A Summary of the Albuquerque Model for Substance Abuse Treatment Services Management

The City of Albuquerque's system is built around two basic elements. The first is the unbiased assessment and referral using standardized instruments. The second is patient choice among qualified providers with subsidies available for those unable to meet the costs of care through a voucher system. Both these elements are tied together by an electronic management information system that facilitates assessment, referral, client tracking and billing and by treatment standards that insure quality treatment services.

To assure unbiased assessment and referral, the City has separated assessment from the provision of substance abuse treatment. Albuquerque Metropolitan Central Intake (AMCI) is a specialized agency that provides professional assessment of patients presenting for problems related to substance abuse. The primary assessment tool is the well-known, standardized, Addiction Severity Index (ASI) which we administer in English and Spanish. For adolescents, AMCI uses the Modified Adolescent Drug Abuse Diagnosis (MADAD) instrument.

Based on the findings of the assessment, patients are referred to the treatment providers who are best able to meet their needs from within the City's Provider Network. This network currently consists of 20 different providers ranging from large public agencies to single private practitioners. The network is open to any provider that wishes to join and agrees to comply with the City's clinical standards and reporting requirements. This means we welcome providers that are public and private, for-profit and non-profit, secular and faith-based so long as they meet our clinical standards.

Income eligible patients are issued a "voucher" to assist with the cost of their treatment along with a referral to appropriate providers within the network. The value of the voucher is determined by the level of care the patient requires. For example, vouchers for "Early Intervention" (brief therapy and education) which is principally for persons without severe abuse problems—many of them first time DWI offenders—is capped at $390. For Intensive Outpatient treatment with methadone, on the other hand, a voucher may reach $3,510.

A patient is issued a voucher following assessment which is activated when that patient is admitted to treatment with a network provider. The patient has up to one year from the time the voucher is issued to enter and complete voucher funded services. Providers may bill against the voucher for set rates for various services. The AMCI database automatically matches the services provided against what was originally authorized under the voucher and the patient's account is automatically debited until the funds are exhausted. If treatment needs to continue after the voucher is exhausted, the treatment providers are expected to transition the client to a sliding fee scale.

During the fiscal year beginning July 1, 2003, AMCI received service requests for 3,347 unduplicated patients. Of these, 3,306 were offered assessments, 3,296 completed assessments and were provided referrals for treatment (subsidized and unsubsidized),

2,870 were assisted with vouchers, and 2,631 were admitted to, and received, subsidized treatment services. The total amount of treatment billed through their vouchers was $1,463,100.

Alcohol abuse or dependency was the most frequent diagnosis, with 46% of the patients reporting these as their primary problem. This was followed by opioid abuse/dependence (17%), cocaine abuse/dependence (8%), and amphetamine abuse/dependence (5%). The primary source of referrals was the criminal justice system, which accounted for more than 58% of patients entering the system.

What have we gained from this system? First, we think that we have a better managed system with rigorous controls of treatment-related expenditures. Authorized units of treatment are based on objective assessments of needed services and billed accordingly. We buy what is needed and pay only for what we buy. This was not the case in our previous system built primarily around cost reimbursement contracts with a small group of provider agencies that independently determined what treatment the client's needed. To agencies whose principal tool was a hammer, most client problems looked like nails.

Beyond better management, we believe that opening the system to a broader range of practitioners, increased the likelihood of matching patients to the treatment approach and setting that best meets their assessed needs and preferences. Rather than narrow options to a handful of publicly-supported providers, we now offer a broad ranger of treatment approaches and treatment settings that gives the system substantially greater flexibility in meeting differing needs. Most of the providers in the network, moreover, participate in the private market for treatment services and are not wholly dependent on the City for their financing. City subsidized clients at a given agency in a recent 45 day period ranged from only one or two to 165, with a mean of 17.

Offering clients genuine choice in the selection of a provider, finally, appears to affect the process in a couple of important ways. First, there is some element of market discipline. The patient is free to change providers if she/he does not believe that their needs are being met. We actually have had relatively few patients electing to change providers even though they can take their voucher accounts with them. More important, perhaps, is that it makes the patient an active, empowered, participant in the process from the outset.

How has all of this affected treatment outcomes? This is a question about which we must be cautious, in substantial measure because we have no valid way of comparing the current voucher based system to the system of fixed, cost-reimbursement contracts that preceded it.

Still, the methodologically valid outcome data we do have is encouraging. Clients report a reduction in alcohol use, binge drinking, drug use, stress related to substance use, depression, and anxiety.