
**Center for Substance Abuse Treatment (CSAT)
Division of State and Community Assistance (DSCA)
2003 Regional Workshops—West Coast, September 16-17**

Performance Management: Using Data to Put a Face on Recovery

Summaries of Plenary Sessions

Day One

Welcoming Remarks

**Jesse McGuinn, M.S.W., Deputy Director, Program Operations Division,
California Department of Alcohol and Drug Programs**

Mr. McGuinn welcomed the group to California and thanked SAMHSA for the conference. Budgets are being cut all over, he said, and everyone is being asked “to do more with less.” The cuts are starting to hurt treatment, which is devastating. As we move science into service, we need to collect data and be willing to cut ineffective treatment services in order to better direct resources, Mr. McGuinn said. “It is the right thing to do to know what works,” he concluded.

Anne Herron, M.S., Director, Division of State and Community Assistance, CSAT

Performance measurement to improve systems of care and services is here; it’s not going away, and it’s not new, Ms. Herron said. She previewed the conference’s sessions on results-based data systems, data services, and the many workshops. “We need to share what works and what doesn’t,” she said. “Most of all, we need to learn from one another.”

General Session: Overview of Results-Based Data Systems

- ***Presenter:* Ken Stark, M.Ed., M.B.A., Director, Division of Alcohol and Substance Abuse, Washington State**

Mr. Stark was introduced as the “godfather of performance management” by Ms. Herron. He first said that knowledge and data are the power to influence.

Why Do I need Data?

Mr. Stark said that State treatment agencies, or Single State Authorities (SSAs), need to plan to know where they want to arrive. “See it, believe it, achieve,” is one motto, he said. Data, which should be published in journals to build credibility, informs stakeholders—such as the government, legislature, and public—of the results of treatment, he said. Data can promote, influence, and manipulate public policy. “We need to dispel the myths and tell our story, that people can and do recover,” Mr. Stark said.

How Do I Identify Data Needs?

SSAs need to build knowledge with a cadre of supporters among stakeholders, who range from consumers to government agencies to the State legislature and members of Congress. Mr. Stark suggested that SSAs discover outside expectations using focus groups and other methods. Information needed includes extent of use, abuse, and dependence; consequences of the problem; the need for treatment; the use and outcomes of treatment; and the treatment gap. He suggested SSAs frame data in terms of money and power, such as detailing the criminal justice costs of untreated addiction. This amounts to about \$2.6 billion a year in Washington State, Stark said.

How Do I Develop Data Collection Systems?

By this point, Mr. Stark said, SSAs should know why and what data to collect and how much they have to spend. Other sources of data—government agencies, universities, consumer groups, and others—may have data you need. Consider who will use the data and why. Do not overload others with information: give them what they need. SSAs should develop a management information system (MIS) “target” to avoid excessive data collection and “scope creep.” “We have more than 400 elements in our MIS and that’s too much,” Mr. Stark said. SSAs may save money by doing data collection in-house or using college researchers in their off-time. Issues to consider include staffing, workload, training (verification is important if treatment providers report their own results), and storage. SSAs also may consider contracting out their data analysis, as Washington State does.

Using Data to Influence Policy, Research, Practice, and Attitudes

Officials should know the purpose, audience, and meaning of the data. Present data in various ways for various audiences. Washington State releases data in various forms: long reports, one-pagers, fact sheets, etc. Keep policy papers short, he said.

Consequences of Good Data and the Lessons Learned

Good data is essential and will, said Mr. Stark, increase your credibility, revenues, and partnerships. At the same time, it will give you more work, increase expectations and cause fear among some groups, he said. Fear of budget cuts can motivate you and providers to comply with data collection, but good data can convert foes or skeptics into supporters, Mr. Stark said.

Discussion

- In response to a question, Mr. Stark said Washington State paid an economist to adapt a data collection system developed by Texas, saving money over the long term.
- Mr. Stark said his agency’s funding has increased every year, even in hard times, due to its effective reporting of data. (The SSA receives \$121 million annually, 40 percent from the Federal government and most from the State.)
- His SSA is relatively small, with 100 FTEs, and 97 cents of every \$1 is contracted out. The agency’s information systems division employs only 10 FTEs.

General Session: Introduction of Participants

- ***Facilitator:* Anne Herron, M.S., Director, Division of State and Community Assistance, CSAT**

State teams introduced themselves and mentioned some of their interests and concerns, and their strengths and weaknesses, regarding data systems, collection, and use. Here is a brief summary of major points.

- Budget cuts and staff reductions in many States and Territories have hindered data system development and data collection and analysis.
- Some SSAs have been shuffled internally or merged into larger health or behavioral health agencies, such as in Arkansas, Alaska, Utah, and Nebraska.
- Many States plan strategically based on performance data linked to client information.
- Some States have instituted a single core assessment for substance abuse, mental health, and other categories, such as Arizona.
- Some States have a single database for various disability categories, such as Kansas.
- Most States are pushing the lessons of science into services.
- Web-based data entry has been adopted in some States, such as Colorado and Hawaii.
- Too much data and too little analysis is a common problem, as in Hawaii, Idaho, and New Mexico.
- Some States have contracted out for MIS or data analysis, such as Idaho.
- The co-occurring disorders initiative may represent a threat if SSAs are swallowed up in mental health agencies, according to Ken Stark, who said that most substance abusers do not have a co-occurring mental disorder.
- A few States have had steady or increased budgets, such as Washington and Wyoming. Oregon had budget cuts restored, in part, after producing good data on results. And Wyoming reversed current trends when its SSA was separated from mental health.
- The Territories present—Guam, Micronesia, Northern Mariana, Palau, and American Samoa—reported many of the same problems as the States. They also deal with the effects of weather problems, a decline in tourism dollars, and data difficulties. For instance, half the 69,000 residents of the Northern Mariana Islands are migrant workers who are hard to track.
- Several States reported Federal help on data systems.

General Session: CSAT Initiatives and Activities

- ***Presenter:* Anne Herron, M.S., Director, Division of State and Community Assistance**

Ms. Herron said that SAMHSA wants to help States improve performance, provide services based on need, and document service impact. These concerns are common threads in SAMHSA initiatives, including the Substance Abuse Prevention and Treatment (SAPT) Block Grant. Their importance flows from requirements of the Government Performance and Results Act (GPRA) of 1993.

The National Household Survey on Drug Abuse (2001) revealed that the U.S. continues to face significant challenges in combating drug abuse. An estimated 15 million Americans over the age of 12 were current drug users in 2001. This represents 7.1 percent of the population in this age group. An estimated 14 million Americans (7.4 percent of the population) meet the diagnostic criteria for alcohol abuse or dependence. States spent more than \$3 billion on prevention and treatment. Federal block grants have added another \$1.6 billion. Ms. Herron said that the question remains: Did we get what we paid for?

The three themes of strategic planning remain accountability, capacity, and effectiveness (ACE). These themes apply to SAMHSA's seven domains: drug and alcohol use, employment and education, criminal justice involvement, family and living conditions, social support, access to services, and retention in treatment. Performance management applies to all these domains. Projects will need to develop feedback loops to provide information on their progress in addressing these areas. They must also engage in continuous quality improvement (CQI) to upgrade their performance and to provide evidence of improvements.

SAMHSA initiatives include the following:

- Access to Recovery vouchers to provide access to treatment services for individuals who have been assessed with substance abuse but lack private insurance.
- Substance Abuse Prevention and Treatment Block Grants, which provide Federal funds to be used flexibly by State partners.
- Programs of Regional and National Significance (PRNS), "to support those things that make a difference," said Ms. Herron.
- Screening, Brief Interventions, and Treatment (SBIRT), under which applicants will identify a treatment gap and report on changes made as a result.
- Practice Improvement Collaboratives (PICs), which are designed to improve the quality of treatment with evidence-based practices. There are 14 PICs, and more than 25 projects.
- The Recovery Community Services Program (RCSP), to increase participation of consumers and their families in policy and program development.
- Addiction Technology Transfer Centers (ATTCs), consortia that support States, the District of Columbia, and Territories in upgrading practice and education through training, materials development, and other strategies.
- Methadone Accreditation, overseen by SAMHSA and under which all methadone treatment programs will be accredited by recognized organizations.
- State Incentive Grants, including grants to help States address co-occurring disorders through improved infrastructure (COSIGs). The COSIGs are pilot Performance Partnership Grants (PPGs) and must employ specific performance measures.
- Joint HHS, HUD, and VA grants to end chronic homelessness, which will require evaluations across the seven domains.

Performance management principles and processes are embedded in these initiatives across the seven domains. Showing constant improvement is no longer an option. Ms. Herron said we can only succeed together. Information on each initiative is on the SAMHSA Web site (www.samhsa.gov).

- **Presenter: Winifred Mitchell-Frabel, M.P.A., Team Leader, Performance Partnership Grant Program Branch, Division of State and Community Assistance**

Ms. Mitchell spoke on the status of the Performance Partnership Plan. After reviewing the performance measures the plan will require, she discussed the management challenges she believes Federal and State partners must address together as the plan moves forward. A working group has been meeting, and the Report to Congress on the Performance Partnership Plan should be finished this fall. It will reflect comments received from State and other sources on both the substance abuse and mental health proposals, Ms. Mitchell added.

The core measures of the PPG include the National Outcome Measures, which correspond to SAMHSA's seven domains of:

- cessation of drug and alcohol use
- employment and education
- crime
- stable living conditions
- social support
- access to services
- retention in treatment

Ms. Mitchell said that the PPG core measures are often developmental measures such as penetration rate or length of stay. Additional measures could include the number of pregnant women served or access to services for people with HIV or TB.

There are many management challenges, Ms. Mitchell said. For instance, Federal and State partners need to complete work on the developmental measures, establish an evaluation process, and train staff on the system. The measures may change over time. States welcome the PPG concept but are concerned about its costs and about being held accountable for outcomes outside their control. They report they will need additional funding to implement PPGs. Consumers have requested their say in the process to ensure that their needs are addressed.

The implementation plan is and will be designed to improve outcomes. Ms. Mitchell said that SAMHSA is here to help SSAs meet their needs in implementation and CQI.

- **Presenter: Kevin Mulvey, Ph.D., Social Science Analyst, Organization and Financing Branch, Division of Services Improvement**

Dr. Mulvey began by talking about the HHS initiative to establish performance measures for all its service programs. He emphasized the importance of the Government Performance and Results Act (GPRA), a public law intended to connect management decisions about resource allocations to program performance. GPRA requires Federal departments and agencies to develop strategic plans, set performance targets, and evaluate programs based on performance monitoring data.

In addition to measures that SAMHSA must report in each of these three established areas, the Office of Management and Budget (OMB) is now requiring agencies to measure their efficiency,

which is defined as the cost per person served. Three reporting mechanisms are used to determine how well SAMHSA is meeting its goals and objectives: GPRA, PPG, and the Program Assessment Rating Tool (PART), which SAMHSA uses to provide data on program performance to OMB. All these measures collect a uniform set of data elements, but PART is used to assess outcomes at the program rather than the client level. The measurements are also taken at different times. For GPRA, measurements occur at admission to services and at 6 to 12 months after admission, while PPG requires measures at admission to services and at discharge (whenever that occurs). PART requires pre and post (before and after) measurements, including follow-up measures taken after discharge.

GPRA is consonant with PPG in that both measure client-level outcomes, and with PART, which uses both PPG and GPRA data to determine program-level outcomes. Under PART, said Mr. Mulvey, "We want to know what happened to people," using specific measures such as delinquency. GPRA looks at a change, such as 0-6 months out. These systems mesh with the SAMHSA themes of accountability, capacity, and effectiveness (ACE).

To ACE is added efficiency, or the cost per person served, Mr. Mulvey said. CSAT has developed cost ranges for different treatments with the goal that 60 percent of Targeted Capacity Expansion (TCE) grantees fall within that range. "We will support those that do well, and help others to improve," he added. SAMHSA wants SSAs to join as partners in promoting data-driven approaches to CQI.

Day Two

General Session: Data Sources

Data Resources Available Through Indian Health Services

- ***Presenter: Jon Perez, Ph.D., Director, Division of Behavioral Health, Office of Clinical and Preventive Services, Indian Health Service***

Dr. Perez began by noting that he has moved, professionally, from the clinical and personal level to the abstract and general. He showed the audience two maps: one, from a prayer book published in 1250 that showed the world with Jerusalem at the center; the second from the Navajos and depicting time past and present, and used as a key to Indian wisdom. The challenge is to combine different world views, which also differ among tribes. Each is valid, he said.

The Indian Health Service has a mission to work with American Indians and Alaska Natives (AI/AN) "to raise their physical, mental, social, and spiritual health to the highest level." There are 560 Federally recognized tribes. IHS serves about 1.6 million people (out of the 2.5 million AI/ANs in the U.S.) with a budget of \$2.9 billion.

Per-capita health care expenditures by IHS are \$1,914, far below those of other Federal programs, such as Medicaid (\$3,879) or Medicare (\$5,915). American Indians/Alaska Natives also have access to far fewer doctors, nurses, and dentists. Though mortality rates have dropped among AI/ANs, these are several times higher than the general population.

At the top of the pyramid of factors for community-oriented primary care are cultural and spiritual factors. "Behavior was not taken all that seriously in IHS until recently," Dr. Perez said, but it accounts for 50 percent of the influence on health. He praised the recent combination of substance abuse and mental health, in his position, and said the future of behavioral health lies with villages, tribes, and urban programs and not the IHS.

Dr. Perez spoke of the divergence and convergence of Western knowledge and Indian wisdom. But to Indians, facts and figures do not yield understanding. However, he constantly tells grantees that data is now a matter of funding life or death. The IHS data system (RPMS) integrates multiple clinical systems and tracks the movement of data. IHS is rolling out a new behavioral health MIS with 1,000 variables and 187 data fields. It is user-friendly and Web-based, he added. States can use it to see data on a tribe, problem, etc. and to receive timely notices of changes. "I will work with you," Dr. Perez said.

In response to questions, Dr. Perez that SSAs and sometimes AI/AN tribes should be able to pull out IHS data for purposes of planning, grants, etc. He said that States will deploy the new MIS system later this year, and other parties will do so in 2004. IHS will announce and publicize the system and offer it to all reservation tribes and, through CSAT, to SSAs.

Performance Management: Improving State Systems Through Information-based Decision Making

- ***Presenter:* Hal Krause, M.P.A., Division of State and Community Assistance, CSAT**

Mr. Krause told the audience that more particulars were coming on plans for the Performance Partnership Grants (PPGs). A Technical Advisory Group, with Federal, State and professional members, is preparing the PPG. The group defined performance management (PM) as "a process for using data to improve services and outcomes."

The overall goals are to help States adopt PM and to improve their access to technical assistance, case studies, and a framework for self-assessment. PM will answer an SSA's critical concerns such as:

- Are you getting what you paid for?
- Has client retention improved?
- Has substance abuse and crime among clients been reduced?
- Are there increases in employment, education and income among clients?

He said providers sometimes resist PM since they are doing well, and they cannot afford to spend money on data systems. States are already improving data quality, developing feedback systems, building partnerships, and implementing PM contracts with providers to improve services. New York and Oklahoma, Mr. Krause said, are developing feedback systems to tell providers where they are and need to go. Other lessons so far include:

- Start today but slowly.

- PM is a partnership, so work closely with providers.
- Improve PM as you go along.
- There is no ideal solution.

Building Information Technology Infrastructure for States

- **Presenter: Javaid Kaiser, Ph.D., Division of State and Community Assistance, CSAT**

Dr. Kaiser said he would discuss technical and performance measurement and how to build the information technology infrastructure. His division, the Data Infrastructure Branch, is there to help SSAs.

Many States are building information technology initiatives and checking the validity of their data. Dr. Kaiser said that Federal requirements for data have multiplied through the PPG, the Treatment Episode Data Set, HIPAA, and GPRA. States are evaluating programs, targeting populations by redirecting resources, assessing need and launching new initiatives. “But you may still say, ‘We have too much data and can’t interpret it, or we have too much data and we don’t trust it,’” Dr. Kaiser said.

State Capacity and Linkage

State capacity varies widely. Dr. Kaiser gave the following breakdown for discharge data:

- 7 States use paper forms.
- 9 States use “mail-in” disks.
- 8 States use electronic means.
- 7 States have Web-based systems.
- 10 States and Territories have no discharge data collection system.

The remaining States use a combination of these. State treatment agencies also vary in their linkages with other agencies. Here’s a breakdown of those with connections to:

- criminal justice 7
- welfare/employment 15
- mental health 10
- Medicaid 9
- health services 9

Web Infrastructure for Treatment Services (WITS)

The CSAT program, Web Infrastructure for Treatment Services (WITS), has been developing Web-based software to help SSAs with data collection. WITS is offered to States for reporting PPG performance measures, and as an option for States and treatment providers to comply with HIPAA and other regulations. States share software under SAMHSA leadership, and WITS software should be available soon.

WITS operates at three levels:

- administrative—to adjust software to the right level and agency;
- clinical—for intake, administration, waiting lists, discharge, and follow-up; and
- treatment—for planning, consent, and referrals.

You can adjust the modules to your needs, Dr. Kaiser said. WITS soon will be beta-tested in Iowa, Utah, and Nevada, then fine-tuned and packaged. Even after adopting WITS, an SSA will need a roadmap to adapt it to local needs. “If you can’t tell your story, you are in danger of budget cuts,” Dr. Kaiser said.

Roadmap for IT Planning and Implementation

States should consider user requirements, functional requirements, and software selection needs when developing their IT plans, Dr. Kaiser said. Additional steps include the following:

- Customize software.
- Integrate software.
- Select hardware.
- Deploy the system.
- Test the system.
- Train staff.
- Maintain the system.
- Place IT within a continuum.
- Start at any point.

The goal is a Web-based system integrated with and suited to an SSA’s needs. “We are here to help you,” said Dr. Kaiser.

SSAs should consider what they need to meet Federal, State, county, and provider requirements in setting up their IT system. What do SSAs have on hand now in terms of a database, software, etc.? What type or level of security do SSAs have and need? Issues include rules for ownership, sharing, security, and for establishing an audit trail. Remember, Dr. Kaiser added, it is usually more expensive to customize an old system than to adopt a new one.

Functional Requirements

State treatment agencies will need to customize their IT system in terms of data fields; value codes; and modifications to business practices, transactions rules, screens, links to other entities, and security requirements. Integration of the IT system involves the host machine, backup, and determining who sees what. To estimate cost, SSAs should consider the user requirements, their existing system, the modifications needed, and deployment. Maintenance will involve system backup, disaster recovery, licensing fees, retiring the old system, and continuing modifications or upgrades.

Those States with good systems should consider sharing information with other SSAs and CSAT, Dr. Kaiser said.

General Session: Open Discussion/Next Steps

- ***Facilitator: Anne Herron, M.S., Director, Division of State and Community Assistance, CSAT***

Ms. Herron and CSAT staff addressed various issues as well as questions raised by SSA Directors. (Topics and questions are in bold italics.)

- ***States and technical assistance (TA).*** Gayle Saunders, DSCA Project Officer, said that the State Project Officer is the first person to contact for technical assistance, and the State Director must sign off on the request. The request is forwarded to Federal technical support staff and assigned to a contractor, who provides the requested support. A 2-day Director's Orientation can be provided on request, up to 10 a year on a first-come basis.

States may request a technical review of certain services, such as women's treatment, or request other tailored TA. The State Project Officer (SPO) and Government Project Officer (GPO) must both sign off on a request for technical review. The TA plan will be developed with the contractor and the SSA.

- ***How can States exchange information with each other?*** The Division of State and Community Assistance is willing to set up conference calls for interested States. The SSA Director can send a note to information@treatment.org. Ms. Herron said that CSAT/DSCA would help SSAs that want to share expertise. Also, her office would be glad to share TA prepared for one State with other States. Ms. Saunders said there will be a list of TA provided on the Director's Roundtable on the TIE Web site (www.tie.samhsa.gov).
- ***Women, Co-occurring Disorders and Violence Study.*** Jim Herrell of DSCA's Co-occurring and Homeless Activities Branch referred participants to a discussion of the study that was distributed. He recalled that Montgomery County, MD, previously treated substance abuse, mental illness, and violence separately. But more than half the women helped had problems in all three areas. The 16-site SAMHSA study will soon report results.
- ***States requirement for "maintenance of effort" (MOE).*** SAMHSA is considering sending a letter to Governors on the importance of maintaining the level of effort, raising awareness that there is no margin for budget reduction in treatment.
- ***State Treatment Needs Assessment Program (SNAPS).*** There is no mechanism for funding right now, but CSAT has the issue under discussion.
- ***Set-asides for pregnant women and women with children.*** SAMHSA is proposing performance measures for this group.

- ***PPGs and data collection.*** TA funding helps greatly when an SSA has too much data, said Ken Stark of Washington State. CSAT staff said that there will be a help desk for the WITS system, when adopted. If Congress approves Access to Recovery vouchers, CSAT will offer TA. With PPGs, there will be a 3-year implementation process, and each SSA will negotiate it with their Federal Project Officer.
- ***Behavioral Health Organizations (BHO).*** States that use BHOs, such as Idaho and Iowa, reported that a BHO can be for-profit or non-profit, and that costs may actually rise due to increased administration. Idaho also reported that their BHO standardized processes and reduced duplication.
- ***Block Grants.*** The block grant application system will soon be Web-enabled. For PPGs, a 3-year grant cycle is being considered.

State Directors were reminded to e-mail ideas and requests to information@tie.samhsa.gov.

The conference was adjourned.