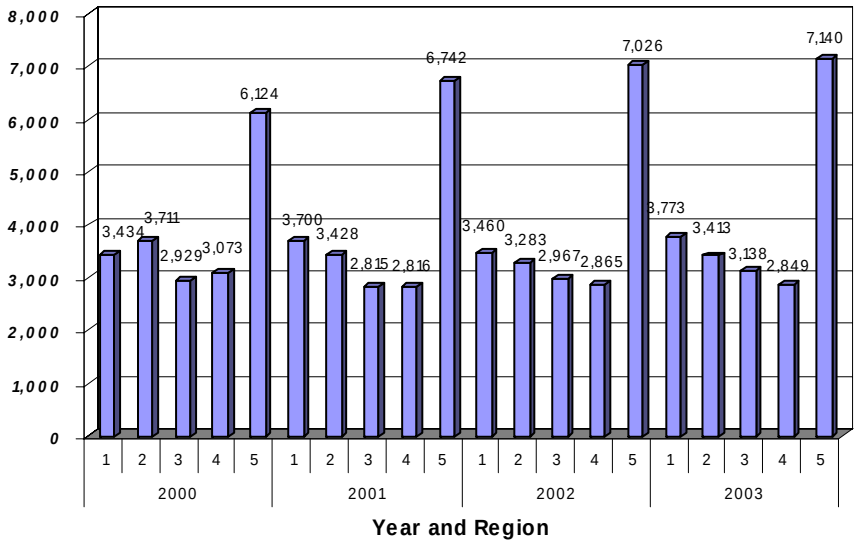
Graphs 4 and 5 show that alcohol-involved automobile crashes and DWI arrests have risen steadily and proportionately by region throughout the state in the past several years.

Graph 4. Alcohol - Invloved Crashes
2001 through 2003



Source: University of New Mexico Division of Government Research-Produced for Traffic Safety Bureau of New Mexico Department of Transportation

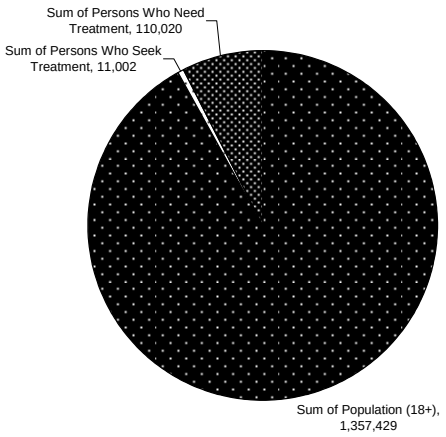
Graph 5. DWI Arrests
2000 through 2003



Source: University of New Mexico Division of Government Research-Produced for Traffic Safety Bureau of New Mexico Department of Transportation

Substance Abuse Problem in New Mexico. Because of the large substance abusing population, the limited number of abusers who seek treatment, and the undeterminable success rates, the overall impact of publicly funded treatment efforts in New Mexico is virtually unnoticeable to the public. As reflected in graph 6, of the age 18 and older New Mexico population of 1.36 million in FY04, the DOH Office of Epidemiology estimates that 8.1 percent, or about 110,000 people, were in need of substance abuse treatment. The office further estimates that about 10 percent, or 11,000, of those persons who needed treatment actually sought treatment publicly or privately. As discussed later in this report, the impact of treatment efforts as a percentage of persons who seek treatment cannot be accurately measured due to extremely limited valid outcome-related data.

Graph 6 - New Mexico Citizens Who Need and Seek Substance Abuse Treatment 2004



Source: New Mexico Department of Health Office of Epidiomology and University of New Mexico Division of Government Research

Substance Abuse Treatment Structure and Finances. The following agencies were contacted to determine statewide substance abuse spending:

- Department of Health
- Department of Finance and Administration
- Administrative Office of the Courts
- Corrections Department
- Human Services Department
- Children, Youth and Families Department
- Public Education Department
- Aging and Long-Term Care Department
- Labor Department
- Division of Vocational Rehabilitation
- Indian Affairs Department

None of the agencies that provided financial information normally account for substance abuse treatment, prevention, and administration separately. The agencies had difficulty providing the information in the format requested. For that reason, certain assumptions were made, resulting in data limitations. For example, some funds that passed through to other agencies might have been counted twice. The amounts were judged to be immaterial to the total dollars presented.

The data was compiled from unaudited agency records. DOH financial information includes regional care coordination networks; non-network treatment, prevention, and administrative providers; school-based treatment services; the substance abuse treatment component for certain facilities; and statewide administrative costs. Three such facilities are Fort Bayard, the New Mexico Rehabilitation Center, and Turquoise Lodge. HSD's FY04 expenditures were used for FY05 because FY05 data was not available.

Only six of the 11 agencies contacted reported receipt of specifically designated substance abuse treatment and prevention monies. Tables 2 and 3 summarize FY04 expenditures by region and by activity. Tables 4 and 5 summarize FY05 budgets by region and by activity. All four tables show the federal and state share.

Table 2. FY04 Substance Abuse Expenditures by Region
(in thousands)

Agency Name	Region 1	2	3	4	5	Statewide/ Non-Region Specific	Total	General Funds	Federal Funds
Human Services Department	$ 137.6	$ 588.2	$ 826.7	$ 1,058.3	$ 1,381.7		$ 3,992.5	$ 898.7	$ 3,093.8
Department of Health									
- RCC and Network Providers	$ 2,146.8	$ 5,657.3	$ 1,743.9	$ 3,062.1	$ 3,752.8		$ 16,362.9		
- Non-RCC and Other Providers	$ 1,514.5	$ 5,137.6	$ 838.6	$ 580.7	$ 1,009.9	$ 4,196.6	$ 13,277.9		
- School-Based Treatment Services	$ 93.7		$ 102.7			$ 32.2	$ 228.6		
- Facilities			$ 927.8	$ 1,607.9	$ 3,360.5		$ 5,896.2		
Subtotal - Department of Health	$ 3,755.0	$ 10,794.9	$ 3,613.0	$ 5,250.7	$ 8,123.2	$ 4,228.8	$ 35,765.6	$ 25,249.6	$ 10,516.0
Administrative Office of the Courts	$ 598.9	$ 1,425.1	$ 1,377.7	$ 507.7	$ 2,618.1		$ 6,527.5	$ 6,055.4	$ 472.1
Department of Finance and Administration	$ 1,795.1	$ 2,655.6	$ 1,437.4	$ 1,524.9	$ 4,643.5		$ 12,056.5	$ 12,056.5	
Corrections Department	$ 271.9	$ 856.4	$ 1,286.7	$ 2,088.6	$ 381.3	$ 400.4	$ 5,285.3	$ 4,671.0	$ 614.3
Children, Youth and Families Department	$ 77.9	$ 165.0	$ 44.8	$ 103.5	$ 49.2	$ 127.0	$ 567.4	$ 273.3	$ 294.1
Grand Total	$ 6,636.4	$ 16,485.2	$ 8,586.3	$ 10,533.7	$ 17,197.0	$ 4,756.2	$ 64,194.8	$ 49,204.5	$ 14,990.3

Source: Agency files.

Table 3. FY04 Substance Abuse Expenditures by Activity

(in thousands)

Agency Name	Treatment	Prevention	Administration	Total	General Funds	Federal Funds
Human Services Department	$ 3,992.5			$ 3,992.5	$ 898.7	$ 3,093.8
Department of Health						
- RCC and Network Providers	$ 14,305.7	$ 93.7	$ 1,963.6	$ 16,363.0		
- Non-RCC Providers and Statewide	$ 5,070.2	$ 6,963.0	$ 1,244.5	$ 13,277.7		
- School-Based Treatment Services	$ 228.7			$ 228.7		
- Facilities	$ 4,834.9		$ 1,061.3	$ 5,896.2		
Subtotal - Department of Health	$ 24,439.5	$ 7,056.7	$ 4,269.4	$ 35,765.6	$ 25,249.6	$ 10,516.0
Administrative Office of the Courts	$ 2,904.7	$ 3,163.3	$ 459.5	$ 6,527.5	$ 6,055.4	$ 472.1
Department of Finance aqnd Administration	$ 6,708.7	$ 3,533.3	$ 1,814.5	$ 12,056.5	$ 12,056.5	$ -
Corrections Department	$ 4,819.8	$ 65.1	$ 400.4	$ 5,285.3	$ 4,671.0	$ 614.3
Children, Youth and Families Department	$ 88.7	$ 473.4	$ 5.3	$ 567.4	$ 273.3	$ 294.1
Grand Total	$ 42,953.9	$ 14,291.8	$ 6,949.1	$ 64,194.8	$ 49,204.5	$ 14,990.3

Source: Agency files.

Table 4. FY05 Substance Abuse Budget by Region

(in thousands)

Agency Name	Region 1	2	3	4	5	Statewide/ Non-Region Specific	Total	General Funds	Federal Funds
Human Services Department	$ 137.6	$ 588.2	$ 826.7	$ 1,058.3	$ 1,381.7		$ 3,992.5	$ 898.7	$ 3,093.8
Department of Health							$ -		
- RCC and Network Providers	$ 2,150.1	$ 5,299.8	$ 1,887.5	$ 2,785.5	$ 3,510.8		$ 15,633.7		
- Non-RCC and Other Providers	$ 1,634.0	$ 9,382.9	$ 1,087.8	$ 586.5	$ 1,564.4	$ 11,596.7	$ 25,852.3		
- School-Based Treatment Services	$ 62.3		$ 106.6			$ 32.2	$ 201.1		
- Facility			$ 1,400.0	$ 2,222.1	$ 4,227.8		$ 7,849.9		
Subtotal - Department of Health	$ 3,846.4	$ 14,682.7	$ 4,481.9	$ 5,594.1	$ 9,303.0	$ 11,628.9	$ 49,537.0	$ 26,280.0	$ 23,257.0
Administrative Office of the Courts	$ 438.2	$ 1,678.2	$ 1,768.3	$ 759.2	$ 2,986.7		$ 7,630.6	$ 6,381.3	$ 1,249.3
Department of Finance aqnd Administration	$ 1,774.0	$ 2,724.1	$ 1,603.2	$ 1,651.6	$ 4,030.8		$ 11,783.7	$ 11,783.7	
Corrections Department	$ 268.9	$ 1,064.1	$ 2,231.3	$ 2,095.2	$ 439.8	$ 523.8	$ 6,623.1	$ 6,401.1	$ 222.0
Children, Youth and Families Department	$ 75.0	$ 443.0	$ 55.5	$ 256.5	$ 86.0	$ 110.0	$ 1,026.0	$ 376.0	$ 650.0
Grand Total	$ 6,540.1	$ 21,180.3	$ 10,966.9	$ 11,414.9	$ 18,228.0	$ 12,262.7	$ 80,592.9	$ 52,120.8	$ 28,472.1

Source: Agency files.

Table 5. FY05 Substance Abuse Budget by Activity

(in thousands)

Agency Name	Treatment	Prevention	Administration	Total	General Funds	Federal Funds
Human Services Department	$ 3,992.5			$ 3,992.5	$ 898.7	$ 3,093.8
Department of Health						
- RCC and Network Providers	$ 13,836.1	$ 94.7	$ 1,703.0	$ 15,633.8		
- Non-RCC Providers and Statewide	$ 15,939.2	$ 8,085.5	$ 1,827.5	$ 25,852.2		
- School-Based Treatment Services	$ 201.1			$ 201.1		
- Facilities	$ 6,436.9		$ 1,413.0	$ 7,849.9		
Subtotal - Department of Health	$ 36,413.3	$ 8,180.2	$ 4,943.5	$ 49,537.0	$ 26,280.0	$ 23,257.0
Administrative Office of the Courts	$ 3,540.3	$ 3,601.4	$ 488.9	$ 7,630.6	$ 6,381.3	$ 1,249.3
Department of Finance aqnd Administration	$ 6,302.6	$ 3,782.1	$ 1,699.0	$ 11,783.7	$ 11,783.7	$ -
Corrections Department	$ 6,031.4	$ 67.9	$ 523.8	$ 6,623.1	$ 6,401.1	$ 222.0
Children, Youth and Families Department	$ 174.6	$ 846.0	$ 5.4	$ 1,026.0	$ 376.0	$ 650.0
Grand Total	$ 56,454.7	$ 16,477.6	$ 7,660.6	$ 80,592.9	$ 52,120.8	$ 28,472.1

Source: Agency files.

Statewide, FY04 expenditures and FY05 budgets for substance abuse treatment and prevention are $64.2 million and $80.6 million, respectively. In both fiscal years, DOH was the most heavily funded agency.

All regions were funded at higher levels in FY05 than in FY04, except Region 1, where funding decreased by $96.3 thousand. In FY04, Region 5 received the greatest amount of funding ($17.2 million), with Region 2 coming in second at $16.5 million. The situation reversed in FY05, with Region 2 receiving $21.2 and Region 5 receiving $18.2 million, respectively.

From FY04 to FY05, statewide substance abuse treatment, prevention, and administration funding increased by $16.4 million. Both general fund and federal support also increased from FY04 to FY05. State funding increased by $2.9 million and federal funding increased by $13.5 million. The large increase in FY05 federal funding is primarily due to the access to recovery grant and expansion of the Screening, Brief Intervention, Referral and Treatment program.

In FY04, treatment, prevention, and administration activities comprised 66.9, 22.3 and 10.8 percent of total expenditures, respectively. In FY05, budget components for treatment, prevention, and administration activities were 70, 20, and 10 percent, respectively. From FY04 to FY05, treatment activity increased slightly (3.1 percent), prevention activity decreased slightly (2.3 percent) and administration decreased by 0.8 percent. Administration includes RCCs, DOH facilities, and statewide costs.

Because the focus of our review was primarily on DOH substance abuse programs, in-depth analysis of the substance abuse-related efforts of other state-funded programs was not performed. Review of these other programs was limited to the extent necessary to obtain an understanding of program activities, general monitoring, and outcome measurement. Refer to Appendix A for a general discussion of these other programs.

Funding Distribution Methodology. DOH could not adequately provide documentation that demonstrates how funds were distributed to the different regions in the state prior to FY02. It was not until FY02 that a formula-driven methodology was developed to distribute funds throughout the state. This current methodology is based on a social indicator resource model that uses weighted data from an array of eight social indicators, including drug- and alcohol-related mortality, population, available treatment dollars, estimated substance abuse prevalence, and number of uninsured adults. Furthermore, DOH could not provide the documentation or data that would support FY02 and subsequent distributions based on the formula.

Without adequate documentation, there is no way to ensure the allocation decisions have been, are or will be justifiable or equitable.

Recommendation. DOH should develop and maintain a methodology that ensures equitable funding distribution to substance abuse providers throughout the state. The department should maintain adequate documentation that clearly shows and supports all calculations and assumptions.

Average Cost Per Recipient. Tables 6 through 8 below show the calculation of average treatment cost per unduplicated client in the RCC system for DOH and Medicaid. For Medicaid managed care, the costs reported as having been incurred by the managed care organizations for substance abuse services to Medicaid clients were used. Due to data compatability and availability issues, the average cost per client for non-DOH and HSD programs or for services provided outside the RCC system were not computed. Region 2 (Santa Fe, Sandoval, San Miguel, Rio Arriba, San Miguel, Colfax, Union, Mora, Harding and Taos counties) shows the highest average cost per RCC client. This is consistent with the fact that Region 2 exceeds the other regions in inpatient and residential treatment.

Table 6. HSD Medicaid FY04 Direct Costs, Number of Recipients and Average Cost Per Recipient by Region

Type of Service	Region 1	Region 2	Region 3	Region 4	Region 5	Total
Fee for Service						
- Cost	$ 58,329	$ 115,619	$ 206,659	$ 256,367	$ 180,139	$ 817,113
Clients	222	302	316	344	744	1,928
Average Per Client	$ 263	$ 383	$ 654	$ 745	$ 242	$ 424
Managed Care						
- Cost	$ 79,247	$ 472,534	$ 620,090	$ 801,886	$ 1,201,590	$ 3,175,347
Clients	250	729	1,126	1,101	1,722	4,928
Average Per Client	$ 317	$ 648	$ 551	$ 728	$ 698	$ 644

Source: Human Services Department Management Information System

Table 7. RCC FY04 Direct Costs for Substance Abuse and Co-Occurring, Number of Recipients and Average Costs Per Recipient by Region

	Region 1	Region 2	Region 3	Region 4	Region 5	Total
Cost*	$1,889,196	$4,978,471	$1,534,657	$2,694,665	$ 3,302,438	$14,399,427
Clients	1,226	2,618	1,190	2,150	2,311	9,495
Average Per Client	1,541	1,902	1,290	1,253	1,429	1,517

* Direct Costs Only

Source: DOH financial records; BHIS recipient data

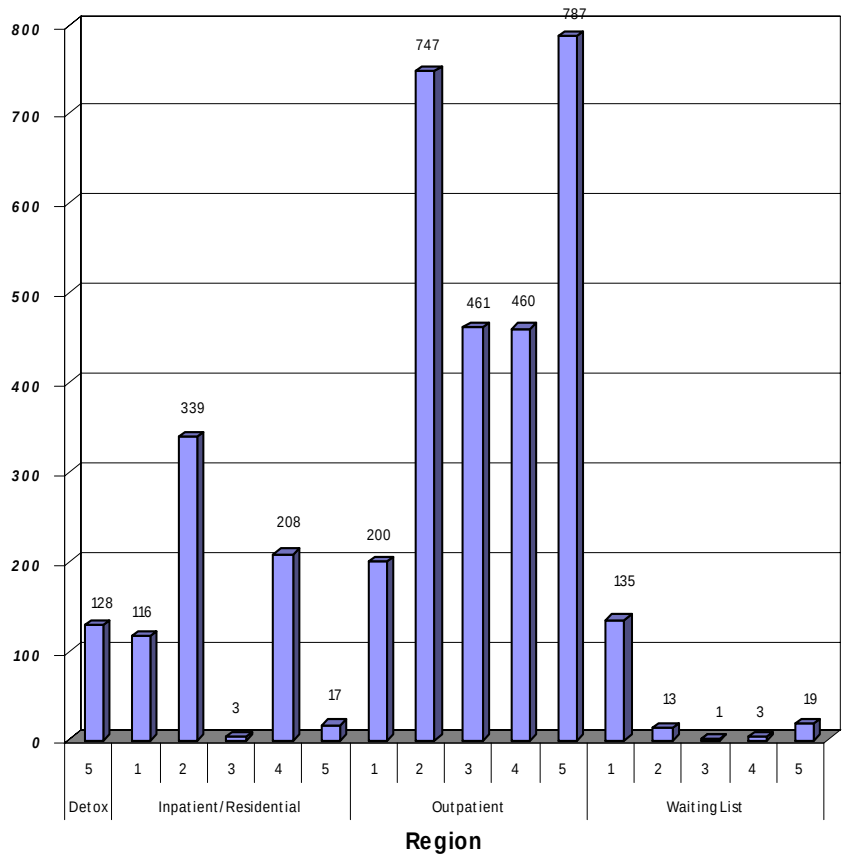
Table 8. HSD and RCC Total Direct Costs, Number of Recipients and Average Cost Per Recipient by Region

	Region 1	Region 2	Region 3	Region 4	Region 5	Total
Cost	$2,026,772	$5,566,624	$2,361,406	$3,752,918	$ 4,684,167	$18,391,887
Clients	1,698	3,649	2,632	3,595	4,777	16,351
Less: Duplicates	(41)	(70)	(92)	(113)	(204)	(520)
Unduplicated Clients	1,657	3,579	2,540	3,482	4,573	15,831
Average Per Client	$ 1,223	$ 1,555	$ 930	$ 1,078	$ 1,024	$ 1,162

Source: Human Services Department Management Information System and DOH

Types of Treatment. Graph 7 shows the FY04 regional distribution of inpatient, outpatient and detoxification treatment services for clients in the DOH/RCC system. As is evident, in FY04 the highest concentration of inpatient and residential treatment was in Region 2. Inpatient and residential treatment is more expensive than outpatient treatment. Regions 2 and 5 had the highest concentrations of outpatient treatment.

Graph 7. Type of Treatment FY04



Source: DOH BHIS Treatment Table

Limitations of BHIS Data. DOH is the only state agency that maintains comprehensive substance abuse treatment and cost data. Data types contained in this system include encounter services and cost, client registrations and demographics, client treatment, and outcome information.

Although BHIS contains extensive substance abuse data, it has significant limitations, including incompleteness of the outcome measuring ASI data. (The ASI is further discussed in the outcomes section of this report.) Various analyses of the ASI data by the committee audit staff, the DOH Information Technology (IT) staff, the RCCs, and a DOH private contractor (Inflexxion, Inc.) demonstrate that the BHIS data limitations make it unreliable for program-outcome measurement. DOH IT staff analysis reflects that 3,320 of 6,183 new registrations in FY04 (54 percent) had at least one ASI administration. Only 658 (11 percent) of the new registrants had more than one score. Two or more scores are needed to determine improvement.

DOH and RCC staff agree that because of the large volume of data rejected for technical reasons, BHIS contains less data than RCC databases. The RCCs believe that many of the reasons given for the rejections are not significant enough to warrant rejection.

Because of inconsistencies and completeness issues, this review is unable to adequately compare the various data tables for plausible relationships. For example, the volume of clients treated for substance abuse in the treatment or registration tables in a given period does not agree with the total number of substance abuse clients identified in the encounter table. Notwithstanding these data limitations, we were able to analyze BHIS data for other purposes, such as comparison between regions.

Other states contacted as part of this project had systems that differed significantly but appeared to be much more sophisticated. In Texas, substance abuse program-outcome monitoring is primarily data driven. Contractors are required to have appropriate Internet access and an adequate number of computers of sufficient capa-

bilities to support the system used for clinical, billing, and reporting purposes. Washington state maintains a statewide web-based system that all contractors are required to use. In addition, Washington has a substance abuse research unit that examines existing administrative data sets for information about clients, such as data from the Employment Security Department to obtain information about who is working and how much they are earning. Other administrative data sets include the criminal justice system, mental health services, child welfare and Medicaid.

Washington State maintains a statewide web-based system that all contractors are required to use. In addition, Washington has a substance abuse research unit that mines existing administrative data sets for information about clients, such as data from the employment security department to obtain information about who is working and how much they are earning. Other administrative data sets include the criminal justice system, mental health services, child welfare and Medicaid.

Linking internal and external administrative data sets can produce powerful results. For example, one fact sheet demonstrated that youth felony arrests decreased from 41 percent to 18 percent between the year before and the year after treatment for inpatient clients and from 41 percent to 19 percent for outpatient clients. Adult felony arrests declined by 33 percent in the year after treatment (compared to the year before). The fact sheet also indicated that for every dollar spent on drug court, taxpayers receive roughly $2.45 in benefits to the criminal justice system.

Another fact sheet concluded that earnings increased significantly among clients; that treatment completers were more likely to become employed after treatment; that treatment completers showed pronounced post-treatment wage increases; and that chemically dependent Aid to Families with Dependent Children recipients had increased employment and earnings after treatment. A final fact sheet illustrated that chemical dependency treatment reduces emergency room costs and visits for Supplemental Security Income (SSI) recipients in that monthly emergency room costs are 35 percent lower for SSI clients receiving chemical dependency treatment.

Recommendation. DOH should work with the collaborative to develop a comprehensive database that links all statewide substance abuse-related treatment activities. Ensure that such database includes, at a minimum, all the data elements of the current BHIS, federally required data and cost and outcome data by program.

Outcomes. Substance abuse treatment outcomes are not adequately measured. Clients are not tracked after completion of the treatment program (post-treatment follow-up) to determine long-term effectiveness of treatment efforts.

Section 43-3-13-A-5, NMSA 1978, states that DOH shall develop and update annually prior to August 30 of each year a substance abuse service plan that documents the extent of New Mexico's substance abuse problem and describes the effectiveness of existing services.

The DOH Office of Epidemiology produces a report titled *The Burden of Substance Abuse in New Mexico*. The most recent report was issued on January 5, 2004. The report provides various drug and alcohol statistics, including population characteristics and deaths, DWI, and youth risk behaviors. The office also published a report titled *Drug Abuse Patterns and Trends in New Mexico in September 2004*. Consistent with its title, the report provides various statistics about drug abuse trends and patterns. From the contents of both reports, the reader can generally understand the extent of New Mexico's substance abuse problem; however, neither report addresses the effectiveness of existing services.

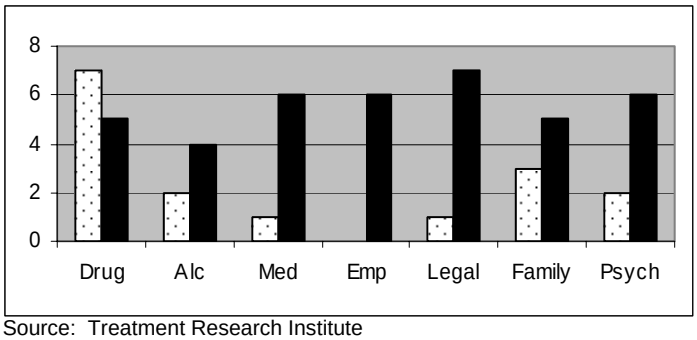
DOH BHIS is the only IT tool that attempts to track outcome data from registration to departure from a program, via the addiction severity index (ASI). The ASI is the instrument most widely used nationally to assess addiction severity. Its most commonly used form involves a one-hour interview that gathers information about seven domains of a substance abuse client's life. Another form (ASI-MV) involves client self administration, via computer. DOH is currently evaluating this form for wider use. The seven domains are:

- Drug use,
- Alcohol use,
- Medical status,
- Employment history,
- Legal status,
- Family history and other social relationships, and
- Psychiatric status.

The evaluator also determines a drug and/or alcohol severity score of from zero to nine; with zero indicating no drug or alcohol problem and nine indicating an extreme problem. The client is presumed to have benefited from the treatment efforts if his/her drug and/or alcohol severity score(s) at the end of the program indicate that the problem is not as severe as it was at the beginning. Additionally, the ASI can be used to measure improvement in health conditions, personal relationships, employment status, housing stability, and interactions with the criminal justice system. Following is an illustration of how the ASI works and why the instrument is crucial in accurately assessing treatment types needed for clients with different issues and in evaluating outcomes.

The graph and explanation below the National Conference of State Legislatures (NCSL) Spring Forum 2005 Workshop-*What is Success? Measuring and Rewarding Performance in Addiction Treatment* depicts the results of ASI scores for two people. Each of the seven problem areas evaluated by the ASI are shown on the X axis and the severity of each problem is measured on the Y axis. It is very simple – the bigger the problem, the bigger the bar.

Graph 8. Comparative ASI Scores



Source: Treatment Research Institute

The first client (in white) is actually an addicted physician - an anesthesiologist. He has a very serious drug problem (high score). The drug use was very serious as evidenced by the fact that he had been stealing pain medication from his patients and injecting it several times each day in a very clandestine manner. He didn't have many other problems other than family relationship problems. His wife was very upset about his secretiveness and his mood swings, and, as can be seen by the last bar on the chart, he was also upset with himself. This physician was treated in a very direct way – with an opiate antagonist that basically prevented him from being able to get high on opiates. He also

received family counseling to address the issues that had taken on a life of their own in the marriage.

The second profile (in black) is very different. This is the profile of a pregnant girl about 19 years old who had been using cocaine and developed some medical complications to the point where she was seen in the emergency room and referred her against her will into treatment. The first thing to notice is that the drug-use bar is not as high as that of the addicted physician. The bar is shorter and her use less severe because she was only using on a weekly basis or when she got some money from somewhere. Also she was not injecting the drug but rather smoking or inhaling it. However, this does not mean she will be easier to treat.

She had been drinking as much as she was using cocaine. She had very serious medical problems due to lack of prenatal care. She had no employable skills or employment history. She had significant legal problems - shoplifting and two probation violations. She also had essentially no family support and she was living with an aunt. Her mother, father, and brother were all addicted. Finally, she was very depressed, upset, and confused. She initially did okay in treatment because she went to a residential program where she had a healthy baby, but her treatment ended and, because she did not have the personal or social resources to maintain herself, she lost the baby to welfare and has not been heard from.

The main point to be made is that different clients have different needs and the same treatment strategy is not likely to work with all.

Although the provider contracts require an initial ASI administration at registration, a second after 90 days and additional administrations until the client leaves the program, providers have failed to comply. RCC clients often do not remain in a treatment program long enough for a second ASI to be administered. In other cases, a client may have completed or participated in a program long enough to warrant two or more administrations, yet the ASI was not administered by the provider.

DOH efforts relating to outcomes have focused on persuading the RCCs and providers to administer ASI and submit results into BHIS. Although BHIS shows some improvement in ASI data volume in the past few years, sufficient data has still not been processed into BHIS to enable its effective use as an outcome measurement tool. Given the lack of such data, DOH's performance target that 85 percent of clients receiving treatment for substance abuse will experience diminishing severity cannot be calculated.

The Substance Abuse and Mental Health Services Administration (SAMHSA), in collaboration with the states, has developed national outcome measures that identify 10 domains (Appendix B). These measures are the beginning of a state-level reporting system that will create an accurate and current national picture of substance abuse and mental health services. The strategy of SAMHSA is to create a tight system of performance measures to better show effectiveness.

National Outcome Measures include the following domains:

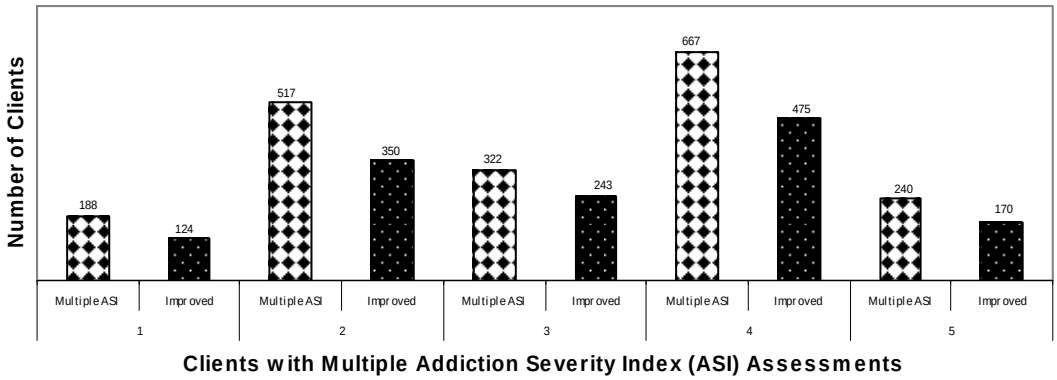
- The first and foremost domain is abstinence from drug use and alcohol abuse or decreased symptoms of mental illness with improved functioning.
- Four domains focus on resilience and sustaining recovery. These include getting and keeping a job or enrolling and staying in school; decreased involvement with the criminal justice system, securing a safe, decent and stable place to live; and social connectedness to and support from others in the community.

- Two domains look directly at the treatment process itself in terms of available services and services provided. One measure is increased access to services for both mental health and substance abuse. Another is increased retention in services for substance abuse or decreased inpatient hospitalizations for mental health treatment.
- The final three domains examine the quality of services provided and include client perception of care, cost-effectiveness, and use of evidenced-based practices.

The cost-effectiveness (average cost) measure is required by 2003 Office of Management and Budget Program Assessment Rating Tool Review and requires cost per client to be broken down by type of treatment. BHIS cannot currently provide data in this format. As a result, BHIS data is noncompliant with federal requirements.

Recommendations. DOH should continue use of the appropriate ASI for both initial assessment and follow-up, giving consideration to all ten national outcome measure domains. DOH should consider post-treatment follow-up assessment of all inpatient and residential clients treated for substance abuse disorder. DOH should determine and report annually the effectiveness of existing services as required by Section 43-3-13-A-5 NMSA 1978, and develop a methodology to track cost per client based on the type of treatment provided.

Graph 9. RCC Alcohol and Drug Clients Who Have Improved FY04



Source: DOH BHIS ASI table

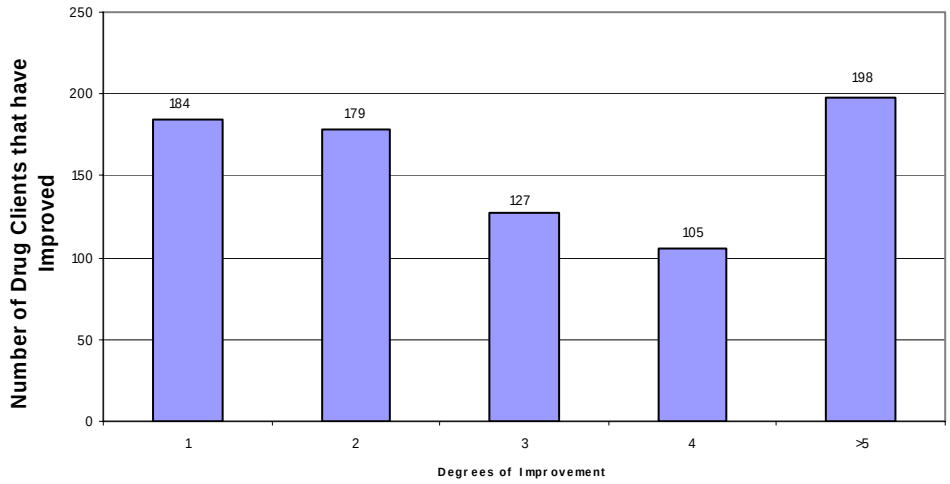
Effect of Length of Treatment on Client Improvement. Despite the fact that many clients do not stay long enough to benefit from treatment, an analysis of the limited available ASI data supports the belief that persons who stay in a program long enough to receive two or more ASI administrations do show improvement. Graph 9 compares the number of clients with two or more scores to those same clients who showed improvement. For example, of the 667 persons in Region 4 who had more than one score, 486 (73 percent) showed a decrease in severity in the use of drugs or alcohol or both. In Region 2, 360 (70 percent) of 517 clients with more than one ASI administration showed improvement.

Past research has demonstrated that length of time in treatment positively correlates with enduring reductions in substance abuse. However, former research studies focused on the traditional model for treatment, residential or inpatient, where substances are not available in the treatment environment and where over 75 percent of clients continue to the point of planned discharge. Post-treatment outcome evaluation has been the traditional method of assessing the performance and accountability of treatment. Fixed amounts or durations of treatment have been provided and their effects evaluated six to 12 months after care completion. The explicit expectation of treatment has been enduring reductions in substance use, improved personal health, and social function.

Because of significant changes in healthcare delivery, over 90 percent of addiction treatment is now delivered in outpatient settings. This is important because it cannot be assumed that clients are abstinent or even making progress during treatment. Multiple administrations of the ASI would help determine whether clients are abstinent and engaged in the treatment process, thus increasing the likelihood of successful treatment outcomes.

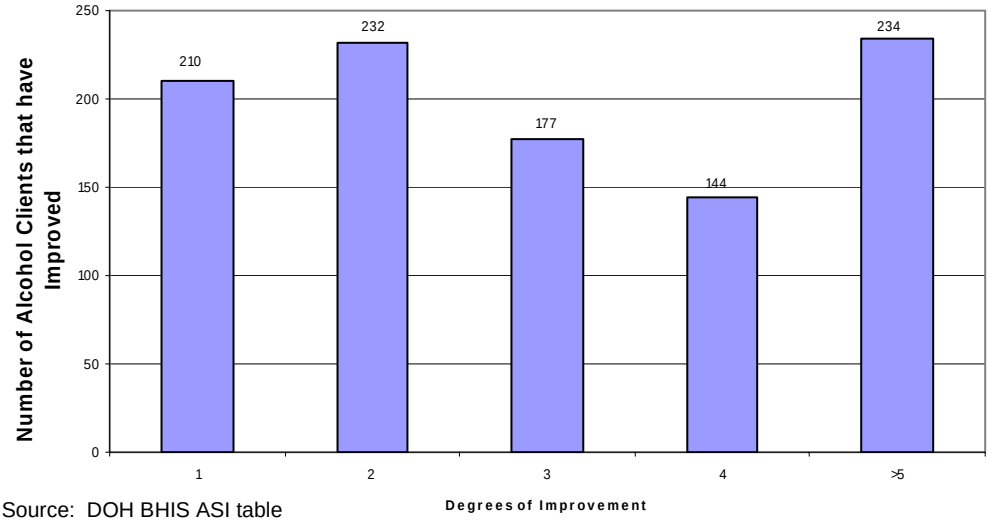
Graphs 10 and 11 show the degrees of alcohol- and drug-use improvement from the initial to final score for those clients who received ASI administrations more than once. The degree of improvement is calculated by subtracting the final from the initial score. For example, if a client's initial and final scores were five and two, respectively, the degree of improvement would be three. The graphs show that 198 drug and 234 alcohol clients state-wide improved by five or more severity points.

Graph 10 - RCC Statewide Drug Dependence Degrees of Improvement
FY04



Source: DOH BHIS ASI table

Graph 11. RCC Statewide Alcohol Dependence Degrees of Improvement
FY04

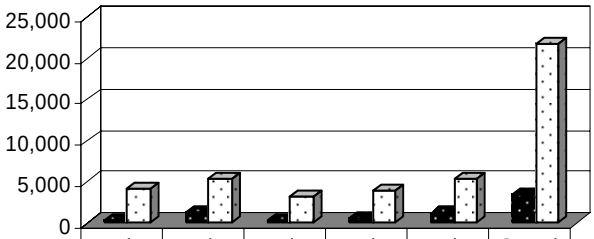


Source: DOH BHIS ASI table

Recommendations. DOH should continue to use the appropriate ASI for both initial assessment and follow-up giving consideration to all 10 national outcome measure domains. DOH should consider post-treatment follow-up assessment of all inpatient and residential clients treated for substance abuse disorder.

Multiple Client Registrations. A substantial number of clients in the RCC system registered for treatment services more than once. As reflected in Graph 12 below, the data from the BHIS registration table shows that 3,441 of 21,857 substance abuse treatment clients (16 percent) registered more than one time during fiscal years 2000 thru 2004.

Graph 12. Clients that Registered More than Once FY00 through FY04

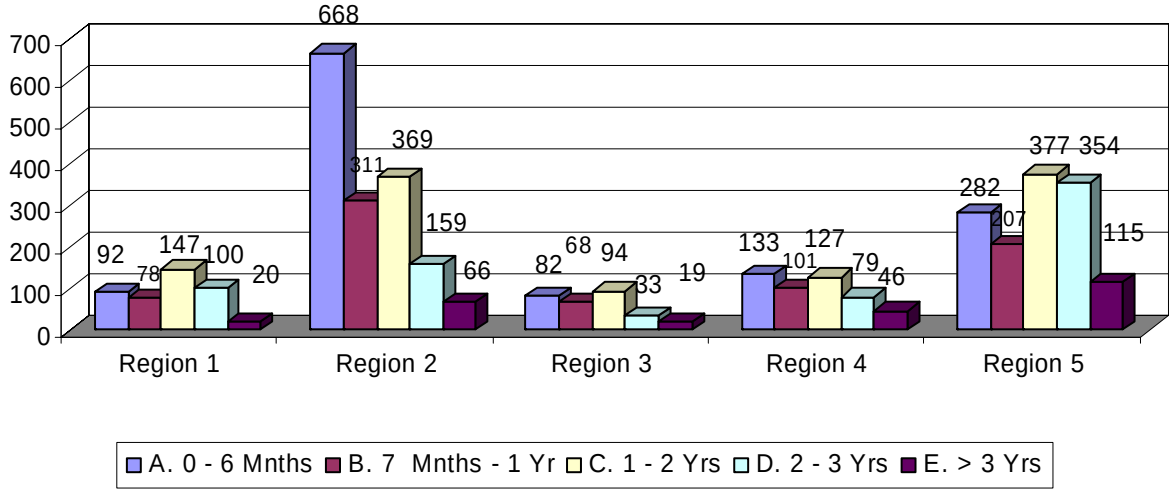


	Region 1	Region 2	Region 3	Region 4	Region 5	Grand Total
Duplicate Registrants	382	1,199	275	445	1,140	3,441
Unduplicated Registrants	4,103	5,465	3,092	3,924	5,273	21,857

Source: DOH BHIS registration table

Graph 13 shows the regional distribution of time between registrations for the period FY00 through FY04. In Region 2, for example, 668 registrants had registered before sometime in the previous six months. In Region 5, 377 registrants had registered before sometime between one and two years prior.

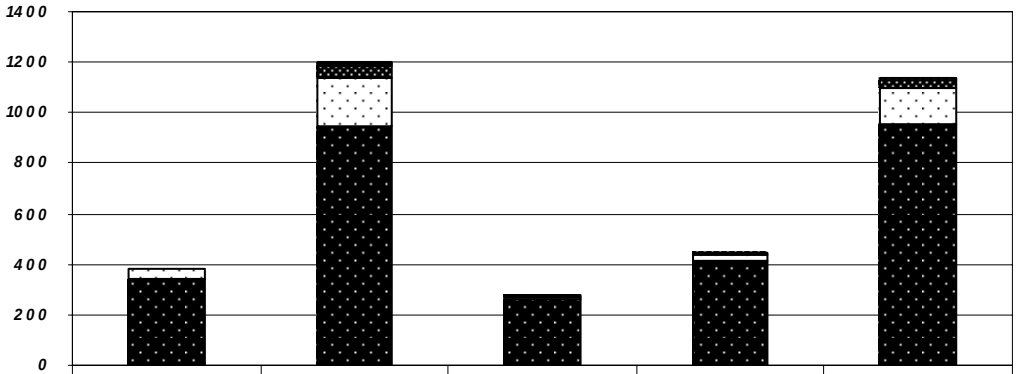
Graph 13. Length of Time Between Registrations FY00 through FY04



Source: DOH BHIS registrations table

Graph 14 shows the number of clients who registered more than once from FY00 thru FY04. For example, in Region 5, 954 clients registered two times and 12 registered five times during this time period. In Region 2, 946 clients registered twice and two clients registered seven times. Statewide, 2,912, or 85 percent, of the 3,441 clients registered twice and 529 registered more than two times.

Graph 14. RCC Statewide Clients With Multiple Registrations FY00 through FY04



	Region 1	Region 2	Region 3	Region 4	Region 5
7		2			
6		4		1	
5		10		2	12
4	3	49	2	3	29
3	39	188	11	29	145
2	340	946	262	410	954

Number of Clients Registered 2 to 7 times by Region

Source: DOH BHIS Registration Table

Department Oversight. Due to the overwhelming work loads of the three fulltime DHI Quality Management Bureau (QMB) auditors, DOH cannot provide adequate oversight of the three RCCs and more than 200 RCC programs and non-RCC healthcare program providers statewide. Furthermore, the audit program is strictly programmatic in nature and focuses on compliance with the comprehensive behavioral health standards promulgated by NMAC 7.20.2 and other federal standards. QMB audits each of the three RCCs and two to three providers within each of the five DOH regions annually. These audits are not designed to test for internal controls or fiscal accountability. The responsibility for auditing RCC and subcontractor accountability has been assigned to DOH's Office of Internal Audit (OIA) . The extent of the OIA review has been follow-up on findings reported by the independent auditors.

Other oversight measures include annual quality assurance reviews of providers by their respective RCCs and monthly clinical chart reviews on three to 10 charts by providers themselves. The provider self audits are reported quarterly to the RCCs. Results of either of these reviews are not reported to DOH.

The current system depends largely on RCCs to monitor providers without sufficient DOH involvement and does not ensure adequate oversight or fiscal accountability of providers. Inadequate oversight can result in substandard delivery of client services as well as inaccurate and incomplete data submission. Ultimately, situations such as those described in the findings below occur. Most states contacted reported that program and contract oversight staffing levels are insufficient.

Recommendation. DOH should develop an oversight methodology that will ensure compliance with the comprehensive behavioral health standards and systematically test for internal controls and fiscal accountability.

Medical Loss Ratio (MLR). The current medical loss ratio (MLR) monitoring methodology are inefficient, ineffective, and an open invitation to abuse and possibly fraud. The contracts between DOH and RCCs and between RCCs and providers do not require RCCs or providers to account for the value of services for which they are paid. The contract amount is based on the provision of services to an estimated target population. RCCs and providers are paid 1/12th of their annual contract amount each month whether or not they perform services of equal value, as evidenced by the encounter data submitted to the BHIS.

The program-monitoring centerpiece of RCC contracts is the MLR. Essentially a service utilization measure, the MLR is defined as the value of services reported by an agency in BHIS (i.e., encounters times the contractor's regional service rate schedule) as a percent of the monthly disbursement by the contractor to an agency. For a utilization monitoring system such as the MLR to work, it is essential that providers report only the services paid for entirely by DOH.

Providers in the RCC system, however, often report services paid for in part by other funding sources, as well as clients receiving services paid for by other funding sources. This reporting of encounters funded by multiple funding sources results in MLRs for DOH services exceeding 100 percent. DOH or RCCs do not reconcile or account for the impact these other funding sources have on provider MLRs.

The contracts state that regional managers will calculate the ratios at the regional and agency levels each month, and data will be discussed at monthly meetings. If the regional MLR falls below an 85-percent average for any three consecutive months or if a single agency's MLR falls below an 80-percent average, a "reallocation plan" may be required. Such plan should include the contractor's steps to correct contributing problems, options to withhold agency funds, and, if no progress is achieved, immediate reallocation of funds within the provider network.

The current MLR monitoring allows providers to combine funding and services paid for by multiple funding streams and report all such services into BHIS. Although DOH and the RCCs are aware that providers often submit encounter data paid by other funding sources, they do not attempt to formally reconcile or adjust the value attributable to those other sources.

With regard to MLRs that fall below 100 percent, neither DOH program managers nor RCCs were able to provide adequately documented justification for the continued payment to providers that clearly were not performing at the levels for which they were being paid. One explanation for low MLRs was provider staffing issues that impact the completeness of BHIS encounter data by increasing data input lag time. Another reason given was the general remoteness of the service areas of some providers. Accordingly, clients in outlying frontier areas often miss scheduled appointments resulting in provider failure to meet targeted service volumes. Table 9 shows some MLR highs and lows at the end of FY04.

Table 9. MLR Utilization Highs and Lows as of Fiscal Year Ending June 30, 2004

Region and RCC	Network Provider High FY04	Network Provider Low FY04
R1-Presbyterian Medical Services	Family Crisis Center 191%	PMS Western 67%
R2- R2BHP	The Life Link 146%	Rio Grande Treatment Center 58%
R3- Rio Grande BHS	Socorro Mental Health 125%	Sierra Vista Hospital 56%
R4- Rio Grande BHS	Counseling Associates 177%	PMS – Artesia 50%
R5-Presbyterian Medical Services	The Crossroads 746%	St. Martin's 56%

Source: DOH BHIS.

Another problem that impacts MLR monitoring is that individual RCCs and subcontractors use their own methodologies to arrive at a value for their own services. They then report the cost of services based on those values to BHIS. Scientific methodology such as actuarial analysis would have been a more solid foundation for determining value across all statewide services.

Of additional importance in relation to MLR monitoring is the informal and insufficiently documented reconciliation of MLR report variances between BHSD and the RCCs. MLR reports are used to demonstrate the ratio of encounter data to direct service dollars allocated to each subcontractor in a region. Questions that arise about the variances between DOH and the RCCs are often poorly communicated and undocumented. In the fiscal year ending June 30, 2004, the following unreconciled MLR variances were noted between DOH and RCC data.

Table 10. Unreconciled MLR Variances as of Fiscal Year Ending June 30, 2004

Regional Care Coordinator	RCC Reported Cumulative MLR	DOH MLR for Region	Variance
Region 1 - Presbyterian Medical Services.	103.07%	125%	21.93%
Region 2 - R2BHP	104.89%	81%	23.89%
Region 3 - Rio Grande Behavioral	*	80%	*
Region 4 _ Rio Grande Behavioral	*	97%	*
Region 5 - Presbyterian Med. Services	131.62%	196%	64.38%

* Rio Grande Behavioral (Regions 3 and 4) did not provide FY04 MLR information.
Sources: RCC MLRs from individual RCC's. FY04 DOH MLRs from the Behavioral Health Services Division.

BHSD and RCC staff stated that data volume differences are the reason for the discrepancies. Data received from RCCs is frequently rejected by BHIS, resulting in MLR variances between the two. In most cases data used by an RCC in their own MLR calculations is not included in the BHSD calculation. Extreme variances are discussed informally, but not formally reconciled.

Utilization management is critical and is the means by which an agency or managed care organization monitors and manages service utilization by enrollees. Utilization patterns can be managed in several different ways. The most common methods include (1) using utilization review staff to monitor the appropriateness of admission into particular levels of care and the duration of treatment at that level of care; (2) delegating utilization to network providers; and (3) using a database of network providers describing their patterns of delivering

care. Public purchasers can use the contract to influence utilization management functions. For example, they may wish to contractually address the qualifications of utilization reviewers, their supervision, and the qualifications of the supervisor and the range of their authority.

Texas and Washington set benchmark utilization rates. Arizona uses the following method to judge sufficiency and adequacy of services provided. A utilization review unit looks at all inpatient files and procedure codes. The codes are clustered by region and consideration is given to units per thousand enrolled. Each service cluster is grouped by regional provider and compared side by side. Quality of service is judged by individual case review. All medical records are examined. Arizona also contracts with an independent peer review organization.

Payment methods varied among states contacted. Arizona pays regional contractors in fixed monthly amounts, but closely monitors utilization, as discussed above. In Texas and Florida, treatment contracts are unit-cost based, and prevention and intervention contracts are cost reimbursable. Washington pays for substance abuse treatment services like a private insurance company. Costs for different levels of care are specified per day. Services must be provided before payment is made.

Delaware pays monthly incentives to providers for adequate utilization and successful client outcomes. Programs that exceed the 80 percent utilization rate and three of four active participation targets for any month earn an incentive payment of five percent of the $1/12^{th}$ contract amount. In addition, programs earn an incentive of $100 for each client who successfully completes or graduates from treatment during the month, up to an amount specified in the contract.

Recommendation. DOH should consider a fee-for-service or other type of contractual arrangement to ensure that providers are paid only for the services provided. The department should consider monthly or annual incentives for adequate utilization and successful client outcomes. Until an alternative system is established, DOH should perform formal, well-documented utilization reviews and reconciliation of MLR variances and adjust payment allocations in the event of provider nonperformance.

Recovery from Addictions Program (RAP). Instances of fiduciary negligence, reporting deficiencies, and egregious activities by RAP were discovered during recent quality assurance and clinical chart reviews performed by the Region 2 RCC, Region 2 Behavioral Health Care Providers, Inc. (R2BHP). The reviews revealed the following clinical and financial deficiencies at RAP:

1. RAP had inadequate or no documentation of some service procedures, clinical supervision, client progress, and diagnosis.
2. The same clinical procedure was documented as having been performed twice by the same physician at overlapping times – one session from 10:30 am to 11:30 a.m. and another from 11 a.m. to noon.
3. Administrative activities, such as phoning clients to schedule and canceling clinical appointments, were reported as case management services.
4. Numerous instances were documented where priority determination guidelines were ignored and individuals who did not qualify for the program were registered and received services. Examples include the following:

- Client 18 is retired, insured by Blue Cross/Blue Shield, and has annual income of $70,000
- Client 33 is employed, not insured, but has an annual income of $32,000
- Client 47 is employed, insured by Blue Cross/Blue Shield, and has annual income of $22,000
- Client 52 is employed, insured by Carpenter Health Insurance, and has annual income of $65,000 to $70,000
- Client 54 is employed, insured, and has annual income of $60,000
- Client 25 is employed and has an annual income of $65,000.

5. RAP billed multiple times for the same service and sometimes for services not provided. Of reported services valued at $162,118 to 68 clients for the period July 1, 2004, through November 30, 2004, alone, only $3,570 (two percent) was supported by clinical documentation.
6. R2BHP estimated $265,860 as the combined amount of erroneous payments made to RAP as a result of multiple billing and billing for services not provided during FY04 ($107,312) and FY05 ($158,548) and demanded a full refund in that amount.
7. RAP had accumulated hundreds of thousands of dollars in outstanding debt, including $187,000 in taxes to the Internal Revenue Service.

Article 3.2 Standards and Requirements of the service agreement between R2BHP and RAP states that the provider shall comply fully with the requirements and provisions of R2BHP standards, protocols, and policies, including but not limited to clinical criteria and standards. It also requires the provision and implementation of care management and service protocols, utilization management and quality management procedures, performance monitoring, contracting, financial payment, and reimbursement by the provider. Article 4.12.1 Maintenance and Retention Records stipulates the provider shall establish and require its practitioners to have an organized system of keeping records related to a consumer's symptoms, treatment, care, plan, prognosis, and progress.

BHSD established general, clinical, and financial criteria to determine the population to receive services under the RCCP in chapter 3 of the policy manual. The financial criteria states that persons receiving services under the plan must be at or below 150 percent of the most current federal poverty level for adjusted income ($13,965 for a family of one according to the 2004 Federal Poverty Guidelines) and uninsured.

Article 6.3 Compensation for Provider Services states that if, at any time, it is determined that an erroneous payment occurs, the provider shall refund the full amount of the payment within 30 days. It further states that an erroneous payment is defined as any payment made to the provider and determined to have been paid in error, including but not limited to the following:

- 6.3.1. Any payment for data elements submitted by provider determined to be false or erroneous,
- 6.3.2. Any payment for data elements incorrectly submitted,
- 6.3.3. Any payment for data elements submitted for services not covered by the program or for services provided to a nonregistered consumer, or
- 6.3.4. Payment for which there is inadequate documentation to support the billing.

As a result of these deficiencies, R2BHP terminated its contract with RAP pursuant to Articles 7.1.1.1 through 7.1.1.5 Provider Default, Contract Enforcement and Sanctions of the service agreement between R2BHP and RAP and referred the matter to the Attorney General (AG). Initially, AG declined to investigate because the funds in question were not Medicaid. However, after further discussion with LFC staff and review of documents provided to them, AG investigative staff agreed that, although the funds in question were not Medicaid, they were public funds and opted to open an inquiry.

Later the AG Director of Investigations reported that because a former member of RAP's board of directors is currently employed with AG, a conflict of interest exists that prevents their office from investigating. The letter suggests the matter be referred the Department of Public Safety, Santa Fe Police Department, or Santa Fe Sheriff's Department for investigation and to the 1st Judicial District Attorney for criminal prosecution.

The problems with RAP were a direct result of inadequate and insufficient oversight. DOH's QMB had not audited RAP since FY02. The problems were detected by a combination of mere chance and the keen awareness of the then newly appointed R2BHP director. The failure of RAP to respond to some basic external auditor questions triggered the curiosity of the current R2BHP director who followed up with some basic inquiries of her own.

Recommendation. DOH should develop a system of oversight that ensures compliance with the Comprehensive Behavioral Health Standards and adequately test for internal controls and fiscal accountability. DOH should refer the matter to the Department of Public Safety, Santa Fe Police Department or Santa Fe Sheriff's Department for investigation and to the 1st Judicial District Attorney for criminal prosecution as suggested by the AG.

Anti-Donation Clause Violation. Due to nonperformance by network providers of an intravenous drug use pilot project in Region 2, BHSD reduced the reimbursement amount to R2BHP by $91,294. The reduction occurred through an amendment of the FY04 contract between the RCC and DOH. According to department sources, orders to return the money came directly down the chain of command from DOH top management. Essentially, return of the money can be described as a "forgiveness" of their nonperformance and considered a violation of the anti-donation provision of the New Mexico Constitution, which states the state shall not directly or indirectly make any donation to any person, association, public or private corporation.

In a letter dated May 18, 2004, from the BHSD deputy director to the R2BHP director, DOH reduced the contract for not providing medical detoxification services for an intravenous drug user treatment pilot project located in Rio Arriba County. R2BHP then withheld $74,641 from Hoy Recovery and $14,400 from Rio Arriba County Human Services Department for nonperformance.

According to provider agreement criteria between R2BHP and Hoy Recovery, the latter was to provide 1,825 medical detoxification bed days in Rio Arriba County. As of May 10, 2004, only 356 had been provided. Rio Arriba County Human Services Department was to provide outpatient substance abuse services to 40 newly registered clients, but services were provided to only 22.

Article 35, Contract Enforcement (e) Sanctions (1)(d) of the DOH General Provisions for RCC Contracts states that the department, upon written notice to the contractor, may sanction nonperformance under the contract consistent with DOH policy through compensation reduction. As a sanction, DOH may reduce the compensation of the contractor to satisfactorily perform its contract obligations through a number of methods at the discretion of the department. These include a reduction in the amount of compensation paid to the contractor for services not performed fully and satisfactorily in accordance with the terms of the contract.

DOH management subsequently reconsidered and again amended the contract to reverse the previous amendment requiring the $91,294 be returned to the R2BHP. Justification for the decision to return the money was neither explained nor documented. R2BHP returned $74,641 to Hoy Recovery and $14,400 to the Rio Arriba

County Human Services Department. The difference of $2,253 was placed in the administrative budget of R2BHP.

Recommendation. DOH should develop strict oversight policies, amend provider contracts, or both to ensure the firm enforcement of sanctions, particularly reduction of compensation, for provider non-performance. Most states contacted reallocate funding based on utilization and other specific state-required standards.

Duplicate Billing. An analysis of DOH and Medicaid encounter data revealed that numerous clients received substance abuse treatment from both agencies programs. In FY04, approximately 464 clients received 19,227 combined DOH and HSD treatment services. Because some services may be covered by one program and not the other, funding participation by both programs may sometimes be appropriate. From the analysis, however, it appears that often both programs (DOH and HSD-Medicaid) may be paying for the same service. The data clearly shows that numerous same or similar services by the same providers to the same clients on the same days were billed separately to both programs. DOH and HSD are currently conducting a joint inquiry into the matter. Although only FY04 data was analyzed, there are strong indications that the same situation has existed for several years.

Due to data availability and compatibility limitations, an attempt to match clients from other agencies' substance abuse-related programs to the DOH and Medicaid databases was not performed. The same situation could exist with those programs.

Article 6.3 Compensation for Provider Services states that if at any time an erroneous payment is determined to have occurred, the provider shall refund the full amount of the payment within 30 days. It further states that an erroneous payment is defined as any payment made to the provider that is determined to be paid in error, including, but not limited to

- 6.3.1. Any payment for data elements submitted by provider that are determined to be false or erroneous
- 6.3.2. Any payment for data elements incorrectly submitted

Recommendations. DOH should continue to work with HSD to investigate the apparent double billing of not only the FY04 data provided to them as a result of the review, but also for several years prior. If it is determined that double billing of one or both agencies did in fact occur, reimbursement should be demanded. If the inquiry suggests the existence of fraud, the matter should be referred to an appropriate law enforcement or prosecutorial agency, or both.

DOH should work with staff from other agencies' substance abuse programs to determine if this situation exists with those programs and work with the collaborative to ensure that controls exist to prevent the continuance of this problem.

Emerging Best Practices. Addiction treatment works: A substantial body of research documents this fact. Among individuals receiving addiction treatment, the public demands increased abstinence, lower rates of arrest and incarceration, reduced healthcare expenditures and less need for child welfare and other services. Soon the federal government will want to know the same thing. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), the deadline to implement the National Outcome Measures is September 30, 2007.

Best practices identified during this review include federally required National Outcome Measures (discussed elsewhere in this report) an ongoing year-long project on benchmarking addiction treatment programs, an emerging expert consensus on Concurrent Recovery Monitoring (developed specifically for outpatient substance abuse treatment), and linking payment to performance outcomes.

National Benchmarking Project. The National Conference of State Legislatures, the State Associations of Addiction Services, and the Philadelphia-based Treatment Research Institute are conducting a year-long project on benchmarking addiction treatment programs to help determine whether funding appropriated for substance abuse treatment is producing acceptable outcomes, whether tax dollars are being used effectively, relevant indicators of success, and whether indicators can be measured and reported affordably.

Concurrent Recovery Monitoring. Concurrent Recovery Monitoring follows a chronic disease model. Treatment for chronic illnesses such as diabetes, hypertension, and asthma has been provided for undetermined periods and the effects evaluated during the course of those treatments. The Concurrent Recovery Monitoring model's expectations are for most of the same results, but only during the course of treatment. Many similarities between addiction and mainstream chronic illnesses stand in contrast to the differences in the ways addiction is conceptualized, treated, and evaluated.

Concurrent Recovery Monitoring retains traditional patient-level, behavioral outcome measures of recovery, but suggests that these outcomes should be collected and reported immediately and regularly by clinicians as a way of evaluating recovery progress and making decisions about continuing care. Post-discharge follow up may be appropriate in residential or inpatient treatment, but the majority of addiction treatment is now being delivered in outpatient settings. Concurrent Recovery Monitoring answers evaluations questions for contemporary outpatient treatment including: Are clients actively participating in treatment, reducing their drug or alcohol use, improving their health and social function and reducing threats to society? These questions are important because so many clients are referred to treatment due to addiction-related social problems such as crime, unemployment or infectious disease.

Concurrent Recovery Monitoring was conceptualized to respond to the changing treatment delivery scene; to the public's need for more accountability and greater effectiveness; and to the practitioner's need for more economical, rapid and clinically relevant information to guide decision making. The procedures could be costly to sustain, but not as costly as post-treatment follow-up procedures.

Linking Payment to Performance Outcomes. The basic principles of payment for performance include using contracts and payments to reward performance. The goals are to improve performance, continually attend to performance, and improve outcomes. As stated in Join Together's report titled *Rewarding Results – Improving the Quality of Treatment for People with Alcohol and Drug Problems – Recommendations from a National Policy Panel – 2003* the panel's primary recommendation was that purchasers of treatment services should reward results. This recommendation was consistent with other leading edge efforts to improve the quality of health care for other diseases. The report encouraged shifting to a system that recognizes and rewards the providers who consistently deliver better treatment outcomes.

Linking payment to performance outcomes is consistent with Concurrent Recovery Monitoring because it focuses on the chronic disease model, effectiveness during the course of treatment, and continuing treatment (discharge is expected to produce relapse).

Incentives or rewards could be linked to the following:

- Engagement and Utilization – increase admissions and client engagement;
- Active Participation – expect attendance at a minimum number of treatment sessions that vary according to the stage of treatment; and
- Program Completion – expect participation, abstinence, and achievement of treatment plan goals.

Concurrent Recovery Monitoring and performance-based contracting are natural allies in the quest to improve treatment accountability and effectiveness (adapted from the NCSL Spring Forum 2005 Workshop – What is Success? Measuring and Rewarding Performance in Addiction Treatment presentation by Jack Kemp, Director of Substance Abuse Services, Delaware Division of Substance Abuse and Mental Health).

Collaborative Contract with ValueOptions New Mexico. Although the collaborative request for proposals (RFP) and resulting contract with ValueOptions New Mexico fell outside of the scope of this project, a cursory review of both documents was performed because of their general relevance. The RFP and contract are extensive in scope, incorporate many additional documents, and contain many requirements. The first year is the transitional and implementation phase. The current system will not change other than by the elimination of the RCCs. Most details are the responsibility of the contractor. Specificity is lacking in certain critical areas. For example:

- ***Performance Outcomes.*** Phase 1 performance outcomes include use of the ASI-Lite, which may provide less information for initial assessment. The ASI-Lite contains 22 fewer questions than the full ASI, and clinicians are instructed not to calculate severity ratings. Because of this, providers will not have access to severity ratings that are a useful clinical summary for initial treatment planning and referral.

- ***Utilization Rates.*** The contract is silent on utilization rates. The contractor is required to provide appropriate utilization management activities for service provision and to develop and implement a system of performance and tracking measures that emphasize (1) the delivery of quality and appropriate services, (2) timely and accurate payment of providers, and (3) development of data and accurate reporting for multiple systems.

- ***Contract Oversight.*** The contract is silent regarding collaborative performance-monitoring activities. Contract oversight of the contractor is designated to an interagency oversight team, which will address quality issues and other program development issues that may arise and will advise and direct the contractor.

- ***Data Ownership.*** The contract appears to be silent regarding data ownership. The following is stated on page 13, item i., "The SE [contractor] shall provide access to designated members of the Collaborative to the SE's data warehouse (DW) and provide training in the use of the DW reporting tool and, as requested, grant ability to State staff to develop and retrieve reports directly from the SE's data warehouse."

- ***Provider Incentives/Sanctions***. The contract is vague with regard to provider incentives and sanctions. The contractor is required to include clearly defined, contractually enforceable sanctions. If contracted providers do not perform according to agreed-upon standards and expectations, immediate corrections or remedy will be possible. However, the contract is silent on when and how sanctions should be enforced.

With regard to incentives, the contractor must demonstrate a collaborative approach to working with providers that includes incentives and rewards, formal and informal incentives for providers to learn, grow and change and to "do the right thing" consistent with the Behavioral Health Collaborative vision for system performance and customer and family outcomes. The contract is silent on when and how incentives should be allotted and provided.

- ***Payment to the Contractor and Justification for Payment.*** The contract and RFP are vague about the methods for paying the contractor and the justification for payment by merely stating that the contractor will have to provide data or other information required by the collaborative to justify the expenditure of funds.

Recommendations.

DOH should take the following steps:

- Require use of the best ASI for initial and follow-up assessments;
- Require specific ASI assessment intervals;
- Specify utilization rates or ranges;
- Fully document collaborative contract oversight responsibilities and activities;
- Contractually require state ownership of all participating agencies' data.;
- Enforce contractor use of provider performance incentives and sanctions;
- Require corrective action plans and funding reallocation in instances of poor provider performance,
- Provide performance incentives for the contractor and enforce sanctions for poor performance,
- Specify how the contractor will be paid and the required justification by agency,
- Involve service providers in developing performance standards and outcome targets,
- Provide regular feedback to service providers regarding performance and/or require corrective action plans,
- Provide comparative performance data to both service providers and to the public.

ASI Data Analysis Conducted by Inflexxion, Inc. DOH contracted with a Massachusetts firm Inflexxion, Inc. to analyze BHIS and RCC ASI data for January 2000 through December 2004. Inflexxion issued its report on June 30, 2005. The executive summary and recommendations of the report are included as Appendix C. The primary purpose of the project was to provide to the collaborative a foundation of client population characteristics; drug and alcohol dependence severity, including medical, family and psychological domains; and drug and alcohol composite score changes for use in negotiating and establishing contractor outcome data-gathering and -measuring requirements.

The report concludes BHSD had made very good progress in collecting substance abuse outcome data and that the volume of initial and follow-up ASI data is reasonable, and a solid foundation of standardized and reliable data is in place to support future efforts. The report makes 16 recommendations for the collaborative to consider in its requirements and oversight of the contractor.

Inflexxion received data on 19,253 ASI administrations to 12,337 clients for calendar years 2000 through 2004. Of the 12,337 clients, only 4,123 had more than one ASI administration. Therefore, the progress of the other 8,214 clients with only one ASI administration could not be analyzed. Of the 4,123 clients who had more than one ASI administration, a number of clients had initial scores of zero (zero indicates no drug or alcohol problem). Hence, the number of clients with usable follow-up ASI administrations would be further reduced if those clients with initial scores of zero were removed. The number of clients whose initial drug or alcohol scores were greater than zero and who had more than one useable ASI administration during the two-year period of calendar years 2003 and 2004 was 2,652.

The Inflexxion report does not attempt to analyze the completeness of the data in relation to all clients who should have had initial and follow-up ASI administrations. The report merely analyzes the usable data that was provided by DOH and the RCCs.

Without a clear understanding of these data limitations, the report can be misleading to the uninformed reader. Although it should not be used to draw broad conclusions about program characteristics, it can be used as a starting point for future efforts and support its use as a tool to establish expectations of the Collaborative and the ValueOption New Mexico. Notwithstanding the data limitations, we believe that there is sufficient basis for Inflexxions's 16 reommendations.

Recommendation. DOH should read and use the contents of the Inflexxion report cautiously with cognizance of its data limitations. The department should also use the report as a starting point for future efforts, but not attempt to draw broad conclusions. DOH should accept the report's recommendations and urge the collaborative to consider them in its future monitoring efforts.

NEW MEXICO DEPARTMENT OF HEALTH

Department of Health Response to LFC Review of Substance Abuse Program

Context: Solving the problems and transforming the system

The Department of Health (the Department) and its Behavioral Health Collaborative (the Collaborative) partners welcome this opportunity to review with the Legislative Finance Committee how New Mexico is tackling the serious substance abuse problems we face. The audit report highlights a number of important aspects of our past approaches to this challenge. We are well aware of those deficiencies and the complexities involved in addressing them. The Department of Health and her 14 sister state agencies are working with an extraordinary commitment and intensity, demonstrating to the nation that it is possible to transform a state system, to do the right thing, to make a difference in people's lives and help communities support the resiliency and recovery of their members.

In July 2002, we received the final report of a comprehensive study of the way New Mexico has addressed substance abuse and mental health challenges. We learned that the prevalence rates of alcohol or drug dependence for most age groups in New Mexico are considerably higher than the national average. Only one other state had a higher prevalence rate. And we learned that the substance abuse problems of New Mexicans are severe and complicated by other health problems and by social and economic conditions. We learned also how our fragmented system, like the systems of other states, undermines our efforts to address these problems and what a good system would look like and cost.

Even before the Behavioral Health Collaborative was formed, the Department of Health's Behavioral Health Services Division (the Division) responded to the emerging findings and recommendations of the Needs and Gaps Analysis. In FY02 the legislature appropriated a significantly higher amount of funding for substance abuse services. The Division began helping providers to use evidence-based practices, encouraging better collection of outcome data, seeking and securing federal grant support for new and more effective treatment and prevention services and tracking the real experiences of consumers of those services.

Many of the report findings point to deficiencies in our state system that were powerful drivers for the formation of the Interagency Behavioral Health Purchasing Collaborative. When Governor Richardson announced his intention to create the Collaborative in September 2003, he described his wish to have better services, better access and better use of taxpayer dollars. The Collaborative and its goals and tasks were created by the Legislature to solve many of the specific problems identified in this audit report.

We have been very open about those problems, calling the public's attention to them and inviting extensive public comment and involvement in the processes of forming the Collaborative, designing a plan for a new and better state system, issuing a Request for Proposals for a single state entity, choosing ValueOptions New Mexico (VO-NM) as the state's partner in this transformation of our system, creating a structure for continued community involvement, building a state-wide behavioral health plan and putting into place a new and better

way of ensuring quality and accountability.

In every public meeting for the past year and a half we have identified these "problems to be solved:

- Lack of common agreement about goals and outcomes and insufficient focus o n recovery and resiliency;
- Fragmentation, i.e. multiple approaches, plans, service definitions, billing processes, reporting requirements for similar or related services;
- Multiple sets of performance and outcome measures;
- Insufficient or duplicative oversight of providers and services;
- Duplication of effort and infrastructures at state and local levels, resulting in confusion for consumers, families, referral sources, providers;
- Higher administrative costs for providers due to multiple state approaches and multiple contracting entities;
- Insufficient services; inappropriate services (not always evidence-based);
- Not always maximizing resources across funding streams;
- Multiple disconnected advisory groups and processes working toward different sometimes disconnected goals.

Doing The Right Thing: Evidence-based Practice and Research-based System

One of the critical goals of our changing substance abuse prevention and treatment system is an emphasis on evidence-based and promising practices and thinking. While this is a subject about which the audit report is silent, it is the foundation on which all of the recommendations about funding, assessment, performance and oversight rests. "Doing things right" is only one aspect of quality. "Doing the right thing" is what will determine whether New Mexicans experience recovery and resiliency.

For several years now, the Division has been promoting and funding the introduction and implementation of evidenced based practices within the adult substance abuse treatment system. We focus on these clinical practices because we know they will have an effect on people's lives. They have been rigorously researched and have the scientific evidence that the treatment approaches will produce positive client outcomes. For example, we know that relapse prevention, Motivational Enhancement Therapy, Brief Intervention, opioid replacement, Reinforcement Therapy in Methadone Maintenance Treatment and Community Reinforcement with Vouchers programs all produce positive outcomes with substance abusers.

The Division is implementing the brief intervention evidence-based practice through our 4 year federal Screening, Brief Intervention Referral and Treatment (SBIRT) grant which also ties treatment into primary care sites. Our Access to Recovery grant uses the community reinforcement plus vouchers evidence-based practice. We are working to design ways to expand our Intensive Outpatient Treatment services and explore Medicaid reimbursement for this highly effective alternative to costly and less effective residential treatment. The Division helped Albuquerque to establish a Assertive Community Treatment program and is assisting Las Cruces to undertake a similar program. We brought together Albuquerque physicians and the Metropolitan Detention Center to start a methadone-based detoxification program that makes continued recovery after release from detention more likely.

The Division continues to implement an evidence-based practice for persons with co-occurring disorders of

substance abuse and mental illness and are working through another federal grant to further implement best practice for co-occurring disorders and to build out provider skills in delivery effective treatment. Implementing and sustaining evidence-based practices takes coordination of administrative, policy, clinical and financial supports and training. Division staff are working with VO-NM as well as with our Collaborative partners to intensify our training, technical assistance to providers and practical support for this effort.

The audit report claims that the public "expects safe, complete detoxification…" While we do not know the source of that claim, we do know the characteristics of a good system for effectively treating adults with substance abuse or dependence. These characteristics are well established and increasingly research-based, and include:

1. No single treatment is appropriate for all individuals;
2. Medical detoxification is only the first state of addiction treatment and by itself does little to change long-term drug use;
3. Treatment needs to be readily available;
4. Effective treatment attends to multiple needs of the individual, not just his/her drug use;
5. An individual's treatment and services plan must be assessed continually and modified as necessary to ensure that the plan meets the person's changing needs'
6. Remaining in treatment for an adequate period of time is critical for treatment effectiveness;
7. Counseling and other behavioral therapies are critical components of effective treatment for addiction;
8. Medications are an important element of treatment for many individuals, especially when combined with counseling and other behavioral therapies;
9. Treatment does not need to be voluntary to be effective;
10. Possible drug use during treatment must be monitored continuously;
11. Treatment programs should provide assessment for HIV/AIDS, Hepatitis C and C, tuberculosis, and other infectious diseases, and counseling to help patients modify or change behaviors that place themselves or others at risk of infections;
12. Addicted or drug-abusing individuals withy co-occurring mental disorders should have both disorders treated in an integrated way
13. Recovery from drug addiction can be a long-term process and frequently requires multiple episodes of treatment..

Protecting Our Future: Prevention Working

The audit report found that prevention activities at the Division are very well planned and managed. They are far better than that; they are effective and showing sufficiently strong outcomes as to be replicated in other states. One such program that started in Gallup has now been introduced in at least 30 communities outside New Mexico and is a featured SAMHSA model program. Evidence-based prevention services are critical in New Mexico in order to stop the individual, family and community destruction caused by substance abuse. Our prevention programs have strong evaluation components and have consistently shown positive outcomes.

Alcohol, tobacco and other drug abuse prevention is an active process that promotes the personal, physical and

social well-being of individuals and families and enhances healthy communities. The goal of prevention services has been to prevent substance abuse through the reduction or abatement of risk factors and the strengthening of protective or resiliency factors. Prevention activities include various strategies aimed at educating the community at large and other strategies for individuals and families who are at greatest risk for substance abuse but are not in need of treatment. These activities also include reducing environmental and normative conditions that encourage the use of substances, and strengthening or creating pro-social norms or regulations that decrease the likelihood of illegal or inappropriate use and abuse.

The Division is about to launch its third five-year Alcohol, Tobacco and Other Drug Abuse Prevention Plan and is building new collaborative projects with the Department of Public Safety, as well as with other Collaborative agencies. Our planning, implementation and evaluation efforts also receive national recognition. We assess with communities, we plan, and then we do things that work – funding providers and training prevention specialists throughout the state.

Making Sure It Makes a Difference: Expectations, Data and Oversight

The Department and the Collaborative have very specific goals for the transformation of New Mexico's behavioral health system that address many of the findings of the audit report. We share the Legislature's desire to have a real impact on the lives of New Mexicans. Recovery and resiliency are driving forces behind the whole of our collaborative effort. Three of the specific goals that relate to the audit findings are:

- A single billing system and consistent data collection and management;
- A common age-appropriate assessment process used in all service settings;
- Uniform program standards, including common utilization management requirements and system performance expectations;

These goals were contained in the detailed Request For Proposals, were addressed by VO-NM in its successful bid, are expectations incorporated into our contract with this new partner, and are now being elaborated in the work plans of the cross-agency Oversight Team. One of the Division's objectives of that oversight is to make sure the appropriate level of care is provided to adequately meet the individual's needs at the right time in the right amount to assure the best possible outcomes and the best possible use of limited financial and staff resources and to make sure that care is likely to achieve positive outcomes for non-Medicaid eligible persons.

In addition to the cross-agency Oversight Team, four other cross-agency teams have been formed and chartered and are working with VO-NM to ensure that our goals for New Mexicans and for our service delivery system are met. They are an Administrative Team; Policy & Planning Team; Capacity, Program Development and Research Team; and Local Collaborative Team. Division staff work in all five teams and the Director and Deputy Director of the Division lead two of the five teams. Each cross-agency team is led by a senior staff member of one of the Collaborative agencies and each works with a sub-committee of the Collaborative comprised of Cabinet Secretaries or Directors.

Many of the deficiencies of the past in our system have been due to a lack of data-based decision-making. What we require of VO-NM, in our contract and in our daily work and communication, are accurate, timely and consistent data gleaned from a variety of sources that are used to drive system planning, budgeting, and

quality management and performance evaluation. What we require of ourselves are decisions made at all levels based on consistent analyses and interpretations of accurate and timely data. The Division currently works with VO-NM several times each week to identify progress on implementation, data reporting needs, and any potential obstacles or clinical issues.

VO-NM has been tasked not only with reporting on services provided and billed, but also with developing our network of providers and providing both clinical and administrative training and technical assistance to help providers succeed and to expand our capacity statewide. Its regional offices are staffed to assure onsite assistance to providers – both clinical and administrative. The Division has established a pilot regional placement in southern New Mexico to enable closer monitoring and collaboration with the local community providers and VO-NM staff.

In addition to analyzing data collected by VO-NM through quality and utilization management methods, the Division is also working with its Collaborative partners to continue its assessments of consumers' satisfaction with access, appropriateness of treatment, effectiveness of care and consumer empowerment. As of FY05, the Division has five year trends on consumers' satisfaction with 42 elements. We use measures from the national Mental Health Systems Improvement Project plus additional measures

focused on substance abuse treatment, supported housing and employment services. We will continue to build upon our track record of empowering consumers and families, presenting our data to consumer groups, advocates and providers so as to identify strategies for continuing to improve service delivery. The Division's Office of Consumer Affairs is leading the collaborative effort to develop peer support services and trained and certified peer support specialists.

The Department welcomes the particular attention in the audit report to the Addiction Severity Index (ASI) as an important tool for assessing outcomes of addition treatment. The Division's work to increase this tool's use by providers is reflected in the Inflexxion report. We commissioned this report to assess the potential use of this tool to measure positive outcomes and patterns of response to treatment statewide. "The raw number of initial and follow-up ASI data increased significantly in all regions between 2002 and 2003 and progress continued in 2004. The state average improvement in initial ASI administrations in 2003 was 380% greater, and in follow-up ASI administrations, 770% greater than 2002."

The audit report criticizes providers for failing to do post-treatment follow-up administrations of the ASI and recommends that the ASI be used for follow-up assessments. While this recommendation appears reasonable and logical, it would require a significant increase in General Fund appropriations. A large number of substance abuse clients are transient, moving from residence to residence because of financial issues or because of damaged relationships. These movements are generally within the same geographical area, which increases the already difficult task of tracking these clients. There have been a number of national government research studies pointing to the difficulties tracking clients after treatment, even when federal funding is used to pay clients for completing follow-up assessments and to pay staff to aggressively seek out clients in the community.

Equitable Funding: When Need Is Not Equitably Distributed

The audit report recommends development of a methodology to ensure equitable distribution to providers throughout the state. Again, while this may appear to be reasonable, it is a much more complex issue. Substance abuse treatment *needs* are not equitably distributed throughout the state and vary from year to year. Higher expenditure in a particular area does not necessarily indicate better services or better outcomes.

The Department and its partners in the Collaborative will in the future be able to look at the whole picture of funding across the state through its data and utilization reports from VO-NM and seek to identify where funding redistribution can have a positive impact on real outcomes. The involvement of the single state contractor that is collecting data and monitoring service provision and working with local collaborative groups means that in the future the Collaborative will be able to provide the Legislature with more reliable and sophisticated information about both money that is spent and outcomes that are seen.

Part of the complex picture of resource distribution is the overall availability of funding. At the time of the Needs and Gaps Analysis, $169 million was needed to fund a good substance abuse system and $217 million was needed for an ideal system of substance abuse services. The State at that time was spending just under 19% of a good system of care and just under 15% of an ideal system of care. Without a much higher level of funding, trying to create 'equitable' funding could simply result in shifting funds needed by one group of underfunded providers to another group of underfunded providers.

In addition, some fiscal years include special appropriations for specific localities for specialized services. For example, special funds were allocated to the Department this year in SB190 for Doña Ana County to develop mobile crisis teams and assertive community treatment teams and help them become sustainable, Medicaid-billable services. Both of these forms of treatment delivery are evidence-based and less expensive as well as more effective than higher cost hospital beds. Further, the lessons learned in developing those services in one county will then be available to other counties seeking to develop similar services. Likewise, services developed in one area of the state to address a particularly serious drug overdose problem can then become models for other areas of the state in the future.

A Continuing Conversation

The Department of Health and its 14 partners have undertaken the goal of assuring that public funds are well spent and contribute to changes in the lives of people in New Mexico. We mean for the transformed New Mexico system to help generate real recovery and resiliency. We know that the transformed system will produce better information for legislators, state agencies and the Executive to use in making decisions about resources and priorities. The Department of Health welcomes the opportunity to discuss these issues with the committee now and to continue that conversation in the upcoming session and in the future.

[1] HB 271 in 2004, sponsored by Representative Sandoval and Senator Komadina

[2] Behavioral Health Needs and Gaps in New Mexico, July 15, 2002, page 181,182

[3] The RFP and Contract are publicly available on the Collaborative web site: http://www.state.nm.us/hsd/bhdwg/history.html The VO-NM response to the RFP is available for inspection at the BHSD offices in the Department of Health.

[4] Addiction Severity Index Data Analysis, June 30, 2005

APPENDIX A

Summary of Other Agencies' Substance Abuse Services

DOH (Substance Abuse Prevention) DOH Behavioral Health Services Division (BHSD) substance abuse prevention activities are primarily performed by the Prevention Services Bureau (PSB). Initial discussions with PSB staff, review of documentation provided and a favorable February 2004 Substance Abuse and Mental Health Services Center for Substance Abuse Prevention site visit report all indicated an effectively run program. This summary is based primarily on the site visit report.

PSB monitors services and contractual accountability and manages statewide prevention services delivered through over 35 prevention contractors. Prevention leadership and staffing have been relatively stable. PSB staff is well versed in prevention practice and theory and dedicated to improving the prevention system. They are well respected by the prevention community and by other DOH staff who continually call on them for assistance and ideas.

The organizational structure of the prevention system reflects strong commitment to the principles expressed in the current five-year strategic plan (2002-2006). The regional structure accommodates the significant differences between urban and rural centers. PSB's organizational structure and services acknowledge the state's geographic, political, and cultural diversity and provide a framework for both the staff and the provider community to better address the special needs of the multiple populations served.

Prevention services are the first line of defense against substance abuse. The Institute of Medicine model is currently applied in New Mexico. According to that model, the sole focus of prevention efforts is on decreasing the degree of individual/family/community vulnerability to related risk and protective factors. Emphasis is placed on providing youth with skills, opportunities for involvement, and recognition to help ensure that they form pro-social bonds and develop healthy beliefs and clear standards.

Prevention contractors are required to follow accepted substance abuse prevention standards, which include the following:

- Conducting community needs assessments regarding local alcohol, tobacco, and other drug issues;
- Developing prevention plans with measurable goals and objectives based on the needs assessment, utilizing data from the needs assessment and input from community members;
- Utilizing multiple prevention strategies (information dissemination, education, identification and referral, community processes, and environmental strategies) across multiple domains (community, school, family, peers, individuals) aimed at having a broader impact on the population receiving services;
- Implementing evidence-based prevention services proven to impact variables associated with the abuse of alcohol, tobacco, and other drugs; and

Conducting high-level outcome evaluation of prevention services in order to make necessary modifications and to demonstrate the effectiveness of the services.

To date, there are five prevention programs developed in New Mexico that have received national recognition as Exemplary Substance Abuse Prevention Programs through a nationwide competitive process.

The process for monitoring provider activities is comprehensive and makes full use of staff capabilities and experiences. As part of the process, PSB periodically convenes all prevention staff for a collective review of reports and other performance data submitted by providers. Comments from all reviewers are collected, archived, and incorporated into a project evaluation that is documented and retained for future reference. Prevention staff also incorporate site visits when possible as part of the program evaluation.

A multilevel system of evaluation is used to drive outcomes-based initiatives. This system mandates use of external evaluators by prevention providers (through a 10- to 20-percent provider set-aside), a state "evaluation

team" to review outcomes and program efficacy, and an external contractor to provide evaluation of all single state authority prevention activities.

Department of Finance and Administration (Local DWI Grant Fund Program) The local DWI Grant Fund Program (LDWI) is funded from liquor excise taxes to assist local governments in their efforts to curtail DWI and alcohol abuse within their communities. Per Section 11-6A-3 NMSA 1978, counties and local communities may be funded for new, innovative, or model programs designed to prevent or reduce the incidence of DWI, alcoholism, alcohol abuse, drug addiction or drug abuse, and other alcohol-related issues, such as domestic violence. Program funds can also be used for treatment services, prevention and enforcement activities, and screening and assessment of persons convicted of DWI.

In 2005, costs were budgeted into the following components: Prevention, Enforcement, Screening, Domestic Violence, Treatment (outpatient and jail-based), Compliance Monitoring/Tracking, Alternative Sentencing, and Coordination, Planning and Evaluation. For the purposes of this analysis, treatment and screening are considered to be treatment; coordination, planning, and evaluation are considered to be administration; and all other categories are considered prevention.

A 2004 Legislative Finance Committee follow-up of the 2003 audit of the LDWI indicated that the LDWI Grant Fund Program made significant administrative improvements, addressed many findings satisfactorily, and implemented many recommendations. The program appeared to be gaining momentum and fiscal and program accountability appeared to be improving.

Program data is tracked through a centralized web-based program that provides a screening instrument and tracks offenders' compliance with court sentencing. Program staff is also working with the DOH Prevention Services Bureau to track the prevention component. Currently, about six programs have loaded their data. The evaluation reporting component has been revised and statewide performance information should be available in the future.

Administrative Offices of the Courts - Drug Courts A drug court is a specially designed court calendar or docket, the purposes of which are to achieve a reduction in recidivism and substance abuse and to increase the participants' likelihood of successful rehabilitation through early, continuous, and intense judicial oversight; treatment; mandatory periodic drug testing; and use of appropriate sanctions, incentives, and other community-based rehabilitation. The first New Mexico drug court was implemented in Las Cruces in 1994. Currently, there are 28 active drug courts in New Mexico: six adult/felony, 13 juvenile, three family dependency, and six DWI/drug courts.

Because financial data was obtained from the AOC drug court coordinator, three municipal courts are excluded (Las Cruces, Mesilla, and Santa Fe). Treatment costs are those associated with the drug court's treatment provider, usually a multi-year flat fee contract. Prevention costs are for salary and benefits for drug court team members. Administrative costs are all other drug court expenditures. Another limitation of the financial data presented in this report is that courts are directed to include costs of team members and other expenses that are necessary to their drug court's operation, even when the court is not actually billed for that team member. An example is the public defender salary, which is frequently covered by the Public Defender's Office.

Drug court outcome data is currently being tracked independently by the drug courts on standalone databases. The drug courts submit quarterly reports that include information on counts of cumulative and currently active participants, graduates and other separations, recidivism of graduates, and costs per client per day to the AOC drug court coordinator. The drug court coordinator compiles the information and creates a statewide report that shows rates on graduation, recidivism, and retention.

The graduate rate is calculated by dividing the number of graduates by the total number of people who graduated and left the program for other reasons. The recidivism rate, which measures the extent to which graduates re-enter the justice system, is determined by the number of graduates who re-offend divided by the total number of graduates. Recidivism is calculated on graduates only and not on all program participants.

Corrections Department. The Corrections Department's goal is to ensure effective coordination of services and supervision for offenders as they are released back to the community. Programs are designed to meet the short-term needs of the offender as they transition from incarceration or to divert the offender from incarceration.

Adult Community Corrections programs are located throughout the state to provide services to probationers, parolees, and probation and parole violators. Program length is a minimum of six months and a maximum of 12 months for non-residential programs. Residential program stay is six months. Transitional reporting centers provide for immediate identification of offender needs. The centers serve as an "emergency room, triage center" for both behavioral health and life maintenance. Program staff works to gradually transition individual needs to services available in the community and through other state agencies. Services are accessed for an average of three to four months depending on level of need and individual ability to adjust to community supervision and programming. Probation and parole staff is co-located with the treatment provider at the program site in Albuquerque to ensure close collaboration, coordination, and communication.

Program-outcome data for community corrections is tracked in a standalone database designed and maintained by the University of New Mexico Institute of Social Research. The database is used to track supervision and population and is not clinical in nature. Program measures tracked include number served, successful program completion rate, statewide occupancy rate, and negative drug-test rate.

The Addiction Services Bureau provides therapeutic community residential substance abuse treatment programs in prison; recruitment and support for AA/NA meetings in prison; recruitment and support for AA/NA sponsorship programs in prison; outreach to provide AA/NA support after prison release; meditation living units in prison; participation in multi-disciplinary team programs to bring education and faith-based services into substance abuse programs; and sex offender residential programs in prison.

Human Services Department (Medicaid Fee for Service and Medicaid Managed Care). Medicaid, which is administered by the New Mexico Human Services Department (HSD), covers up to twelve (12) hours of psychiatric therapy services for the treatment of substance abuse for recipients age 21 and over. It does not gather outcome-related data of any sort. Encounter data for both managed care, which is administered by the managed care organizations (MCO's) and fee for service (administered by HSD) includes diagnosis codes, procedure codes, cost, and provider and recipient identification and demographics. Since MCOs are paid a set monthly rate per recipient for all medical services, the specific substance abuse cost to the state cannot be determined. MCO substance abuse treatment related costs, however, are reported to HSD in the encounter data submitted by MCOs. Medicaid fee-for-service costs are the amounts actually paid to providers for substance abuse treatment of non-managed care Medicaid recipients.

Children, Youth and Families Department. The Children, Youth and Families Department (CYFD) manages three substance abuse treatment and prevention programs and provides drug-detection services, as well as limited prevention services through Juvenile Community Corrections. The Chimayo Crime Prevention Organization program provides services to target populations of (1) children and their families involved with CYFD Protective Services or Juvenile Justice or referred by CYFD and (2) those at risk of involvement. The program provides substance abuse services including mental health screenings and treatment plans, skills training and development on an individual (one-to-one) basis, and group skills training and development. The agency also provides proactive prevention/harm reduction services, up to and including intervention when substance abuse treatment referrals are necessary for the clients.

Enforcing Underage Drinking Laws is a federal block grant program that enforces state underage drinking laws and provides underage drinking prevention and education programs throughout the state. Fourteen communities have been funded in FY05 with an emphasis on collaborative enforcement, prevention, and education. In addition, the Enforcing Underage Drinking Laws Rural Communities discretionary grant was awarded to New Mexico in 2004. The three-year grant of $927,080 will focus on four rural communities: Taos, Ruidoso, Clayton and Santa Rosa.

Early intervention services are provided by Las Cumbres Learning Services, Inc. as part of a birth-to-five early childhood mental health wrap-around project. The primary outcome is the development of a true wrap-around system of care for children under the age of 6. A gap analysis in New Mexico showed that such a system does not exist for this age group. Desired outcomes include training in, and fidelity to, the wrap-around model for Rio Arriba providers: Increased secure attachment for the children as a result of caregivers' ability to be present and responsive to infant needs and cues, and increase in positive behavioral-coping strategies.

Public Education Department. The Public Education Department does not have a program devoted solely to substance abuse treatment or prevention. However, it receives funding under Title IV, Part A – Safe and Drug-Free Schools and Communities, which is a federal formula grant. The program purpose is to provide supplemental funds to assist school districts develop drug and violence prevention activities, strategies, and programs. FY04 expenditures were about $2.4 million, and the FY05 budget is $2.8 million.

With the exception of a small amount of administrative funds, the bulk of the money is passed through to school districts and can be used in a variety of ways. Because the funding is passed through to districts that decide independently how it will be spent, the department cannot account for how much goes toward dedicated substance abuse treatment, prevention, and related administration.

To receive funding, a district must prepare needs assessment, use research-based activities, and establish district performance measures.

Permissible uses include but are not limited to the following:

- Activities to support parent, student, and community planning of drug- and violence-prevention initiatives targeted at English language learners, immigrant students, gang members, adjudicated children, and students involved with the juvenile justice system
- Activities to evaluate the effectiveness of such prevention programs
- Activities to participate in a uniform management and reporting system to track the incidences of violence, threats to student safety, use of weapons, and drug use at school
- Professional development for staff in drug and violence prevention programs
- Dropout prevention programs
- Allowable administrative and indirect costs.

Funds may not be used for programs, services, and activities for non-targeted students; activities and services not specified in the approved application; or activities normally funded by non-federal (state or local) funds.

Substance Abuse and Mental Health Services Administration
National Outcome Measures (NOMS)

DOMAIN	OUTCOME	MEASURES		
		Treatment		Prevention
		Mental Health	Substance Abuse	Substance Abuse
Abstinence	Abstinence from Drug/ Alcohol Use	NOT APPLICABLE	Reduction in/no change in frequency of use at date of last service compared to date of first service ▶	30-day substance use (non-use/reduction in use) ▶
				Perceived risk of use ▶
				Age at first use ▶
				Perception of disapproval
	Decreased Mental Illness Symptomatology	Under Development	NOT APPLICABLE	NOT APPLICABLE
Employment/ Education	Increased/Retained Employment or Return to/Stay in School	Profile of adult clients by employment status and of children by increased school attendance ▶	Increase in/no change in number of employed or in school at date of last service compared to first service ▶	ATOD suspensions and expulsions; workplace AOD use and perception of workplace policy
Crime and Criminal Justice	Decreased Criminal Justice Involvement	Profile of client involvement in criminal and juvenile justice systems	Reduction in/no change in number of arrests in past 30 days from date of first service to date of last service ▶	Drug-related crime; alcohol-related car crashes and injuries
Stability in Housing	Increased Stability in Housing	Profile of client's change in living situation (including homeless status) ▶	Increase in/no change in number of clients in stable housing situation from date of first service to date of last service ▶	NOT APPLICABLE
Access/Capacity	Increased Access to Services (Service Capacity)	Number of persons served by age, gender, race and ethnicity ▶	Unduplicated count of persons served; penetration rate - numbers served compared to those in need ▶	Number of persons served by age, gender, race and ethnicity
	Increased Retention in Treatment - Substance Abuse	NOT APPLICABLE	Length of stay from date of first service to date of last service ▶	Total number of evidence-based programs and strategies
			Unduplicated count of persons served ▶	

APPENDIX B

Retention	Reduced Utilization of Psychiatric Inpatient Beds - Mental Health	Decreased rate of readmission to State psychiatric hospitals within 30 days and 180 days ▶	NOT APPLICABLE	NOT APPLICABLE
	Increased Social Supports/Social Connectedness [2/]	Under Development	Under Development	Under Development
Social Connectedness	Client Perception of Care [1/]	Clients reporting positively about outcomes ▶	Under Development	NOT APPLICABLE
Perception of Care	**Cost Effectiveness (Average Cost)** [1/]	Number of persons receiving evidence-based services/number of evidence-based practices provided by the State	Number of States providing substance abuse treatment services within approved cost per person bands by the type of treatment	Increase services provided within cost bands within universal, selective, and indicated programs
Cost Effectiveness	Use of Evidence-Based Practices [1/]		Under Development	Total number of evidence-based programs and strategies
Use of Evidence-Based Practices				

Note: Prevention measures pending stakeholder approval.

[1/] Required by 2003 OMB PART Review.

[2/] For ATR, "Social Support of Recovery" is measured by client participation in voluntary recovery or self-help groups, as well as interaction with family and/or friends supportive of recovery.

APPENDIX C

I. Executive Summary

In the spring of 2003, the Director of the New Mexico Department of Health, Behavioral Health Services Division, Pam Martin, Ph.D. contracted with Inflexxion, Inc. and Albert Villapiano, Ed.D., vice president of clinical development and psychologist, to provide Addiction Severity Index – Multimedia Version (ASI-MV) programs and training to all Regional Care Coordinator (RCC) providers. ASI-MV licenses were purchased by the state to give each of the five RCC regions 2,000 uses or administrations of the program with which to get started.

Inflexxion, Inc. is a research and development company, delivering scientifically-based solutions to consumers and clinicians in critical areas of health education, prevention and disease management. A majority of product development funding comes through the National Institutes of Health (NIH) and the Small Business Innovative Research (SBIR) program. All products are clinically tested in carefully designed field trials and the ASI-MV is one of those products.

The ASI-MV is a multimedia version of the Addiction Severity Index (ASI) which is a required substance abuse assessment tool in NM. The ASI-MV, however, is client self-administered on a computer, with audio and video components and does not require staff time to ask questions or enter data. Inflexxion developed the original ASI-MV about seven years ago with a grant from the National Institute on Drug Abuse (NIDA) and studies have shown it to have excellent reliability and validity (Butler, et al. 2001). Extensive field use of the ASI-MV over the past six years, has demonstrated the program's ease-of-use among a wide range of clients, regardless of education level, reading ability, or prior computer experience.

Several years prior to working with Inflexxion, the BHSD had established performance indicators that used the percentage of Composite Score change, between the first and most recent administration of the ASI, as the measure of client improvement in substance abuse treatment. Unfortunately, not enough ASI data was received from the RCCs and subsequently, there was an insufficient number of second ASI administrations, or most recent ASI scores in their system to measure client improvement adequately. In early 2003, the Behavioral Health Services Division (BHSD) decided to focus on improving compliance with ASI administrations and helping the RCCs and their providers implement the ASI-MV was a part of that decision. During the summer of 2003, ASI-MV trainings were conducted in each region of the state and many, but not all providers began using the new program. Some providers chose to continue with their current way of administering the ASI.

In the fall of 2004, BHSD contracted with Inflexxion and Al Villapiano and Stephen Butler, Ph.D., senior vice president and chief science officer at Inflexxion, to analyze all the state's available ASI data and develop a report of the findings. This document is the report of those findings based on all the ASI-MV data and the other ASI data from the Behavioral Health Information System (BHIS) gathered from providers between January and April 2005. The report focuses on ASIs administered to clients between the calendar years 2000 and 2004, inclusive.

Data Characteristics

Between the calendar years 2000 and 2004, Inflexxion obtained from New Mexico 19,253 unique ASI administrations. The breakdown of the initial and most recent ASI administrations of clients who were matched by their Social Security numbers over this period of time is detailed later in this report, however there are several important points to highlight:

1. The raw number of initial and follow-up ASI data increased significantly in all regions between 2002 and 2003 and progress continued in 2004. The state average improvement in initial ASI administrations in 2003 was 380% greater, and in follow-up ASI

administrations, 770% greater than 2002.
2. During 2003 and 2004, the raw number of follow-up ASI administrations averaged 46% and 76% of the total initial administrations, respectively.
3. New Mexico BHSD has made a very good start in gathering a significant amount of standardized, reliable, substance abuse outcome data. These data will provide a solid foundation for NM to better understand its population's needs and to develop appropriate services, now and in the future.
4. To increase the value of ASI data in the future, a variable indicating whether the ASI was an intake or follow-up ASI should be included in data gathering. This would allow the analysis of recidivism, as well as more accurate measurement of client improvement, and the ability to use more data in analyses.

While compliance with the NM BHSD performance indicators for ASI administration was not 100%, nationally, substance abuse delivery systems report being unable to adequately collect, evaluate and use outcome data. Inflexxion conducted a survey in February 2003 of an Outcomes listserv sponsored by grants from the Center for Mental Health Services (CMHS) and the Substance Abuse and Mental Health Services Administration (SAMHSA) to the Human Services Research Institute. This survey revealed no instances of a successful after-treatment outcome study funded only with agency dollars. There is little in the literature directly addressing outcome studies conducted in substance abuse treatment facilities. Those that do exist typically focus on "how to" and rarely report extensive treatment follow-up client data, and cite personnel costs associated with the "repeated and laborious task of tracking hard-to-reach clients" (Brown et al., 2003, p. 32) as the primary obstacles to successful outcome studies.

It is suggested by some researchers (McLellan and Durell, 1996) that "response rates" for gathering follow-up data should be at least 70% for generalizable results and to guard against bias. Three of the five NM regions met or exceeded this rate.

Recommendation:

1. Consider establishing 70% as the expected rate of follow-up ASI administrations over the next three years. This could be accomplished incrementally with annual targeted increases of 50% the first year, 60% the second and then 70% by year three.

2. Establish a procedure requiring that all ASI administrations be identified as an intake or follow-up in the future, to facilitate outcome measurement.

Percentage of ASI Composite Score Change

The percentage of ASI alcohol and drug Composite Score change was calculated for all regions from three perspectives: when the most recent ASI was done within 30 to 60 days; 61 to 90 days; and 91 to 365 days. The graphs presented, display these data in Positive, Negative and No Change bars. It is important to note that there were a large number of clients who did not have a Composite Score above zero in the alcohol or drug domains of the initial ASI administered (3,965 or 35%) and we identified three reasons that could account for this:

1. Some ASIs were administered to clients not entering substance abuse treatment and without alcohol or drug problems, such as those entering mental health treatment.
2. Some ASIs were administered to clients just out of jail or other controlled environments where substances were not available. Since Composite Scores are based on substance use in the previous 30 days, it is likely those clients would not score above zero.
3. It is possible that some of the clients who were administered the ASI more than two weeks after admission (3,430 or 29%) had already stopped using substances and therefore, as stated above, would not score above a zero.

When a client has an initial alcohol or drug score of zero, the best he or she could do in treatment is not change, however, in the current NM performance measurement process this would be viewed as "no progress" in treatment. An analysis of this group was done and information

presented to support excluding this group from any statistical analysis of change.

Recommendations:

1. All initial ASI administrations be completed no later than two weeks after admission;
2. Clients coming from a controlled environment use the Criminal Justice version of the ASI-MV or be instructed to answer "30-day" questions about the 30 days prior to their incarceration;

Clinically Meaningful Categories to Measure Change

In addition to calculating the percentage of composite score change, which is a numeric measure of client improvement currently used by NM BHSD, an attempt was made to also look at clinically meaningful change in Composite Scores. It was clear that a client who scored high in his or her alcohol Composite Score could actually achieve a positive change numerically by, for example, drinking to intoxication a few days less per month. The question raised was, is this real or clinically meaningful progress?

We conducted a number of analyses and developed four clinically discrete categories in which all clients could be classified according to the initial severity of their alcohol and drug Composite Scores. These **High**, **Medium**, **Low** and **None** categories correspond to specific Composite Score ranges in the alcohol and drug ASI domains. Positive and, possibly, clinically meaningful progress was then defined as change to a lower category. More clinician input is needed to finetune the range or definition of these categories, but we believe this is a good beginning.

Recommendations:

1. BHSD consider using this categorical change metric as a measure of treatment progress, in addition to, or in place of the current numerical change score (percentage of Composite Score change).
2. Obtain input from clinicians on this new measure of clinically meaningful change.

Population Characteristics

Statewide, 41% of the clients served in the ASI sample were female which may be an indication that women view substance abuse treatment services positively.

The race and ethnicity mix is very different in each region and seems to present a complicated clinical picture. Native Americans represented 22% of the treatment population in region 1, but no more than 4% in any other region. Hispanic Mexicans made up over 55% of the treatment population in regions 2 and 5, but no more than 21% in the other three regions. BHSD may need to continually review the unique needs of this diverse population to provide the most effective services.

Statewide, 32% of the clients did not have a high school degree and 68% had no education beyond high school. Also, 42% were unemployed at the time of entering treatment and the unemployment rate in region 5 was 52%. Those working full-time averaged 25% across the state, but only 15% in region 5.

Recommendation:

1. Review the unique needs of the diverse populations of each region to identify gaps, identify resources and provide the most effective services.

Alcohol and Drug Data Analysis

Statewide, 29% of the clients in the ASI-MV sample reported drinking to intoxication (defined as five or more drinks in one sitting) and 35% reported taking any drug during the 30 days prior to taking the ASI. The rate of those drinking to intoxication and using drugs during the previous 30 days was 49%.

The top four drugs used were: **marijuana** (18%); **sedatives** (11%); **opiates**, other than heroin or

methadone (9%); and **cocaine** (8%). Regions 1 and 5 were excluded from the ASI-MV data analyses because, after the data were cleaned, there were not enough cases to use (N<10)

Percentage of Alcohol and Drug Composite Score Change

The percentage of positive change in alcohol and drug Composite Scores was relatively consistent, regardless of the time period of the most recent score (30-60 days; 61-90 days; and 91-365 days), except for region 3. Although the numbers are small, region 3 appears to have less positive alcohol and drug score change when the most recent ASI was administered within 30 to 60 days after the initial one. These numeric, percentage of change rates do not account for the severity with which a client enters treatment and to be clinically useful, we believe initial severity is important to factor into any measurement of change.

Recommendation:

1. Augment or replace this percentage of change method of measurement with category change method described below.

Category Change in Alcohol and Drug Composite Scores

Statewide, those clients who started out in the **High Category** of initial alcohol and drug abuse had the highest percentage of positive category change (71% and 62% respectively). That means their Composite Score improvement was large enough to move them to, at least, the next lowest category.

Those in the **Medium Category** of initial alcohol and drug abuse had improvement, or category change rates of 66% and 61% respectively. Those in the **Low Category**, as expected, not only had the lowest percentage of positive category change (29% and 39% respectively).

Clinically, those clients who start out with a High or more severe alcohol or drug problem have more room for improvement and since that is probably the focus of their treatment, one would expect higher percentages of change with appropriate treatment. Conversely, if clients start out with a Low or less severe alcohol or drug problem, it would not be surprising if there was little or no change, even with appropriate treatment. These clients may be focusing on related issues in their lives that may not involve efforts to reduce their substance use.

Recommendations:

1. Consider establishing **75% to 80%** as the target category change rate for **High Category** alcohol and drug users.
2. Consider establishing **65% to 75%** as the target category change rate for **Medium Category** alcohol and drug users.

3. Gather clinician input to learn more about the characteristics of those falling into the **Low Category** of alcohol and drug users, and determine what unique performance measures would be most clinically useful.

Court Referred Client Data Analysis

Of the 9,267 clients with court referral information, **30% or 2,780 were referred by the courts**, according to the BHIS data. For the purpose of this analysis, a court referral is defined as anyone referred by one of the following: probation; parole; state federal or tribal courts; diversionary and pre-prosecution programs; DWI referral; and other adjudication or legal entity.

A question was raised about the “honesty” of court referred clients and whether or not they were responsible for a higher percentage of zero alcohol and drug Composite Scores than those not court referred. The data indicate that the rates of zero scores for court referred and non-court referred clients was 33% and 35% respectively and therefore, no difference in “honesty” was found.

The analysis of these data revealed that a lower percentage of court referred clients started treatment in the High or Medium Category when compared to the non-court referred clients, however, the rates of category change were almost identical. We believe this supports the findings of a number of research studies, (Hubbard et al., 1998 and NIDA, 1999) that **even**

clients who are "court referred" or coerced into treatment, can benefit from help and show progress.

Recommendation:

1. Continue court referrals into substance abuse treatment, because they exhibit very similar progress as those not court referred.

ASI-MV Detailed Data Analysis

Since the ASI-MV data set included answers to all of the ASI questions, we were able to look more in depth at a number of other important issues that affect clients in substance abuse treatment, such as medical, employment, family and psychological problems. Where possible, comparisons were made to the Drug Evaluation Network Systems (DENS)[1] database of over 58,000 ASI cases of clients in outpatient, inpatient and criminal justice settings, to provide a frame of reference. Unfortunately, there were not enough usable data from regions 1 and 5 to use in these analyses (N<10). Some key findings that are important to explore further include:

1. Statewide, those clients reporting **serious depression and anxiety problem**s in the 30 days prior to their ASI, averaged 43% and 47% respectively (compare with DENS, an existing database of ASI intake administrations, the corresponding statistics were 31% and 28%). Region 4 had rates of 57% and 59% respectively and region 3 had a 78% serious anxiety rate.
2. Statewide, those clients reporting they were victims of **physical and sexual abuse** during the 30 days prior to their ASI, averaged 4% and 1% respectively (DENS = 3% and 1%).
3. Statewide, those clients reporting they had **suicidal thoughts and plans or made suicide attempts** during the 30 days prior to their ASI, averaged 6% and 2% respectively (DENS = 6% and 1%). Region 3 reported suicidal thoughts or suicide attempt rates of 22% and 9% respectively, however their number of total cases was low (N=32).
4. When the percentages of **suicide attempts** were converted to numbers it was found that 29 people statewide made at least one suicide attempt in the 30 days prior to their ASI.
5. Statewide, those clients reporting they had **trouble controlling their violent behavior** during the 30 days prior to their ASI, averaged 22% (DENS = 7%). Region 3 had 41% of their clients reporting trouble controlling their violent behavior.

It is evident that New Mexico's substance abuse population has a significant incidence of cooccurring disorders, sometimes 100% greater than the DENS comparison group[2]. Region 3 appears to have a high concentration of these co-occurring, psychological problems. In part, this could be due to providers' successful efforts in identifying mental health issues in substance settings, but further study is needed. It is important to repeat that region 3 had a low number of ASI-MV cases (N=32) and caution should be taken before drawing any conclusions or making any generalizations.

Nationally, co-occurring disorders are common, affecting about 10 million adults. Among adults with serious mental illness in 2002, 23% had substance abuse problems, while the rate among adults without serious mental illness was only 8%. Among substance abusing adults, 20% had serious mental illness, while the rate of serious mental illness was 7% among adults who were not substance abusers (OAS 2003 and SAMHSA, 2002). In light of these numbers, NM appears to be doing a very good job identifying persons with co-occurring disorders.

Recommendations:

1. Study the high incidence of co-occurring disorders statewide to determine if there are adequate resources and skills to provide the best treatment available.
2. Investigate the problems of clients in region 3 to understand their needs and, if needed, develop a plan to correct gaps in services and resources.

[1] DENS was created by Treatment Research Institute, Philadelphia, with funding from the White House Office of National Drug Control Policy (ONDCP). More information can be found at http://www.tresearch.org/tx_systems/dens.htm

3. Explore resources statewide to establish a larger support network. This should include employment assistance, legal aid, medical resources, housing, educational opportunities, transportation options, child and elder care resources, family support, safe houses, etc.

[2] Note that DENS data are collected from inpatient, outpatient, methadone treatment and criminal justice settings and modalities. Comparison with New Mexico data is for illustrative purposes only, as we have not been able to match settings and modalities. Such comparisons should be interpreted cautiously.

Alcohol and Drug Change Compared to Other Domains

Those clients, who achieved Positive Change in their alcohol Composite Scores, also achieved a statistically significant positive change in all the other ASI domains except for medical and employment. The medical domain change was positive, but not significant and the employment domain change was significantly negative.

Similarly, those clients who achieved Positive Change in their drug Composite Scores also achieved a statistically significant positive change in all the other ASI domains except for employment. Like the alcohol group, the employment domain change was significantly negative and this is discussed further in Section X (page 50).

There is considerable research that supports the notion of using multidimensional approaches to substance abuse treatment to achieve optimal outcomes. That is, when a client's total life situation is addressed, such as family, legal, medical, employment and psychological problems, he or she is more likely to be successful with substance abuse treatment. The data summarized above indicates that in NM, positive change in non-substance abuse areas in one's life is related to positive change in substance abuse treatment and success.

Recommendations:

1. Explore resources for addressing non-substance abuse problems clients are experiencing in order to maximize the treatment experience.
2. Study the issues related to the negative change in employment Composite Scores and, if needed, develop a plan to address them.

Conclusion

New Mexico BHSD has made very good progress in collecting substance abuse outcome data, especially since 2003. The volume of initial and follow-up ASI data is reasonable and a solid foundation of standardized and reliable data is in place to support future efforts.

Substance abuse can be a chronic disease that studies show can be managed, but rarely "cured." New Mexico's rates of positive alcohol and drug change are good and compare well with treatment success in reported studies. There is a significant amount of co-occurring disorders, such as serious depression and anxiety, which providers are identifying and managing in substance abuse settings. BHSD needs to carefully review the skills and resources available in all its regions to ensure the complex and diverse needs of its population are effectively met.

Finally, we encourage the reader not to generalize too broadly from the data presented. In many analyses the N or numbers are small and the findings sometimes present trends more than statistical significance. We believe this report contains valuable information about New Mexico's behavioral health treatment population at the state and regional level. There is much more that can be learned through discussing these findings with key stakeholders in New Mexico. We look forward to this and our continued work together.

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