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Mr. Chairman, members of the Subcommittee, I thank you for inviting me to speak to you on the topic of measuring the effectiveness of treatment for drug addiction. It is my understanding that the Subcommittee is interested in strategies for improving treatment quality and how measuring results can contribute to that improvement

In January, Join Together, a project of Boston University School of Public Health, funded by the Robert Wood Johnson Foundation, released a report titled “*Rewarding Results: Improving the Quality of Treatment for People with Alcohol and Drug Problems.*” The report was based on the deliberations of a panel of experts from various fields touching on treatment, background papers by nationally recognized scholars commissioned for the panel by Join Together, and testimony offered by dozens of interested parties. I had the privilege of chairing the panel and overseeing the preparation of the report. Because the contents of the report are so germane to the present interests of this Subcommittee, I will offer some highlights in my oral testimony and will submit the entire report for use by the Subcommittee as it sees fit. Before summarizing the report’s main themes, I would like to offer some preliminary thoughts on the evaluation of drug and alcohol treatment.

First, how one evaluates or measures the effectiveness of drug and alcohol treatment programs depends very much on the purpose for undertaking the evaluation. For example, an employer who wants to know if a program covered by the company’s insurance plan is effective may be interested not only in whether or not the problem drug or alcohol use has stopped, but also in how likely it is that recovery will be stable and how soon the employee can return to work. Another agency may be more interested in knowing if treatment has resulted in decreased criminal activity. Depending on resources and goals, one can obtain information directly by finding and interviewing patients, or indirectly by analyzing existing databases. It is also possible to look at surrogate measures of outcome, measures that correlate highly with good outcome, such as retention in treatment.

Large scale evaluations sponsored by the Federal government over the past 25 years have used direct patient interviews to look at multiple outcomes, such as use of drugs and alcohol, criminal activity, and the utilization of welfare and medical services. They have also looked at how long the effects of treatment persist after the period of active treatment ends, how various approaches to treatment compare in effectiveness, and what aspects of treatment contribute to outcomes. In the process, a rich store of knowledge has accumulated about the duration of treatment and the kinds of services that are likely to lead

to good outcomes. There is little doubt that good treatment leads to reduced drug use and other benefits to society.

Federal agencies have been working hard to improve the quality of treatment and have put out a number of guidelines that, if properly implemented, can improve the overall quality of treatment. But guidelines aimed at improving quality are unlikely, in and of themselves, to do the job. They cannot compel high quality treatment. Crucial to high quality treatment is a well-trained treatment workforce, as well as better application of the findings that have emerged – and continue to emerge - from research. But in the real world of treatment, where there are about 12,000 programs, two major problems impede the implementation of those reasonably well thought out guidelines. First, many programs are quite small, and many (even large ones) lack the financial resources to put guidelines into practice. Second, because the job is stressful and salaries are low, there is a high turnover of personnel, not only among first line drug counselors and clinicians, but also among program supervisors and managers. With such turnover, much of the investment that programs make in clinical and management training is lost.

When the Join Together panel looked at this situation we concluded that unless there are real and continuing incentives to provide quality treatment, quality will always take second place to program survival or expansion. What is needed to drive quality improvement is a commitment by those who pay for treatment to reward good outcome – in other words, to *reward results*. Again, depending on resources, the rewards can vary. Merely publicizing how the programs compare can have the effect of stimulating pride in the better programs and stimulating a sense of urgency in the less effective ones. It is also possible to make the rewards more tangible by paying more to the better programs or directing more patients to those programs. When this is done, programs delivering superior results will tend to flourish and those delivering poorer outcomes will either improve, merge with more effective programs, or cease to function.

In making the recommendation to reward results, the Join Together panel did not in any way intend to devalue the importance of increasing resources for the introduction of new technologies and stabilization of the workforce. There are hard-working and dedicated people on the frontlines of addiction treatment who are dealing with some of life's toughest problems with often threadbare resources. And despite such difficulties we often see good results. But until there are real rewards for getting good outcomes, those who make treatment decisions will not be motivated to ask continually: How are our patients doing? What are we doing that we could be better? Do we need to change what we are doing because evidence suggests that another approach would have produced a better outcome?

There is still no consensus about which types of treatment approaches are most effective in creating durable recovery from drug and alcohol addiction. However, when funding agencies begin to pay attention to outcomes, the public will be more likely to believe that treatment for drug and alcohol addiction does produce useful results, and the

credibility of treatment will be strengthened when it is competing with other public priorities for funds. Implementing systems that look at outcomes will require additional resources. These should not be carved from what is now available for treatment. Rewarding results should be seen as a means to improve outcome. It is not pathway to getting more treatment for less money.

The Join Together report contains specific recommendations to Federal and State agencies, employers, funders, and community leaders for rewarding results. No doubt, whether the method selected involves only providing a public report card or actual differential payment, objections will be raised to the idea of rewarding results. The major concern will be that each case is different, that programs or practitioners cannot be compared, and that practitioners or programs will “cherry pick” to avoid the most difficult patients. These objections cannot be lightly dismissed. Our panel recognized that mechanical approaches to program comparison may always remain imperfect. However, the panel is confident that care managers can use quantitative data together with site visits and patient input to form fair comparative judgments about program quality.

In both the private and public sectors there are already efforts to introduce performance measurement as a means to improve treatment quality for alcohol and drug problems. For example, the Department of Veterans Affairs (VA) is now obtaining data on addiction treatment delivered in all VA hospitals and clinics, making it possible to compare facilities in terms of performance. Differences in performance could result in funding adjustments. The Health Plan Employer Data and Information Set (HEDIS) is now introducing a few measures of how well alcoholism problems are dealt with, allowing employers to compare private health plans in terms of their performance in this area.

The Join Together panel was informed about the careful work of many, including the Washington Circle group, to develop consensus indicators of program quality. We appreciated these efforts and did not wish to duplicate them by developing our own set of indicators or measurements. We believe that the deep question is not to how to measure outcome or quality, but rather whether those with responsibility for paying for care will have the courage and management capacity to begin using available measures to reward results.

The Join Together panel recommends that rewarding results be defined as a national goal. On the road to reaching that goal there are many technical and political obstacles to be overcome, and many different groups that will have to be persuaded that it can be done and should be done.

*I thank you for your time and ask that the full content of my remarks and the Join Together report, “Rewarding Results”, be introduced into the record.*