

TESTIMONY

Provided To

**JOIN TOGETHER PANEL
BLUEPRINT FOR THE STATES: POLICIES TO IMPROVE THE WAY
STATES ORGANIZE AND DELIVER ALCOHOL AND DRUG PREVENTION
AND TREATMENT**

By

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Good afternoon. My name is John Daigle, and I am testifying here today in my capacity as a consultant to the Legal Action Center. As some of you know, the Legal Action Center is the only nonprofit law and policy organization in the United States whose sole mission is to fight discrimination against people with addiction, HIV/AIDS, or criminal justice records, and to advocate for sound public policies in these areas. For three decades, the Legal Action Center has worked to combat the stigma and prejudice that keep these individuals out of the mainstream of society. The Legal Action Center is committed to helping people reclaim their lives, maintain their dignity, and participate fully in society as productive responsible citizens.

I am also Executive Director of the Florida Alcohol and Drug Abuse Association, which represents 115 community-based substance abuse treatment and prevention service agencies throughout Florida, as well as several community coalitions.

I was asked to testify here today as one of three authors (along with Anita Marton and Gabrielle De la Guerroniere from the Legal Action Center) of a resource paper for the Center for Health Care Strategies entitled: “Identifying State Purchasing Levers for Promoting the Use of Evidence Based Practice in Substance Abuse Treatment.” The project was funded by the Robert Wood Johnson Foundation.

First of all, I want to commend Join Together for convening this panel. The subject matter of this panel really focuses on some very basic, core challenges facing the field of

substance abuse treatment and prevention: how should state systems be structured to ensure that the appropriate level of leadership and organization resources are in place to adequately support and promote quality of care and cross agency collaboration to the maximum degree possible.

What I would like to do here today is to share with you an overview of the Legal Action Center report which I referenced earlier which looked at state efforts to implement evidence-based practices and, more-specifically, what incentives states are utilizing to promote the utilization of evidence-based practices. I first want to give you a very quick overview of the process involved in gathering information for this report and then address a number of the report learnings and recommendations. And though the report did not specifically focused on state systems organizational issues, I will try and present the learnings and recommendations in a way that may be most relevant to the charge of the panel and as helpful as possible to you.

Process

The LAC, along with the Center for Health Care Strategies, conducted a number of activities as part of the process of writing this report. They included:

- A review of the literature related to the use of levers to promote EBPs
- An environmental scan which included interviews with more than 20 key informants.

Informants included state purchasers of substance abuse treatment, managed care entities, substance abuse treatment providers and organizations representing treatment providers and researchers.

- A small group consultation of substance abuse treatment experts and service purchasers

Following these activities, state profiles of four states that have made significant advances in the utilization of levers to promote the use of EBPs were developed .

Before sharing the findings of the report, I want to talk very briefly about the subject of utilizing incentives to promote systems change, as a backdrop to the findings. The utilization of incentives to effect system change has received a fair amount of attention in the last few years. It should be noted that the Join Together National Panel on Quality of Treatment for Substance Abuse Disorders in its report recommends the utilization of incentives-based contracts as a tool to improve the quality of care.

As noted in our report, mainstream health care provides some models of purchasing that utilize incentives. Research supported by the Robert Wood Johnson Foundation indicates that there are more than 100 pay-for-performance pilots that pay incentives for better, safer, more efficient care. And that Medicare is testing a new way to pay doctors who meet quality measures.

Also, if you've read the best-selling book on economics, "Freakonomics", the authors, Steven Levitt and Stephen Dubner, state that "incentives are the cornerstone of modern life." The authors go on to say that "economics is, at the root, the study of incentives..." In the book, the authors give numerous examples of the power of incentives. The authors

also give examples of the possible unintended consequences that can occur when a policy is changed. And there are numerous examples of that in our addiction treatment and prevention systems that I will touch on later.

Report Learnings and Recommendations

It's my understanding that members of the Panel have been provided with a copy of the report. I've tried to sift through the report with the charge of this panel in mind, and in the interest of time, what I'd like to do now is to focus my comments to those report learnings and recommendations, which I believe are most relevant to the charge of the panel. And because the report was not intended to specifically address issues related to state organizational structure, I'd like to tease out some of the report findings which I believe could be applicable to the subject of state organizational structure and which could without much difficulty be translated into recommendations.

The learnings and recommendations of the report that I believe are most relevant to the panel fall into two categories. Those related to:

- State agency organizational structure to support practice improvement
- State agency organizational structure which supports multi-agency collaboration

State Government Organizational Structure to Support Practice Improvement

The report learnings related to "organizational structure" came for the most part from the state profiles. They were that:

- The implementation of EBPs and the associated use of levers are occurring not in isolation but in the context of the larger, extremely challenging state government with multiple priorities.
- Rather than an isolated project implemented with a radically new approach, the implementation of EBPs and utilization of levers in most cases is done utilizing an already existing structure and philosophy related to the role of service providers and other stakeholders.
- The existence of long-term, stable leadership within the state agency is a positive contributor to progress.
- The existence of a positive, long-term relationship with service providers is critical to success.
- Utilization of outside expertise is a significant contributor to success.
- Success of this initiative requires a long-term commitment to training, supervision, and oversight.
- To a certain degree, significant service system changes must be accompanied by parallel changes in the state agency internal system.
- The implementation of EBPs requires a multi-year process. Recognizing that it is a process, incentives to bring about change are a valuable tool.

What can we draw from these learnings related to organizational structure?

From these learnings, I would suggest the following:

- 1) That the state agency must be organized in a way that structurally and systemically values, prioritizes and incentivizes the implementation of EBPs and practice improvement on an ongoing, long-term basis. Likewise, policies, rules and regulations must be aligned to support these efforts.

- 2) That the agency should be structured and adequately resourced to provide the leadership to support implementation of EBP.

As the learnings indicate, efforts to implement EBP and to improve care in general do not occur in isolation. They occur in the context of a state agency system with multiple priorities. Resources must be dedicated to practice improvement if EBP is to be implemented and sustained. This also includes an organizational commitment to workforce development, training, clinical supervision and oversight.

- 3) As indicated above, the presence of long-term stable leadership is key. Though change is possible without long-term stable leadership, to a large degree, change is more likely to be brought about if there is a positive, stable relationship between the state agency leadership and the service providers. This trust is built over time.

In addition to strengthening the systemic leadership, I believe there is an overall need for leadership training and development for both state agency staff and service providers. Many of our field's leaders come from the promotion of clinical staff

into management and leadership positions, and they did not have an opportunity for formal leadership preparation. I would point out that CSAT has supported the development of a Leadership Institute through its Addiction Technology Transfer Center program (ATTC). The Institute, I'm proud to say, originated in Florida and is now being replicated nationally through the 14 ATTCs. Though created for service provider staff, interest has been expressed by a number of state agencies that similar training could be beneficial for their staff as well.

It is also my opinion (and this is not a report recommendation) that the role of the state director must be strengthened if we are to accomplish this massive systems change.

- 4) State agencies must be organized in a way that values, supports and promotes stakeholder involvement on a systemic, ongoing basis.

Again, stakeholder involvement is not something that should occur just on one specific project. It should be part of the agency philosophy, part of the system. The report found the involvement of service providers, for example, to be very important in the implementation of EBPs and practice improvement. Service provider buy-in is essential.

Multi – Agency Coordination

A number of the learnings and recommendations are related to the issue of multi-agency collaboration that is one of the specific areas that I was asked to address.

The report found that one of the biggest challenges in the area of multi-agency coordination is the fact that there are multiple funding streams and multiple payers involved in financing substance abuse treatment services. In most cases, each of those payers has different contractual requirements, different regulatory requirements and different financial requirements. The result is that while the service provider system is motivated to provide services for new populations and for new payers, there is a disincentive in that doing so will be accompanied by a new set of administrative requirements which are costly, time consuming and often redundant.

The report recommended that increased collaboration and coordination between state agencies should be pursued and recommended that one mechanism which should be given further attention was the development of MOUs, memoranda of understanding, between state agencies as one tool to expand collaboration, maximize funding and incentivize quality improvement.

The report also recommends that the development of other joint contracting models should be pursued that would allow for the purchasing of services across the continuum of care regardless of program management or ownership. Formulating a single contract with a provider that encompasses two or more funding streams could enable the

purchasers to concentrate their bargaining power and achieve better results. It would also reduce the potential for multiple contracting, regulator and financing approaches.

As I stated earlier, the report found the area of multi- agency collaboration to be one of the biggest challenges related to practice improvement and to the effective integration of services.

In my opinion there are a number of reasons for that. In many states, there is currently very little incentive for state agencies to work together. In many cases, each state agency is overworked and under-resourced. Each has its own mission, culture and system of doing business. Systems incentives must be utilized to incentivize collaboration, such as cross-agency performance outcomes.

I know the panel has examined a number of mechanisms for effective coordination.

Though, in my opinion, there is no single “right” approach, I believe there are elements which are necessary to achieve effective collaboration of state agencies. These include:

- The existence of one entity with the authority and operational capacity to bring state agencies together
 - Having “the right people” at the table; that is, individuals who are able to make decisions on behalf of the agency
 - Dedicated staffing and resources in each state agency involved to sustain the effort.
- Again, as indicated in earlier recommendations, collaboration must be systemically valued, supported and promoted within the state agency organizational structure. In

my experience, both the state drug czar approach and the cabinet level SSA-approach have the most potential for success.

In any case, as I mentioned earlier, I believe that in many states, it is important that the role of the SSA, the single state agency, needs to be elevated and strengthened. I know that you also heard testimony from Suzanne Gelber from the AVISA Group on these issues who has done a lot of excellent work in this area.

Mr. Chairman, that concludes my remarks. I would be glad to try to answer any questions that you or any member of the panel might have.