Report to
The Vermont Legislature

Substance Abuse Treatment Services
Objectives and Performance Measures Progress:
Second Annual Report

In Accordance with Act 179 (2014) Sec. E.306.2 (a)(2)

Submitted to:	**Joint Fiscal Committee** **House and Senate Committees on Appropriations** **House Committee on Human Services** **Senate Committee on Health and Welfare**
Submitted by:	**Barbara Cimaglio** **Deputy Commissioner**
Prepared by:	**Division of Alcohol and Drug Abuse Programs**
Report date:	**January 15, 2017**

VERMONT
AGENCY OF HUMAN SERVICES
Department of Health

108 Cherry Street, PO Box 70
Burlington, VT 05402
802.863.7280
healthvermont.gov

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Substance Abuse Treatment Services Objectives and Performance Measures Progress: Third Annual Report
Due on or Before January 2017

Executive Summary

The initial Substance Abuse Treatment Services Objective and Performance Measures legislative report, required by Act 179 (2014), Sec. E.306.2 (a)(2), was submitted on September 11, 2014 by the Vermont Chief of Healthcare Reform, the Secretary of Human Services, the Commissioner of Health and the Commissioner of Vermont Health Access. The report outlined the program objective (this could also be referred to as a goal or a population outcome) of preventing and eliminating the problems caused by alcohol and drug misuse. In addition, the report outlined five (5) performance measures by which to assess Vermont's progress over time. This year's results of these measures indicate that Vermont is making progress toward its program objective. It is important to note that these performance measures are long-term targets. Once the targets have been achieved and sustained over time, new targets or alternate measures will be considered in order to continuously improve the progress toward meeting the program objective. These five (5) performance measures have also been applied in other areas such as grant performance measures, Vermont Department of Health Performance Dashboard measures, and Programmatic Performance Measure Budgeting for the Agency of Administration.

Performance Measures

1. *Are students who may have a substance abuse problem being referred to community resources?* The percent of students screening positive for possible substance use disorders who are referred for assessment has trended upward over time with the most recent reporting period at the target of 90%.
2. *Are youth and adults who need help starting treatment?* Treatment initiation has been trending upward for three (3) years and there has been an 80% increase in the number of people initiating treatment between 2009 and 2015 due in part to the increased number of individuals diagnosed with a substance use disorder.
3. *Are youth and adults who start treatment sticking with it?* The percent of Medicaid recipients with 2 or more substance abuse services within thirty (30) days of beginning treatment has been trending downward for three (3) years. However, this is due in part to the increased number of people with a substance use diagnoses. There has been a 59% increase in the number of individuals engaged in treatment between 2009 and 2015.

4. *Are youth and adults leaving treatment with more support than when they started?* The number of individuals exiting treatment who have either maintained four or more support services per week or have increased the number of support services between treatment entry and exit has leveled off over the past five (5) quarters after a downward trend between 2011 and 2013.
5. *Are adults seeking help for opioid addiction receiving treatment?* The number of individuals ages 18-64 receiving medication assisted treatment has continued on an upward trend for twelve (12) quarters. This will continue to increase with the addition of the Franklin/Grand Isle hub in early 2017.

The most recent information including a narrative summary identifying the partners involved, strategies used to meet the goals, and an action plan to address the measure is available on the Vermont Department of Health Performance Dashboard:
http://healthvermont.gov/hv2020/dashboard/alcohol_drug.aspx

Legislative Charge:

Act 179 (2014)
Sec. E.306.2(a)(2) SUBSTANCE ABUSE TREATMENT SERVICES
(a) Program Objectives And Performance Measures:

(1) On or before September 15, 2014, the Chief of Health Care Reform, the Secretary of Human Services, and the Commissioners of Health and of Vermont Health Access in consultation with the Chief Performance Officer shall submit to the Joint Fiscal Committee, the House and Senate Committees on Appropriations, the House Committee on Human Services, and to the Senate Committee on Health and Welfare the program objectives for the State's substance abuse treatment services and three performance measures to measure success in reaching those program objectives.

(2) Thereafter, annually, on or before January 15, the Chief, Secretary, and Commissioners shall report to those committees on the service delivery system's success in reaching the program objectives using the performance measure data collected for those services.

Introduction:

On September 11, 2014, Vermont's Chief of Healthcare Reform, the Secretary of Human Services, the Commissioner of Health and the Commissioner of the Department of Vermont Health Access submitted a legislative report titled "Substance Abuse Treatment Services Objective and Performance Measures."[1] This report outlined the State's objective[2] in supporting programs to prevent and eliminate problems caused by alcohol and drug misuse. The following five measures were selected to assess consistently how much Vermont is doing, how well Vermont is doing, and whether Vermont is making a difference:

1. Are students who may have a substance abuse problem being **referred** to community resources?
2. Are youth and adults who need help **starting** treatment?
3. Are youth and adults who start treatment **sticking with** it?
4. Are youth and adults leaving treatment with **more support** than when they started?
5. Are adults seeking help for opioid addiction **receiving treatment**?

This is the third annual report of the service delivery system's ability to reach the program objective using the performance measure data. Progress toward the objective and performance measures are reported on the Vermont Department of Health Performance Dashboard.[3] There, progress towards the goals is shown on a continuous basis with many measures updated quarterly. The most recent measures can be reviewed at: http://healthvermont.gov/hv2020/dashboard/alcohol_drug.aspx.

Progress: Vermont has experienced mixed progress achieving measured targets used to assess success in meeting the objective of preventing and eliminating the problems caused by alcohol and drug misuse. It's important to note that these are long-term targets resulting in the need to track the data over an extended period of time to assess success. Once the targets have been achieved and sustained over time, new targets or alternative measures will be considered in order to continuously improve progress toward meeting the program objective. For example, the target for access to medication assisted treatment was updated in 2015 because the target had been

[1] http://legislature.vermont.gov/assets/Documents/Reports/302293.PDF

2 The term *objective*, as used in this report and in Act 179, is often referred to as a *goal*. Similarly, in Vermont state government, the term *population outcome* would be used to describe what Act 179 refers to as an *objective*. The term *population outcome* is used as part of Vermont's Results-Based Accountability framework as required by Act 186 of 2014.

[3] http://healthvermont.gov/hv2020/dashboard/alcohol_drug.aspx

achieved. This target is anticipated to change again in 2017 in response to the opening of a new opioid treatment hub in the Franklin/Grand Isle region.

Also, these measures are continuously being refined. For example, the treatment initiation measure was modified in October 2014 to account for Vermont's innovative funding mechanism for hubs, a monthly case rate, which had been excluded in the previous calculation method.

In addition, in 2015 the treatment engagement measure was expanded from a measure specific to the Vermont Department of Health's Division of Alcohol and Drug Abuse Program's Preferred Provider network to a measure that reflects all Vermont Medicaid recipients. This change better reflects statewide service delivery, but will require significant coordinated cross-departmental efforts to reach the goal.

The following presents the Performance Measures, followed by a discussion of each. The report concludes with a discussion of the direction state efforts will take to improve progress toward the achievement of identified targets.

PERFORMANCE MEASURE 1: School Screenings: Are we referring students who may have a substance use problem to community resources?

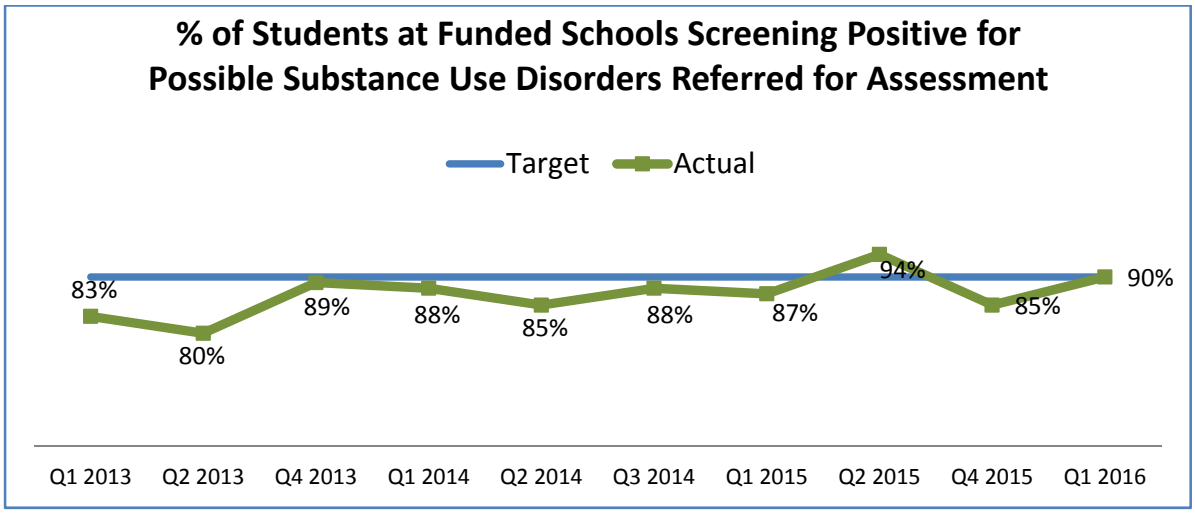
The Centers for Disease Control and Prevention (CDC) has developed an evidence-based model for coordinated school health. Following this model, recipients of state-funded School-Based Substance Abuse Services (SBSAS) grants support a comprehensive substance use prevention effort. Supported activities include:

- Classroom curricula
- Advising and training of youth empowerment groups
- Family outreach and community involvement
- Staff training
- Delivery of educational support groups
- Screening and early identification
- Providing screening and appropriate referral in schools

Early identification of substance use issues has been shown to improve treatment and recovery efficacy and significantly enhance overall health outcomes. Evidence-based screening and referral services for substance use and mental health are essential components of SBSAS. While in most cases referral is appropriate, not everyone who screens positive should be referred for additional services, which is why the target for this performance measure is below 100%.

Percent of supervisory unions with state-funded SBSAS and state funding totals:

Years	Percent of all SUs funded	Total funding amount
2013-2014	35%	$703,237
2014-2015	35%	$947,302
2015-2016	34%	$769,848

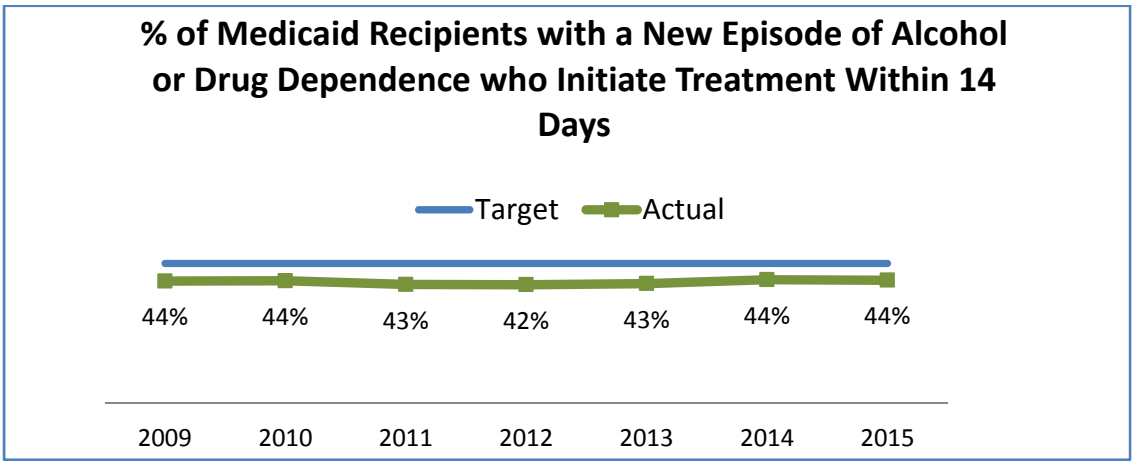


PERFORMANCE MEASURE 2: Treatment Initiation: Are youth and adult Medicaid recipients who need help starting treatment?

When an individual is identified as potentially in need of treatment for a substance use disorder, there are often many perceived or actual barriers to initiating treatment. These barriers may include waiting lists for treatment, lack of transportation, or an inability to find childcare. The most frequently cited reason for not engaging in treatment is the individual's perception that treatment is unnecessary. As with other chronic diseases such as diabetes or heart disease, the sooner an individual seeks treatment, the more likely they are to recover. For successful recovery, individuals with substance use disorders need to know where to get help, and then begin (initiation) and remain in treatment (engagement).

As the numbers in the graph suggest, it is necessary to develop better methods and practices to remove barriers and encourage treatment initiation in a timely manner. One method is for medical professionals to improve screening of patients during office visits. The Agency of Human Services (AHS) has added screening to AHS programs and is currently doing district-level pilot programs to improve coordination between service providers, AHS, and other stakeholders.

The treatment initiation measure is a standardized Healthcare Effectiveness Data and Information Set (HEDIS) Measure used by more than 90% of America's health plans to measure performance. It is defined as, *the percent of adolescent and adult Medicaid recipients with a new episode of alcohol or other drug dependence, as identified by a diagnosis of a substance use disorder, who initiate treatment through an inpatient alcohol or drug admission, outpatient visit, intensive outpatient encounter or partial hospitalization stay within 14 days of the diagnosis*. This standard measure has been modified to compensate for Vermont's monthly case rate funding of opioid treatment hubs and to be more inclusive of residential treatment in the calculations. While the initiation rate has been relatively stable, the number of individuals initiating treatment between 2009 and 2015 has increased 80% in part due to the increased number of individuals diagnosed with a substance use disorder.

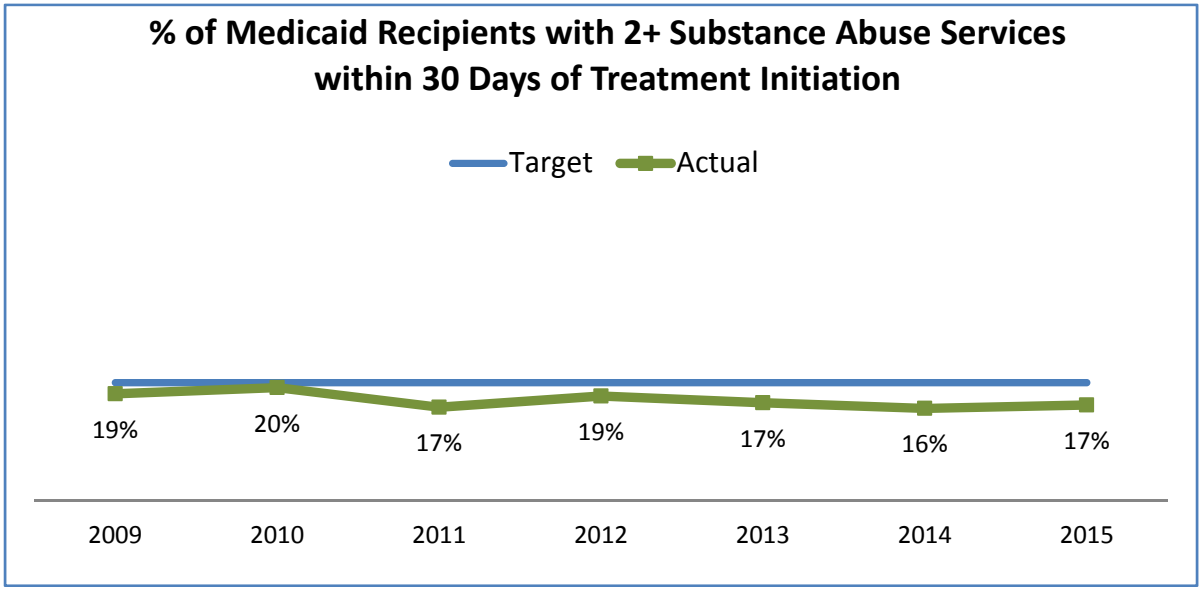


PERFORMANCE MEASURE 3: Treatment Engagement: Are youth and adult Medicaid recipients who start treatment sticking with it?

Behavioral health treatment for substance use is an ongoing process which requires multiple visits in order to modify behavior, build the skills needed to address the contributing factors in addiction, and prevent relapse. In order for substance use treatment to be effective, the individual must attend and stay in treatment. Research indicates that those who are engaged in treatment have better treatment outcomes.[4]

This treatment engagement measure is a standardized Healthcare Effectiveness Data and Information Set (HEDIS) Measure used by more than 90% of America's health plans to measure performance. It is defined as, *the percent of Medicaid recipients age 13 and up who both initiate care, as in Performance Measure 2, and receive two or more additional services with a substance use disorder diagnosis within 30 days of initiation*. This standard measure has been modified to compensate for Vermont's monthly case rate funding of opioid treatment hubs and to be more inclusive of residential treatment in the calculations.

While the engagement rate has been trending slightly lower, the number of Vermont Medicaid recipients engaging in treatment between 2009 and 2015 has increased 59%, likely due to the increased number of individuals diagnosed with a substance use disorder. ADAP is contracting with a quality improvement facilitator to provide assistance to treatment providers in this and other performance measures.



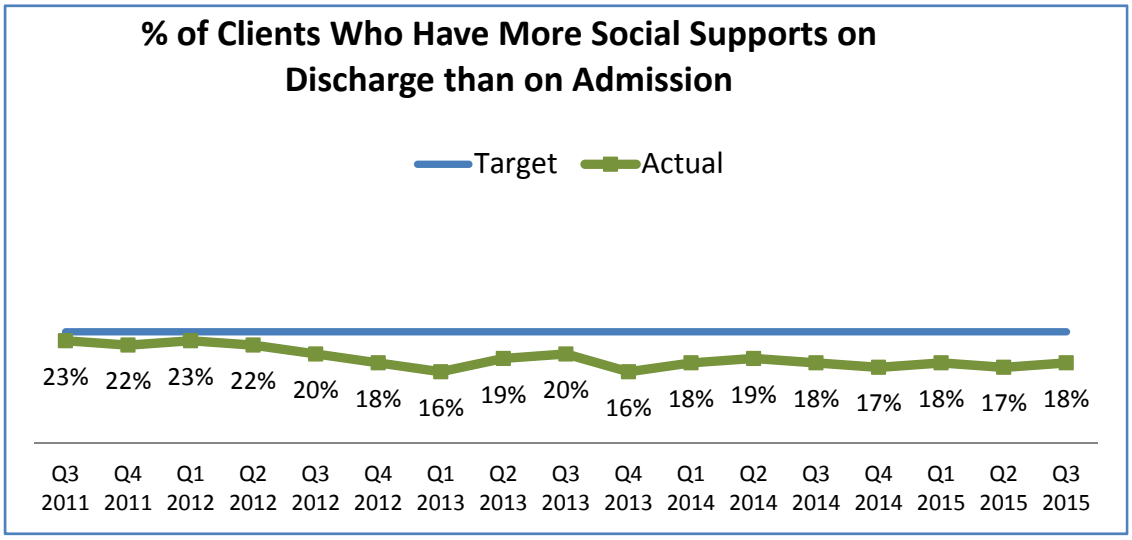
[4] Harris et al, "Does meeting the HEDIS substance abuse treatment engagement criterion predict patient outcomes?", *Journal of Behavioral Health Services and Research* (2010 Jan);37(1):25-39. doi: 10.1007/s11414-008-9142-2. http://www.ncbi.nlm.nih.gov/pubmed/18770044

PERFORMANCE MEASURE 4: Social Supports: Are youth and adults leaving treatment with more support than when they started?

Individuals with addiction often have challenging lives. There is also shame and stigma associated with this disease which can result in isolation for those struggling with addiction. This isolation prevents individuals from accessing positive supports that are needed to assist in recovery from addiction. Socials supports include recovery-oriented self-help groups such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA), supported housing, recovery coaching, faith-based services, as well as substance free gathering places such as the recovery centers. Individuals with positive social networks are more likely to succeed in their recovery.[5]

Social supports is a measure of the portion of individuals exiting treatment in the ADAP-funded Preferred Provider network who have either maintained four or more social support services or have more social supports at discharge than at admission. It is important to note that residential services are excluded from this measure because residential stays are typically 14 days and best practice is for individuals to step down to lower levels of care rather than relying solely on social supports.

ADAP has been working with providers to improve rates of social supports through quality improvement processes and, until the FY16 budget recessions, incentives. There is significant variation in performance between providers and not all providers have participated in quality improvement opportunities. ADAP is leading efforts to strengthen collaboration between Recovery Centers and treatment providers and is beginning to connect clients receiving medication assisted treatment to recovery coaches.

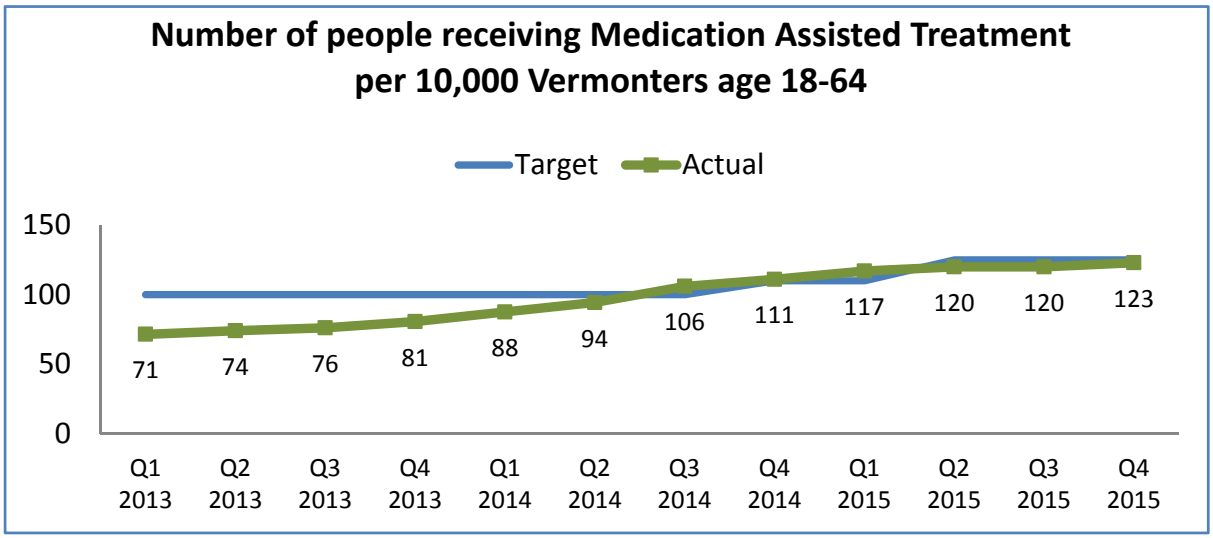


[5] Laudet et al, "The Role of Social Supports, Spirituality, Religiousness, Life Meaning and Affiliation with 12-Ste Fellowships in Quality of Life Satisfaction Among Individuals in Recovery from Alcohol and Drug Problems", *Alcohol Treat Q.* 2006; 24(1-2): 33–73. doi: 10.1300/J020v24n01_04

PERFORMANCE MEASURE 5: Access to Medication-Assisted Therapy (MAT): Are adults seeking help for opioid addiction receiving treatment?

The use of heroin and misuse of other opioids (e.g., prescription narcotics) has been identified as a major public health challenge in Vermont. The potential health, social, and economic consequences of this problem have led to the development of a comprehensive treatment system that is focused on opioid addiction. This system, called the Care Alliance for Opioid Addiction (also called the hub and spoke system), has substantially increased access to care in Vermont. Vermont has a multifaceted approach to addressing opioid addiction that involves multiple community partners. Programs and services include regional prevention efforts, drug take-back programs, intervention services through the monitoring of opioid prescriptions with the Vermont Prescription Monitoring System (VPMS), the Screening, Brief Intervention and Referral to Treatment (SBIRT) initiative, recovery services at eleven Recovery Centers, overdose death prevention through the distribution of Naloxone rescue kits, and a full array of treatment modalities of varying intensities to fit individual needs.

For those with opioid dependence, treatment with methadone or buprenorphine, medications used to reduce cravings for opioids (e.g., heroin or prescription pain relievers), allows individuals the opportunity to lead healthier lives. Medication assisted treatment (MAT) was developed because detoxification followed by abstinence-oriented treatment had been shown to be ineffective and there is clear evidence of effectiveness for MAT using either methadone or buprenorphine.[6] Positive medication assisted treatment outcomes include: abstention from or reduced use of illicit opiates; reduction in non-opioid illicit drug use (e.g., cocaine); decreased criminal behavior; and decreased risk behavior linked to HIV and hepatitis C.



[6] http://healthvermont.gov/adap/treatment/opioids/documents/MAT_Factsheet_Apr2014.pdf

Conclusion:

Performance measures for Vermont substance abuse services show mixed progress toward the long-term program goal of preventing and eliminating the problems caused by alcohol and drug use. These measures offer program funders, planners and administrators consistent feedback about the success of efforts to help youth and adults avoid or recover from alcohol and drug use. State government agencies realize that improvement takes time, requiring ongoing interdepartmental commitment, and a willingness to respond to data. Continued collaboration and attention to metrics of improvement will enable programmatic adjustments in a more timely manner. On the basis of this year's data, the following steps and efforts will be pursued to move Vermont closer to the statewide objective:

- ADAP and DVHA are working on a performance improvement project (PIP) to increase treatment initiation. This group has reviewed data and met with stakeholders including the AHS-wide Substance Abuse Treatment Coordination Initiative (SATC) central and regional groups as well as regional providers such as Central Vermont Medical Center. A PIP is a concentrated effort focused on a particular problem; it involves gathering information systematically to clarify issues or problems, and intervening for improvements.
- ADAP continues to work with treatment providers through regular performance measures meetings. In addition, ADAP has solicited proposals for a quality improvement facilitator to work directly with providers to improve measures. The facilitator will begin in FY2017 and will focus on working with providers to improve treatment engagement and social connectedness.
- Medication assisted treatment capacity is continuing to increase. In the first quarter of 2017, a new hub will open to serve those in Franklin and Grand Isle counties. It is expected that the hub will significantly decrease wait times in the northwest portion of the state and decrease drive times for those individuals receiving services in hubs in the Northeast Kingdom and Burlington. In addition, spoke capacity has been steadily increasing thanks in part to the work of the University of Vermont Medical Center. A new spoke program in Bennington County began in 2015 that serves individuals at high risk of diverting buprenorphine although the program has remained small with approximately 30 patients. ADAP is continuing to link individuals receiving medication assisted treatment to recovery coaches to improve retention in treatment and assist clients in getting the social, physical and cultural resources necessary for successful recovery.
- The school referral measure will continue to be monitored. Vermont will continue to employ the coordinated school health model; provide training on use of evidence-based tools used for screening; monitor referral rates among grantees; and provide training opportunities for best practice. Should the measure continue to exceed the target over time, a new measure with opportunity for improvement will be selected.