Proposal Summary

Advancing Recovery: State and Provider Partnerships for Quality Addiction Care

Organization
Office of Substance Abuse

Project Title
Advancing Recovery in Maine

Registrant Info
Applicant ID
MaineOSA

Name
Ms. Kimberly Johnson

Organization
Office of Substance Abuse

Department/Unit
#11 State House Station

Street Address 1
Marquadt Building 3rd floor

City
Augusta

State
ME

Zip
0433-0011

Phone
207-287-6344

Fax
207-287-4334

Email
kimberly.johnson@maine.gov

About My Organization
Legal Name of Organization
Office of Substance Abuse

Department/Unit
Department of Health and Human Services

Street Address 1
#11 State House Station

Street Address 2
Marquadt Building 3rd floor

City
Augusta

State
ME

Zip
04333-0011

Phone
207-287-6344

Fax
207-287-4334

Website
www.main eos.org

Key Contacts
Project Director (required)

Name
Ms. Kimberly A Johnson

Credentials
MSEd, MBA

Organization
Office of Substance Abuse

Unit
Director
#11 State House Station

Address
Marquadt Building 3rd floor
Augusta, ME 04333-0011

Phone
207-287-6344

Fax
207-287-4334

Email
kimberly.johnson@maine.gov
Principal Investigator (required)
Name: Ms. Kimberly A Johnson
Credentials: MSED, MBA
Organization: Office of Substance Abuse
Unit: Director
Address: #11 State House Station
         Marquadt Building 3rd floor
         Augusta, ME 04333-0011
Phone: 207-287-6344
Fax: 207-287-4334
Email: kimberly.johnson@maine.gov

Financial Contact (required)
Name: Mr. John D Mower
Credentials: 
Organization: Department of Health and Human Services
Unit: Behavioral Health
Title: Finance Director
Address: #11 State House Station
         Marquadt Building 3rd floor
         Augusta, ME 04333-0011
Phone: 207-287-2595
Fax: 207-287-4334
Email: john.d.mower@maine.gov

Proposal Author (required)
Name: Ms. Kimberly A Johnson
Credentials: 
Organization: Office of Substance Abuse
Unit: Director
Address: #11 State House Station
         Marquadt Building 3rd floor
         Augusta, ME 04333-0011
Phone: 207-287-6344
Fax: 207-287-4334
Email: kimberly.johnson@maine.gov

Project Info
Proposed Project Title: Advancing Recovery in Mainetesting
Project Start Date: 11/01/2006
Number of months anticipated to complete the project: 24
Total Funding Requested from RWJF: $348,660

1. These questions are used to ensure adequate diversity among potential grantees, as measured by geography, agency type, etc.
Unit of state government

What type of corporation is the owner or legal entity of the applicant organization?
Entity in state government responsible for only substance abuse services
3. If you did NOT select "Other" in the previous question, please type "N/A" in the text box below. If you responded "Other" to N/A Question 2, please specify the type of applicant organization in the text box below.
4. Which one category best describes the geographic region in which the applicant organization is located? 

New England (CT, ME, MA, NH, RI, VT)

Executive Summary

1. Please note that the Advancing Recovery selection committee will verify your responses to these questions if your partnership is selected for a site visit.

Please succinctly state what your partnership will accomplish if selected as a grantee under the Advancing Recovery initiative.

The state of Maine will significantly increase the number of people in treatment, the number of people that complete treatment and improve the outcomes of those people who receive addiction treatment by increasing the use of medication assisted therapy and by providing additional supports through case management and wrap around services.

2. Please describe and identify the applicant organization that will assume contracting responsibility with the Robert Wood Johnson Foundation (RWJF). From that organization, please indicate a contact person, including: title, postal address, email address, and telephone number.

Kimberly Johnson, Director
Office of Substance Abuse
DHHS
State House Station #11
Augusta, ME 04333-0011
207-287-6344
kimberly.johnson@maine.gov
Organization: Maine Office of Substance Abuse

Partnership
1. The following two items are relevant questions related to the applicant partnership
   (a) Please provide a Memorandum of Understanding for your partnership that describes the role of each participating agency or organization.
   (b) For each partner (e.g., SSA, community treatment agency, state licensing board, Medicaid office, etc.), please designate the executive sponsor, project director (Change Leader), and lead data specialist. For each of these individuals, indicate the percent time that they will be allocated to this project and describe their relevant qualifications.

(a) There are four major partners in this application, the Office of Substance Abuse (OSA, the state SSA), the Maine Association of Substance Abuse Programs (MASAP), the state provider association, and the Maine Alliance for Addiction Recovery (MAAR), an advocacy organization for people in recovery from addiction and the city of Portland public health division. The SSA, as the Executive Sponsor, will lead the partnership. In this role, OSA will coordinate the collaboration of the partners and guide the process by identifying problems, collecting and sharing data, arranging for necessary training sharing the knowledge from each organization with MASAP and other partners. The primary role for MASAP is to interface and coordinate between the SSA and provider agencies participating in this project through the development and ongoing implementation of a “learning collaborative” that will be the catalyst for continued education, training, and knowledge dissemination through a structured approach. MASAP will also recruit agency partners to participate in this project. The primary role for MAAR will be the engagement and active participation of members of the recovery community in the site visit, project implementation and ongoing monitoring of outcomes based on consumer feedback that is collected in a variety of different modalities including surveys and focus groups as well as
commentary on walk-throughs. The City of Portland will be responsible for identifying underserved minority populations and coordinating provider efforts to better treat them. They will work with OSA to develop the resources necessary to serve the identified populations and will monitor progress.

(b) The Office of Substance Abuse will be the lead agency for this application. The executive sponsor of this grant project is Kimberly Johnson, MSEd, MBA who will spend 10% of her time on this project. The project director role will be shared by two people, one at OSA, one at MASAP. The OSA project director will be Linda Frazier, treatment team manager. She will devote 15% of her time to this project. The MASAP Project Director is Ruth Blauer, Executive Director, MASAP. Ten percent of her time will be devoted to this project. The MAAR Project Director is Deb Dettor, MAAR Coordinator. She will spend fifty (50) percent of her time working with the recovery community on this project. The Lead Data Specialist is Mary Henderson, OSA, and she will spend 15% of her time on this project. The City of Portland project director is Bankole Kolawole, Minority Health Coordinator for the city of Portland. He will assume the lead on the effort to use case management and wrap services with the minority populations in the city of Portland.

2. For the applicant organization that will assume contracting responsibility, please provide evidence that you will be able to rapidly complete all necessary contracting, hiring, and other administrative procedures required to initiate and support the project. For example, you could cite experience from a recent project that had similar requirements.

The Office of Substance Abuse has successfully completed numerous federal grants that have had multiple fiscal and programmatic requirements. We have successfully completed the federal State Incentive Grant (SIG) grant process and were the highest scorers in the new SPF SIG grant
that we have been performing under for the past year. We have successfully implemented a variety of programs in conjunction with both MASAP and MAAR including some recent work in rapid cycle improvement. The State Association of Addiction Services (SAAS) recently chose Maine as a site for its CSAT funded rapid cycle improvement grant because of both the working relationship between the SSA and the provider association and the successful launch of the rapid cycle improvement process in Maine. OSA and MASAP have a long and successful contracting partnership. Currently, MASAP provides OSA staffing support for various critical functions as an efficient method of meeting short term needs. Through OSA funding, MASAP serves as the fiscal and administrative entity for certain shared and dedicated OSA/MASAP positions under other grant funded programs including the Center for Substance Abuse Prevention funded SPF SIG and a federally funded position to manage the prescription monitoring program. MASAP provides rapid contracting, recruitment, and other personnel services and support for these OSA positions.

**Consumer Involvement**

3. Please describe your working relationship, if any, with consumers and/or recovery organizations. Were consumers and/or recovery organizations involved in the preparation of this application? In what capacities will consumers and/or recovery organizations be involved in the site visit, project implementation, and monitoring of the project?

The Maine Alliance for Addiction Recovery (MAAR) is a program of MASAP. MAAR works closely with OSA and represents the voice of individuals in recovery throughout Maine. MAAR’s focus is advocacy, coalition building, stigma reduction, and consumer activism for the improvement of access, treatment and recovery support services. OSA provides funding support to MAAR. The MAAR Coordinator has participated in the development of this proposal and has shared its intent with the MAAR Advisory Committee, a representative group of individuals in
recovery. This group is supportive of this proposal and applauds the involvement of MAAR with both consumers of treatment services and those further along in their recovery. MAAR staff and members will participate in the site visit, in ongoing project implementation and monitoring as relevant and appropriate. MAAR will be responsible for identifying consumer level barriers using a variety of tools including walk-throughs, focus groups and surveys.

**Walk-through Exercises**

4. For the treatment agency walk-through, please answer the following questions:
   a. What aspect of the treatment agency’s system related to a category of evidence-based practices did you select for the walk-through? Why do you think the particular category of evidence-based practices will be appropriate for your partnership to focus on?
   b. Who participated in the walk-through process and why were they selected to participate?
   c. What were the two most salient observations that you identified as a result of the walk-through?
   d. What were some significant barriers embedded in the provider system that prevent the use of your selected evidence-based practice?

a. The change to utilize medication assisted therapy is being driven by two factors. One is the growth of opiate addicted patients who cannot succeed without medication and who are dying at an alarming rate; and two is the increase of available medications to treat addiction. Our system is not adopting these practices fast enough to meet demand and we are losing people that need to be in treatment because of our inability to meet their need for medication assisted therapy.

b. We have completed seven treatment agency walk-throughs to date. Only one agency has focused on implementing an evidenced based practice as opposed to addressing an administrative process thus far. In the Health Reach walk through, Emilie Van Eeghan, vice president, played the role of an opiate addicted young woman. The medical director of the agency played the role of her brother. They were chosen to do the walk-through as the most senior people in the organization that had interaction with the program on a normal basis and were in a position to make necessary changes.
c. They discovered that the brother was not allowed to participate in the intake session, so in her debilitated state, Emilie as the client had to handle the process herself. She learned that the hospital could not detox her from her drug of choice, despite the fact that the hospital had a detox license because they didn’t have an appropriate protocol for opiate detox. But without the detox, she was not allowed admission into any of the agency’s programs. So effectively, the agency could not treat the fastest growing client population – young opiate addicted women. The agency’s first change project was to admit anyone to treatment regardless of secondary diagnosis or medications that they were taking. This one change increased the number of admissions in two programs – the women’s program from an average daily census of 5 to 6.5 and the adolescent program from an average daily census of 5.3 to 6.4. While these changes are modest, they are in the right direction.

d. The biggest barrier to this change was employee resistance. The medical director thought it was already agency practice to admit people on medications and was surprised to find that there was a lack of clarity. One staff person in a program level leadership position had been blocking the admission of people on medication or requiring people to agree to withdraw in order to participate. Other staff felt they were getting mixed messages and were relieved when the medical director sent out a letter containing the directive to admit people on medication. The agency has been experiencing a decrease in clients and had decided to close two rural offices due to their financial unsustainability.

Unfortunately, this is not a unique experience. It is difficult for people to enter many treatment programs if they are on or seeking medication to assist their recovery. Most out-patient and residential treatment programs in Maine require people to be fully detoxified before entering treatment. There is fear among clinical staff that people using medication assisted
therapy will somehow negatively impact the recovery of people who are not using medication.

There is a perception that somehow people using medication are not really in recovery.

Therefore, they create program level rules that prevent people from benefiting from treatment.

5. For the state system walk-through, which is directed toward an administrative process or procedure mandated by a state agency (not by law), please answer the following questions:
   a. What aspect of the state system related to a category of evidence-based practices did you select for the walk-through? Why do you think the particular category of evidence-based practices will be appropriate for your partnership to focus on?
   b. Who participated in the walk-through process and why were they selected to participate?
   c. What were the two most salient observations that you identified as a result of the walk-through?
   d. What were some significant barriers embedded in the state system that prevent the use of your selected evidence-based practice?

   a. We wanted to continue to look at barriers to using medication in the treatment of addiction.

   While we believe that the greatest barrier to the use of medication is values and belief systems, we wanted to observe difficulties that government put in place. We chose to look at access to medication for opiate addiction as it is the fastest growing drug problem in Maine, and based on data from the National Survey on Drug Use and Health, Maine is one of the states with the highest rate of unmet need for drug treatment while we are in the middle of the pack in unmet need for treatment for alcoholism.

   b. This “walk-through” was conducted in a series of ongoing discussions with the Maine Association for the Treatment of Opioid Dependence. Participants include Kim Johnson, OSA director, Paul MacFarland, state methadone authority, and Linda Frazier, treatment team manager.

   c. The most significant observation is the desire of the clinic staff to help their clients. All but one of the methadone clinics in Maine are for-profit and have a reputation of only caring about the bottom line not patient well being. This is not the reality. The second observation is that we
have a two-tiered reimbursement system. Over 60% of people in methadone treatment are on Medicaid, and there is no grant funding for this service, so Medicaid reimbursement drives agency policy. The one clinic that is non-profit is hospital based and is able to bill under hospital regulations, so it charges by the service not a bundled rate. It is able to offer more intensive medical and counseling services when necessary regardless of cost. The ability to bill Medicaid on a per charge basis allows them to serve more indigent patients and to provide more extensive services to all of their patients. It also has a reputation as the best clinic – so quality in Maine is identified with non-profit treatment and lack of quality is identified with for-profit treatment, but the real quality issue seems to be mechanism of reimbursement. All non-hospital treatment programs bill under the substance abuse treatment regulations where there is a bundled rate of $80 per week to include all medical and counseling services.

d. There are multiple difficulties in increasing access to medication assisted therapy. First, for methadone programs, there is the difficulty in finding a location that won’t require a lawsuit and three years of negotiation to open. Second, the state regulations require both a substance abuse treatment license and a pharmacy license on top of meeting federal regulations. State regulations require local input into siting the facility and have greater restrictions than the federal regulations regarding take-home doses forcing clients to show up daily for months prior to being allowed a single take home dose. Third, for most programs, methadone treatment is delivered with a bundled rate reimbursable by Medicaid that requires all medical and counseling services to be delivered at a single cost. There are no grant dollars to fund the treatment of people who are indigent, so with a bundled rate there is very little a clinic can offer those who cannot pay. The bundled rate is $80 per week which means that a clinic must use methadone rather than
buprenorphine even for people for whom buprenorphine might be more appropriate because the cost of the drug alone exceeds the reimbursement rate.

6. If you are selected to participate in the Advancing Recovery project, what is the first category of evidence-based practices you will address and why? Which specific evidence-based practice(s) in that category will you try to implement and who are the clients you intend to impact? What type of assistance, if any, will you need to implement the evidence-based practice(s)?

The first evidenced based practice that we will address is medication assisted therapy. While Maine has made great progress in this arena over the past five years, we still are light years away from the appropriate use of medication in the treatment of addiction. Because of the well documented rapid increase in addiction to prescription opiates in rural states such as Maine, we have opened five methadone treatment programs since the year 2000. Maine has more Suboxone® trained physicians per capita than any other state except for Vermont. Despite the growth in access to medication assisted therapy for opiate addiction, the demand for treatment continues to outstrip the supply and the ability to open methadone treatment programs is severely hampered by community reaction and local government interference. State government has imposed more cumbersome regulations on methadone treatment agencies in response to a growth in methadone overdose deaths and to community uproar blaming the treatment for the disease. In addition, many treatment providers and people in recovery “don’t believe” in the use of medication to treat addiction, so they do not offer it or actively block patients on medications from participation in behavioral programs. According to the National Survey on Drug Use and Health, Maine has the third highest unmet treatment need for people who are 18-25 and drug dependent and the fourth highest unmet treatment need for drug dependent adolescents.

We would like to expand the use of Suboxone and medications to treat alcoholism through this grant process. In one of our agency walk throughs, the Vice President of Behavioral
Health at Maine General Medical Center (Health Reach) with services and facilities on two campuses in Central Maine acted out the role of a prescription opiate addicted young woman. She was stunned to learn that there was no program to help her withdraw and no program in her organization that was willing to treat her until she had fully withdrawn and was abstinent. In essence, her agency was unwilling to treat anyone who was still sick from the disease that needed to be treated. It should come as no surprise to a reader that the agency was under-utilized and was closing offices due to a lack of clients. While she was angry and embarrassed by her experience, it is the norm not the exception in the state. Our goal is to follow three paths to increase access to medication assisted therapy. The first is to identify three other large treatment agencies willing to go through a walk through process similar to Health Reach as an opiate addicted patient trying to find medication assisted therapy near their home and to change their practice to admit people who need medication and provide that medication either on site or through referral. The second is to identify barriers to the use of medication to assist in the recovery from alcoholism. We will conduct a survey of treatment agency medical directors to identify barriers and develop a statewide action plan to remove them. Finally, we need to make changes to the reimbursement structure for medication assisted therapy so that medication assisted treatment is the standard of care for severely affected patients. The support we need is coaching on the rapid cycle process for the new agencies and education on the appropriate use of medication assisted therapy for both physicians and counselors. The training for physicians will need to focus on medical practice and the training for counselors will need to focus on the whys of biological based interventions. We would like to open medical practitioner training to all physicians not just those that work in treatment agencies as we believe that much of the delivery of medication can be done through the primary care system (while we are interested in the use of
the chronic care model in the treatment of addiction and the role of the primary care provider in that model, we have an active change process already evolving funded through a local foundation so will not use this grant to support those activities). We expect to need some support and coaching for the treatment programs to make this philosophical transition.

We also need support to analyze Medicaid data. We believe the agency that is able to bill by charge has better outcomes and therefore costs Medicaid less over time. We know that their retention rate is better than any of the other agencies, and believe that this improved retention rate leads to lowered medical costs. It will be critical to demonstrate this cost savings in order to change the rates.

7. If you are selected to participate in the Advancing Recovery project, what is the second category of evidence-based practices you will address and why? Which specific evidence-based practice(s) in that category will you try to implement and who are the clients you intend to impact? What type of assistance, if any, will you need to implement the evidence-based practice(s)?

Our second category of evidenced based practice to develop is wrap around services and case management for identified populations. The Office of Substance Abuse has the authority in rule and statute to develop these services and they are allowable under our Medicaid regulations, but we have not actively developed wrap services and case management for two reasons. The first is a philosophical reason that is based entirely upon the prejudice of the current SSA. Her belief is that the mental health system seems to have gone completely away from active treatment to funding only support services that never seem to lead to improvement in patient’s symptoms. This expenditure has become a black hole in the state budget and the largest single expense in Medicaid after medication. The current director of OSA has been afraid of going down the same path, and has only used case management for drug court clients and as a way of meeting the federal block grant requirement for interim services for women waiting for treatment. The
second reason has been a lack of funding. We cannot start new services without money to do them.

We believe that it is time to reconsider this position and are willing to seek funds to provide these services in order to ensure that more people make the connection between levels of care, connect with support services and a recovery community, and receive other services such as medical care and mental health services that are necessary to maintain recovery. We would like to begin by adding case management services for families involved with the child welfare system, for minority and refugee populations, and for people who begin their services at a high level of care such as hospital detox or residential treatment.

While our walk-through processes thus far have not identified this need, it has been raised in a variety of other settings that leads us to believe that our lack of this support underlies our dismal statewide 50% treatment completion rate. We believe it is related to the reason our child welfare system is unable to meet federal requirements for reunification or permanency for children. At least 40% of these families have clear identified substance abuse issues, but many parents don’t make it into treatment, and have poor completion rates when they do. In Sacramento, a recovery focused case management model has increased family reunification significantly. We would like to replicate that model.

We also know that a growing number of Latino men in the Portland area are in need of treatment and have difficulty accessing it due to language and cultural barriers, but do not stay in treatment even when they get there because of the lack of support, feelings of isolation even in a group setting, and continued language barriers. This population needs multiple levels of support which will be described in greater detail in a later section, but we believe that case
management/wrap services by people in the Latino and other minority communities will be one of the ways that we can support them.

Finally, we would like to provide case management and support to people in high levels of care as they move through the system. There is a population of chronically addicted people who do well in residential treatment, but cannot make the transition to sobriety in a community setting. We would like to provide them with case management services and support for community living.

For this effort we will need both training and guidance in best practice. We have identified a model that will work with the child welfare population, but are still awaiting federal technical assistance in developing culturally appropriate services for the minority populations we have identified and have not found an addiction model for our chronic population, though we believe that it may mirror successful support programs for the serious and persistently mentally ill. We believe we may have a model for the minority populations, but it has just begun to be used in Maine and the evidence base is still only anecdotal.

**Data Exercises**

8. For each participating community treatment agency, please provide aggregate data on the number and demographic characteristics of clients served in FY 2005.

**Acadia Family Center:** White Men: 21, American Indian Men: 1, Mexican Men: 1, White Women: 19, American Indian Women: 1

**Acadia Health Care:** White Men: 572, American Indian Men: 20, Black Men: 4, White Women: 339, American Indian Women: 14, Other: 3
**Aroostook Mental Health Center**: White Men: 555, Men of Hispanic Origin: 8, American Indian Men: 10, Black Men: 2, White Women: 221, American Indian Women: 19, Black Women: 6


**Counseling Services Inc.**: White Men: 93, Black Men: 1, Asian Men: 1, American Indian Men: 3, White Women: 59, American Indian Women: 1, Asian Women: 1

**Crisis and Counseling Services**: White Men: 138, Black Men: 3, White Women: 63, American Indian Women: 1, Hispanic Women: 1

**Crossroads for Women**: White Women: 320, Black Women: 5, Hispanic Women: 4, American Indian Women: 9, Asian Women: 2


**Health Reach Network**: White Men: 423, American Indian Men: 9, Black Men: 5, White Women: 74, Black Women: 3, American Indian Women: 3, Other: 4

**Kennebec Valley Mental Health**: White Men: 102, Black Men: 1, American Indian Men: 1, White Women: 65, American Indian Women: 1, Asian Women: 1


Phoenix House (adolescent program): White Men: 30, Hispanic Men: 1, Other: 2, White Women: 8


Youth and Family Services: White Men: 103, Other: 2, White Women: 28

If numbers were not so low in some categories, we would have broken this out by age as well.

We also collect outcome data including reason for discharge, abstinence and decrease in use at discharge, services received in treatment and all federally required outcome data. Maine was one of the first states to receive funds from CSAT for providing them with our data rather than for developing our system so that we can collect the data.

9. For the two or more categories of EBPs you have selected, describe how you will use data to monitor EBP implementation, as well as the impact implementation will have on processes and/or proximal outcomes? Please identify:
   a. How you will measure change in the use of evidence-based practices among providers
   b. Your selected proximal outcomes
   c. How you will measure change in the selected proximal outcomes
   d. The process you will use to collect data (please identify any challenges associated with data collection)
   e. Please provide any data you have for your selected proximal outcomes and indicate the time period during which the data was collected.

If you do not have data collection systems currently in place, describe the process you will implement to collect the necessary data on a regular basis.
a. We will conduct provider surveys prior to and after the first and second year of the project to assess change in use of and attitudes toward medication assisted therapy and case management services. During the course of the project we will change our treatment data collection discharge form to gather this information on each client at discharge. Currently we ask about a variety of services but the questions are either irrelevant or too vague to be helpful regarding evidenced based practice. We can also measure the change in the use of medication by reviewing Medicaid data prior to the project, at one year and two years into the project. Changes in prescribing practices for Suboxone can be obtained from the prescription monitoring program, but it does not collect information on drugs that are not scheduled.

b. Our first outcomes to measure will be 1. increased use of medication including methadone, buprenorphine, naltrexone and acamprosate in the Medicaid and other populations and 2. increase in positive attitude of counseling staff and supervisors regarding use of medication in the treatment of addiction. 3 Change in length of stay and treatment outcome medication users vs. non-users.

For people using case management and wrap around services we will develop a briefer version of the TDS form to capture the needs and services received. We already collect data on a number of services received during treatment. We will measure the use of wrap services and compare the outcomes for those who have them vs. those who don’t and measure improvement over time.

c. Increased use of medication will be measured by comparing Medicaid data for the year prior to, one year into and two years into the project. Buprenorphine can be measured for all payers through the prescription monitoring program. We will add a question to the TDS form that will indicate whether or not the patient received medication to assist treatment by the end of year one.
and that can also be used to measure change from the end of year one to the end of year two. The change in attitude will be measured by a survey delivered by MASAP to clinicians and supervisors. A question will be added to the current client satisfaction survey that will determine whether people were offered medication. In addition, MAAR will survey people in recovery using medication to assess client perception of clinician attitude toward use of medication. The treatment data system will be used to measure length of stay and treatment outcomes comparing people using medication and those not using medication and measuring changes in outcomes for all clients over time.

d. Medicaid data is claims data and is collected from all providers if they want to be paid. TDS data is collected from licensed substance abuse treatment programs. It collects all data except for hospital data unless the hospital is providing methadone treatment in which case it is required to submit data on those clients. Data is collected at admission and discharge. This system is relatively malleable and we are in the process of changing some fields to better capture the NOMS data required by the federal government. The prescription monitoring system collects data from all pharmacies licensed to dispense in Maine – including legitimate mail order pharmacies – on all prescriptions filled for scheduled drugs.

e. Medicaid data is currently difficult to extract and 2005 data is not available due to systems issues. However the prescription monitoring system and TDS are operational and can provide the following data for calendar year 2005:

People who received prescription medication during treatment had a completion rate of 53% vs. only 36% of people who did not.

People who received transportation assistance for treatment had 47% completion rate while those that did not had a 41% completion rate. More significantly those that received transportation
assistance left treatment against medical advice 16% of the time while those that did not left against advice 23% of the time.

People who received housing assistance completed treatment 55% of the time, while those that did not completed 42% of the time. Only 17% of clients that received housing assistance dropped out of treatment, while 23% of those that did not dropped out.

The number of individuals having a prescription of buprenorphine went from 616 in March of 2005 to 1084 in March of 2006.

10. Please describe how you intend to sustain changes that support the use of your selected evidence-based practices.

By the end of the project we will have identified the data that best measures the outcomes that we want to achieve and will have changed our instruments to capture that data. OSA already has a performance based contracting system. Performance is measured in two ways: efficiency and effectiveness. Efficiency measures the number of units of service provided based on the number contracted for. Effectiveness measures the agencies outcomes on a variety of measures including abstinence at discharge, completion of treatment, arrests etc. Agencies that fail to meet the standard which is based on averages for the year 2003 have a year to get up to par or they lose some or all of their funding. In state fiscal year 2007 we will also reward agencies that exceed by 10% all of the performance based criteria. We will adjust performance criteria over the course of the grant project so that agencies will be expected to meet the outcomes we desire.

11. One common shortcoming of EBP implementation is that practices are not customized to meet the needs of underserved or minority populations. How do you plan to approach this challenge?
Maine has an especially difficult time meeting the needs of minority populations. The minority populations are so small and diverse that it is infeasible to develop specialized programming as many states and communities have done. We need to find a way to make our existing system more welcoming to people who are in the minority. Groups that have been identified as needing but not able to access services are Latino and Somali populations in Portland and Lewiston, mostly Latino migrant farm workers in rural Aroostook and Washington counties, and other refugee populations including Vietnamese. A social worker in a local homeless shelter described the process of trying to access detox services for a Latino man. First, he speaks no English and there are no Spanish speaking employees at the detox facility. Second, he is intoxicated, so the well meaning attempts to use the ATT relay translation system is a farce as the translator cannot understand him when he slurs his words and even if he were sober, has a hard time translating treatment jargon into Spanish. Generally people leave before the intake process is finished. If someone actually sticks with the intake, he finds himself isolated in a foreign environment where he must communicate intimate details of his physical and emotional life to a stranger through a translator. This would be uncomfortable even for Americans where the confessional culture is the dominant culture. For someone in whose culture this is anathema, this tends to be the hurdle that is insurmountable. We have also had it pointed out to us that our treatment system is particularly secular and for Latino people, religion is a central part of life. Another difficulty that has been pointed out is that the vast majority of the treatment providers are women, which creates an additional barrier for Latino men.

While there are many changes that need to be made to make the system more accessible to minorities, one of the ways to help them navigate the system is to identify people from their culture who can act as case managers. They can be the touch point through and beyond an
episode of care. The city of Portland has developed a case management system for minorities to access general health care, and we believe rather than creating a separate system for substance abuse services, these Community Health Outreach Workers (CHOW) should also address substance abuse services. This program is only nine months old, but in the first two quarters of operation: July – December 2005 served 36 people in the Portland Latino community and 76 Somali people. The city believes that in order to meet the demand, they will need to add another CHOW worker to add substance abuse to the work load. OSA has made a commitment to the city to find the funds to make this project work.

**Change Exercise**

12. Applicants selected for a site visit will be required to present and document the results of changes targeted to (1) a treatment agency process and (2) a state system process (two changes total) to facilitate the use of an evidence-based practice. Please indicate
   a. The treatment agency process targeted for change, and the change you intend to implement
   b. The state system process targeted for change, meaning an administrative process or procedure, and the change you intend to make
   c. How you intend to measure the results of these two changes

   a. Health Reach will take its effort to make it easier to get into their treatment facilities another step by removing the requirement that patients must be detoxed prior to admission.

   b. The state will perform a survey of medical directors of treatment agencies that asks four questions: 1. Are you aware of the availability of Suboxone, Naltrexone and Camprodol? 2. Do you prescribe these medications to your patients? 3. If yes, why do you think other physicians don’t prescribe these medications? 4. If no, why don’t you prescribe these medications? We will use the survey results to identify a change in a state level process, either reimbursement or administrative and begin to identify any training needs.
c. Health Reach will collect data for three weeks pre-change to measure the number of admissions and no-shows, and collect data for three weeks post change to measure number of admissions and no-shows. The hypothesis is that people do not make it to the admission appointment because they haven’t been detoxified or are turned away at the admission appointment because they haven’t been detoxed. By admitting them into the program regardless of detox status, they believe they will increase admissions and decrease no-shows.

OSA will measure change depending on the answers to the survey. The hypothesis for this survey is that many medical directors believe they can’t prescribe either for reimbursement or bureaucratic reasons that may or may not be real. If they have misinformation, then the change will be an information campaign. If the issue is reimbursement, we will address the reimbursement issue. We will begin this process immediately so that data from a change is available at the site visit. We can measure the change in use of medication through the Medicaid system.

i State system: These are any of the administrative or statutory rules applied by the state or local government agency (usually the SSA) that directly affect the delivery of care in substance abuse treatment agencies.

ii Proximal outcome: A reasonably immediate change in patient or community treatment agency behaviors that is logically connected to the changes implemented. For example, the implementation of motivational interviewing might reasonably be expected to affect the proximal outcomes of next day return to treatment or total length of stay in a treatment episode.
Advancing Recovery:
State and Provider Partnerships for Quality Addiction Care

Site Visit Worksheet

Organization: Maine Office of Substance Abuse

Please identify three preferred dates for site visits in the table below. The responsible directors of all the potential partners (government departments, collaborating agencies, community treatment agencies) must be present at the site visit and prepared to discuss the financial and administrative arrangements necessary for the Advancing Recovery project to take place. For the two-day time slots that you select, you must be available both days, and the visit will last approximately one and one-half days. Site visits scheduled to take place on Tuesday and Wednesday will occur all day Tuesday and half-day on Wednesday. Site visits scheduled to occur on Thursday and Friday will take place all day Thursday and half-day on Friday. Each day should be scheduled for 8:00 AM to 4:00 PM on the first day and 8:00 AM to noon on the second day.

To help us coordinate the visit, please answer the three additional questions below. If you are selected for a site visit, you will be notified of the exact date of your visit on or around June 26, 2006. Complete this information; save, and upload the document.

<table>
<thead>
<tr>
<th>Dates</th>
<th>Preferences</th>
</tr>
</thead>
<tbody>
<tr>
<td>July 18 to 19 (T to W)</td>
<td></td>
</tr>
<tr>
<td>July 20 to 21 (Th to F)</td>
<td></td>
</tr>
<tr>
<td>July 25 to 26 (T to W)</td>
<td>6</td>
</tr>
<tr>
<td>July 27 to 28 (Th to F)</td>
<td>5</td>
</tr>
<tr>
<td>August 1 to 2 (T to W)</td>
<td>2</td>
</tr>
<tr>
<td>August 3 to 4 (Th to F)</td>
<td>3</td>
</tr>
<tr>
<td>August 8 to 9 (T to W)</td>
<td>4</td>
</tr>
<tr>
<td>August 10 to 11 (Th to F)</td>
<td>1</td>
</tr>
</tbody>
</table>

1. What is the closest major airport?
Portland, Maine

2. How long does it take to drive from that airport to your facility?
One hour

3. Can you recommend two local hotels that could accommodate the site visit team? Please list names and (if available) phone numbers.

Comfort Inn Civic Center: (207) 623-1000

Senator Inn (Best Western): 1-877-772-2224
### Advancing Recovery: State and Provider Partnerships for Quality Addiction Care

Office of Substance Abuse
Advancing Recovery in Maine

#### Personnel

<table>
<thead>
<tr>
<th>Line Items</th>
<th>Period 1</th>
<th>Period 2</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>RWJF Amount</td>
<td>Non-RWJF Support</td>
<td>RWJF Amount</td>
</tr>
<tr>
<td></td>
<td>FTEs/Fringe %</td>
<td></td>
<td>FTEs/Fringe %</td>
</tr>
<tr>
<td>Project Dir./Principal Inv.</td>
<td>0.10</td>
<td>8,500</td>
<td>0.10</td>
</tr>
<tr>
<td>Administrative Staff</td>
<td>0.30</td>
<td>15,000</td>
<td>0.30</td>
</tr>
<tr>
<td>Other Staff</td>
<td>0.00</td>
<td>0</td>
<td>0.00</td>
</tr>
<tr>
<td>Fringe Benefits</td>
<td>0.00</td>
<td>0</td>
<td>0.00</td>
</tr>
<tr>
<td>Subtotal</td>
<td>0.40.00%</td>
<td>9,400</td>
<td>0.40.00%</td>
</tr>
<tr>
<td></td>
<td>$0</td>
<td>$32,900</td>
<td>$0</td>
</tr>
</tbody>
</table>

#### Other Direct Costs

<table>
<thead>
<tr>
<th>Line Items</th>
<th>Period 1</th>
<th>Period 2</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>RWJF Amount</td>
<td>Non-RWJF Support</td>
<td>RWJF Amount</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>FTEs/Fringe %</td>
</tr>
<tr>
<td>Office Operations</td>
<td>1,500</td>
<td>0</td>
<td>1,500</td>
</tr>
<tr>
<td>Comm. and Marketing</td>
<td>1,000</td>
<td>0</td>
<td>1,000</td>
</tr>
<tr>
<td>Travel</td>
<td>10,000</td>
<td>0</td>
<td>10,000</td>
</tr>
<tr>
<td>Meeting Expenses</td>
<td>2,000</td>
<td>0</td>
<td>2,000</td>
</tr>
<tr>
<td>Surveys</td>
<td>2,500</td>
<td>0</td>
<td>2,500</td>
</tr>
<tr>
<td>Equipment</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Project Space</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Subtotal</td>
<td>$17,000</td>
<td>$0</td>
<td>$17,000</td>
</tr>
</tbody>
</table>

#### Purchased Services

<table>
<thead>
<tr>
<th>Line Items</th>
<th>Period 1</th>
<th>Period 2</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>RWJF Amount</td>
<td>Non-RWJF Support</td>
<td>RWJF Amount</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>FTEs/Fringe %</td>
</tr>
<tr>
<td>Consultants</td>
<td>45,000</td>
<td>0</td>
<td>45,000</td>
</tr>
<tr>
<td>Contracts</td>
<td>107,680</td>
<td>0</td>
<td>107,680</td>
</tr>
<tr>
<td>Subtotal</td>
<td>$152,680</td>
<td>$0</td>
<td>$152,680</td>
</tr>
</tbody>
</table>

#### Indirect Costs

<table>
<thead>
<tr>
<th>Line Items</th>
<th>Period 1</th>
<th>Period 2</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>RWJF Amount</td>
<td>Non-RWJF Support</td>
<td>RWJF Amount</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>FTEs/Fringe %</td>
</tr>
<tr>
<td>Indirect Costs</td>
<td>4,650</td>
<td>0</td>
<td>4,650</td>
</tr>
<tr>
<td>Subtotal</td>
<td>$4,650</td>
<td>$0</td>
<td>$4,650</td>
</tr>
</tbody>
</table>

#### Grand Total

<table>
<thead>
<tr>
<th>Line Items</th>
<th>Period 1</th>
<th>Period 2</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>RWJF Amount</td>
<td>Non-RWJF Support</td>
<td>RWJF Amount</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>FTEs/Fringe %</td>
</tr>
<tr>
<td></td>
<td>$174,330</td>
<td>$32,900</td>
<td>$174,330</td>
</tr>
</tbody>
</table>

---

**Printing Tip!**
## Category: Personnel

<table>
<thead>
<tr>
<th>Item Narrative</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Project Director/ Principal Investigator</strong></td>
</tr>
<tr>
<td>This item is state supported. 10% of Kimberly Johnson, OSA director will be devoted to this project</td>
</tr>
</tbody>
</table>

| **Project Staff** |
| Two OSA staff will devote 15% each of their time: Linda Frazier, treatment team manager and Mary Henderson, data and research team manager. |

| **Administrative Staff** |
| This item does not apply. |

| **Other Staff** |
| This item does not apply. |

| **Fringe Benefits** |
| State benefits are 40% of salary. This is a state contributed cost. |

## Category: Other Direct Costs

<table>
<thead>
<tr>
<th>Item Narrative</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Office Operations</strong></td>
</tr>
<tr>
<td>Includes paper and office supplies; printing, photocopying of meeting materials, and telephone at 10% for Kim Johnson and 15% for Linda Frazier and Mary Henderson</td>
</tr>
</tbody>
</table>

| **Communications and Marketing** |
| These funds will be used to develop materials-brochures and other materials to market the project and any training developed under the project. |

| **Travel** |
| Two trips each year for three people to Advancing Recovery meetings estimated at $1360 per trip per person, plus in state travel for project staff @ $0.36 per mile. |

| **Meeting Expenses** |
| Food and rented space for project meetings. Conference call expenses for phone meetings. A variety of meetings will be held with consumers and providers. Change project leaders will meet monthly by phone. Face to face meetings will be held between project staff from OSA, MASAP, MAAR and other partners. |

| **Surveys** |
| At least two consumer and two provider agency mail in surveys will be conducted. The cost is for the development, printing and mailing of the surveys. The surveys will be made using scantron technology to reduce the data entry costs. Additional agency surveys may be conducted, but will use internet Survey Monkey technology. |

| **Equipment** |
| This item does not apply. |

| **Project Space** |
| This item does not apply. |
### Category: Purchased Services

#### Item Narrative

**Consultants**

Consultants not yet identified but needed to train physicians and advanced level (prescribers) healthcare practitioners on medication assisted therapy, counselors and clinical supervisors on medication assisted therapy, evidence based models for wrap services and case management with minority populations, and data collection and analysis.

Data consultants will modify the Treatment Data System to meet identified data necessary to measure client level improvements not yet collected in the system and to analyze Medicaid data.

- **Training consultants:** $20,000 each year including consulting fee and travel and lodging
- **Data consultants:** $25,000 each year: $10,000 Medicaid analysis, $15,000 TDS changes in each year.

#### Contracts

**MASAP:** $8000 per year for 10% of Ruth Blauer salary w/ fringe

- $20,000 per year agency stipend to reimburse lost billable hours for first ten agencies involved
- $15,000 per year to develop learning collaborative
- $3,870 overhead

**MAAR:** $37,440 per year half time position w/ fringe to work on walk-throughs, hold client focus groups, design and conduct surveys and feed back information to the project team, and provide outreach for consumer education regarding medication assisted therapies and case management/wrap services.

- $3,370 overhead

- **City of Portland Public Health Division:** $10,000 per year to pay for coordination of effort to improve care for minorities

- **Adcare Educational:** $10,000 per year to manage training including registration, rental of space, set up and meals

### Category: Indirect Costs

#### Item Narrative

**Indirect Costs**

7.5% of operations and consulting costs as required by Maine State Government rule.