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Report to the Chairman and Ranking Minority Member, Committee on Veterans' Affairs, U.S. Senate

November 1996

SUBSTANCE ABUSE TREATMENT

VA Programs Serve Psychologically and Economically Disadvantaged Veterans

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The Honorable Alan K. Simpson
Chairman
The Honorable John D. Rockefeller IV
Ranking Minority Member
Committee on Veterans' Affairs
United States Senate

Substance abuse is a chronic, relapsing medical disorder that afflicts a significant number of Americans, including veterans who get their health care from Department of Veterans Affairs' (VA) medical centers. In fiscal year 1995, more than 125,000 (about 25 percent) of all VA patients discharged from inpatient settings had a primary or secondary diagnosis of substance abuse (alcohol and/or drug dependency). VA estimates that it spent $2 billion, or about 12 percent of its health care budget in fiscal year 1995, to treat veterans with substance abuse disorders.

The VA health care system is currently reorganizing and evaluating what services to offer and where to provide those services. The new organizational structure, called the Veterans Integrated Service Network (VISN), essentially replaces VA's central office and regional structure with 22 networks of hospitals and clinics. The networks are consolidating and realigning services within their areas to provide an interlocking, interdependent system of care. VA expects this consolidation and realignment to improve efficiency by trimming management layers, eliminating duplicative medical services, and better using available public and private resources.

To better understand VA's current substance abuse program and the effect of VA's reorganization on this program, you asked us to provide the following information:

- characteristics of veterans who receive substance abuse treatment,
- services VA offers to veterans with substance abuse disorders,
- methods VA uses to monitor the effectiveness of its substance abuse treatment programs,
- community services available to veterans who suffer from substance abuse disorders, and
- implications of changing VA's current methods for delivering substance abuse treatment services.

Our work focused on VA medical center inpatient and outpatient units designated specifically for substance abuse treatment. We did not examine medical, surgical, or psychiatric units that may also provide substance abuse treatment. We gathered demographic and program data from VA reports and fiscal year 1995 VA patient treatment files, the most recent files available. We interviewed senior officials at VA headquarters and VA medical centers in Chicago, Denver, and Seattle and national experts in substance abuse treatment about program monitoring. We conducted case studies in Colorado and Illinois to obtain information about non-VA substance abuse programs and spoke with federal, state, and private-sector officials about these services' availability to and use by veterans. Finally, we reviewed the literature and discussed with VA and non-VA officials the potential implications of eliminating VA's substance abuse services or contracting these services out to non-VA providers. We did our work between November 1995 and July 1996 in accordance with generally accepted government auditing standards.

Results in Brief

In fiscal year 1995, VA inpatient and outpatient substance abuse treatment units served about 180,000 veterans. Our analysis showed that about half of the inpatients were homeless at the time of admission, and about a third also had psychiatric disorders. Many of these veterans were chronically unemployed, had problems maintaining relationships, reported low incomes, or were criminal offenders. Over 75 percent of the veterans treated served during or after the Vietnam War era.

To respond to the demand for treatment, VA has established 389 substance abuse treatment programs at over 160 medical centers. A variety of treatment settings is available, such as inpatient and extended-care programs, outpatient clinics, and residential rehabilitation programs. VA uses a variety of treatment approaches, such as Alcoholics Anonymous's 12-Step program and cognitive behavioral therapy. Between fiscal years 1991 and 1996, VA's funding for treatment increased from $407 million to $589 million to accommodate its growing substance abuse treatment program. Although the number of inpatients and inpatient programs at VA medical centers has remained fairly stable since fiscal year 1991, the number of outpatients and outpatient programs has grown significantly—from 37 percent and 78 percent, respectively, during this time period.

VA currently lacks the necessary data to adequately measure and fully evaluate the efficacy of its many treatment programs. To monitor the quality of its substance abuse treatment programs, VA has primarily relied on utilization information and recidivism rates (relapses within 1 year of treatment). However, like other providers of substance abuse treatment services, VA is developing a performance monitoring system based on treatment outcome measures.

In addition to VA's many substance abuse services for veterans, numerous non-VA substance abuse treatment programs are also available to and used by veterans. In Colorado, for example, non-VA substance abuse treatment programs served nearly 10,000 veterans in fiscal year 1995. Many veterans treated in community-based public programs are like those treated in VA programs.

Changing the delivery of VA substance abuse treatment services may have significant implications. For example, if VA stopped treating veterans for substance abuse, resulting societal costs may shift to welfare or other social services, other federal or state substance abuse treatment programs, and the criminal justice system. The implications of VA's contracting out for these services rather than providing them directly are difficult to ascertain at this time, however. This is because VA lacks critical information needed to make realistic assessments, such as the health care needs of eligible veterans, the number veterans who might seek care, and the actual cost of treating veterans with substance abuse disorders.

VA's current reorganization is unprecedented. Directors of the newly created VISNs and other VA officials have not yet decided how substance abuse treatment services will be delivered and what outcome measures will be used to evaluate treatment and program effectiveness. Once these decisions are made, VA treatment outcomes can be compared with the outcomes of other substance abuse treatment programs, and the feasibility and cost of contracting these services out can be better assessed.

Background

VA began providing formal treatment for alcohol dependency in the late 1960s and treatment for drug dependency in the early 1970s. According to VA, the guiding principle behind its national substance abuse treatment program has been the development of a comprehensive system of care for veterans. In accordance with this principle, VA has developed a network system of care that is supposed to afford veterans access to facilities

offering a range of substance abuse treatment services, including inpatient, residential, and ambulatory care.

VA requires its medical centers to maintain quality assurance programs so that veterans receive quality care. Such care is defined as the degree to which health services increase the likelihood of desired health outcomes and are consistent with current professional knowledge. Quality assurance programs measure whether quality care is provided and use performance indicators to measure whether established standards have been met.[1]

VA Serves a Problematic Veteran Population

VA's substance abuse treatment programs serve a population characterized as psychologically and economically devastated. For example, in fiscal year 1995, nearly one-half of veterans in substance abuse treatment inpatient units were homeless at the time of admission, and 35 percent had both substance abuse and one or more psychiatric disorders. In addition, veterans treated in substance abuse treatment units were chronically unemployed, had problems maintaining relationships, reported low incomes, or were criminal offenders.

In fiscal year 1995, VA treated 57,776 veterans in inpatient substance abuse treatment units and 121,812 veterans in outpatient substance abuse treatment units (see table 1). About 70 percent of these veterans were eligible for VA health care because of their low incomes rather than because of a service-connected disability. More than 50 percent of the veterans were Vietnam War-era veterans and another 25 percent served after that time. Only 6 percent of the inpatients and 9 percent of the outpatients had a service-connected disability of 50 percent or more.

Table 1: Demographics: Veterans Receiving Substance Abuse Treatment, FY 1995

	Inpatients (57,776)	Outpatients (121,812)
Nonservice connected	74 percent	69 percent
Service connected	25 percent	31 percent
Pre-Vietnam War	14 percent	20 percent
Vietnam War era	54 percent	53 percent
Post-Vietnam War	27 percent	24 percent
Median age	43 years	45 years

[1]Performance indicators can be classified as (1) structure: the capacity of a provider or institution to deliver quality health care, for example, the ratio of nurses to inpatient beds; (2) process: provider activities performed to deliver the care, such as adherence to 12-Step program protocols; and (3) outcomes: the results of provider activities, such as veterans abstaining from alcohol for 1 year and patient satisfaction with treatment provided.

Characteristics of veterans treated in inpatient and outpatient substance abuse treatment units differed somewhat from veterans treated in VA's medical and surgical units. Veterans in the medical and surgical units were older than those in the treatment units. Their median age was about 59, compared with veterans in all substance abuse treatment units, whose median age was 43. Furthermore, more veterans in medical and surgical units were eligible for VA treatment because of their service-connected disability than were veterans being treated in substance abuse treatment units. About 34 percent of the inpatients and 47 percent of the outpatients seen in medical and surgical units had a service-connected disability, compared with 25 percent and 31 percent, respectively, for veterans in all substance abuse treatment units.

VA Offers a Variety of Substance Abuse Treatment Services

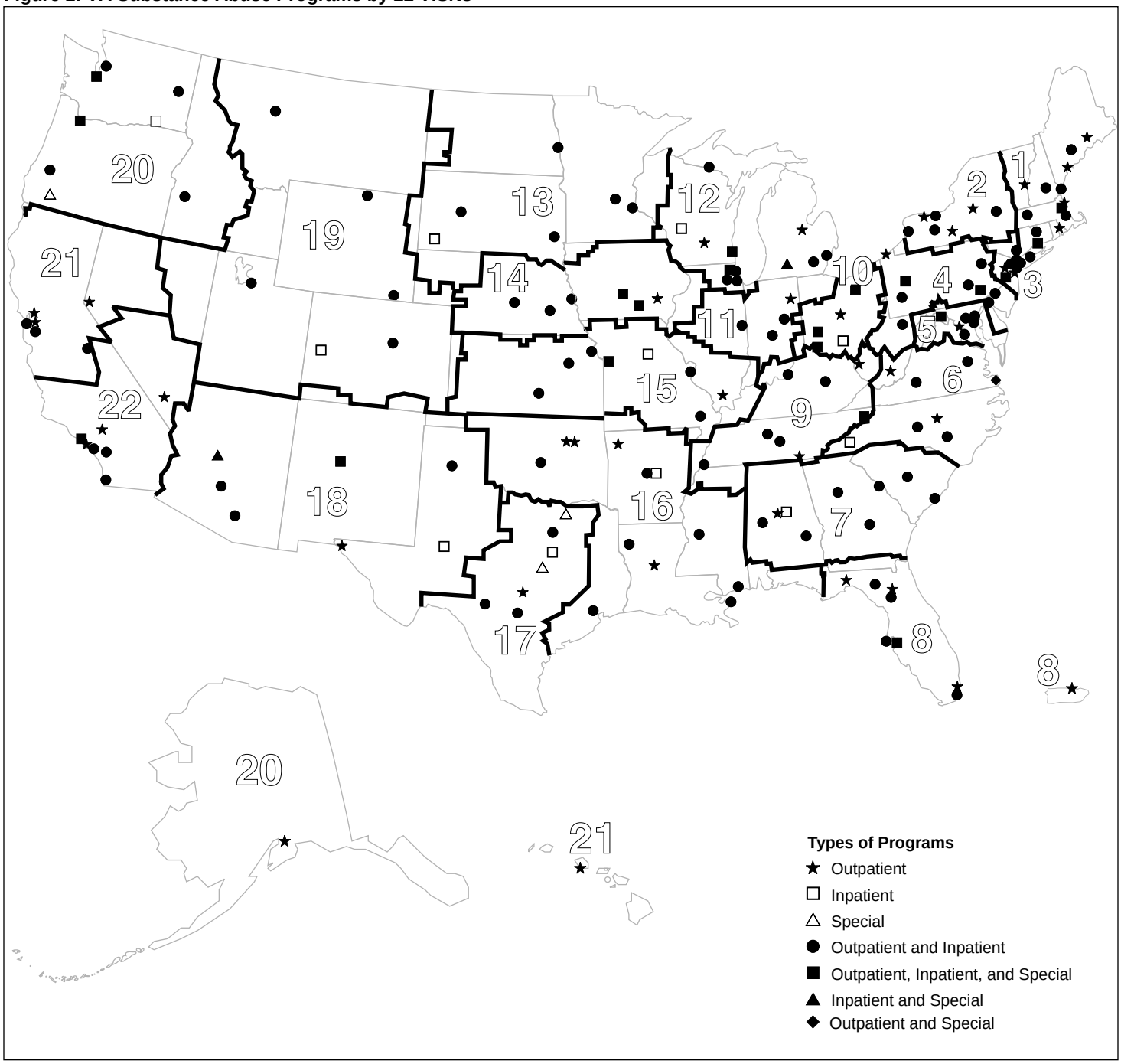
VA strives to offer a continuum of services to treat veterans nationwide with substance abuse disorders. Since fiscal year 1990, VA has used additional funds to expand the number of substance abuse treatment programs, patients treated, and staff. The additional funds, accompanied by an increased emphasis on outpatient treatment, have resulted in significantly increasing the number of outpatients served at VA medical centers.

VA Has a Variety of Programs and Treatment Approaches

VA operates 389 substance abuse treatment programs at more than 160 medical centers throughout the United States and Puerto Rico. These programs include 203 inpatient or extended-care programs, 152 outpatient programs, 22 methadone maintenance clinics, 9 residential rehabilitation programs, and 3 early intervention programs. Typically, these medical centers provide a combination of treatment settings, incorporating inpatient or extended-care programs, outpatient clinics, and residential rehabilitation programs. VA provides most substance abuse programs directly. However, it does rely on some non-VA facilities, such as community residential facilities, to provide some services.[2] Figure 1 shows the locations and types of VA substance abuse programs provided as of October 1, 1994.

[2]VA spends about $10 million annually to place veterans in community residential facilities.

Figure 1: VA Substance Abuse Programs by 22 VISNs



Note: Programs as of October 1, 1994.

Like other providers, VA uses a variety of approaches in treating veterans with substance abuse disorders. Table 2 describes the treatment approaches used in VA programs.

Table 2: VA's Drug and Alcohol Program Treatment Approaches

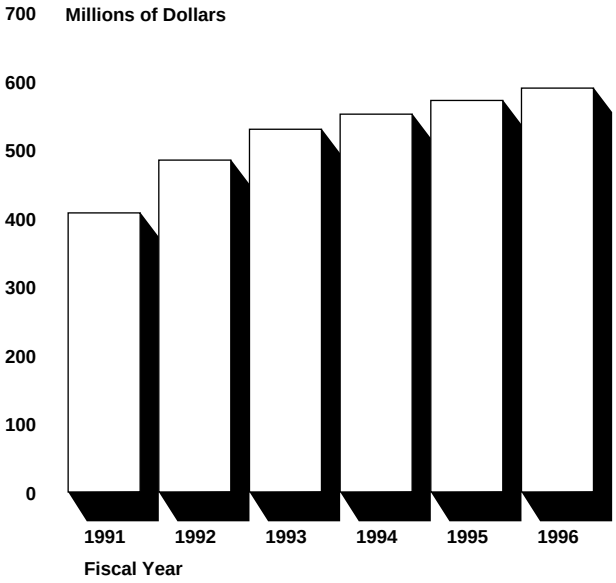
Program	Treatment approaches
Alcoholics Anonymous/12 Step	Emphasis on Alcoholics Anonymous and Narcotics Anonymous goals and activities, such as helping patients accept that they are powerless over the abused substance and working through the 12 steps
Cognitive behavioral	Emphasis on developing confidence in coping with high-risk situations for relapse and helping patients identify alternative responses to using drugs or alcohol
Social	Emphasis on improving communication and interpersonal skills and on teaching patients how to enhance assertiveness
Insight	Emphasis on understanding how substance abuse dependencies develop and on gaining new insights into personal relationships
Marital/family systems	Emphasis on strengthening marital and family relationships and on involving spouses and other family members in treatment
Therapeutic community	Emphasis on accepting personal responsibility for decisions and actions and on assigning patients chores or duties as part of the treatment
Rehabilitation	Emphasis on developing better work habits and on acquiring new job skills
Dual diagnosis	Emphasis on using specialized treatment for patients who have both substance abuse and psychiatric problems
Medical	Emphasis on using medications to lessen withdrawal symptoms and on using formal diagnoses as the basis of treatment plans

Additional Funds Expanded Treatment Capacity

As part of the President's national drug policy program, VA received $105 million annually in recurring funds in fiscal years 1990 to 1993. VA used these funds to expand substance abuse treatment services to more eligible veterans. The additional funds and emphasis on outpatient treatment resulted in significantly increasing the number of outpatients served at VA medical centers.

As shown in figure 2, obligations for VA substance abuse treatment programs increased about 45 percent, from $407 million to $589 million from fiscal years 1991 to 1996.

Figure 2: VA Substance Abuse Program Obligations, FY 1991-1996



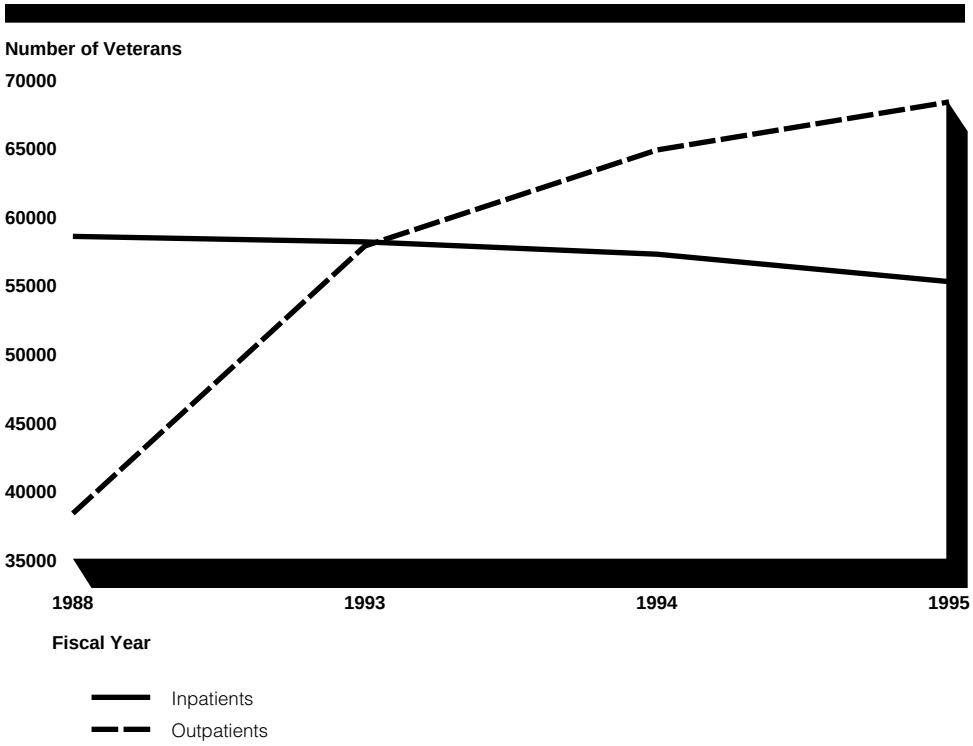
Note: Fiscal year 1996 total is estimated.

Source: VA budget data.

As shown in figures 3 and 4, the number of inpatients and inpatient programs has remained fairly stable over the years; the number of outpatients and outpatient programs has grown significantly, however. According to VA, the number of inpatients served in VA substance abuse treatment units declined slightly from 58,500 to 55,200 patients in fiscal years 1988 to 1995. The number of outpatients in substance abuse treatment in those same fiscal years rose dramatically, however, from 38,300 to 68,300 patients—about a 78-percent increase.[3]

[3]Our analysis of fiscal year 1995 patient treatment files showed a higher number of substance abuse patients than VA reported. The major difference stems from outpatient treatment file data that include veterans who received both inpatient and outpatient treatment in fiscal year 1995. For trend analysis, we relied on data reported to VA's Program Evaluation and Resource Center, which excludes those outpatients also treated as inpatients in substance abuse treatment units in the same fiscal year.

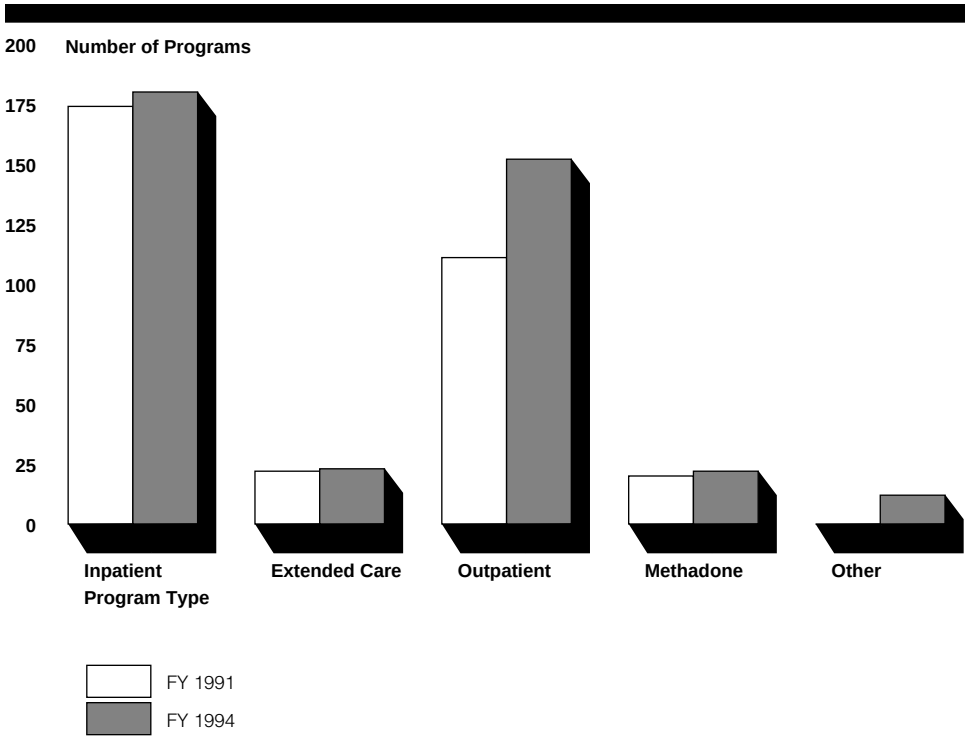
Figure 3: Number of Inpatients and Outpatients Treated in VA Substance Abuse Units, FY 1988-1995



Note: Outpatient statistics exclude veterans who also received inpatient substance abuse treatment during the same fiscal year.

Source: Program Evaluation and Resource Center, Palo Alto, California.

Figure 4: Number and Types of VA Substance Abuse Treatment Programs, FY 1991 and 1994



Note: "Other" includes nine residential rehabilitation and three early intervention programs.

Source: Program Evaluation and Resource Center, Palo Alto, California.

A similar trend has occurred in the number of inpatient and outpatient treatment programs. The number of inpatient programs increased from 174 to 180 (about 4 percent) between fiscal years 1991 and 1994. However, the number of outpatient programs increased from 111 to 152—about a 37-percent increase.

Traditionally, medical center directors determined the extent to which their centers offered substance abuse treatment services. This may change, however, under the VISN structure. The VISN directors, who are accountable to the Under Secretary for Health for their VISNs' performance, are charged with providing coordinated services for all eligible veterans living within their network areas. Although VISN directors and the respective medical center directors have discussed possible changes to the substance abuse treatment programs, no changes had yet been made

during the time of our study. On the basis of discussions with VA officials, however, some current programs will likely be consolidated and others will likely change focus.

VA Is Changing Its Quality Management Philosophy

VA currently lacks the necessary data to adequately measure and fully evaluate the efficacy of its many treatment programs. VA is therefore developing a new performance monitoring system, using new outcome measures, to compare treatment and program effectiveness both internally and with non-VA substance abuse treatment providers. VA's efforts compare with outcome measurement approaches used by non-VA providers of substance abuse treatment services.

Substance abuse treatment staff at VA medical centers monitor program quality through the accreditation process and internal studies. VA medical center substance abuse treatment programs must meet the standards promulgated by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). Through its review process, JCAHO determines whether each medical center has the necessary programs in place that should result in good care. In addition, medical centers have instituted quality improvement programs, in part to satisfy accreditation requirements, using a variety of measures. The medical centers we visited track readmissions, length of stay, and patient satisfaction. At the VA medical center in Denver, for example, recidivism rates have been monitored since 1988. At a VA medical center in Chicago, discharged inpatients are monitored to determine whether they show up for outpatient follow-up care.

VA's quality management philosophy and staffing resources have constrained the central office staff's monitoring role. Central office officials have primarily played a consultant role on quality assurance matters. This role has been based on VA's philosophy that, because care takes place at the medical centers, staff at the centers are the best suited to monitor their programs and take the appropriate actions to improve care. Central office officials do, however, monitor the many substance abuse treatment programs by reviewing (1) annual reports on the substance abuse treatment programs at each medical center; (2) reports on program services, staffing, and utilization from VA's Program Evaluation and Research Center; (3) the Quality Improvement Checklist, a systemwide quality improvement tool that includes one indicator about the rate of readmission for alcohol- and drug-related disorders for patients discharged from inpatient substance abuse treatment units; and (4) the

results of patient satisfaction surveys. These officials also work with staff from the Center for Excellence in Substance Abuse Treatment and Education to test models of care, help identify best practices, train students, and provide continuing education in substance abuse treatment. Except for the Center's reviews, however, none of these reviews focuses on the outcomes of the specific treatments provided.

In November 1995, in a shift in philosophy, VA central office officials proposed a systemwide approach to quality management using a variety of performance indicators, including treatment outcome measures. Believing substance abuse to be a chronic disease that frequently recurs, VA has dropped two previously used indicators, recidivism and discharge disposition, because staff felt that these indicators did not adequately measure program success.[4] The new indicators will rely on data currently collected but not aggregated. Three indicators relate to the number of veterans starting substance abuse treatment programs and visiting outpatient units. Two indicators compare the number of patients in and visits to outpatient substance abuse treatment units with the number of all patients in and visits to these units as well as the number of patients in all VA substance abuse treatment units as a percentage of the total number of patients in care.

In the future, VA plans to develop other performance indicators based on data not currently available to assess treatment effectiveness. These indicators will be based on data collected through a standardized data collection instrument, the Addiction Severity Index (ASI). The indicators will measure treatment outcomes that include changes in medical status, employment, alcohol use, drug use, criminal activity, family and social relationships, and psychiatric symptoms. VA is considering administering a comprehensive ASI to all patients within 3 days of entering any substance abuse treatment setting and then annually while the patient remains in treatment. An abbreviated ASI would be administered after 1 month and again after 6 months of treatment. Although both VA and non-VA substance abuse treatment officials agree that patient data collected through the ASI would be useful in determining the proper treatment and its efficacy, some are concerned that it may be too expensive and time consuming to administer.

[4]Although the goal for VA substance abuse treatment programs is still complete abstinence, VA recognizes that 40 to 60 percent of the patients will relapse within a year of treatment. Therefore, VA and non-VA providers have developed other measures of treatment success such as reduced alcohol and drug use.

The revised performance measures will be used to evaluate individual substance abuse treatment programs and compare them with each other as well as with non-VA programs. For example, VA is already piloting a performance monitoring system developed by its Program Evaluation and Research Center. The system ranks, according to cost and utilization data, the relative performance of mental health and substance abuse units among the medical centers and 22 VISNs. To ensure that the comparisons fairly assess program performance, VA intends to account for veteran characteristics, such as other coexisting medical or psychiatric diseases, that might affect the outcome of the substance abuse treatment.

VA's current and planned initiatives to monitor program performance compare with those used or planned by non-VA providers and managed behavioral health care organizations we contacted. For example, one large managed behavioral health company that has used outcome measures since 1993 collects information about readmission, complaints, and patient and provider satisfaction, among other data. A large local provider had no systematic outcome measurement efforts under way at the time of our study, but it would provide data for requested state or federal studies. Such data might include detoxification use, employment, housing, and treatment service use. Comparisons of VA's programs with publicly supported non-VA substance abuse programs should be possible once VA's various programs' treatment outcomes are known and the data are properly adjusted to account for any differences in patient characteristics.

Community Services Are Available to and Used by Veterans

Non-VA substance abuse providers and programs are also available to and used by veterans. In Colorado, for instance, approximately 400 facilities that receive some public funding to treat patients with low incomes served five times the number of veterans treated at the Denver VA medical center in fiscal year 1995. The 10,000 veterans treated by state-funded facilities in Colorado represent about 18 percent of the patients seen at the facilities. Similarly, in Illinois, we found that 8,200 patients, about 8 percent of those treated in facilities receiving state funds, were veterans.

According to VA officials and officials of the non-VA programs we visited, veterans who qualify for publicly supported treatments are like those treated at the VA medical centers. For example, in Colorado and Illinois, we found that the veterans treated by state-funded providers have low incomes and high levels of unemployment; many were homeless. Moreover, the vast majority of the veterans were male—97 percent in both Colorado and Illinois—and most did not have insurance.

Although non-VA providers told us they were willing to treat more veterans, they currently do not have enough staff to do so. Therefore, these providers would need additional funding to hire staff capable of treating a significant number of low-income veterans with multiple problems.

Implications of Changing VA's Service Delivery Methods Are Uncertain

The number and health status of eligible veterans, potential demand for substance abuse treatment services, and the cost of specific programs are just some of the data needed to determine the implications of changing VA's service delivery methods. However, VA currently has neither this information nor the systems in place to gather it. This situation and the decisions VISN directors might make about what and where services will be offered make it difficult to estimate the effects of VA's changing its current delivery structure.

One possible change to VA's services you asked us to explore is VA's reducing its substance abuse treatment program. If VA were to stop treating veterans for substance abuse, societal costs would likely increase. Researchers have indicated that the costs of treating people with substance abuse disorders tend to shift to other sectors, including welfare and other social services, other medical providers, and the criminal justice system, when people go untreated. Although we expect that many of VA's substance abuse patients would qualify for publicly supported treatment programs if VA ended its services, VA officials told us that some veterans would surely "fall through the cracks." These officials are concerned about the uneven distribution of care now provided through state-assisted programs and about how VA patients would fare in a managed care environment.

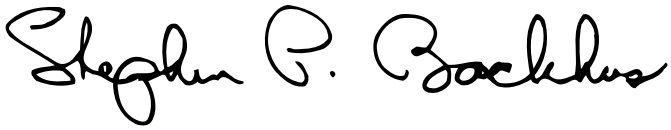
You asked us to look at the implications of VA's contracting out for substance abuse treatment services instead of eliminating or reducing the number of such services. The implications of this approach to VA and the community are difficult to determine at this time. VA lacks information on the health care needs of eligible veterans, the number of veterans who might seek care if it were more accessible, the actual cost of treating such veterans, and the outcomes of specific treatments. Before contracting out substance abuse treatment services, VA would have to better understand its patients, treatment outcomes, and costs. Only then could it define a number of key contractual elements, such as the type of service delivery model preferred, the actual services it would and could afford to cover, the treatment philosophy to be employed, responsibilities for program

monitoring, and the distribution of financial risks. The lack of this information limits our ability to evaluate the cost-effectiveness of contracting out program services and the implications of this action on the relative quality of services veterans might receive.

Agency Comments

VA reviewed a draft of this report and commented that it was a fair and accurate assessment of its substance abuse program and the initiatives it has under way.

This report was prepared under the direction of Sandra Isaacson, Assistant Director; Tom Laetz; Mary Needham; and Bill Temmler. Should you have any questions, please call me at (202) 512-7111 or Sandra Isaacson at (202) 512-7174.



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