Blueprint for Change

Redesign
For
Milwaukee County
AODA (Alcohol and Other Drug Abuse) Service Delivery System

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MILWAUKEE COUNTY AODA (ALCOHOL AND OTHER DRUG ABUSE) SERVICE DELIVERY SYSTEM
BLUEPRINT FOR CHANGE
Highlights

The redesigned AODA system will feature:

- **Centralized intake process:** Management of the access/screening process will be centralized to foster consistency, although there will still be multiple intake sites.
- **Comprehensive screening and assessment:** The screening and assessment process has been enhanced to focus not only on treatment needs, but also on recovery support services such as housing and employment.
- **Use of standardized tools:** Staff will be trained in use of the nationally recognized Addiction Severity Index (ASI) and the American Society of Addiction Medicine's (ASAM) patient placement criteria.
- **Individualized Care Plans:** Each client will have an individualized care plan rather than being authorized for a standard amount of treatment.
- **Provider Profiles:** Clients will receive detailed provider profiles to help them choose providers that best meet their needs.
- **Recovery support services:** People with substance abuse disorders typically have difficulties that extend far beyond the addiction and interfere with their ability to participate effectively in treatment. With the help of a federal grant, the BHD will add housing assistance; job readiness skills; pre-employment counseling; family support and child care; family services, including marriage education, and parenting and child development services; recovery coaching (including stage-appropriate recovery education, anger management, assistance in recovery management, telephone monitoring); training in daily living skills; and spiritual support.
- **Strategies to reduce waiting lists:** Use of the new patient placement criteria, as well as the new process for individualized care plans and service authorization, will lead to better management, and possibly reduction, of waiting lists. The use of "brief intervention" will also be explored.
- **Education/training plan:** The new comprehensive screening process and the integration of evidence-based practices into the service delivery system will require an education and training plan.
- **Care coordination:** Care coordination involves actively coordinating the process of service planning and delivery, as well as the traditional case management function of helping the client to access services.
- **Evaluation plan:** The plan will contain specific goals and objectives to be evaluated for identified AODA programs and services.
- **Integration of all AODA/mental health functions**: i.e. contract management, service delivery, management information systems, quality assurance and evaluation.

MILWAUKEE COUNTY AODA (ALCOHOL AND OTHER DRUG ABUSE) SERVICE DELIVERY SYSTEM BLUEPRINT FOR CHANGE

I. Background and Events Leading to Redesign

AODA services transferred to Mental Health Division

In January, 2002, as a result of a Milwaukee County Board of Supervisors' resolution, the administrative and programmatic responsibility for public sector AODA (alcohol and other drug abuse) services was transferred from the Adult Services Division of the Milwaukee County Department of Human Services to the Mental Health Division of the same department. Concurrent board action resulted in a name change from the Mental Health to the Behavioral Health Division (BHD) to reflect the inclusion of substance abuse services responsibility.

The transfer was appropriate and timely, especially given the federal Substance Abuse and Mental Health Administration's (SAMHSA) 2002 Report to Congress which indicates: "Forty-one to 65 percent of individuals with a lifetime substance abuse disorder also have a lifetime history of at least one mental disorder, and about 51 percent of those with one or more lifetime mental disorders also have a lifetime history of at least one substance abuse disorder"[1]

Transfer brings issues to the forefront

After one year of responsibility for publicly-funded AODA services, [the] Behavioral Health Division (BHD) identified, with active input from the community, a number of issues that detract from the optimal delivery of services to Milwaukee County residents with substance use and co-occurring disorders. These include:

1. The treatment access system is fragmented and lacks uniform policies/procedures governing operation of intake sites. While a successful model for treatment/services access already exists on the Division's mental health side with the SAIL (Service Access to Independent Living) Program, a similar mechanism does not exist for AODA clients.
2. The community lacks a profile of the population with substance abuse disorders. This lack of information has resulted in the loss of federal grants which could have brought millions of dollars into the community.
3. "Best practice" treatment engagement processes e.g., motivational interviewing, are unevenly employed.
4. The system service array is limited, incomplete, and does not comply with best practices, e.g., no case management, co-occurring disorder program. Old levels of care (outpatient, day treatment, residential) do not meet the AODA field's current options (HFS 75 has definitions for many more levels of care).

[1] SAMHSA, Report To Congress On The Prevention And Treatment Of Co-Occurring Substance Abuse Disorders And Mental Disorders, 2002.

5. Other client life domains are not assessed/addressed; even if assessed, the system is unable to directly assist clients, e.g. no ancillary support service availability, e.g., housing.
6. An appropriate Consumer Informed Choice Model is lacking.
7. There are no mechanisms to help client bridge gap between screening and treatment and no effective treatment alternatives while "waiting" for treatment.
8. There is no holistic process for assuring program quality.
9. There is a lack of coordination with other systems, e.g., mental health, corrections.
10. There is a significant variance in the service array available to TANF eligible clients vis-à-vis MTC eligible clients. Very simply, TANF eligible clients have access to not only primary substance abuse treatment but also to a wide variety of ancillary or supportive services. In contrast, MTC eligible clients had access only to limited array of services, e.g. residential, outpatient.

Community Redesign Coalition Created

BHD administrators determined that a "blueprint for change" was needed for publicly-funded AODA services in Milwaukee County. In May 2003 the Re-Design Community Coalition (RDCC) was convened to act as architects of the blueprint. The Coalition met on a regular basis from May 2003 to June 2004.

The Community Redesign Coalition set forth the following principles to guide the redesign process:

- We want to employ evidence-based practices.
- We want to improve access and retention.
- We want to better integrate AODA and Mental Health, especially with the increased recognition of and emphasis on co-occurring disorders.
- We want to take a more holistic approach, looking at other domains of a person's life that impact on substance abuse.

Federal Access to Recovery (ATR) Grant Added to the Mix

In March of 2004 the federal Substance Abuse and Mental Health Services Administration (SAMHSA) announced the availability of Access to Recovery, a $100 million discretionary grant program for states to provide people seeking drug and alcohol treatment with vouchers to pay for a range of appropriate community-based services. ATR is characterized by:

- **Consumer Choice**. The process of recovery is a personal one. Achieving recovery can take many pathways: physical, mental, emotional, or spiritual. With a voucher, people in need of addiction treatment and recovery support will be able to choose the programs and providers that will help them most.
- **Outcome Oriented**. Success will be measured by outcomes, principally abstinence from drugs and alcohol, and including attainment of employment or enrollment in school, no involvement with the criminal justice system, stable housing, social support, access to care, and retention in services.
- **Increased Capacity.** ATR will expand the array of services available including medical detoxification, inpatient and outpatient treatment modalities, residential services, peer support, relapse prevention, case management, and other recovery support services.

On June 3, 2004, the State of Wisconsin submitted its ATR application to SAMHSA, and on August 3, 2004, the State received a notice of grant award from SAMHSA to fund its application for the Wisconsin Supports Everyone's Recovery Choice (WIser Choice) program. Milwaukee County Behavioral Health Division will serve as the contracted project management agency for WIser Choice. WIser Choice will help to fund major elements of the redesign, such as:

- The enhancement and expansion of the Milwaukee Central Intake System to improve initial engagement, access and treatment retention.
- The provision of recovery support services in addition to treatment, thus addressing needs that are directly related to substance abuse, thereby achieving better outcomes.
- Development of a broader provider network so that consumers have more treatment options (including a focused outreach to the faith-based community).
- Development of a comprehensive continuum of low/no cost natural supports in the community to help sustain recovery, including organizing faith congregations to provide such resources as mentors, employment opportunities, housing, child care and transportation.
- The fostering of genuine, free and independent choice by making available "Provider Profiles" that include "Provider Score Cards."
- Establishment of a data-driven, results-oriented management system to monitor and improve outcomes.
- Rewarding results by implementing an innovative system of provider incentives.
- The enhancement of its existing voucher system Management Information System so that the bulk of performance and financial indicators and measures will be reported on and maintained electronically. This will enhance accountability of both the provider and the system.

II. Integration of Evidence-Based Practices Into Service Delivery System

A major component of the redesign is greater integration of evidence-based practices into the service delivery system. What, specifically, are evidence-based practices?

> Evidence-based practices are specific clinical guidelines that help bridge the gaps between what researchers find to be effective treatment and what is implemented at the practice level. Their use is growing in all areas of health care in an effort to reduce ineffective interventions and improve health. One scientist estimated that 19% of medical practice was based on science and the rest on "soft-science" or opinions, clinical experience, or "tradition." It is likely that even less of substance abuse practice is based on science, given the state of the art of substance abuse research and practice.[1]

The federal Substance Abuse and Mental Health Services Administration's Center for Substance Abuse Treatment (CSAT) has been concerned with this gap between research and practice and instituted two major programs to help bridge the gap:

1. The Practice Improvement Collaboratives (PIC) program was initiated in 1999, partly to identify successful methods and models for implementing evidence based practices in community based treatment organizations. CSAT awarded grants to14 PICs, including the state of Iowa, where the grant recipients eventually produced a manual defining evidence-based practices.
2. Addiction Technology Transfer Centers are charged with the dissemination of evidence-based practices to the field in forms that are tailored to different disciplines or settings. Among its goals are:
    - Advancing Knowledge Adoption: Keeping pace with the latest science on addiction and then *translates* it so that it can be understood and applied by the treatment workforce.
    - Building a Better Workforce: Improving the competency of current and future practitioners by creating and expanding continuing education and university coursework, developing academic programs, increasing clinical placements and setting educational standards.

The Iowa PIC has done substantial work in defining evidence-based practices.
According to the Iowa PIC, evidence-based practices often focus on treatment approaches, such as motivational enhancement, and include copious data from the research behind the practice. Project MATCH, a multisite clinical trial of alcohol treatment, has eight monographs that are evidence-based treatment for alcohol use disorders.[2] The National Institute on Drug Abuse's Principles of Effective Drug Treatment are also a source of clinical guidelines for effective treatment.

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[1] Evidence-Based Practices: An Implementation Guide for Community-Based Substance Abuse Treatment Agencies. Spring 2003. The Iowa Practice Improvement Collaborative (PIC) Project supported by a grant from the Substance Abuse and Mental Health Services Administration.

[2] The manuals in this series are the result of the collaborative efforts of the Project MATCH investigators and are used as guides by the therapists in the trial. They are presented to the alcohol research community as standardized, well-documented intervention tools for alcoholism treatment research. The manuals are provided to the public to permit replication of treatment procedures employed in Project MATCH. Monographs can be accessed at http://www.commed.uchc.edu/match/pubs/monograph.htm.

The Iowa PIC developed a handbook titled *Evidence-Based Practices: An Implementation Guide for Community-Based Substance Abuse Treatment Agencies* (Spring 2003). An evidence-based practice, according to their guidelines, must possess the following characteristics:

1. At least one randomized clinical trial has shown this practice to be effective.
2. The practice has demonstrated effectiveness in several replicated research
3. Studies using different samples, at least one of which is comparable to the treatment population of our region or agency.
4. The practice either targets behaviors or shows good effect on behaviors that are generally accepted outcomes.
5. The practice can logistically be applied in our region, in rural and low
6. population density areas.
7. The practice is feasible: It can be used in group format, is attractive to third
8. party payers, is of low cost, and training is available.
9. The practice is manualized or sufficiently operationalized for staff use. Its key
10. components are clearly laid out.
11. The practice is well accepted by providers and clients.
12. The practice is based on a clear and well-articulated theory.
13. The practice has associated methods of ensuring fidelity.
14. The practice can be evaluated.
15. The practice shows good retention rates for clients.
16. The practice addresses cultural diversity and different populations.
17. The practice can be used by staff with a wide diversity of backgrounds and training.[1]

The state of Oregon now mandates that evidence-based treatment practices must be used by programs funded by the state. [2] If Oregon and Iowa are bellwethers, then many more states -- and private payers -- may require the use of evidence-based practices in substance use treatment.

The RDCC paid close attention to evidence-based practices in creating its blueprint for change.

[1] Evidence-Based Practices: An Implementation Guide for Community-Based Substance Abuse Treatment Agencies. Spring 2003. The Iowa Practice Improvement Collaborative (PIC) Project supported by a grant from the Substance Abuse and Mental Health Services Administration.
[2] Join Together Online. Demand Treatment E-News. May 14, 2004

III. Major Elements of the Redesign

The RDCC focused on five major areas in developing its blueprint for change:

A. Access/retention.
B. Service array.
C. Management information systems.
D. Evaluation.
E. Mental Health/AODA integration.

Following are discussions of the major issues associated with each area, followed by the "blueprint for change."

A. Access/Retention

Issues Related to Access/Retention

- The treatment access system is fragmented and lacks uniform policies/procedures governing operation of intake sites. While a successful model for treatment/services access already exists on the Division's mental health side with the SAIL (Service Access to Independent Living) Program, a similar mechanism does not exist for AODA clients.
- "Best practice" treatment engagement processes e.g., motivational interviewing, are unevenly employed.
- Other client life domains are not assessed/addressed; even if assessed, the system is unable to directly assist clients, e.g. no ancillary support service availability, e.g., housing.
- An appropriate Consumer Informed Choice Model is lacking.

What Evidence-Based Practices Say

- **There are a variety of legitimate intake models.** There is room for a variety of intake models among AODA treatment systems. These can range from decentralized, provider driven models to the central intake and assessment agencies that some states have set up.[1]
- **Screening and comprehensive assessment are critical.** Assessment is one of the five critical elements of effective substance abuse treatment. It is the first stage of intervention with persons who are chemically dependent. A comprehensive appraisal of the individual's alcohol or drug problem, and how it affects his or her health and functioning, is vital for selecting treatment resources that best meet his or her needs.[2] Assessments must be culturally sensitive.[3]
- **Patients must be placed into and moved through appropriate levels of care.** A systematic approach to initial and ongoing assessment may prevent patients from "getting lost" and dropping out. A key ingredient to success is evaluation of patients on multiple parameters using tools such as the Addiction Severity Index (ASI) and Patient Placement Criteria.[4]
- **Each patient's personality, background, and mental condition and the duration, extent, and type of drug use must be considered when selecting a treatment program or**

[1] CSAT TIP 13: The Role and Current Status of Patient Placement Criteria in the Treatment of Substance Use Disorders.
[2] SAMHSA, Chapter 4, Screening and Assessment of TAP 11: Treatment for Alcohol and Other Drug Abuse: Opportunities for Coordination, 1994.
[3] SAMHSA, Chapter 6 of TAP 11: Treatment for Alcohol and Other Drug Abuse: Opportunities for Coordination Chapter 6–Special Populations.
[4] TIP 13, The Role and Current Status of Patient Placement Criteria In the Treatment of Substance Use Disorders, 1995.

approach. Patient-treatment matching is not an exact science; it might be necessary to adjust the treatment plan following periodic reassessment of the individual's progress in treatment or when a relapse occurs. Much has been learned, but additional research is needed to maximize the benefits of selecting the most appropriate treatment approach for various individuals.[1]

- **Motivational interviewing/enhancement at the point of access is a best practice**. Motivation for change is a key component in addressing substance abuse. Motivation-enhancing techniques are associated with increased participation in treatment and such positive treatment outcomes as reductions in consumption, higher abstinence rates, better social adjustment, and successful referrals to treatment. In addition, having a positive attitude toward change and being committed to change are associated with positive treatment outcomes. Motivated clients developed better relationships with their counselors and stay in treatment longer.[2]
- **Individuals have the right to choose any duly licensed/certified professional for mental health and substance abuse services.** Individuals have the right to receive full information regarding the education and training of professionals, treatment options (including risks and benefits), and cost implications to make an informed choice regarding the selection of care deemed appropriate by individual and professional.[3] While choice among the various clinical treatment and/or recovery support services options resides with the individual, the assessor is responsible to ensure that the individual is fully conversant with all of the therapeutic alternatives available from eligible providers.[4]

Blueprint for Change

- **Install centralized intake process:** Management of the access/screening process will be centralized, although there will still be multiple intake sites. All intake workers will follow the same screening/assessment process.
- **Employ comprehensive screening and assessment:** A comprehensive screening process has been carefully constructed which combines the functions of:
  - ⇒ *Screening* – to determine whether a substance abuse problem is present and whether specialized substance abuse treatment is needed; and
  - ⇒ *Initial Assessment* – to determine which AODA treatment, case management and recovery support services are appropriate for the person's unique life situation. The assessment will be holistic and will focus not only on treatment needs, but also on recovery support services such as housing and employment.
- **Employ standardized tools:** The BHD will require use of the Addiction Severity Index (ASI)[5] and the American Society of Addiction Medicine's (ASAM) patient placement

[1] SAMHSA, TAP 11, Chapter 5: The Importance of Patient Treatment Matching
[2] CSAT, TIP 35, Enhancing Motivation for Change in Substance Abuse Treatment.
[3] American Psychiatric Association, Bill of Rights.
[4] From SAMHSA Access to Recovery grant announcement.
[5] The ASI is a semi-structured interview designed to address seven potential problem areas in substance abusing patients: medical status, employment and support, drug use, alcohol use, legal status, family/social status, and psychiatric status (*National Institutes of Health, National Institute on Alcohol Abuse and Alcoholism).*

criteria[1] as part of the comprehensive screening process Staff will be trained in use of these tools.

- **Develop individualized Care Plans:** Each client will have an individualized care plan. The amount and type of services authorized will emanate from this plan. Currently, service authorizations are based on program type rather than an individualized plan of care, i.e. clients needing residential treatment are usually authorized for 90 days.
- **Distribute Provider Profiles:** Clients will receive detailed provider profiles to help them choose providers that best meet their needs.
- **Revisit Milwaukee County's Three Strikes Policy:** Persons who have not had successful outcomes after three treatment admissions are no longer eligible for publicly-funded AODA services in Milwaukee County. There is increasing evidence linking addiction to genetic and physiological factors.[2] The costs of not treating are simply shifted to other systems.

[1] The ASAM criteria are the most widely used and comprehensive national guidelines for placement, continued stay and discharge of patients with alcohol and other drug problems *(American Society of Addiction Medicine).*

[2] The Neuroscience of Psychoactive Substance Use and Dependence report released by the World Health Organization (WHO) in March, 2004 concludes that addiction is as much a disorder of the brain as any other neurological or psychiatric illness. The WHO advocates policies that do not stigmatize patients, are community-based, and cost-effective. Researchers from the University of Colorado are close to identifying the gene that causes alcoholism and have determined "the neighborhood" where the gene is located. Drug addiction, researchers agree, should be treated like a chronic disease, such as diabetes or asthma, rather than as a moral failing.

How substance abuse services specified in State of Wisconsin HFS 75 and Milwaukee County services coincide	
Service Category	**Milwaukee County currently provides**
75.04: Prevention Service	Yes
75.05: Emergency Outpatient Service	No
75.06: Medically Managed Inpatient Detoxification Service	No
75.07: Medically Monitored Residential Detoxification Service	Yes
75.08: Ambulatory Detoxification Service	No
75.09: Residential Intoxication Monitoring Service	Yes
75.10: Medically Managed Inpatient Treatment Service	No
75.11: Medically Monitored Treatment Service	Yes
75.12: Day Treatment Service	Yes
75.13: Outpatient Treatment Service	Yes
75.14: Transitional Residential Treatment Service	Yes
75.15: Narcotic Treatment Service For Opiate Addiction	Yes

B. Service Array

Issues Related to Service Array

- The system service array is limited, incomplete, and does not comply with best practices, e.g., no case management, co-occurring disorder program. Old levels of care (outpatient, day treatment, residential) do not meet the AODA field's current options. The State of Wisconsin HFS 75 allows for provision of 12 types of substance abuse services. Milwaukee County currently provides 8 of these services.
- There continues to be a waiting list for AODA treatment, and there are no mechanisms to help clients bridge the gap between screening and treatment.
- Although we know a great deal about the evidence-based practices that produce better outcomes for clients, these practices are unevenly employed throughout Milwaukee County's AODA service system.
- There is limited or non-existent continuity of care between levels of care and between other systems, such as mental health and corrections.

What Evidence-Based Practices Say

- **Case Management:** Even in light of the implementation and methodological concerns about case management research, all the studies together with the findings of other addiction research suggest that case management can be an effective enhancement to intervention in and treatment of substance abuse. This is especially true for clients with other disorders, who may not benefit from traditional substance abuse treatments, who require multiple services over extended periods of time, and who face difficulty gaining access to those services. Research suggests two reasons why case management may be effective as an adjunct to substance abuse treatment. First, treatment may be more likely to succeed when "drug use is treated as a complex of symptom patterns involving various dimensions of the individual's life" Case management focuses on the whole individual and stresses comprehensive assessment, service planning, and service coordination to address multiple aspects of a client's life. Second, retention in treatment is associated with better outcomes, and a principal goal of case management is to keep clients engaged in treatment and moving toward recovery and independence. Studies looking at treatment retention and case management posit a positive relationship between the two.[1]

[1] Comprehensive Case Management for Substance Abuse Treatment , Treatment Improvement Protocol (TIP) Series 27, 1998.

- **Co-Occurring Disorders:** Substance dependent patients with comorbid psychiatric disorders who had a brief episode of inpatient care immediately prior to community residential treatment had better substance use outcomes than those who went directly into the community programs.[1]
- **Brief Intervention:** Variations of brief intervention have been found effective for helping non-alcohol-dependent patients reduce or stop drinking, for motivating alcohol-dependent patients to enter long-term alcohol treatment, and for treating some alcohol-dependent patients. Research indicates that brief intervention for alcohol problems is more effective than no intervention.[2]
- **Care Coordination:** The concept of care coordination is well-known in "wraparound" programs, initially designed for youth, but now evolving to include clients of all ages, including substance use disorders.[3] Applied to youth, the term "wraparound" is a metaphor for "enveloping" the young people and their families with all the services necessary for those experiencing complex, multi-dimensional problems. The wraparound model not only provides a comprehensive array of services, but also seeks to maximize the strengths of individuals. One of the most successful and well-known wraparound programs for youth is the Wraparound Milwaukee Program, operated by the Milwaukee County Behavioral Health Division.
- **Recovery Support Services:** McLellan and other researchers (1998)[4] have suggested that providing holistic, community-based support services enhances treatment outcomes. Indeed, SAMHSA now has an entire program devoted to recovery support services.

[1] Moos, R.H.; Finney, J.W.; Moos, B.S. Inpatient Substance Abuse Care and the Outcome of Subsequent Community Residential and Outpatient Care. Addiction 2000, 95, 833-846.
[2] Fleming M.F. Brief interventions and the treatment of alcohol use disorders: current evidence. Recent Dev Alcohol. 2003;16:375-90.
[3] Evenson RC, Binner PR, Cho DW, Schicht WW, Topolski JM. An outcome study of Missouri's CSTAR (Comprehensive Substance Abuse Treatment and Rehabiliation) alcohol and drug abuse programs. (A community program with wraparound services and intensive case management). *Journal of Substance Abuse Treatment* 1998 Mar-Apr;15(2):143-50.
[4] McLellan, A.T., Hagan, T.A., Levine, M., Gould, F., Meyers, K.& Bencivengo, M., et al. (1998). Research report: Supplemental social services improve outcomes in public addiction treatment. *Addiction, 93(10),* 1489-1499.

Blueprint for Change

- **Use comprehensive screening to demonstrate need for additional levels of care:** Although there are no immediate plans to add new levels of care, the new comprehensive screening process may produce evidence that additional levels are needed.
- **Add recovery support services:** People with substance abuse disorders typically have difficulties in other life domains that can interfere with their recovery. In the past, Milwaukee County lacked resources to offer recovery support services, but the ATR grant will now provide funding to add these services which can include housing assistance; supportive, temporary drug-free housing services; job readiness skills (resume preparation, interview training, linkage to basic education); pre-employment counseling; family support and child care; family services, including marriage education, and parenting and child development services; recovery coaching (including stage-appropriate recovery education, anger management, assistance in recovery management, telephone monitoring); training in daily living skills; spiritual support.
- **Use new processes to better manage waiting lists:** Use of the new patient placement criteria, as well as the new process for individualized care plans and service authorization, will lead to better management, and possibly reduction, of waiting lists. However, the RDCC wishes to explore the evidence-based practice of "brief intervention" as another way to reduce waiting lists. Research shows that brief intervention may be all that some clients need.
- **Create an education and training plan:** The new comprehensive screening process and the integration of evidence-based practices into the service delivery system will require an education and training plan. An education committee will be appointed to develop such a plan. The ATR grant provides for hiring of a best practices coordinator.
- **Provide care coordination:** Care coordination has worked well in other service delivery systems and will be an enhancement to the redesigned AODA system, funded in part by the ATR grant. The care coordination model to be used is actually adapted from Milwaukee County's Wraparound Program for Youth. A central tenet of this Wraparound approach is the role of Care Coordinator, which involves actively coordinating the process of service planning and delivery, as well as the traditional case management function of helping the client to access services.
- **Use reauthorization process to enhance continuity of care:** The process of reauthorization provides an opportunity for individualized care plans to be reviewed at prescribed intervals and for decisions to be made regarding continuation at the same level of care or movement to a different level.

C. Management Information Systems

Issues Related to Management Information Systems

The AODA system is outdated and is now on a separate information system platform (SCRIPTS) from the mental health data system. The SCRIPTS system is inadequate to provide information needed to manage the system. Its ad hoc reporting capability and ability to interface is limited.

Blueprint for Change

BHD staff had already decided to develop a new information system to replace the current SCRIPTS system. This project, called the AODA Replatform Project, is paralleling the AODA redesign. The new system will:

- Employ the same software (CMHC/MIS) currently being used in the mental health system;
- Better support the business rules and processes of the AODA delivery system, including client intake and assessment, wait list processing, eligibility/verification, claims activities, HIPAA[1] requirements, and state reporting requirements.
- Pave the way for future integration of mental health and substance abuse services.

[1] HIPAA stands for the *Health Insurance Portability and Accountability Act*, which became effective in April 2003, the first-ever federal privacy standards to protect patients' medical records and other health information provided to health plans, doctors, hospitals and other health care providers.

D. Evaluation

Issues Related to Evaluation
Evaluation is currently limited to some quality assurance mechanisms, e.g. billing audits, compliance with certification standards. There is a need for development of:

- Performance measures for the system and programs;
- Process and program objectives;
- Program outcomes;
- Outcomes attained by consumers.

Blueprint for Change

Create an evaluation plan:

This plan will contain the following elements:
- Purposes/priorities for AODA evaluation activities;
- Evaluation research questions to be answered;
- The level of measurement desired;
- Financial and personnel resources needed;
- Information system capability to support evaluation;
- Specific goals and objectives to be evaluated for identified AODA programs and services.

E. Mental Health/AODA Integration

Ultimately, all BHD contract management, service delivery, data management, quality assurance and evaluation functions must be integrated. To accomplish this, the following steps will be taken:

- Co-locate AODA and mental health staff (already accomplished).
- Integrate mental health/AODA functions, e.g. management of clients in residential services.
- Establish one quality assurance and performance review process. Add one Quality Assurance Specialist position.
- Integrate data management. Add position of Applications Manager to collect data from providers and issue reports to service system managers.
- Add Contract Services Coordinator position to manage financial resources of the integrated behavioral health community service system.
- Add two Administrative Coordinator positions for care authorization and re-authorization.