MULTNOMAH COUNTY ALCOHOL AND DRUG TREATMENT SYSTEM: FY2002
PRESENTED TO THE BOARD OF COUNTY COMMISSIONERS APRIL 2, 2002

MATT NICE, DIVISION OF BUDGET AND SERVICE IMPROVEMENT

HIGHLIGHTS

WHAT DO WE SPEND ON ALCOHOL AND DRUG TREATMENT?

- Multnomah County budgeted[1] $28.7 million for A&D in FY2002, $3 million more than FY2000
- 57% of the budget was managed by Office of Addiction Services (OAS), 40% by the Department of Community Justice (DCJ), and 3% by the Office of School and Community Partnerships (OSCP)
- Most funding went to Adult treatment services (83%). Youth services accounted for 15%, with the remaining 2% for departmental administration and planning

WHAT SERVICES DID WE BUY (FIGURES FOR THE ADULT CONTINUUM)?

- Adult services funds can be broadly categorized into residential (65%), outpatient (14%), or treatment access-supports (21%)—each category is comprised of various treatment modalities ranging in intensity (**see 11x17 spreadsheet, symbolized**)
- Treatment services are usually contracted to community providers, although the County provides some direct services (e.g., InterChange, Clean Court and DUII staffing, Family Involvement Teams, and assessments and referral)
- Residential services are the most expensive, with just two types (standard and secure) accounting for half the total adult budget
- Outpatient services are the least expensive and account for the greatest number of treatment episodes (73% of 19,000 episodes)
- Access-support services are a substantial portion of the adult budget. The category includes direct service assessment referrals which may occur at health clinics and DCJ locations; Clean Court and DUII services staffing; Family Involvement Teams; acupuncture services; A&D education; and the SOSCF evaluation.

WHAT'S CHANGED IN THE ADULT SYSTEM SINCE FY2000?

- The adult services budget has increased $4.8 million since FY2002
- Provider residential rates have substantially increased (spending increased $4m)
- A&D-free housing availability/capacity has increased ($1.3m), especially at DCJ
- Secure treatment capacity has been reduced by 85 beds with the IJIP closure and the InterChange capacity limitations

[1] There may be small amounts of additional funds used for A&D services at other departments, not included in this analysis.

HOW MUCH TREATMENT SERVICE DID WE BUY?

- According to CPMS and DCJ data, Multnomah County provided 19,000 adult treatment episodes in FY2001—this figure excludes 12,894 sobering episodes
- 73% of these episodes were adult outpatient episodes, the majority of which were standard/intensive outpatient and methadone maintenance episodes
- A&D detoxification services accounted for the greatest number of residential treatment episodes
- Depending on the modality, non-whites accounted for between 15% - 42% of all treatment episodes
- DCJ episodes tend to be longer and more expensive than OAS episodes because they simultaneously address high-risk offenders' serious criminality problems and A&D problems

WHAT ARE THE OUTCOMES OF TREATMENT?

- Using the State's CPMS definition (see attached Definitions), treatment completion rates varied by modality from 40% - 79%—those in residential services are most likely to complete treatment
- Treatment completion rates vary depending on the managing Department: DCJ has greater leverage over a client's treatment and thus higher completion rates
- Like other diseases, relapse is common and part of the treatment cycle

WHAT'S THE BENEFIT OF TREATMENT?

- Nationally recognized cost-benefit research (CALDATA, 1994) finds for each dollar spent on standard residential treatment services, $4.8 are saved
- Additionally, for every dollar spent on standard outpatient treatment services, $11 are saved
- The S.T.O.P. Drug Diversion Evaluation (Finigan, 1998) estimated societal cost-savings of $10 for every $1 spent on the diversion program
- Cost-savings occur from future avoided costs: criminal justice costs, victim losses, theft losses, and health care costs

WHAT WE DON'T KNOW AND FUTURE STEPS.

- There is little in the way of *system-wide treatment outcome measures*, for example relapse/level of abuse, recidivism/severity, quality of health, employment, living situation, etc.
- We cannot determine how long it takes to access services and whether clients are accessing the services they need, want, and/or are most appropriate (e.g., can a Russian-speaking client access language appropriate services—if so, how long do they wait)
- Cost-benefits analysis for several currently used modalities are not available
- OAS and DCJ both have various differing *non-clinical business practices* (e.g., contracts, data collections, data systems, measures, evaluations, review-monitoring, etc.)—this is an opportunity for learning, better integration, and possible savings

SPREADSHEET DEFINITIONS

The 11x17 spreadsheet is for Adult Services detail, organized in the following manner: The top plum-colored rows identify the service categories (residential, outpatient, and supports) by modality (e.g., sobering, detoxification, etc). The left-hand column identifies a variety of performance measures from capacity (beds/slots), to budget (including budget specifics), to workload, and outcomes. Most performance measures are split between the two departments—DCJ and OAS. Areas that are blank are likely due to department's not performing that specific service modality or because specific information was not available. NA refers to programs were data is not available because it is not yet in service or the available data was not meaningful.

1. **Residential Services**. A "24/7" alcohol and drug treatment service that includes meals and a place to sleep. These can range from a place for inebriates to sober to a secure lock-down facility for long term stays.

2. **Outpatient Services**. These are Alcohol and Drug treatment services that do not include a place to sleep. Typically they include group counseling and/or one-on-one counseling.

3. **Treatment Supports**. Those aftercare services that help the success of residential and outpatient services. These may include A&D free housing, booster sessions to prevent relapse, mentoring, or other supports.

4. **Resources**. Either beds (residential) or slots/units (outpatient) and their budgeted funds for operation. Slots/units designation is based on whether the service is a slot-rate services (a group of slots is purchased), or fee-for-services (units of service are reimbursed for each clients that utilizes the service).

5. **DCJ. Department of Community Justice**. Services in the A&D continuum provided by DCJ are specific to the high percentage of the offender population with A&D problems. Services include a significant component to address criminality, in addition to A&D treatment.

6. **OAS. Office of Addiction Services** (Department of County Human Services). Services under this sphere are for Multnomah County residents in need of A&D treatment services, but without the means to pay for treatment. A number of these individuals are also offenders. The main focus of DCHS/OAS funded treatment is abstinence from alcohol and other drugs.

7. **Cost per Day**. How much the contracted or calculated cost per day is for services (e.g., InterChange). It is calculated by dividing the total contract by the product of total bed/slots * 365 days.

8. **Average Length of Stay (LOS)**. Average amount of time from first treatment to last treatment for all client episodes (successful, unsuccessful, neutral completion of treatment). For residential services, this is the average number of days each client was in a residential treatment facility, while outpatient indicates average number of days from first to last outpatient treatment episodes (they may have 1 or more treatment days per week). For DCJ this is based on the contract database, for OAS it is based on state A&D Client Process Monitoring System (CPMS). Some LOS data is unavailable, so best estimates are given (e.g., A&D free housing).

9. **Cost per Episode**. This is the actual cost per episode (not budgeted cost per episode); a calculated field, which is a product of the average length of stay and average cost per day.

10. **General Fund**. Percentage of the A&D treatment service which is funded by General Fund dollars. The remaining amount of funds may include a mixture of Federal, State, grants or other funding

sources. Often the non-general fund dollars are restricted for use to specific modalities (e.g., state funded residential services).

11. **Culturally Specific**. Percentage of the A&D treatment service which has either contractually dedicated funds (e.g., 5 beds for Hispanic/Latinos), or those providers who are recognized as providing culturally specific services (e.g., NARA- Native American Rehabilitation Association). This does not necessarily reflect the number of culturally appropriate services that are rendered, nor does it necessarily reflect the number of racial/ethnic minority persons enrolled in the publicly funded A&D treatment system.

12. **Co-occurring Specific**. Percentage of the A&D treatment service funds contractually dedicated to the treatment of both A&D and mental health disorders. While exact figures are not available, it is estimated that a significant percentage of those needing A&D treatment also have co-occurring mental health problems. It is also recognized that, despite little specific co-occurring disorders funding in their contracts, 60% of adult service providers are capable of delivering either Co-occurring Capable (formal collaborative Tx regimen) or Co-occurring Enhanced (qualified staff performing intergraded Tx service at a single setting) services.

13. **Treatment (Tx) Episodes**. The total number of treatment episodes is calculated from a variety of sources. Mostly modalities are computed by CPMS plus the number from Volunteers of America-VOA (VOA does not accept state funds; therefore they are not required to submit CPMS data). Services specific to DCJ are calculated using the contracts database (e.g., Community Intensive Residential Treatment—CIRT, S.T.O.P.), while InterChange is calculated from discharge summary data. Episodes differ from the number of unique people serviced, as often persons have multiple services episodes. This is a more accurate workload indicator, as these are the actual services delivered.

14. **Minority Episodes**. The percentage of total Tx episodes reported above, whose clients were non-white. This may include ethnic and/or racial combinations, as different programs assess ethnic/racial categorizations differently.

15. **FY01 Completion Rate**. The percentage of treatment episodes that meet the CPMS definition of successful completion. CPMS definition: Successfully completed a minimum of 2/3 of the program and abstinence for 30 or more days (90+ for DUII) -- excluding neutral service discharges (e.g., treatment service change, program closures, etc.).

16. **FY01 Utilization Rate**. The average total program utilization, based on average monthly *bed-rate* or *slot-rate* calculations. *Bed-rate* calculations are total possible bed days (beds*365) divided by the number of days clients were actually using a bed—simply put, is someone in a bed or is it empty—(note this can exceed 100% when providers offer additional capacity *pro bono*).

    Slot-rate is the total number of monthly funded slots divided by the average monthly number of clients in service. This calculation typically exceeds 100%. For example, if a client shows for just one treatment service in a month, that slots is considered "utilized." Often, a client may show for only one service, not to return, at which point another client may be added before the first client is "terminated" from treatment. This inflates the utilization count (i.e., 1 slot, with 2 clients equals a 200% utilization rate). In addition, it is also possible for agencies to add clients to its outpatient and not get paid for serving that person. Together, these calculations problems can make the *slot-rate* outpatient utilization data somewhat misleading.

17. **Cost-Benefit Savings Research**. Data based on Evaluating Recovery Services: The California Drug & Alcohol Treatment Assessment (CALDATA), 1994. *Total system benefits and costs for taxpayers*, pg 85. The STOP Drug Diversion estimates based on An Outcome Program Evaluation of the Multnomah County S.T.O.P. Drug Diversion Program (Finigan, 1998). Estimates made for those without specific data based on *similarity of modality*, and no specific program evaluation results were available generalizations should be viewed with caution.