March 11, 2015

I come today as a representative from the Vermont Association of Addiction Treatment Providers (VAATP), the organization that represents the system of care from a service provider perspective. I am also, of course, representing the Brattleboro Retreat, where my work is to oversee the outpatient programs.

The VAATP is a diverse organization that is sometimes confused with the designated agency system; while out organization includes many DAs, our organization is broader, and represents more diverse group of providers. We comprise DAs and non-DA outpatient programs, residential and inpatient programs, Hubs, supportive housing providers, and others. We provide a full range of services to Vermonters with substance use disorders, and help these most vulnerable Vermonters by providing effective, evidence-based treatments that save lives.

I applaud the committee for doing the work of updating the legislation that outlines the structures for oversight of the addiction treatment system in the State of Vermont. Herein, I will offer some thoughts for consideration with respect to the system of treatment from a provider's point of view.
The State's oversight of addiction services, as it currently exists, is complex. ADAP and DVHA are both involved in the payment and reimbursement structures for providers; the preferred providers deal mostly with ADAP, but the network of physician practices delivering addiction services in the "spoke" model of care deal mostly with DVHA, as do acute inpatient services. Other agencies interface with the addiction treatment system as a core part of their work – most notably DOC and DCF.

The addiction treatment system is likewise a complex system, and is often misunderstood. The treatment system can be seen as a microcosm of like the medical system as a whole. Our system provides services to individuals with a chronic illness that manifests in acute periods of immediate need and profound dysfunction. Treatment, therefore, needs to be both able to respond quickly to the acute needs of those we service as well as to their long-term needs, considered over a lifetime. The design of the service system needs to reflect the entire range of services that clients need to manage recovery from this chronic illness: of addiction. All of the services are needed here, from the high-intensity inpatient and residential to IOP and outpatient, etc. The existence of a comprehensive network of care is critical to the success of the system as a whole.

In the spirit of comparisons to the medical system, I encourage this committee to consider issues related to parity when considering the addiction treatment system. State and Federal parity laws have contributed to great strides in care not being denied to those who are in need. With private payors, the provider and the consumer have guarantees that care is being fairly and adequately delivered in a way that is directly comparable to traditional medical care. On the public side, however, because of limitations to the parity laws, the same guarantees do not always exist. This has caused, at times, difficulty for both consumers and providers in the way that care is authorized or denied.

There are also some real opportunities for improvement in the current system. At times, people have looked to the State as the primary source of innovation for the design of the treatment system as a whole. Indeed, Vermont has been a source of innovation in many ways - with the Hub and Spoke system most notable in recent examples. However, the provider network has also been working on these issues in a significant way.

The providers have identified access as a significant issue of concern: the simple truth is that most individuals with a diagnosable substance use disorder are not getting help of any kind. There are many hidden costs to this, including a large human toll. I submit for your consideration a proposal to improve access to the treatment system as a whole in the State of Vermont. This white paper, which has been the result of a more than a year of provider-initiated self-study of the current system, makes recommendations that would seek to establish an integrated service deliver model for access to care.

I should note, there are other threats to the system in its current state, most notable on the workforce side of the equation – addiction counselors are sorely needed, and many areas of the State have had difficulty attracting and retaining the workforce needed to be able to staff their programs adequately.

Oh behalf of the VAATP, I hope that we might be able to work together on these and other complex issues, for the mutual benefit of all.

Respectfully,

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