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## **The COB Initiative: Moving to the Purchase of Outcomes in Addictions Services**

### **INTRODUCTION:**

During the 1980's, the US saw health care costs rise faster than inflation. Between 1988 and 1999, health care costs represented a roughly constant percentage (13.5%) of the gross domestic product (GDP). With many types of cost containments enacted at that time (including introduction of "managed care" principles and practices into the marketplace), national health expenditures still rose between 1996-1999 to a record \$1.1 trillion (EBRI, 2000). This trend of increasing health care costs continued in 2000, and rose 6.9% to \$1.3 trillion (Federal Report, 2002), yet the percentage of the GDP remained constant. During all of these years, however, there was one area of healthcare that saw consistently decreasing expenditures: behavioral medicine. Those providing addictions and mental health services experienced several disturbing trends:

- Expenditures for mental health and substance abuse ("behavioral medicine") services decreased during the 1990's by 74.5% (Bomier, 2000).
- There were many cost savings measures directed at all health services from heart surgery to addictions, though often without a sound research based on outcomes.
- In 1985, there were almost 36,000 beds available in the US for the treatment of addictions; in 1995, there were fewer than 6,000.
- With rising unemployment and a growing number of uninsured among the middle class, this decreased access to professional behavioral services has continued into this millennium and is troublesome from a national health policy perspective. The need has not decreased while access to services has been severely curtailed.

A group of concerned people both within and outside the behavioral medicine field saw these trends and responded by creating a special project of the National Council on Alcoholism and Drug Dependence (NCADD) called the Committee on Treatment Benefits (COB). This paper focuses on development of their model of outcomes-based addictions services.

### **BACKGROUND:**

#### **Outcomes-based system of care for addictions treatment**

The modern alcoholism movement evolved into a treatment movement in the 1970s and 1980s and established a national network of addiction treatment service organizations (White, 1999). While this movement brought more addicted people into treatment in a few decades than had been treated professionally in the previous two centuries, responsibility for objectively documenting outcomes of these services was not required by payors nor collected by providers. Thus, COB began in 1995 with experts in the fields of addictions treatment, research, finance, policy, and administration. These people voluntarily came together with recovering individuals and family members and began a dialogue towards creating an approach to instill greater accountability and credibility to the addictions treatment field. These founding members of COB knew it was essential to

provide services that were clinically and financially appropriate for the patient and general population; therefore, COB made data collection the foundation of its proposed outcome-based system for addictions treatment (Hoffmann, 1999). These COB founders had some predetermined parameters in mind:

- Have their findings and products empirically tested and scientifically defensible,
- Assure the results are relevant to both the private and public sectors, and
- Guarantee their findings are free and available to the public.

Under the aegis of the National Council on Alcoholism and Drug Dependence (NCADD), the oldest affiliate organization created to fight the stigma of addiction, the participants in the NCADD/COB process believed the only way to preserve and possibly increase the availability of services for addicts in need was to return a sense of confidence to the purchasers of addictions services. COB came from a long tradition of advocacy in its association with NCADD, for its founders commissioned the seminal study by medical scientist E.M. Jellinek, *The Disease of Alcoholism*, that led to the recognition by the American Medical Association in 1956 that alcoholism is a disease. Similarly, NCADD/COB was born in the hope that those who buy behavioral health care services would be able to determine if they were receiving measurable value for their expenditures. In order for this to happen, however, the field in general and each service provider in particular would need to objectively demonstrate the benefits of the services provided - to demonstrate the clinical, financial, and social value (or “outcomes”) of the behavioral health services purchased. Such objective demonstrations would require a system-wide transformation. Only recently has the behavioral health system made significant progress towards in demonstrating clinical outcomes, costs, and benefits of care, though this progress has been tempered with challenges. This article identifies the key elements of COB’s outcomes-based system of care for addictions treatment and suggests some additional steps needed to move in that direction.

## ACTIVITIES AND FINDINGS:

### I. Literature Review

At the time of COB’s beginning, there were no uniformly accepted methods of collecting data needed to quantify clinical effectiveness and financial efficiency, so COB went about creating ways to do so. Norman Hoffmann, one of the earliest researchers to routinely evaluate addiction treatment outcomes, was already collecting data on a number of treatment programs through CATOR, a private treatment evaluation system. CATOR audited the efficacy of programs in achieving recovery and documented correlates of that recovery. As a founding member and the Chief Investigator of COB, Hoffmann (insert date) suggested the first step in COB’s developmental process involved reviewing existing literature on data collection in the addictions field to determine the validity of three central components of COB’s approach:

1. All purchasing decisions could ultimately be driven by **verifiable outcome data**.
2. Severity and prognostic indicators could be used to indicate **outcome expectations**.
3. Payers could **measure the cost of services against outcomes, including cost-offsets and other benefits**.

The literature search undertaken by Hoffmann and DeHart indicated that a number of studies (Hoffmann, 1999) support these three central elements of the COB approach. However, the findings were limited because they were based largely on white, middle class alcohol-dependent males. It was not clear if the results of the literature review could

be generalized to other populations and other drugs. A second limitation was the fact that few studies were designed to look at prognostic indicators - patient attributes, beliefs, and behaviors associated with success or “failure” in maintaining abstinence. Instead, most treatment outcome studies simply compared two or more programs or approaches. This resulted in piecemeal indications of prognosis since few studies covered the spectrum of variables that would ideally be included in studying severity and prognosis.

#### **A. Prognostic indicators**

In their literature analysis, Hoffmann and DeHart discovered two consistent findings regarding prognostic indicators:

- “High demographic risk” was defined as being (a) under the age of 25, (b) not having a high school diploma, (c) never having married, and (d) not having a job.
- Those with three or more of these risk factors were found to require more than twice the primary treatment services to achieve reasonable outcomes than patients without three or more of these characteristics.

The literature review also pointed to the importance of aftercare in the achievement and maintenance of abstinence – less than 3 months greatly reduces the efficacy of primary treatment.

It was apparent that the task of creating data collection methods and tools to drive the COB model was complicated by several factors, for example the prognostic indicators included both demographic and clinical indicators. To further complicate COB’s task, there was little agreement across the field on such basics as terminology and what data items should be collected in assessing treatment outcomes, costs, and benefits.

The American Society of Addiction Medicine (ASAM) suggested additional reasons why the behavioral health field was not demonstrating its outcomes sufficiently (Mee-Lee, 1998):

- The addictions treatment field, as well as payors for those services, was slow to move away from *program-driven* treatment and reimbursement protocols and transition to *clinically-driven*, individualized services. (“Program-driven” treatment prescribes a regime of services for all clients with little modifications to accommodate the specific needs of individuals and their families. Program-driven treatment is usually based upon either a philosophy of treatment or upon a model that predefines the type and duration of services to be provided for virtually all cases. In contrast, “clinically-driven” services are based on initial and ongoing multidimensional assessment of a client’s needs and provide flexibility for adjusting not only the amount, but also the type of services to be delivered.)
- There has been inadequate attention paid to outcome in discreet groups of individuals, including adapting models to special populations.
- Many providers lack a mechanism or system of continuous feedback from treatment outcome data used to modify treatment approaches and services. Rather, treatment is provided more by ideology and tradition than by models and protocols influenced by objective measures of clinical efficacy and financial efficiency.

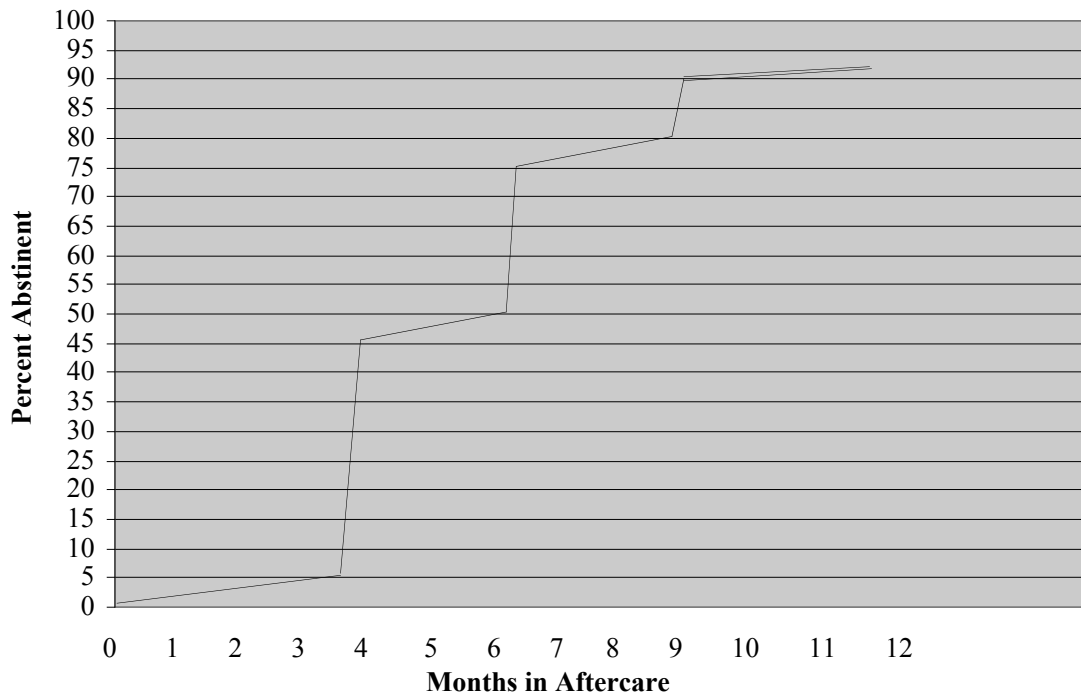
#### **B. Thresholds of care**

As COB's efforts evolved, a novel and important finding emerged: Hoffmann was able to clearly demonstrate for the first time that there are identifiable quantities of service that have reliable effects on the treatment outcomes of studied subjects. There are levels of service too low to effect the targeted result, and conversely, treatment beyond certain levels of care produce only small improvements in outcomes achieved and are therefore wasteful of scarce resources. These findings were based on a non-linear, recursive modeling technique - a statistical method that is more appropriate for identifying changes that occur in the relationships between variables. Leaps of treatment efficacy were found to occur at discrete points (or "thresholds"). Thus, specific "doses" of services produce a

particular level of outcomes (e.g., abstinence). Such threshold effects tend to be underestimated when using traditional parametric statistical methods such as correlations and regression because the basic assumptions of "bell-shaped" distribution in parametric statistics are violated.

For the first time in the addictions field, COB was able to show that minimum and optimal levels of services for clinical effectiveness could be determined. Within the constraints of a certain population, it was now possible to define a range of proper "dosage" of care. (See Figure 1 below.)

Figure 1



*NOTE: The numbers on the graph above are meant to demonstrate the concept, not replicate the exact research findings on a specific population.*

Another consistent finding from this COB research effort was that exposure to treatment services requires a sufficient period of time in order to be effective. In the case of maintenance or aftercare services, approximately three months are required to demonstrate any significant impact on abstinence rates. Prior to three months, little if any

increase is noted whether the individuals receive one or two months of aftercare. However, at three months there is a significant improvement in abstinence rates. For those receiving an additional month, there is no significant rise in abstinence rates; however, once the aftercare reaches about six months, another increase in abstinence rates is seen. The same threshold effect, though in smaller increments, is found at nine and twelve months.

## II. Twin Foci: Clinical and Financial

In addition to focusing on the study and definition of clinical outcomes, COB members knew the financial aspects of addictions treatment and benefit design required study - "How much would the desired outcome and associated 'treatment dosage' cost?" In November, 1996, COB convened a group of the nation's foremost economists and healthcare consultants in Fort Worth, Texas to assess the financial implications of moving the addiction treatment field away from the existing practice of purchasing "program" services to a "procurement system" for purchasing outcomes - "If I spend this much I should get these outcomes in return." As noted previously, decreased resources were being allocated to behavioral healthcare and the payor was buying services without a clear expectation of treatment outcomes. This lack of outcomes-based purchasing in behavioral health stands out in contrast to the trend in many other areas of medicine. The practices of most behavioral healthcare delivery systems were inconsistent with managed care and health cost containment initiatives; consequently, system-wide changes were necessary on both the payer and provider sides.

To address this payor need, in 1990 and 1997, COB convened a series of meetings with health economists and researchers, employee assistance professionals, and governmental healthcare funders to arrive at a broad-based consensus on the foundational tenets for a new system.

Among the important principles and challenges documented through these meetings, was the view that the current method of funding treatment by private insurance, third party indemnity funding, was structurally inappropriate for the delivery of addictions health care services (Wenzel, 2000). Many addictions treatment services are behavioral and therefore inappropriate for traditional medical service reimbursement or don't qualify for "medical necessity." Additionally, the nature of behavioral health problems precluded them from the normal indemnity/actuarial "risk management" approach which often assumes a one-time event with a fixed cost for remediation. Addiction, however, is a chronic, relapsing condition requiring an array of clinical and non-clinical interventions over time.

As part of an initiative to identify potential partners and demonstration sites, COB commissioned a review of the funding of addictions services, to portray historic trends and/or cycles and make recommendations for moving payment systems to outcomes-based purchasing. Dr. William Ford (1999), a veteran of public and private addictions healthcare systems, produced *Understanding the Purchase of Outcome in Substance Abuse Treatment*. In his informative work, Ford noted:

According to the 1996 Uniform Facility Data Set (a state-administered, federally-sponsored survey), public funds account for 69 percent of the total treatment

facility funding, with 48 percent coming from special appropriations from local, state, and Federal funds earmarked for substance abuse treatment as well as other unspecified public funds, and another 21 percent coming from Medicaid and Medicare. Client payments and private health insurance pay for 27 percent of treatment services. About 5 percent of total substance abuse treatment funding comes from other or unreported sources. (Ford, 1999)

Thus, it was clear COB should focus its initial efforts on the public sector. Before this could be done, however, COB needed to make sure participants in these ambitious efforts were speaking the same language and collecting compatible data.

#### **A. Terminology to define outcomes: Essential Data Set (EDS)**

In Boston, in August 1998, COB assembled the most prominent researchers in the addictions field in order to define the universal minimal data elements required to assess treatment outcomes, costs, and benefits. Out of their individual and collective commitment to the field and its advancement, these experts volunteered their time and expertise and reached consensus on an EDS (Addendum A).

A few important notes regarding the EDS:

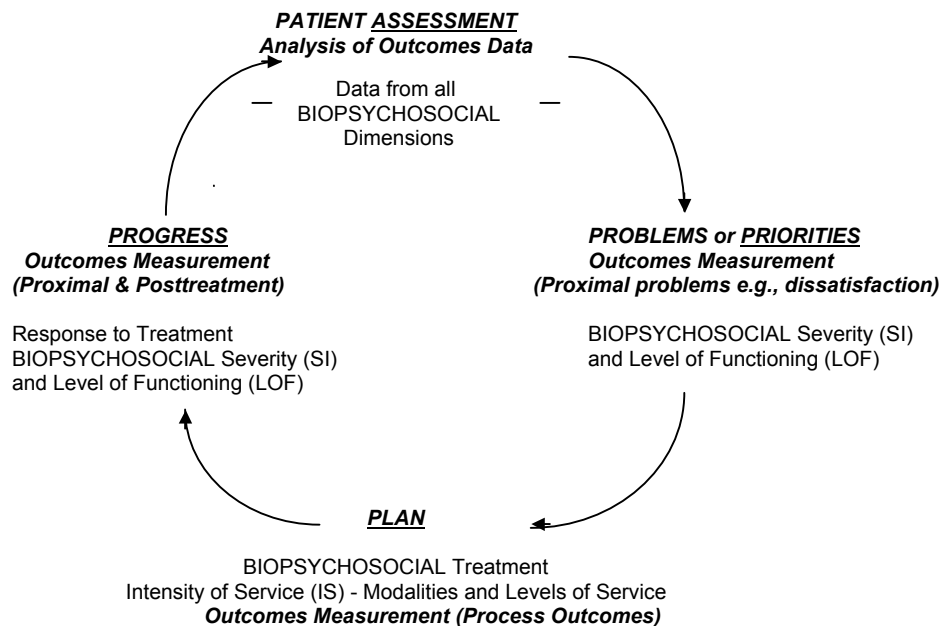
- Since that historic meeting in Boston, there have been numerous adaptations and permutations of the EDS introduced by various groups. It is not COB's concern which particular set is used as long as the essential items are included in whatever tool, instrument, or set that is used. It is only when the same essential data are collected that valid comparisons can be made on different studies conducted at different times, locations, types of services, etc.
- Case management assures services are provided and coordinated in the most appropriate way for the individual client, so it sometimes has services contracted among a range of providers of services. Research since the time of COB's EDS meeting has illustrated the effectiveness and efficiency of coordinating behavioral medicine services with other health and social services. Such "care coordination" (as defined in the NJSAI study below) can work between operational units to minimize duplication and maximize available resources. Such integration of services and client information is a challenge for provider systems that are accustomed to operating as relatively independent entities.
- Case mix (the nature of the treatment population in terms of the addiction severity or the severity of prognostic indicators) is an essential feature in interpreting outcome. For example, In general medicine, some local hospitals may have low post-surgery mortality rates because of their favorable case mix (most of the patients treated are not very ill) while other hospitals have much higher post-surgery mortality rates because many of their patients are quite ill. Similarly, addiction treatment programs that serve populations with severe addiction levels and/or few resources (e.g., supportive family, a job, high levels of educational attainment) would not be expected to have the same rate or types of positive outcomes as programs serving populations with less severe levels of addiction and more resources.

In addition to agreement on the essential items to collect in any system, there must be understanding and agreement on terms that describe the multiple types of outcomes. COB therefore developed and suggested such definitions (Addendum B).

Different stakeholders in addictions treatment (e.g., payors, clients, providers, government agencies) often have different interests, expectations, and priorities regarding treatment costs, benefits, and desired outcomes. A court system may be more concerned about recidivism or return to incarceration whereas an employer may focus on job-related accidents. This illustrates the fact that each party must be clear on what outcomes are desired and to be measured.

It is the interplay of these various outcomes that are most useful for each stakeholder in a comprehensive outcomes-based system. Their dynamic interactions help decision making for the individual client, for the provider system, for the purchaser, and for policy makers. The circular, decision-making nature of outcomes for an individual patient is described in Figure 2 below:

FIGURE 2.  
**Individualized Treatment, Outcomes Measurement and Continuous Improvement**



## B. Results: COB system characteristics

In order to collect reliable and valid EDS data, the assessor must address at least 7 parameters or activities:

### 1. Aggressive Case Finding

Because outcomes based purchasing includes the reduction of problems, costs, and symptoms, finding affected persons becomes a key component to demonstrating outcomes. For example, if achieving a healthier workforce is the goal, it will be necessary to identify the workers who are dependent upon alcohol and other drugs and get them into treatment. If the goal is reduction in alcohol-related auto crashes, alcohol dependent persons who drive while under the influence must be identified and placed into appropriate treatment.

### 2. Assessment

Addictions recovery is not a linear process that always moves through predictable stages, nor is one treatment episode generally effective over the person's lifetime.

Addiction is a chronic, relapsing condition and requires different types of interventions at different points in the recovery process, sometimes repeating certain interventions. An essential part of quality control and treatment improvement is continual assessment of the individual's status. This assessment must be based on consistently applied tools so the information is reliable, valid, and can be compared over time.

The American Society of Addiction Medicine (ASAM) Patient Placement Criteria (PPCIIR) provides empirically-based rationales for selecting the types of treatment to be provided. Whether the clinician uses this or other tools, however, it is essential there be consistent collection and interpretation of data regarding the individual's level of functioning on multiple dimensions or axes.

### 3. Independent Case Management

Because of the dynamic, multifaceted nature of addiction and recovery, optimal treatment processes are characterized by movement between and among services and settings. With payors incentivized to deny services (in order to save money) and providers inclined to increase services (in order to increase billable hours or activities), COB believes it is important to have an independent case manager (or "care coordinator") with the authority to move the client into and out of services. In an ideal system, this care coordinator would use current, "real time" data from the service providers involved with the individual patient in order to know what services are needed for what duration, intensity, etc.

### 4. Service Continuum

It is rare for any one provider to have all the required services available for all clients in one program or setting. The gamut is wide, including pharmacological therapies, detoxification, residential and outpatient clinical services to aftercare group and individual sessions, plus ancillary or "wrap around services" like transportation, housing, childcare and job training. In addition, populations differ significantly from adolescents to employed adults to homeless, etc. An effective service system would ideally have a network of services and providers for a variety of populations and the care coordinator would move the client through and among these services based on what the data show works best for that client.

One of the key values of the ASAM PPCIIR is its method for identifying needed clinical services (or level of service) movements. However, the PPCII does not focus, on the ongoing ("aftercare") services necessary after primary treatment, nor the "safe housing" requirements needed by many public service recipients. Thus services of knowledgeable care coordinators are needed to augment the PPCIIR evaluation. If it is necessary to take the identified client out of the area for essential services, there are potential gains and losses that need to be defined and addressed.

### 5. Documentation and Information Management (IM)

There are important issues for providers who attempt to move their data collection and analysis systems to outcomes-based methods. For example, with the need to make assessment an ongoing, dynamic process (rather than one service provided at admission), it would be unnecessarily duplicative to have to change the treatment plan every time the assessment was redone. Instead, an outcomes-based system has an integrated patient record where all services (and billing for these services) are captured and appropriately inserted into the overall patient record.

Computer software that supports such an integrated record is available and being used in behavioral medicine. In the state of Michigan, for example, nearly all of the statewide public-sector substance abuse coordinating agencies subscribe to an internet-based information system designed by ADIA Care Net. This system, which performs client enrollment, authorization, placement, tracking, billing, outcomes, and state reporting, is operational, and the entire provider network has instant and full access through a simple internet connection. Such systems have great value for the clinician and administrator and are eliminating the duplication and wasted time so familiar to clinicians. In addition, outcomes-based data collection methods clearly and objectively document the clinical effectiveness and financial efficiency of services for their populations – a value to all concerned.

#### 6. Adaptation for Special Populations

In addition to designing effective treatments for individual patients, attention must be paid to the treatment of special populations. An initial listing of such special populations must include at least the following patient group characteristics:

- Ethnicity
- Gender
- Age
- Physically challenged
- Single parents with kids
- Physically, Socio-economically, Vocationally and Educationally Disadvantaged
- Dually Diagnosed
- Mentally Retarded
- Gay/Lesbian
- Criminal Justice
- Homeless

#### 7. Personal Responsibility

A basic tenet of COB's approach is founded in the traditions of the Twelve Step Movement and supported by years of experience: the nature of addiction recovery requires the systematic (re)assumption of responsibility for one's own functioning - recovery must ultimately have the individual person "driving" his or her life. Thus, case managers require ongoing aftercare services to help the client be dynamically involved in resolving the multiple issues in his/her life and become independent as soon and as well as possible.

### C. New Jersey Substance Abuse Initiative (NJSAI)

In order to demonstrate its principles COB helped develop the New Jersey Welfare to Work Substance Abuse Initiative (NJSAI).

The primary focus of the NJSAI program is to use an independent care manager network placed in county welfare offices to identify, assess, refer, and manage the care of those in need of addictions services. In this care management system, a primary focus has been to develop the tools necessary to better match the needs of clients with the services available. Instead of providing one form of treatment to every client moving from welfare to employment (or training), the idea is to accurately assess what the individual client needs and then require the contracted providers to actually supply these services.

While often talked about, this active "care-management" model had seldom been successfully implemented in the addictions arena until the NJSAI program. The services, tools, educational products, etc. needed to get this program running has been substantial and the results have been remarkable. For example, the first year showed a 400% improvement in penetration rate (i.e., getting those in need into treatment), while showing greater than 40% decrease in the actual costs of those increased services. These results

are so positive that the National Institute on Drug Abuse (NIDA) allocated five million dollars to study this project. This is clearly a potentially seminal national demonstration project, and elements of the NJSAI care management model will ultimately be employed in a wide variety of other public and private settings.

### **III. Conclusion**

From its inception, COB has been committed to helping move the field of addictions healthcare to outcomes-based practices. Many funders now require the type data collection methods COB has helped develop. Thus, COB, like the field, has evolved and changed over the years and will continue to do so, adapting to the needs and resources that present themselves. Its founders and many years of participants all understand, though, that the real gain is made when the individual seeking recovery is able to confidently and consistently get the services he/she needs.

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## Essential Data Set (EDS)

### For collecting information on those involved in addictions services

#### I. Management/operational items

- A. Patient identifier
- B. Referral Source
- C. Payor
- D. Essential dates:
  - 1. Admission date
  - 2. Discharge date
  - 3. Length of stay)
- E. Services provided:
  - 1. Core treatment services (e.g. residential detoxification, group therapy, etc.)
  - 2. Additional ancillary services (e.g., transportation to self-help meetings, etc.)
- F. Discharge status
- G. Disposition/referrals

#### II. Demographic information

- A. Age
- B. Sex
- C. Education
- D. Employment
- E. Income
- F. Ethnicity
- G. Marital status
- H. Housing
- I. Spiritual engagement

#### III. Clinical information

- A. Admission status
  - 1. Employment
  - 2. Health
    - a. Physical
    - 4. Mental
    - c. Public sector resource utilization and cost
  - 3. Crime/public safety
  - 4. Social competency/role performance  
NOTE: This item needs to also include information relative to utilization of public resources.
  - 5. Substance use
  - 6. Family/Social
- B. Status mid-treatment  
(Same measures)
- C. End of treatment  
(Same measures)
- D. Post-treatment (6, 12, 18, & 24 months)  
(Same measures)

## Definitions: Types of Outcomes

### For collecting information on those involved in addictions services

Through a process of evolving consensus from discussions with numerous healthcare professionals, COB respectfully suggests the following definitions of the different types of outcome measures and their relative roles in an outcomes-driven system.

#### *Proximal Outcomes:*

Short term measures which provide feedback to allow “real time” planning improvement, such as patient satisfaction, engagement, attendance, and empathic connection to the clinician. *Proximal outcomes* suggest real-time returns on investment from the costs saved by “prescribing” the most effective type, intensity, and duration of treatment appropriate to the individual patient’s needs, rather than over-utilizing treatment resources. These outcomes have great interest for providers, and secondarily to payers and purchasers;

#### *Process Outcomes:*

Measures of the various processes applied in designing, implementing, and measuring patient care, such as evaluation of timeliness and accuracy of assessments and treatment plans, “turn around” time for reimbursement payments to providers, and availability of services for clients in crisis. *Process Outcomes* identify skills, services or systems issues likely to affect post-treatment outcome. For example, the process of rating the severity of each assessment dimension focuses the treatment plan by identifying specific priorities that need immediate attention. Failure to adequately do this jeopardizes the effectiveness of the treatment plan. Another example may be the failure of the patient to receive a recommended level of care due to lack of availability, waiting list, transportation or funding problems. These outcomes hold great value to the provider for improving quality and to the payer for reviewing quality. It is also likely to point up absence of appropriate treatment services and/or lack of necessary benefit structures and funding mechanisms; and

#### *Recovery or Post-Treatment Outcomes:*

Measures of client “success” in terms defined by the individual party, e.g.:

- Provider – Number of days client was chemical free or attended aftercare;
- Purchaser –
  - A. Private employer: Decrease in amount of absenteeism, workman’s compensation, and medical utilization; or
  - B. Public welfare: Client’s ability to stay employed and off welfare.
- Drug Court – Number of (re)arrests during client’s time in his/her program.

Recovery outcomes typically involve a range of follow-up periods from six months to two years and track a wide variety of indicators from alcohol and other drug use, health care utilization by the identified patient and dependents, family and vocational functioning, and legal involvement. These outcomes, which are the crux of an outcomes-driven system, are of great value to all of the stakeholders in the system, the purchaser, provider, payer and patient.

The incentives for achieving these outcomes can be built into the agreement between the purchaser and provider and can be contracted in a wide variety of ways.