Resources for Recovery: State Practices that Expand Treatment Opportunities
An RWJF national program

SUMMARY

*Resources for Recovery: State Practices that Expand Treatment Opportunities* was a national program of the Robert Wood Johnson Foundation (RWJF) designed to help states expand their substance abuse treatment systems through more efficient use of existing resources and funding streams. The program ran from mid-July 2002 to mid-December 2006.

Teams in 15 states analyzed how treatment in their states was financed, administered and delivered and identified strategies to use current resources to purchase more and better services. The program awarded grants to implement improvement strategies to five of the states, and supplied technical assistance to the remaining 10.

Maximizing use of Medicaid—and federal Medicaid reimbursement dollars—to cover substance abuse treatment was a key focus of the program.

**Key Results**

The program staff reported the following to RWJF at the program's conclusion (see Overall Program Results for more details):

- Alabama, Florida and Nebraska-three grant states that focused on enhanced Medicaid reimbursement-increased funding for substance abuse treatment by a total of $5.6 million in the first year of their *Resources for Recovery* projects.

- States that increased their substance abuse treatment funding used the additional funding to purchase evidence-based services or practices considered promising.

- State agencies that had little or no historical relationships developed important collaborations to share financial and staff resources.

- The length of the program was not sufficient to identify appreciable changes in access to services.
Funding and Management

The RWJF Board of Trustees authorized the program in July 2002 for up to $3 million as part of RWJF's new emphasis on improving the quality of addiction treatment.

The Technical Assistance Collaborative, a nonprofit Boston-based consulting firm, managed the program and provided technical assistance to the state teams.

THE PROBLEM

In 2001, the nation's system for treating alcohol and other drug abuse was not keeping pace with the need for treatment services. Data from a federal Substance Abuse and Mental Health Services Administration (SAMHSA) survey that year showed:

- An estimated 16.6 million Americans aged 12 and up (7.3% of the population) either abused or were dependent on alcohol, illicit drugs or both—up from 14.5 million (6.5%) the previous year (a 14.5% increase).

- The number of individuals aged 12 and up who needed treatment for illicit drug use increased to an estimated 6.1 million from 4.7 million the year before (a 29.8% increase).

- Although the number of people receiving treatment for drug problems at a specialty facility increased from an estimated 800,000 in 2000 to 1.1 million in 2001, the number needing but not getting treatment also increased—from an estimated 3.9 million to 5 million (a 28.2% increase).

The Role of the States in Substance Abuse Treatment

Substance abuse treatment funding comes largely from public sources. In 2001, federal, state and local governments accounted for 76 percent of all treatment expenditures, according to a SAMHSA report (National Expenditures for Mental Health Services and Substance Abuse Treatment 1991–2001).

Management of these public treatment dollars rests principally with the states. From 2001 through 2006, when the authorization expired, the states received and distributed federal money from their Substance Abuse Prevention and Treatment Block Grants. Allocated by SAMHSA according to a formula set by Congress, the block grant was the states' major source of substance abuse treatment funding during the years of the program.

The states, in cooperation with the Centers for Medicare & Medicaid Services (CMS) also administer Medicaid, another source of substance abuse treatment dollars. In addition, all states receive state general revenue funds for treatment and prevention services. Various targeted grant programs of SAMHSA, the Department of Justice and other federal agencies also aid state efforts.
As the key manager of substance abuse treatment expenditures, the states were well aware of the treatment gap. For example, Oregon's substance abuse treatment agency estimated in a 2003 report to RWJF that only 16 percent of 405,000 state residents who needed treatment received it in fiscal year 2001–2002.

Closing the gap, however, was not easy. The states faced tightening fiscal restraints and had few, if any, new money sources to tap for substance abuse treatment.

Also, in many states, bureaucratic fragmentation and redundant administrative systems impeded cohesive, efficient purchasing of treatment services.

"Sharing between state agencies is awfully hard," says Eric Persky, an addiction services official in Connecticut. In fact, Connecticut offers an example of one of the key problems that the program addressed: multiple purchasing systems. See Appendix 1 for more information.

**Medicaid and Substance Abuse Treatment**

The joint federal-state Medicaid health insurance program permits coverage of certain substance abuse treatments for people eligible for Medicaid and thus provides states a potential strategy for reducing the substance abuse treatment gap.

For every Medicaid dollar a state spends, the federal government reimburses that state at least 50 cents and potentially as much as 83 cents. A formula based on state per capita income determines the reimbursement rate, with lower income states getting a higher return. In 2005, for example, the federal government reimbursed Mississippi 77 cents on the dollar while California got the minimum 50 cents.

By shifting eligible substance abuse treatment expenditures to Medicaid, a state increases the number of Medicaid reimbursement dollars it gets from the federal government. That, in turn, can free up state treatment dollars that can be used to increase the number of people served and/or the range of treatment-related services offered.

Use of Medicaid for substance abuse treatment varies widely from state to state, however. A few states have been aggressive in leveraging federal Medicaid dollars for substance abuse treatment.

For example, by expanding the use of Medicaid outpatient benefits for substance abuse treatment and coordinating the state's Medicaid and non-Medicaid programs, Ohio increased its Medicaid substance abuse treatment resources from $2 million in 1992 to $43 million in 2002, according to researchers at the Center for Substance Abuse Research and Policy Studies at Oregon Health & Science University in 2003.
Barriers to Medicaid Use

Traditionally most states have not made significant use of Medicaid as a funding source for substance abuse treatment.

Typically in state bureaucracies, responsibility for substance abuse treatment and Medicaid rests with two agencies, often housed in different departments with different missions, procedures and leadership. As a result, communication and coordination can be difficult.

In addition, Medicaid entails more administrative and monitoring requirements than block grant funds. This accountability can make the program less appealing as a funding source—both to state purchasers and to the community health centers, private nonprofit groups and individual practitioners that provide treatment. It is not uncommon for state substance abuse treatment directors to decline to participate in Medicaid due to the enhanced administrative requirements and the scrutiny of a Medicaid audit.

In a 1999–2000 National Association of State Alcohol and Drug Abuse Directors (NASADAD) survey, Alabama ranked near the bottom of the states in per capita expenditures for substance abuse treatment and prevention. It encountered a number of these roadblocks. (NASADAD is a private, not-for-profit educational, scientific and informational organization located in Washington.)

Alabama's substance abuse and Medicaid agencies lacked a common information system able to interface with Medicaid eligibility files and track provider billings. "We didn't know what we had paid for," says Sarah Harkless, deputy director of the state's substance abuse treatment program.

CONTEXT

Reducing the personal, social and economic harm caused by substance abuse has been one of RWJF's goals through the 1990s and into the first decade of the new century. Through the 1990s, the Foundation's efforts in this area focused on preventing addiction, principally through initiatives to combat underage drinking and drug use, with a focus on alcohol abuse.

In 2001, following a presentation on the growing scientific knowledge of the neurobiology of addiction, the Board of Trustees decided to shift the grantmaking emphasis from preventing addiction to improving the quality of addiction treatment.

The first initiative in this new direction was Paths to Recovery: Changing the Process of Care for Substance Abuse Programs—a national program designed to increase access to treatment services by improving the quality and efficiency of the delivery system at the provider level. Victor A. CAPoccia, PhD, former RWJF senior program officer,
characterized it as "an effort to increase the number of people admitted into treatment and the number who stayed in treatment."

Specifically, the program—authorized in 2001 for $9.5 million and scheduled to run through 2008—seeks to redesign treatment-related processes such as client assessment, intake, scheduling and outreach.

RWJF closely followed that program with an initiative to increase the capacity of the treatment system at the state level. In July 2002, the Board of Trustees authorized up to $3 million for what was subsequently named Resources for Recovery: State Practices that Expand Treatment Opportunities.

The strategy behind this program—the subject of this report—was to reduce the substance abuse treatment gap by helping states make better use of available resources and funding streams, principally Medicaid, which can include substance abuse treatment in its medical package as a "rehabilitation option."

PROGRAM DESIGN

The RWJF program staff designed Resources for Recovery to provide state personnel with tools to:

- Analyze their state's systems for financing and delivery of substance abuse treatment, with an eye toward supporting administrative efficiencies.
- Identify appropriate strategies to expand treatment capacity and options (using evidence-based practices) while maintaining current expenditure levels.

For formal statements of the program's mission and objectives, see Appendix 2.

Capoccia, the key RWJF program officer responsible for developing and overseeing Resources for Recovery, viewed expanded Medicaid utilization as the states' most promising strategy and the central focus of the program.

However, participating personnel were also to consider pursuing other approaches, including:

- Identifying opportunities to divert consumers from high-cost services to lower-cost alternatives and use the savings to expand services.
- Entering into collaborative purchasing arrangements with other agencies in the state that buy treatment services. In addition to the state Medicaid agency, these might include the state child welfare agency and criminal justice system.
- Increasing use of underutilized funding streams, such as the federally funded State Children's Health Insurance Program (CHIP) and Early and Periodic Screening,
**Diagnosis and Treatment** (EPSDT), a Medicaid preventive health care program for children.

- Systematically screening addicted persons for co-occurring medical and mental health conditions that would make them eligible for the federal **Supplemental Security Income** (SSI) benefits program for the disabled.

Personnel from the states selected for **Resources for Recovery** would learn from the national program staff, outside experts and each other through the program's various technical assistance components.

**Program Evolution**

Originally, the RWJF program staff planned **Resources for Recovery** as a $9-million initiative that would provide both grants and technical assistance to 20 states. As the plans approached Board approval, however, management reduced the budget to $3 million.

Following the September 11, 2001, terrorist attacks, the states were facing new security-related demands on their already-tight budgets. In that environment, there was skepticism within RWJF that enough states would be interested in altering their substance abuse treatment financing to justify a $9-million program.

To accommodate the reduced budget, staff redesigned the initiative to provide grants of up to $200,000 each to five of the 20 participating states and technical assistance alone to the other 15.

After the program's launch in 2002—in order to stay within funding limits—RWJF reduced the number of participating states to 15: 5 to get grants, 10 to receive technical assistance only.

Providing program participants, or state teams, with different levels of support is unusual for RWJF, although not unique to **Resources for Recovery**. **Partners in Caregiving**—a 4.5-year, $2.5-million program created in 1992 to assist adult day centers—provided funding to some participating centers and technical assistance only to others. The program staff found that the technical-assistance-only sites fared as well as those receiving grants plus a far less rigorous form of technical assistance.

The duration of **Resources for Recovery** also changed. Initially planned as a two-year initiative, RWJF extended the program an additional two years to give the participating states more time to complete their planned improvements.
THE PROGRAM

To manage *Resources for Recovery* and provide technical assistance to the participating states, RWJF established a national program office at the Technical Assistance Collaborative. This nonprofit, Boston-based consulting firm helps public and nonprofit agencies plan, implement and manage programs in the areas of housing, health and human services.

Initially Patrick Lanahan, JD, director of the Collaborative's Columbus, Ohio, office, served as program director. In spring 2004—about 18 months after *Resources for Recovery* began—Lanahan left the program. His replacement was John O'Brien, MA, a senior associate in the collaborative's Boston headquarters who had been assisting Lanahan.

O'Brien's background included positions with KPMG Peat Marwick's government service practice, the Eunice Kennedy Shriver Center for Mental Retardation and the Illinois Legislative Commission on Mental Health, Mental Retardation, Alcohol and Substance Abuse.

Under both Lanahan and O'Brien, the program deputy director was Alicia D. Smith, MPH, a senior program associate in the collaborative's Columbus office. She previously was a health care consultant and Ohio Medicaid agency employee.

To select the five grantees, help provide technical assistance and guide program policy, the national program office recruited eight experts from relevant fields to form an advisory committee. (See Appendix 3 for the membership.)

The Planning Phase

In July 2002, the Technical Assistance Collaborative received a four-month, $47,200 grant from RWJF (ID# 046101) to work with Foundation staff to plan the program's operational details, develop the process for selecting the participating states and draft the call for proposals.

The selection process had two parts: (1) selection of 15 states to participate in the program and (2) selection of five of the 15 to receive grants based on the quality of their improvement plans. (See Appendix 4 for a more detailed description of the selection process.)

Also during the planning period, the national program office subcontracted with Oregon Health & Science University to survey state alcohol and drug abuse agencies for examples of effective financing and management strategies.

Researchers from the Center for Substance Abuse Research and Policy Studies (a unit within Oregon Health & Science University) interviewed officials in 12 states and
assessed the treatment systems in 11 of the 12. The resulting report, issued in September 2003 and titled *Enhancing Resources for Recovery: Strategies and Examples*, became a primary technical assistance tool for the program's state teams. It is available online. See the Bibliography for details.

**Center for Health Care Strategies**

At RWJF's request, the national program office subcontracted with the Center for Health Care Strategies to develop a curriculum for a three-day meeting—termed the *Resources for Recovery* Purchasing Institute—to kick off the program's technical assistance efforts. (See The Implementation Phase.)

At the time, the Center for Health Care Strategies, a nonprofit organization in Hamilton, N.J., directed RWJF's *Medicaid Managed Care Program*, an initiative to increase the capacity of state Medicaid agencies to promote quality health care. Because of its Medicaid expertise, the RWJF program staff wanted to involve the center in *Resources for Recovery*.

Staff of the center also participated in selection of the program's participating states and in other facets of the program.

**The Implementation Phase**

In October 2002, the Technical Assistance Collaborative received a $2-million RWJF grant (ID# 046972) to implement and direct the program. In January 2003, it issued a call for proposals for states wishing to participate.

In the midst of—or rather in the face of—mounting concern by virtually all the states over anticipated increases in Medicaid expenditures, twenty-four states applied. In June 2003, program staff selected 15 states for participation:

- Alabama
- Connecticut
- Florida
- Kentucky
- Louisiana
- Massachusetts
- Michigan
- Montana
- Nebraska
- New Jersey
- North Carolina
- Oregon
- Texas
- Washington
- Wyoming

In September 2003 teams of up to five officials from each state attended the program's Purchasing Institute in Scottsdale, Ariz. Staff from the Center for Health Care Strategies, the national program office at the Technical Assistance Collaborative, advisory committee members and consultants served as faculty, making presentations and
moderating discussions on strategies to improve state substance abuse treatment systems. Program funds covered the states' meeting-related expenses.

Near the end of the three-day meeting, each state team finalized an action plan identifying strategies that they proposed to follow to increase the efficiency, coverage and quality of substance abuse treatment and services.

Based on the quality of the plans, the advisory committee selected five states to recommend for RWJF grants. (One of the five, Washington, declined the funding, citing demands of a larger SAMHSA grant awarded about the same time. The sixth state in the committee's ranking replaced Washington.)

Thus, in late 2003, RWJF awarded "planning and analysis" grants of approximately $200,000 each to Alabama, Connecticut, Florida, Nebraska and Wyoming. The grants' original duration was 18 months, but RWJF extended four of the five grants some additional months. See Appendix 5 for grant details and a list of the state agencies receiving only technical assistance.

**Activities: National Program Office**

To assist the teams in both grant and non-grant states, the national program staff:

- Identified and addressed state-specific technical assistance needs. Staff conducted site visits and maintained contact with individuals at participating state agencies through telephone calls, e-mail exchanges and a password-protected section of the program website.

- Monitored the states' progress-initially through written reports submitted quarterly by the lead agencies in states. Concluding that the value of the reports had decreased, O'Brien substituted regular conference calls in the second year of the states' work.

- Facilitated peer-to-peer consultations and communications to encourage the exchange of information between the participating teams. For example, the program office arranged for a North Carolina delegation to visit Louisiana to help that state's team develop service definitions and eligibility criteria.

- Implemented a series of educational webcasts/teleconferences on six technical topics. Each topic involved multiple sessions. Consultants and staff of the national program office and of the Center for Health Care Strategies conducted the sessions—which began in January 2004—giving individual assistance to state teams. See Appendix 6 for the list of webcast topics.

- Conducted two meetings for participating state personnel in addition to the initial Purchasing Institute:
  - A two-day session in December 2004 in Atlanta to provide targeted technical assistance to teams from four program states—Alabama, Louisiana, North
North Carolina and Wyoming—that requested additional help. Individuals from two other site teams that program staff deemed successful in their action plans—Connecticut and Florida—also attended to share their experience.

— A two-day session in February 2006 in Phoenix that focused on lessons learned by participants in both Resources for Recovery and its sister RWJF program, Paths to Recovery. The agenda of that session also focused on RWJF’s plans for a successor program—Advancing Recovery: State and Provider Partnerships for Quality Addiction Care. (See Afterward for more about this new program.)

This Phoenix session—entitled Moving from Knowledge to Practice: Effective Strategies for Purchasing and Implementing AOD Services—drew representatives from 32 states, including some that did not participate in either Resources for Recovery or Paths to Recovery. ("AOD" stands for "alcohol and other drugs.")

RWJF supported the additional attendance with a one-year, $99,830 grant (ID# 056340) awarded to the Technical Assistance Collaborative in December 2005. The grant—from an RWJF authorization providing small supplemental grants for select projects and programs to enhance their impact and effectiveness as they close—also helped support the Resources for Recovery evaluation. (See Evaluation.)

Expenditures in Non-Grant States

During Resources for Recovery, the national program office spent $201,000 on technical assistance for the 10 non-grant states—or an average of about $20,000 per state—according to O’Brien. The money went principally for consultants and travel expenses. The dollar totals did not include program office staff time.

Expenditures in Grant States

Generally, the grant states purchased their own consulting services using the RWJF funds. For example:

- Florida, for example, contracted with the Florida Mental Health Institute of Tampa, Fla., a research library, for data analyses and management.
- Nebraska contracted for collection and analysis of needs assessment data and for training staff in new protocols of client screening and assessment.

The national program staff also spent significant time advising and visiting the grant-state teams. For example:

- The national staff helped establish design requirements for Alabama’s new information system and supplied RFPs (Request for Proposals) from similar projects in other participating states to serve as models.
State Activities

The national program office considered the strategies pursued by the state teams as falling in four broad categories:

- Enhancing Medicaid coverage of substance abuse treatment.
- Developing infrastructure to increase Medicaid billings for services.
- Pursuing joint purchasing of services by different users.
- Redirecting revenues toward substance abuse treatment.

The states' substance abuse treatment systems differed markedly in structure, funding, provider relationships and client characteristics. As a result, the specific strategies and activities of the states differed considerably, as did the outcomes.

Many states pursued multiple strategies. Specific strategies pursued by state teams included:

- Creating formal partnerships.
- Conducting needs assessments/gap analysis (of gaps in substance abuse treatment and services).
- Exploring funding opportunities for substance use disorder services.
- Identifying and developing evaluation/assessment protocols to better identify individual service needs.
- Consolidating purchasing or contracting arrangements.
- Creating administrative efficiencies.
- Redesigning programs and services.

According to the evaluator, the disparate strategies had two things in common:

- Most of them depended on substantial cross-agency collaborations and cooperation. In many cases, they involved close working relationships between the state's substance abuse treatment agency and its Medicaid agency.
- None of the strategies involved a commitment of substantial new state resources. Instead, given the economic constraints present in all of the states, they were designed to do more with existing resources.

In the program evaluation report, the evaluator gave a number of examples of activities by state teams pursuing these strategies. See Appendix 7 for examples of these strategies.
The makeup of the project team varied from state to state. In addition to the state's lead substance abuse treatment agency—usually part of a larger department—and the state's Medicaid agency, the partnering participants might include staff from other state agencies.

Non-governmental organizations also participated in some states. Florida's project, for example, included the Central Florida Behavioral Health Network, a nonprofit provider network, and the Florida Association of Counties.

**Communications**

With the assistance of an Ohio-based consultant, Edward Howard & Co., the national program office created a program website. The site, which went online in November 2002, provided public information on the program, including the strategies pursued by state teams. See the Bibliography for a fuller description of the site's contents.

The website also included a password-protected section for discussion of technical issues by individuals on the state teams, program staff and consultants. The Technical Assistance Collaborative continued the website after the program ended.

In addition, the national staff:

- Used a variety of communications methods—electronic mail, postcards, teleconferences and news releases—to encourage states to apply to participate in the program.

- Produced and disseminated four short monographs on technical issues related to substance abuse treatment delivery. The staff intended these "briefs" as educational tools for use by substance abuse treatment and Medicaid agencies across the country. (See the National Program Office Bibliography for the titles.)

- Published a bimonthly newsletter online and distributed it, primarily, to national, state and local purchasers of substance abuse treatment services and to others. The newsletter, published between early 2004 and mid-2005, detailed activities in the participating states. The national staff also disseminated a March 2005 report by the Human Services Research Institute on the interim results of the evaluation of the program. (See Evaluation and Evaluation Bibliography.)

- Disseminated program materials through organizations interested in substance abuse issues, including the National Association of State Alcohol and Drug Abuse Directors, State Association of Addiction Services, National Association of State Medicaid Directors and the National Council for Community Behavioral Healthcare. See the National Program Office Bibliography and the Evaluation Bibliography.
• Made presentations on the program to 12 national organizations and agencies, including SAMHSA, the federal Centers for Medicare & Medicaid Services and the National Academy for State Health Policy, an independent academy of state health policy-makers.

Alcoholism & Drug Abuse Weekly, an independent publication for workers in the field, published two articles on Resources for Recovery during its startup years.

Evaluation

The national program office subcontracted with the Human Services Research Institute—a nonprofit organization in Cambridge, Mass.—to conduct interim and final evaluations of the program. Virginia Mulkern, PhD, senior vice president, directed the work.

For the interim evaluation, Mulkern reviewed program documents, interviewed national program staff and state teams and in March 2005 issued a two-part, 44-page report that:

• Summarized the strategies of teams from the participating states and identified factors generally facilitating and impeding implementation.

• Described the specific program activities undertaken in each of the states and the barriers encountered.

For the final evaluation, Mulkern conducted additional telephone interviews with the state teams and also made site visits to Alabama, Connecticut and Florida.

Because of the outcomes achieved by teams at these three states, RWJF and national program staff asked Mulkern to gather more detailed information on the strategies they employed.

The $99,830 grant (ID# 056340) awarded to the Technical Assistance Collaborative in December 2005 supported this additional work.

The final evaluation report issued in October 2006, Final Evaluation: Resources for Recovery: Practices that Expand Treatment Resources, followed a format similar to that of the interim report but with more in-depth analyses of the individual state's teams—their efforts, accomplishments and difficulties. More than a third of the report's 58 pages focused on the Alabama, Connecticut and Florida projects.

For a summary of the report's conclusions and findings, including factors that the evaluator suggests inhibited or facilitated state teams' success, see Evaluation Findings. Additional inhibiting factors from the point of view of the program staff also appear in Challenges. For more on individual state activities see Results: Grant States and Results: Non-Grant States.
Factors Favoring Positive Results at the State Level

By contrast, national program office staff members cite a number of circumstances and factors favoring positive results for some state teams. These included:

- High-level leadership and support for program goals.
- Willingness to change information and administrative systems where needed.
- Inclusion of providers in the design and implementation phase of state action plan.
- Good working relationships among partner organizations prior to the project's start.
- Staff time dedicated to the project.
- Objectives focused and limited in scope.
- Availability of specialized technical assistance focused on issues that would be difficult for staff members to master on their own.

For more on factors challenging or facilitating success of state teams see Evaluation Findings.

Challenges

As cited in a 2005 report to RWJF and a 2006 interview with O'Brien, the program director, the national staff noted a number of challenges facing state teams:

- The inability of some teams to become a cohesive group and reach consensus on implementation of an improvement plan. The national program staff cited this as the largest challenge facing state teams.

- Staff turnover in participating state agencies. At least two non-grant state teams dissolved due to staff turnover combined with a lack of interest among the substance abuse treatment and Medicaid directors, the national staff reported.

- State budget constraints. Several state teams noted "severe fiscal constraints" that significantly reduced their options in expanding access to substance abuse treatment services.

- Inadequate agency staffing. In some states, inadequate staffing, often the result of departmental budget cuts, impeded team progress in expanding access to treatment and services.

- Inadequate information systems. In several states this resulted in a lot of time spent by teams attempting to gather baseline data on service use, costs and expenditures.

- Lack of state staff knowledge about financing in general and Medicaid in particular. This lack of knowledge occurred in some states and not in others.
- "Organizational silos," which made it difficult in some states for team staff to interact with individuals working for other agencies. In some instances, there was no history at all of a working relationship between partnering state agencies. In other instances, there were mistrustful or bad prior relationships between agencies.

- **Significant provider resistance to reform in reporting and billing practices.** In at least three states, this slowed the planned change due to inadequate planning and information to assist providers with implementation.

- **The placing of a higher priority on internally generated initiatives than the Resources for Recovery efforts.** This occurred in some states, delaying implementation of teams' planned improvements.

- **Action plans based on an expectation—which proved false—that there would be program monies to fund staff assigned to action plan work.**

- **Contracting requirements, which in some states delayed procurement of necessary technical assistance.** In Alabama, to circumvent the state's potentially lengthy contracting process, the national program office purchased consulting services for use by the Alabama team. (See Appendix 5 for details on RWJF's grantmaking related to this situation.)

**RESULTS: GRANT STATES**

Results come from reports from the state projects to RWJF, interviews with project directors, the national program office's reports and the evaluator.

The following three states—Alabama, Connecticut and Florida—had project outcomes the national program office staff considered "highly successful."

**Alabama**

**The Problem**

In a 1999–2000 National Association of State Alcohol and Drug Abuse Directors survey, Alabama ranked near the bottom of the states in per capita spending on substance abuse treatment and prevention. Significant budget deficits made any new funding unlikely. Medicaid reimbursed only 9 percent of services.

As Resources for Recovery work in the state commenced, Alabama's information system had insufficient capacity to support treatment monitoring, planning and management activities. In the state, too, staff turnover and the establishment of baseline data for Resources for Recovery work took valuable time from the project.

"We had needs all over the place, and no one was offering any more money," says Sarah Harkless, executive assistant to the associate commissioner for substance abuse (and in
effect the deputy director of the state's substance abuse treatment program), and director of the state's Resources for Recovery team.

Activities

The team worked to maximize the state's Medicaid reimbursement and to establish formal collaborative relationships among all of the state agencies that purchase substance abuse services.

A major focus was development of a Web-based management information system with a unique client identifier and the capacity to handle a range of data:

- Client assessment, admission and discharge data.
- Claims adjudication.
- Payment information.
- Federal and state reporting requirements.

See Appendix 7, #5, for efforts on the part of national program staff to expedite contracting for this work.

Alabama's team secured a $500,000 commitment from the commissioner of mental health and mental retardation to support development of this new information system. The federal Center for Substance Abuse and Mental Health Services supplied an additional $86,000 toward the work.

Among its efforts, the team initiated regulatory changes to expand the number of services eligible for Medicaid reimbursement as well as the number of providers eligible to participate in Medicaid.

Results

The following were among Alabama's results:

- **Formal establishment of the Alabama Commission for the Prevention and Treatment of Substance Abuse as a vehicle to sustain cross-agency collaboration.** The commission included representatives from the Office of the State Attorney General and the three state departments governing areas of mental health, corrections and children's affairs.

- **Design of its new behavioral health management information system.** The team initially expected the system to be operational in October 2006, but delays moved the projected launch date to April 2007.

- **The Alabama substance abuse team developed specifications for an information system that will require substance abuse treatment providers to submit claims**
for services rendered and enable the state to draw down additional Medicaid funds for eligible populations.

- **Removal of barriers to Medicaid optimization, through championing regulatory change, the establishment of new billing procedures and persuasion directed at treatment providers.** In fiscal year 2005, Alabama's federal Medicaid dollars increased by 60 percent over the 2002 baseline year. That was short of the project goal—a 100 percent increase—but represented significant progress nevertheless, the evaluation report said.

- **Development and implementation of new client screening protocols and the drafting of a new client assessment protocol.**

"The most difficult part was just trying to change the culture of our department," Harkless says.

Also, the new information system—which will alter the billing process of providers now making Medicaid claims—drew strong protests from the provider community.

Alabama's reform effort—including educating providers on the new Medicaid regulations—continued after the conclusion of Resources for Recovery in 2006. "This project really hasn't ended. It provides the foundation for what we're doing," said Harkless.

**Connecticut**

**The Problem**

Connecticut government historically has opposed expansion of its Medicaid plan. Consequently, the state's Resources for Recovery team decided to focus on another objective: streamlining the state's redundant procurement system for substance abuse treatment—which the state had taken preliminary steps already to address.

The problem for Connecticut was that—for the same providers—the state paid different rates of compensation, and held to different performance requirements and monitoring procedures. In this, Connecticut offers an example of one of the key problems that the Resources for Recovery program addressed. Learn more about this problem in Appendix 1.

The state, like several others in the program, lacked sufficient capacity in its information system, requiring the project team to spend a great deal of time establishing baseline data for its work.

"We said let's see if we can reduce the administrative burden [of substance abuse treatment services] and use the efficiencies to expand the number of people being
serviced," said Eric Persky, the addiction services official who managed the state's project.

**Activities**

At the team's urging the state established a cross-agency steering committee to direct this effort. In addition to the Department of Mental Health and Addiction Services, which is Connecticut's lead agency for substance abuse treatment for adults, the committee included representatives of the following:

- Department of Correction.
- Department of Children and Families.
- Court Support Services Division of the Judicial Branch.

The proposed collaboration also involved representatives of organizations providing treatment services to the state agencies.

Through this structure, Connecticut's team developed two pilot purchasing initiatives:

- The first focused on creating pooled funding and a common contract for adult residential treatment services used by three agencies: Mental Health and Addiction Services, Correction and Court Support Services.
- The second developed common contract terms and procedures for use by two agencies—the Department of Children and Families and Court Support Services—in the purchase of treatment services for youth called Multisystemic Therapy.

The Connecticut team, like Alabama's, encountered strenuous provider resistance to these planned changes, which affected provider funding and billing.

**Results**

The following were among Connecticut's results cited by the evaluator:

- **Implementation of an inter-agency memorandum of understanding (MOU) permitting pooled funding for adult residential substance abuse treatment.** Some 10 providers participated in this collaborative purchasing.

  Persky explains that under the plan, the state's departments of Correction and Court Support Services funneled their contract funding to the Department of Mental Health and Addiction Services, which pays the providers and provides clinical oversight of the contract.

- **The writing of a collaborative contract for adult residential services for use by three state agencies.** The contract specifies a set of performance metrics, including both process measures and outcome measures for individual clients.
Even with a common contract, the three agencies still paid different rates. Nevertheless, the arrangement facilitated coordinated use of provider beds and reduced contracting and monitoring burdens, Persky said.

- **The establishment of collaborative contracting arrangements for monitoring the quality of Multisystemic Therapy services used by youth in the state.** For the youth services using Multisystemic Therapy, Persky adds, "We've concentrated so far on implementing efficiencies and can't yet say that translates to additional people served. For youth the state can serve 300400 kids."

Unlike the arrangement for adult residential treatment, the Department of Children and Families and Court Support Services continued to use separate contracts for certain of these services. Nevertheless, common contract language reduced the burden on providers, Persky said.

- **In its common contract work for adult residential treatment the state proposed to move from "blended funding" (different provider rates paid for the same work, but under one contract), to "normalized funding" (a common rate paid to providers).** According to Persky in a November 2006 interview, "We hope to have normalized funding in place by July 2007."

- **Overall, according to Persky, the collaborative arrangement in adult services permitted an increase in the number of people served.** However, the state has no measurement data, he says.

The collaboration continued after *Resources for Recovery* concluded. The agencies were working together to develop a common payment rate for adult residential services, according to Persky in November 2006.

**Florida**

**The Problem**

Compared to other states, at the beginning of *Resources for Recovery*, Florida had a low rate of Medicaid use for substance abuse treatment—less than $10 million annually. Medicaid billings represented less than 5 percent of total revenue for local substance abuse treatment agencies.

A number of factors contributed to this, including the preference of providers for the higher reimbursement rates and more familiar reporting and contracting requirements associated with federal block grant and state general revenue funding.

**Activities**

As part of a comprehensive strategy to improve Florida’s substance abuse treatment system, the state's Agency for Health Care Administration, its Medicaid agency, led a multi-pronged effort to increase access to services under Medicaid.
Activities by the agency and its partner organizations in and out of the state government included:

- Conducting an analysis of Medicaid billing data to create a baseline for substance abuse treatment claims.

- Revising regulations to expand the definition of mental health services to include certain new substance abuse treatment services and to expand the range of eligible providers.

- Obtaining authorization to develop an amendment to the state Medicaid plan to permit its coverage of additional substance abuse treatment services.

- Conducting treatment provider outreach and education to increase the number of providers enrolled in Medicaid.

- Obtaining permission from the Florida legislature to use local funds as a match for federal Medicaid dollars. 

  (Resources for Recovery national program office staff arranged for Ohio agency personnel with experience in local Medicaid matching to visit and advise the Florida team on this.)

**Results**

Florida's Agency for Health Care Administration reported the following to RWJF in September 2005:

- **Statewide, Medicaid substance abuse treatment earnings by providers increased 9.82 percent in fiscal year 2003 (July 2003–June 2004) compared to the 2002 baseline year—significantly above the 5 percent goal set for the project.** Earnings increased another 23.5 percent between fiscal 2004 and fiscal 2005.

- **In two fiscal years, 2003 and 2004, in a multicounty pilot region (the Suncoast Region—on Florida's west coast), Medicaid earnings increased 30 percent above the 2002 baseline.** In the first fiscal year (2003), the earnings only increased 7.5 percent, not reaching the 10 percent goal set for the region. However, during the next fiscal year (2004), the Suncoast region's Medicaid earnings increased to 30 percent above baseline (or 22.5 percent above the 2002 baseline in that one year), according to data subsequently provided by the state.

- **During the project period, the agency enrolled 11 new Medicaid substance abuse treatment providers.** Provider recruitment efforts by the state Substance Abuse Program Office and the Florida Alcohol and Drug Abuse Association remained ongoing after the program ended in 2006.

- **Florida's team increased access and treatment capacity with an expanded Medicaid benefits package and increased utilization of Medicaid funds.**
expanded benefits package included a community service ("ambulatory detoxification") alternative, comprehensive community support services for substance use disorders and alcohol and/or drug intervention services.

- **The team decreased the wait time for residential services through implementation of the community services alternative.**

- **The team initiated a local match certification program to allow counties to draw down Medicaid dollars.** This had the added benefit of increasing the collaboration of the state Medicaid agency with counties.

Although formal meetings of Florida's collaborating organizations ended with the conclusion of *Resources for Recovery*, the collaborative effort itself continued, according to Darcy Abbott, M.S.W., of the Florida Agency for Health Care Administration, in late 2006.

Abbott said a major focus was implementation of the plan to use county tax revenue and other local funds to help provide the state Medicaid match.

The move, which still had to be approved by the federal Centers for Medicare & Medicaid Services, would definitely increase the range of available substance abuse treatment services, Abbott said.

**RESULTS: NON-GRANT STATES**

These non-grant states—Michigan, North Carolina and Oregon—represent a range of program experiences among the state teams receiving only technical assistance.

**Michigan**

**The Problem**

Michigan's substance abuse treatment system was highly segmented, with multiple funding streams, contracting procedures and audit requirements:

- The Office of Drug Control Policy in the Department of Community Health administered treatment services through 16 regional organizations, called coordinating agencies. The coordinating agencies contracted with some 300 local providers.

- The Department of Corrections purchased treatment services for people coming out of prisons and those in jail-diversion programs. The department at one time got its substance abuse treatment money from the Michigan Department of Community Health, but in the 1980s, dissatisfaction with the arrangement led to separate funding by the legislature.
Drug courts—special dockets designed to rehabilitate nonviolent substance-abusing offenders instead of sending them to prison—also bought treatment services. The drug courts received treatment dollars from the Department of Community Health.

Through *Resources for Recovery*, Michigan officials hoped to reduce the system's redundancies and invest any savings in increased treatment capacity—an increase needed after 15 years of flat budgets.

"In no way has substance abuse [treatment] funding kept pace with inflation," said Mark Steinberg, manager of treatment contracts in the Michigan Office of Drug Control Policy, in a November 2006 interview.

**Activities**

The main objective of Michigan's *Resources for Recovery* team was to implement a pilot program that would pool substance abuse treatment funding from the departments of Community Health and Corrections and standardize some of the two departments' contracting and monitoring functions.

Representatives of the two departments, the coordinating agencies and the major providers formed a committee to guide the effort. The committee analyzed the practices and procedures of the two departments and identified differences in case management, client supervision and, more broadly, organization culture.

The team also convened a meeting of the coordinating agencies, provider representatives and state staff to explore differences in the way this meeting's participants viewed the mission of the state's substance abuse treatment system.

**Results**

The evaluator and state project staff reported:

- **The two departments (Corrections and Community Health) signed a memorandum of understanding on purchasing, although they were not able to implement collaborative funding and contracting practice.**

  The election of a new governor and resulting changes in department leadership and focus were factors, says Steinberg, who directed the project.

  Nevertheless, Michigan's *Resources for Recovery* team made administrative redundancy a higher priority issue for participants in the state's treatment system, according to Steinberg.

- **As a result of the meetings and discussions, officials began to look for and address redundancies, Steinberg said. "Once you start looking at them, you see them."**
Steinberg said these specific steps in addressing redundancies were attributable to *Resources for Recovery*:

— The coordinating agencies reduced variation in the monitoring requirements they placed on provider organizations and agreed to hire a consultant to develop a master contract for providers.

— The Department of Community Health instituted new budgeting and financial reporting practices that gave the coordinating agencies more flexibility and reduce the frequency and length of their reports to the department.

- "For me, the main benefit of the program is that it changed the conversation and perspective of the people who participated in it," said Steinberg in November 2006.

In addition to their own effort, Michigan officials advised *Resources for Recovery* teams in other states on Medicaid issues.

Michigan officials also participated with national program staff in a presentation of *Resources for Recovery* issues at the federal Centers for Medicare & Medicaid Services, according to O'Brien, *Resources for Recovery* program director.

**North Carolina**

**The Problem**

The North Carolina Department of Health and Human Services—which includes the state's Medicaid and substance abuse treatment programs—was already working to integrate the two programs when the *Resources for Recovery* project in the state got underway.

However, substance abuse treatment services provided separately by the Department of Juvenile Justice and Delinquency Prevention were not part of the state Medicaid plan. Instead, that department used state dollars to pay for treatment of children in the juvenile justice system.

Department of Juvenile Justice officials—as well as outside critics—believed that the level of substance abuse treatment services in the department was inadequate. In fact, judges involved in juvenile justice in the state had taken the Department of Juvenile Justice and Delinquency Prevention to court over this issue of juveniles' access to services, according to the *Resources for Recovery* program evaluation.
Activities

The state's Resources for Recovery project team sought to use Medicaid to expand substance abuse treatment for youth in the juvenile justice system. The secretaries of the two North Carolina departments—Health and Human Services and Juvenile Justice and Delinquency Prevention—committed publicly to achieve that objective.

Medicaid cannot be used for substance abuse treatment services for individuals in institutions. For that reason, the team's strategy was to use Medicaid dollars to pay only for community services provided to children by the Department of Juvenile Justice and Delinquency Prevention.

That would free up state revenues that the department would then use to expand services to youth in institutions.

Team members from the two departments—with assistance from the national program staff—agreed on a collaborative plan to assess and plan for the treatment of children who entered the juvenile justice system with substance abuse issues. They also made plans to pilot the community services strategy in one North Carolina county.

Results

National program and state staff said in November 2006 interviews:

- **The two departments did not implement collaborative purchasing.** After a year of planning, officials from North Carolina's Department of Juvenile Justice and Delinquency Prevention declined to make use of Medicaid dollars after all, says Flo Stein, the state's health and human services official who directed the Resources for Recovery effort there.

  A key reason was the large impact that a switch to Medicaid would have had on department budgeting, provider payments and other business practices, says Stein.

  Also, some community providers would not have been eligible for Medicaid participation [due, for example, to their small staff size], says Stein, who is also chief of community policy management in her department's Division of Mental Health, Developmental Disabilities and Substance Abuse Services.

- **However, as a result of Resources for Recovery, the North Carolina's Department of Health and Human Services did increase its own effort to provide substance abuse treatment services to children in the juvenile justice system, according to Stein.**

  "Even though we didn't end up where we said we would, it [Resources for Recovery] actually helped us quite a bit," she says.
The project, for example, was a factor in the department's decision to include Multisystemic Therapy in the overall expansion of its Medicaid-covered services, she says.

- **Approximately 78 percent of the youngsters in the state's juvenile justice system were now receiving Medicaid-covered substance abuse treatment services through the North Carolina Department of Health and Human Services, according to Stern in a November 2006 interview.**

As part of *Resources for Recovery*, the national staff arranged for North Carolina officials to visit Louisiana and advise that state's project team on Medicaid expansion.

**Oregon**

### The Problem

Officials of Oregon's substance abuse treatment program—a part of the state's Department of Human Services—believed its treatment system was fragmented and failing to move clients effectively through residential treatment and into supportive outpatient transitional care.

In *Resources for Recovery*, they saw an opportunity to strengthen the continuum of treatment care and make the system more recovery oriented.

### Activities

Initially, Oregon's *Resources for Recovery* project team set out an ambitious agenda for enhancing pre-treatment, in-treatment and post-treatment recovery services and for strengthening linkages with community-based sources of support.

Subsequently—in 2003—the team, which included representatives of state and non-state participants in the treatment system, scaled back the project's scope and focused on several specific steps to enhance individuals' recovery.

Budget constraints, staff turnover and a departmental reorganization were factors in the decision to scale back, according to the national program evaluator.

With support from the national program office, a team of Oregon providers visited Tucson, Ariz., to observe an innovative program that integrated mental health services and substance abuse treatment.

On their return, the site visitors issued a written report of their observations with recommendations for improving dual-disorder services in Oregon.
Also with support from the national program office, substance abuse treatment expert Michael G. Boyle, president of Fayette Companies, a behavioral health management firm in Peoria, Ill., visited Oregon and met with state staff and provider representatives.

Boyle discussed recovery management practices, including adding substance abuse treatment case management to the state's Medicaid benefits package.

Also as part of the project, the project team promoted plans for a recovery-oriented model program in Multnomah County (greater Portland, Ore.) that would combine support services with drug-free housing.

**Results**

The evaluator and state project staff reported:

- **As a result of the Arizona trip, a provider in central Oregon initiated integrated mental health/substance abuse treatment for five adolescent residential beds.**

  Under the program, a managed care company agreed—for the benefit to juveniles occupying these five beds—to pay an enhanced rate to cover psychosocial support services delivered concurrently with substance abuse treatment.

- **Oregon funded additional adolescent substance abuse treatment beds via the Medicaid program and used the general revenue "savings" to pay for mental health services for patients with dual disorders.** This increased Medicaid-funded beds from 57 to 71 in the state.

  The idea stemmed from discussions at the 2003 *Resources for Recovery* Purchasing Institute, according to Karen Wheeler, M.A., director of the Oregon project and manager of addictions policy and program development in the Oregon Department of Human Services.

- **The state moved to make case management of substance abuse treatment clients a Medicaid-covered benefit.** Although not a deciding factor, Boyle's visit was helpful in bringing about that change, according to Wheeler.

  Case management is scheduled to become a billable service in Oregon under the Medicaid chemical-dependence benefits package in January 2008, she says.

- **Although funding issues prevented launch of the Multnomah County pilot as planned, according to the evaluation report, the county subsequently did obtain funding to implement the project, Wheeler said in 2006.**

In remarks in 2006 Wheeler noted that:

> [Resources for Recovery] was helpful but it didn't change our lives. It wasn't revolutionary for us. We [the Oregon team] participated in the program's cost offset work but... we had already accomplished a lot of that. We
probably would have done what we accomplished anyway-without the program. But we saw the program as a "launch" project-to see how much progress we could make. It helped make us accountable.

For information on non-grant states Nebraska and Wyoming, see Appendix 8.

OVERALL PROGRAM RESULTS

*Resources for Recovery* did not set specific measurable programwide goals, and the variation in state strategies and outcomes make generalizations about the overall impact difficult. However, the national program staff and the evaluator cited a number of overall program results and findings.

**Results Cited by the National Program Staff**

In a 2006 final report to RWJF, and in oral presentations and interviews conducted in 2006, the national program staff stated:

- **Alabama, Florida and Nebraska-three grant states that focused on enhanced Medicaid reimbursement**-increased funding for substance abuse treatment by a total of $5.6 million in the first year of their *Resources for Recovery* projects.

  Most of the increase came from the identification of other payers for treatment and services previously financed in part or solely by state general revenue funds, according to the final report to RWJF. In an interview, O'Brien said the increases were all Medicaid related—either replacing general revenue funds with Medicaid, or increasing Medicaid program participation in the states, for example increasing service coverage to Medicaid enrolled adults and youth through the Medicaid Rehabilitation Option.

  Second-year data for the three states were unavailable when this report was written. However, the program staff did report that second-year funding for substance abuse treatment was projected to increase by an additional 25 percent—to $7.1 million above baseline levels.

- **States that increased their substance abuse treatment funding used the additional money to purchase treatment services that "had been identified by national and federal organizations as evidence-based [that is, demonstrably effective] or considered promising practices"—as opposed to simply buying the same (and possibly less effective) services that they had been buying.**

  The new services included case management, medication management, community supports and aftercare, community service [or "ambulatory detoxification"] and Multisystemic Therapy.

- **State teams established new or renewed formal collaborations among state purchasers that extended well past the states' grant timeframes.** A clear
demonstration of this occurred in Connecticut, which dealt successfully with multiple purchasers and the problems this engendered. See State Results: Grant States, Connecticut.

- **The length of the program was not sufficient to identify appreciable changes in individuals' access to services.**

While it can be assumed that the increased funding for substance abuse treatment permitted additional individuals to be served, information was not available to determine if in fact the number of people receiving services increased during the program.

The program staff had hoped to measure the systemwide change in treatment capacity. However, the states' lack of adequate baseline data on client numbers—due to duplicative data systems and minimal Medicaid data—precluded such a calculation, at least for the present, O'Brien said.

- **RWJF funds enabled the five grant states to achieve several of the goals they set out to achieve, according to the program office staff.** "Much of the improvement work is replicable and can serve as a model for other states," O'Brien said.

Goals and accomplishments of the state teams varied greatly. For a selection of states' accomplishments see Results: Grant States.

- **Among the non-grant states, the program varied in impact: some used the opportunity offered through the program better than others, according to O'Brien.** For more information see Results: Non-Grant States. Some non-grant states continued to pursue system improvements after the program ended, he added, citing Kentucky as an example.

There, during the program period significant staff turnover and a major agency reorganization impeded Kentucky's plan to maximize Medicaid funding for substance abuse treatment. However, later, following a leadership change in the bureaucracy, the state renewed the effort, according to O'Brien. For more on Kentucky's and other states' efforts at systems improvement see Appendix 7.

**Evaluation Findings**

The program's final evaluation report, submitted by the Human Services Research Institute to RWJF in October 2006, included the following findings:

- **As a group, the five states receiving funding from RWJF and technical assistance "made substantial progress in reforming their substance use disorder service systems with relatively small amounts of funding."**
Although generally successful, the five grant states did have "setbacks and difficulties." The evaluator cited several:

- All five states had "little tolerance for new expenditures," and this constrained the types of solutions the teams could pursue.

- Four of the five grant-state teams entered the program with insufficient data contained in their information systems, including the number of substance abuse clients served and the source of payment for different services. As a result, the teams had to spend significant startup time collecting and analyzing baseline data.

- Turnover among team members and key policy makers "created turbulence" for the efforts in Alabama, Nebraska and Wyoming. See Results: Grant States, Alabama and Appendix 8 for more information on Nebraska and Wyoming.

- Resistance to change among providers ("provider push-back") slowed progress.

- In Wyoming, provider resistance to proposed new billing practices and a statewide client identifier system contributed to the state's failure to implement a planned pilot information system. (Wyoming ended up returning a large portion of its grant money unused to RWJF, due in some measure to this "push-back" from providers.)

- Provider resistance in Connecticut also, stopped plans to move from a system of grants to individual providers to a fee-for-services system.

For more on factors impeding state progress from the program staff's point of view, see Challenges.

Countering these "setbacks and difficulties," several factors facilitated the success of individual grant state teams. "Several factors seem to have been important in this regard," according to the 2006 final evaluation report:

- **Strategic use of limited project resources.** Hiring consultants for narrowly defined work permitted many teams to obtain needed information and analyses that would have been impossible using staff members who had ongoing responsibilities within their department(s). In other states having staff with dedicated time for the project was a helpful factor.

- **Prior relationships with partners.** In Connecticut, for example, the Department of Mental Health and Addiction Services had prior experience giving infrastructure support to purchase and manage substance use disorder services for the Department of Court Services.

- **The ability of the national program office to identify useful information sources.** This saved time and allowed states to make maximum use of the resources available.
— **High-level support within states.** This was a major factor in the facilitation of success by states. According to the final evaluation, "for the most part these states chose targets of opportunity on which there was already a fair amount of consensus. This meant that little time had to be spent in coaxing the players to the table; they were already there. It also meant that the initiatives were better able to withstand "push-back" from various constituents."

— **The Purchasing Institute (meetings to which all state teams were invited), and in general the structure of the grant program.** The meetings served to provide in-depth technical information to state teams; they created opportunities for individuals from different agencies to develop relationships where these did not already exist. And it gave participants time away from everyday tasks to formulate plans for system reform.

— **For most of the funded states, the reporting obligations and deadlines established by the national program office helped move the projects along.**

For more on factors facilitating state teams' successes—but from the national program staff's point of view—see Factors Favoring Positive Results at the State Level.

- **Compared to the five states receiving grants and technical assistance, the experiences of the non-grant states "were more mixed."** Kentucky, Louisiana and Oregon achieved "some level of system reform," but:

  — The Massachusetts project "appears never to have taken hold," and the state's team withdrew from the program.

  — New Jersey's team never fully developed a project. In January 2005 the state withdrew from the program, citing a disinclination to involve its substance abuse projects with Medicaid.

  — Texas was not active in the program.

  — Washington made no further use of program resources after its team attended the Purchasing Institute in 2003. Shortly after that meeting, the Washington team declined an offered program grant, in favor of much larger federal SAMHSA support for essentially the same work. However, some of its staff provided technical assistance to other program states—at the 2003 Purchasing Institute, and at a 2004 Web conference, sponsored by the Technical Assistance Collaborative and the University of Washington (not funded by *Resources for Recovery*), which attracted 150 individuals.

The report did not include synopses of the team efforts in North Carolina and Montana. In 2006, the evaluator noted that in Montana program efforts "never got off the ground," and that in North Carolina, while a lot of change was taking place during program involvement, "it was not clear what was attributable to Resources [for Recovery] and what was happening anyway as part of large systematic reforms."
• Most of the non-grant states failed to identify an initiative that was commensurate with the limited resources available. The states did not have funding to staff their planned initiative or buy significant consulting service to complete it. As a result, the projects were susceptible to "distraction" by staff turnover, office reorganization and other non-program developments.

LESSONS LEARNED

1. Keep in mind that efforts to improve a state's substance abuse treatment system are influenced by the capacity of the state's substance abuse treatment director. The vision and experience of the state director was a key factor and the support from the state executive branch was also critical in determining the outcome of Resources for Recovery efforts in participating states. (Program Director/O'Brien)

2. You must engage the Medicaid director in a state where you are trying to bring substance abuse treatment service reforms. In this program, which stressed shifting substance abuse treatment to Medicaid, the program staff made such engagement an essential criterion for state participation. (Program Director/O'Brien)

3. Give affected state bureaucracies enough time to change. The resistance to change within and external to bureaucracies can make even the most realistically formulated plans quite time-consuming. (Program Director/O'Brien)

4. Expect to give sustained support to state teams as they attempt to overcome provider resistance, or "push-back," to accepting Medicaid reimbursement. State teams without a good external communication strategy, most likely, will encounter provider resistance to change. It may be strong and time-consuming to overcome. Providers may not want to accept Medicaid payments for their services because they are perceived as less than their costs. They may balk at another process to track provider performance and billing, and they may resist the more burdensome reporting standards, billing procedures and-usually-increased paperwork Medicaid reimbursement entails. (Program Director/O'Brien)

5. Be willing to make specialized technical assistance (from peers and from specialists) available to state substance abuse treatment staff members. Among other things such training helps disparate departments' staffs to collaborate effectively. Resources for Recovery showed that state staffs of agencies handling substance abuse treatment and Medicaid services typically underwent a steep learning curve as each tried to become consistent in outlook and methodology with the other. (Program Director/O'Brien; Deputy Program Director/Smith)

6. Encourage state teams to include providers in designing and implementing change. The national program staff concluded that the longer the provider stakeholders participate in the planning and implementing process for state change, the higher the probability of successful implementation. (Program Director/O'Brien; Deputy Program Director/Smith)
7. **Avoid Web-based training, if possible.** This program did not have funding to host training sessions in each of the states and turned to webcasting as an affordable alternative. (Webcasting involves participants connected with each other by phone and viewing the same Web page, with its content controlled by a Web moderator.) However, these sessions failed to engage many of the participants. (Program Director/O’Brien)

8. **Phone conversations that focus on coaching are far superior to written reports when monitoring progress in the field.** Quarterly progress reports by Resources for Recovery state teams tended to focus on the positive and, after time, became repetitive. Phone conversations with individual team members proved essential. (Program Director/O’Brien)

**AFTERWARD**

**A Successor National Program**

The Resources for Recovery program and evaluation demonstrated—in the view of RWJF program staff—that, with support, states can develop creative strategies to improve the financing and efficiency of substance abuse treatment services.

The program also contributed to the staff's understanding of how state agencies perform and the need for—in the words of RWJF program officer Elaine Cassidy, Ph.D.—realistic expectations.


Advancing Recovery promotes the use of evidenced-based practices by treatment providers through partnerships between provider organizations and state agencies. In December 2006, RWJF selected six provider-state partnerships to receive the first round of Advancing Recovery grants.

O’Brien is a consultant to the Advancing Recovery national program office, which is located at the University of Wisconsin-Madison and co-directed by David H. Gustafson, Ph.D., director of Paths to Recovery, and A. Thomas McLellan, Ph.D.

**The Technical Assistance Collaborative**

RWJF awarded the Technical Assistance Collaborative two new grants stemming from its work with Resources for Recovery:
• A 24-month, $133,100 grant (ID# 059304) awarded in October 2006 to disseminate *Resources for Recovery* learning and best practices through presentations and other means, and to provide additional technical assistance to several of the 15 state teams.

The continuing technical assistance was to focus on states that had not implemented their action plan when the program ended but were making progress, O'Brien said in an interview shortly after the grant's award. He anticipated four or five states-including Kentucky, Louisiana, Oregon and Wyoming-would be involved.

The grant funds included the unused portion of Wyoming's *Resources for Recovery* grant.

• A $699,716 grant (ID# 055403) to help states and regions more effectively design and implement integrated financing strategies for mental health and substance abuse treatment services.

The 21-month project, which began in January 2006 under O'Brien's direction, seeks to engage representatives of public agencies, provider organizations and state legislatures in a learning network.

The network features facilitated discussions, peer-to-peer learning and technical support.

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**Prepared by:** Michael H. Brown  
**Reviewed by:** James Wood and Molly McKaughan  
**Program Officers:** Victor A. Capoccia and Elaine F. Cassidy
APPENDIX 1

Connecticut: Redundant Procurement

(Current as of the time of the grant; provided by the grantee organization; not verified by RWJF.)

Connecticut offers an example of one of the key problems that the Resources for Recovery program addressed: multiple purchasing systems.

In Connecticut, the Department of Correction and the judicial branch's Court Support Services Division had separate substance abuse treatment programs—separate from each other and from the Department of Mental Health and Addiction Services, the state's lead agency in substance abuse work.

As a result, each of the three agencies contracted separately for adult inpatient treatment services, using the same set of providers but paying different rates and setting different requirements and monitoring procedures.

"Sharing between state agencies is awfully hard," says Eric Persky, the Department of Mental Health and Addiction Services official who managed Connecticut's Resources for Recovery project.

Each agency has its own mission, constituency and demands—and each wants to be able to respond quickly with its own treatment procurement. "You need things when you need them," Persky says.

The result, however, was inconsistency in standards of care, performance measures, outcomes and payment rates. Also, the lack of a central information system made it difficult to monitor payments and care, especially when a client moved from one agency to another.

Fragmentation meant "inefficient processes and duplication of effort for both the state agencies and service providers," wrote staff of the Department of Mental Health and Addiction Services in their Resources for Recovery application.
APPENDIX 2

The Mission and Objectives of Resources for Recovery

The national program office stated the program's mission and objectives as follows:

**Mission**

To bring about long-term cultural change in the financing and delivery of AOD [alcohol and other drug] treatment services through the identification and dissemination of effective strategies that enhance treatment outcomes, support administrative efficiencies and efficiently utilize available funding.

**Objectives**

Expand AOD treatment capacity or populations eligible for treatment by working with states to:

- Implement strategies to increase access to services.
- Efficiently utilize dollars available for AOD services.
- Enhance collaboration among agencies in planning and implementing AOD services.
- Increase the use of evidenced based practice standards.

APPENDIX 3

Resources for Recovery Advisory Committee Membership

(Current as of the time of the grant; provided by the grantee organization; not verified by RWJF.)

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<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Organization</th>
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<tbody>
<tr>
<td>Neal Cash</td>
<td>CEO</td>
<td>Community Partnership of Southern Arizona Pima County Office</td>
<td>Tucson, Ariz.</td>
</tr>
<tr>
<td>Mady Chalk</td>
<td>Director</td>
<td>Center for Performance-based Policy Treatment Research Institute</td>
<td>Philadelphia, Pa.</td>
</tr>
<tr>
<td>Elaine A. Crider</td>
<td>President</td>
<td>Crider Group</td>
<td>Washington, D.C.</td>
</tr>
<tr>
<td>Colette Croze</td>
<td>Principal</td>
<td>Croze Consulting</td>
<td>Middletown, Del.</td>
</tr>
<tr>
<td>Lewis E. Gallant</td>
<td>Executive Director</td>
<td>National Association of State Alcohol and Drug Abuse Directors</td>
<td>Washington, D.C.</td>
</tr>
<tr>
<td>Angelo McClain</td>
<td>Executive Director</td>
<td>Value Options</td>
<td>Hamilton, N.J.</td>
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APPENDIX 4

The Two-Part Selection Process

The *Resources for Recovery* process for selecting the participant states had two parts:

- **Selection of 15 states to participate in the program's technical assistance activities.**

  The *Call for Proposals*, issued in January 2003, instructed interested states to designate a lead agency to submit a proposal. The proposal was to:

  - Demonstrate a willingness by the state's substance abuse treatment and Medicaid agencies to work together to increase treatment capacity.
  
  - Include a Problem Summary outlining the state's financing and management priorities and the specific program improvements that the state planned to pursue.

  The quality of a state's Problem Summary and the feasibility of its proposed improvement projects were key considerations in the selection decision.

- **Selection of five of the 15 states to receive grants of about $200,000 each.**

  At the program's kickoff meeting—called the Purchasing Institute—a team of officials from each of the 15 states finalized an Action Plan for expanding the state's treatment capacity.

  Based on the content of these plans, the advisory committee recommended five of the 15 states to receive RWJF grants. Factors included:

  - The focus and feasibility of the Action Plan.
  
  - The relationship between the state's substance abuse treatment and Medicaid agencies.

  The remaining 10 states received technical assistance only.
APPENDIX 5

RWJF State Grants Awarded through Resources for Recovery and Technical Assistance to Non-Funded States

Grant States

Alabama

Grantee: State of Alabama Department of Mental Health and Mental Retardation
(Montgomery, Ala.)
Utilizing Medicaid Reimbursement for Alcohol and Other Drug Abuse Treatment Providers
Amount: $200,000 ($25,000 expended)
Dates: November 2003 to December 2005
ID#: 049949

Contact: Sarah H. Harkless
(334) 242-3953
sarah.harkless@mh.alabama.gov

Alabama’s procurement procedure threatened to delay use of the RWJF grant funds to hire needed consultants. To circumvent this potential roadblock, the state returned all but $25,000 of its grant to RWJF.

RWJF, in turn, awarded a grant of identical amount to the Technical Assistant Collaborative (ID# 051992), which used $173,560 of the $175,000 grant to contract consultants to work with the Alabama team.

Connecticut

Grantee: State of Connecticut Department of Mental Health and Addiction Services
(Hartford, Conn.)
Developing a Collaborative Approach to Purchasing and Implementing Substance Abuse Treatment Services
Amount: $200,000
Dates: December 2003 to May 2005
ID#: 050007

Contact: Peter Rockholz
(860) 418-6958
peter.rockholz@po.state.ct.us
Florida

**Grantee: State of Florida Agency for Health Care Administration** (Tallahassee, Fla.)
Identifying Statewide Strategies to Improve Substance Abuse Treatment Capacity
Amount: $200,000
Dates: January 2004 to December 2005
ID#: 050020
   **Contact:** Ken DeCerchio
   (850) 414-9064
   ken_decerchio@dcf.state.fl.us

Nebraska

**Grantee: State of Nebraska Department of Health and Human Services, Finance and Support** (Lincoln, Neb.)
Implementing Statewide Strategies to Increase Alcohol and Other Drug Treatment
Amount: $199,978 ($178,103 expended)
Dates: December 2003 to July 2005
ID#: 050058
   **Contact:** Cecile A. Brady, JD
   (402) 471-9506
   Cecile.brady@ne.gov

Wyoming

**Grantee: State of Wyoming Department of Health** (Cheyenne, Wyo.)
Reforming and Revitalizing Statewide Substance Abuse Treatment and Prevention Systems
Amount: $199,440 ($65,981 expended)
Dates: November 2003 to January 2006
ID#: 049950
   **Contact:** Carol Wood-Grisham
   (307) 777-3353
   cgrisham@state.wy.us

At least in partial response to provider resistance, the state shelved plans to launch a pilot Medicaid management information system. The state returned the unused portion of its grant ($133,459) to RWJF.
Non-Grant States

Kentucky
Kentucky Division of Substance Abuse
Frankfort, Ky.

Louisiana
Louisiana State Department of Health & Hospitals
Office for Addictive Disorders
Baton Rouge, La.

Massachusetts
Substance Abuse Services
Massachusetts Department of Public Health
Boston, Mass.

Michigan
Michigan Department of Community Health
Bureau of Mental Health, Substance Abuse & Long Term Care Services
Lansing, Mich.

Montana
Montana Department of Public Health & Human Services
Office of Program Finance, Director's Office
Helena, Mont.

New Jersey
New Jersey Department of Health & Senior Services
Trenton, N.J.

North Carolina
North Carolina Division of MH/SS/SSA
Raleigh, N.C.

Oregon
Department of Human Services
Salem, Ore.

Texas
Texas Commission on Alcohol & Drug Abuse
Austin, Texas

Washington
Department of Social & Health Services
Division of Alcohol & Substance Abuse
Olympia, Wash.

APPENDIX 6

Topics of Educational Webcasts/Teleconferences

The Cohort Technical Assistance Series hosted by Resources for Recovery staff consisted of 22 educational webcasts with teleconferencing for the program's state teams and other state agency staff. Staff used these sessions to introduce topics for state teams' consideration, augmenting the numerous contacts, phone calls and site visits by staff that were tailored to each state's needs. The sessions took place between January and late August 2004, each session lasting about two hours. They focused on the following six topics:

- Collaboration and consensus building: leading collaborative efforts and building consensus in state agencies.
- Performance measurement: measuring the performance of substance abuse treatment delivery systems.
- Cost offset analysis: designing and implementing cost/benefit and related analyses.
• Benefits design: improving financing, service delivery and management practices.

• Information systems evaluation: determining a system's ability to perform certain functions.

• "Pooled" and "braided" funding: identifying options for integrating funding from different sources.

**APPENDIX 7**

**Seven Strategies Employed by the Program's State Teams to Expand Treatment Resources, With Examples**

The following examples of state teams' strategic activities are from the program evaluation report, *Final Evaluation: Resources for Recovery: Practices that Expand Treatment Resources*. A few appear elsewhere in this report.

1. **Create formal partnerships**

   **Examples**

   In *Nebraska*, the *Resources for Recovery* team developed an interagency collaboration agreement concerned with the implementation of the use of criteria to govern client placement.

   The *Alabama* team established the Alabama Commission for the Prevention and Treatment of Substance Abuse that included representatives of four agencies: the Office of the State Attorney General and the state departments of Mental Health and Mental Retardation, Corrections and Children's Affairs. (For more on Alabama's program efforts, see *Results: Grant States*.)

2. **Conduct needs assessments/gap analysis**

   **Examples**

   In *Louisiana*, the team analyzed system readiness to implement integrated treatment for co-occurring disorders and a case review of historical cases and new intakes over a one-month period to assess the need for integrated co-occurring treatment.

   The *Nebraska* team analyzed AOD [alcohol and other drug] data across multiple state systems (Medicaid, substance use disorders, child welfare and corrections) to identify the types and amounts of substance use disorder services provided by the state as well as to identify the universe of AOD providers.
3. Find funding opportunities for substance use disorder services

Examples

In Wyoming, the team encouraged providers to increase their billing to Medicaid for covered substance use disorder services through provider education, training and new contract requirements for some services.

The Kentucky team identified statewide patterns of billing by existing providers for substance use disorder services under the Early Periodic Screening, Diagnosis, and Treatment program (EPSDT), the child health component of Medicaid, and collaborated with regional provider organizations to increase the number of Kentucky's providers eligible to bill EPSDT.

4. Evaluate/assess

Examples

The Texas team developed a placement protocol based on the Addiction Severity Index, provided training in the use of the protocol and analyzed how placements resulting from the new criteria compared with historical placement data.

In Nebraska, the team created a new comprehensive assessment for children entering the juvenile justice system. The protocol included both clinical and risk/needs assessments as well as the development of a treatment plan within 10 days of the child's entry into the juvenile justice system.

5. Consolidate purchasing or contracting arrangements

Example

The Michigan team conducted preliminary design for a pilot that would pool and/or braid (recognizing separate funding streams while directing them toward the same end) funding between the Department of Community Health and the Department of Corrections and standardize some elements of the contracting and monitoring functions. (For more on Michigan's efforts, see Results: Non-Grant States.)

6. Create administrative efficiencies

Examples

In Kentucky, the state's substance use disorder agency and Medicaid collaborated to streamline authorization processes employed by the state's' private peer review organization.
The **Texas** team developed a Web-based clinical record that makes use of a uniform client identifier. Data are used to understand the shape of the system at any given time, manage provider systems, supply data for both state and provider quality management programs and supply data for the state's reporting requirements.

### 7. Redesign program/service

**Examples**

In **Louisiana**, the team helped draft legislation to address the scope of practice and levels of certification and licensure for counselors providing services for individuals with co-occurring disorders. The team also developed a curriculum on integrated treatment for individuals with co-occurring disorders.

**Texas**' team redesigned program requirements for Outreach, Screening, Assessment and Referral Agencies (OSARs). In addition to their usual screening and assessment content, the new configurations required OSARs to provide motivational interviewing to prepare individuals for treatment, brief interventions for individuals who do not meet diagnostic criteria for extended treatment, and long-term service coordination until the individual begins outpatient services.

### APPENDIX 8

#### Nebraska and Wyoming Results

The following come from staff of the national program office, the program evaluator or state project team leaders:

**Nebraska**

- Nebraska's team implemented a new Medicaid-covered substance abuse treatment for adults and conducted regional provider trainings to communicate the new benefit as well as instruction in billing and claims submission. (Previously the state's AOD [alcohol and other drug] benefit had been for children only.)

- During the first nine months of implementation, the state's Medicaid-reimbursed services grew to more than $800,000. Overall, per capita expenditures for substance abuse treatment increased from $16.20 in 2002 to $17.86 in 2005.

**Wyoming**

- Wyoming's team analyzed its substance abuse treatment population to better understand treatment utilization and cost patterns, and found opportunities for increased coverage billable to Medicaid.
Between fiscal years 2004 and 2005, Wyoming experienced an 86 percent increase in Medicaid substance use disorder revenues—from $385,990 to $719,072.

In that same one-year period, the number of clients served by Community Mental Health Centers and freestanding substance use disorder providers doubled—from 535 to 1,086.

- State staff studied its information system to determine if its substance abuse treatment and the state Medicaid information systems were merge-able, and if so how to do it. However, due to a change in leadership in the project as well as a national program decision not to fund implementation, the state did not implement a planned pilot trial of a merged system.

**APPENDIX 9**

**Glossary**

**Center for Health Care Strategies:** A nonprofit organization in Hamilton, N.J., that directs RWJF's *Medicaid Managed Care Program* (1995–2008) and assisted the *Resources for Recovery* national program office.

**Early and Periodic Screening, Diagnosis and Treatment (EPSDT):** A Medicaid preventive health care program for children.

**Human Services Research Institute:** A nonprofit organization in Cambridge, Mass. It evaluated *Resources for Recovery*.

**Multisystemic Therapy:** An intensive family- and community-based treatment program for youth with severe clinical problems. It is offered by practitioners licensed by *MST Services* and the Medical University of South Carolina.

**Substance Abuse and Mental Health Services Administration (SAMHSA):** An agency within the U.S. Department of Health and Human Services charged with promoting recovery for people with substance abuse and mental health problems. SAMHSA administers a portfolio of federal grant programs and contracts that support state efforts to enhance substance abuse prevention and treatment.

**Substance Abuse Prevention and Treatment Block Grant:** The predominant source of funding for state programs to prevent and treat substance abuse. SAMHSA allocates federal block grant funds to the states according to a congressionally mandated formula.

**Technical Assistance Collaborative:** A nonprofit, Boston-based consulting firm that helps public and nonprofit agencies plan, implement and manage programs in the areas of housing, health and human services. The firm served as the national program office for *Resources for Recovery*. 
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(Current as of date of the report; as provided by the grantee organization; not verified by RWJF; items not available from RWJF.)

National Program Office Bibliography

Reports

Financing Strategies for Publicly Funded Addiction Treatment. Technical Assistance Collaborative, October 2006. (Policy Brief)


Grantee Websites

www.resourcesforrecovery.org (no longer available). Website of Resources for Recovery, a Robert Wood Johnson Foundation national program administered by the Technical Assistance Collaborative, provided contact information and information on the program's purpose as well as activities of the program's participating states, naming states' lead agency and giving contact information. The site also offered reports or resources relevant to the substance abuse treatment field and links to other sites within the field. Boston: Technical Assistance Collaborative, November 2002.

Evaluation Bibliography

Reports
