

**Testimony
Before
The Join Together Panel**

**“Blueprint for the States: Policies to Improve the Way
States Organize and Deliver Alcohol and Drug
Prevention and Treatment”**

Presented by

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Testimony – Join Together Panel

Introduction:

Good afternoon, Governor Dukakis and members of the panel. I want to thank you, along with *Join Together*, for inviting me to talk to you about some of the things that we have been doing in Delaware to improve the delivery of treatment for substance use conditions. I am proud to be able to represent Delaware here before you this afternoon. You know that Delaware has long been known as “The First State”. So, we are proud to be one of the first states, if not the first, to connect payment to performance in a real time way through the use of performance based contracts. This afternoon, I am going to give you some details about how we have done that.

But, first I want to briefly mention the role of the Division of Substance Abuse and Mental Health (DSAMH) as the Single State Agency (SSA) for substance abuse in Delaware, in the context of the role of SSA’s in general. As the SSA in Delaware, just as SSA’s in other states and territories, we are charged with the responsibility of operating a statewide system of prevention and treatment programs. In order to carry out this mission effectively, SSA’s need to have the stature and authority in the governmental structure of their states that will give them access to the

top echelons of state government, and the resources needed to provide services on a statewide basis. In the era of re-examination of the nation's mental and substance use conditions treatment systems, as advocated by the recent Institute of Medicine Report, the work and recommendations of this Panel will play a crucial role.

In this same era when the spotlight is being focused on improving the effectiveness, efficiency and quality of treatment, I appreciate the opportunity to share an example of the kinds of leadership and innovation that SSA's bring to the statewide systems of care in their states. While I will be describing a Delaware specific initiative today, as I am sure you have already heard in the testimony of others, SSA's throughout the country are continually providing the leadership to effect change, to introduce new and effective methodologies, while maintaining the infrastructure that is the foundation of the nation's publicly funded treatment system. I firmly believe that the maintenance of a strong SSA structure is essential to maintain and to improve the nation's substance use conditions treatment systems.

Connecting Payment To Performance:

Now let me turn to what we have been doing in Delaware for the last four years to get the best treatment results for patients. In 2001, in the context of an initiative to expand and enhance our outpatient treatment system, we decided to use the power of the pocketbook to encourage our contract agencies to introduce new and

effective practices that would lead to improved outcomes. The concept of connecting payment to performance was endorsed in 2003 by another *Join Together* panel. *Join Together's Rewarding Results Report* stated: “The panel’s primary recommendation is that **purchasers of treatment services should reward results** . . . [purchasers should] shift to a system that recognizes and rewards the providers who consistently deliver better treatment outcomes.”

Most recently, the Institute of Medicine’s 2005 Quality Chasm Series on Improving the Quality of Health Care for Mental and Substance-Use Conditions recommended “adopting payment methods that create incentives for and reward good quality.” (53)

We have been doing this in Delaware for the past four years. What did we do and how did we do it?

We began by using the state’s competitive procurement process, a process that all government agencies use in one form or another. Periodically, we put all of our major contracts out to competitive bidding; and, in 2001 we decided to bid our outpatient treatment system. We wanted to expand and enhance our statewide system, to introduce new and effective treatment methodologies and to assure that our contractors were using evidence based practices to achieve the best possible results for clients.

As I describe what we are doing in the small state of Delaware, keep in mind that other states can apply the same principles to the

infrastructure of their particular jurisdictions. What we do directly with provider agencies, others can do through counties or cities or other intermediaries.

We decided early on that we wanted to connect payment to performance just like other government agencies do when they procure services. For example, contractors who build highways are often rewarded for completing the construction ahead of schedule, and penalized for failure to meet completion deadlines – financial incentives are used to encourage better performance and outcomes. We decided to use the same concept to purchase outpatient substance abuse treatment.

We knew that we wanted to use our contracts and payments to reward performance, to promote continual attention to performance and to improve outcomes.

The next step was to decide what to reward. Since this was a first for us and we were in uncharted waters, we wanted to base our incentives on principles and tenets that were widely accepted by the addiction field, and backed by science. We chose three that I doubt anyone would question: (1) length of time in treatment is associated with successful outcomes; (2) dosage (i.e., amount of treatment received) makes a difference; (3) evidence based techniques and strategies produce better results. We postulated that, if these were in place, successful outcomes would follow.

Next, we spent a lot of time talking about just what we wanted to reward in this first foray into connecting payment and performance. We chose three: (1) Engagement/utilization in order to increase admissions and to encourage innovation to successfully engage clients; (2) Active Participation to promote attendance at a specified number of treatment sessions, depending on the stage of treatment; (3) Program Completion that was related to participation, abstinence and achievement of treatment plan goals.

We issued the RFP, went through the usual selection process and then invited the successful applicants in to discuss the specific performance targets for their agencies. We decided to set statewide engagement/utilization standards for all programs. But, we asked the programs to propose the active participation targets for each stage of treatment – they could consider case mix, geography, and other factors affecting their individual situations. Interestingly, all agencies proposed targets that were within percentage points of each other – so, we all agreed that it made sense to standardize these targets also.

We opened with a daylong training program to assure that everyone was on the same page. But, perhaps the most important thing that we did early on was to convene bi-monthly meetings of all providers so that they could share ideas, discuss what was working and what was not.

At this point, I want to mention the Robert Wood Johnson Foundation's Network for the Improvement of Addiction Treatment (NIATx). In collaboration with the SAMHSA's Center for Substance Abuse Treatment, RWJF invited Delaware, along with four other states, to participate in a state pilot to test the application of the NIATx process from a state perspective. Since NIATx was focusing on improving access and engagement in treatment, our providers jumped at the chance to learn innovative but simple to use techniques that were directly related to their performance targets. The results of the NIATx process are amazing. I cannot give high enough praise to NIATx, and recommend it to all states and treatment agencies.

So, here we are four years later, and we are extremely pleased with our performance-based contracts. And, our providers like the system – some have even suggested that we use it for other parts of our system. We find that we have achieved what we set out to do. Programs generally, but not always, meet most of their performance targets each month. Client access has improved greatly – clients can get an intake interview at most sites the same or next day. Programs use a combination of evidence based practices and innovative NIATx strategies to enhance client engagement and participation.

Where to from here. Well, we are presently engaged in a new NIDA funded project with Dr. Thomas McLellan to introduce what he calls Concurrent Recovery Monitoring (CRM) in these same outpatient

agencies. Using CRM, programs will continually collect and use real-time data during treatment on several outcome measures, such as drug use, arrests, and employment. Our goal, once we have some experience with CRM, is to connect payment to the achievement of these outcomes.

I will conclude my testimony at this point. I hope that this brief synopsis will help you to understand the core of our Delaware initiative to improve treatment by connecting payment to performance, and to convey our pride in what our outpatient treatment providers have accomplished. I will be glad to answer your questions and to provide the Panel and Join Together more specific details on our Delaware experience.

Thank you once again for the opportunity to testify before this distinguished Panel.