Measuring Performance to Improve the Quality of Substance Abuse Treatment: Challenges Within an Integrated Health Plan

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Overview:
Challenges for Performance Measurement

- A conceptualization of services related to AOD outcomes
- Screening, Brief Intervention, and Referral to AOD Treatment
- Integrating care during AOD treatment
- Continuing Care following AOD treatment
- Challenges and Opportunities

Research funded by NIAAA and NIDA
• Staff-model integrated health care delivery system

• Serves 3.5 million members (about 40% of insured population in the region)

• 18 hospitals, 27 outpatient clinics

• Integrated health care system (medical, psychiatry, AOD services)
One Model of Integration: Performance Measurement at Each Point?

Screen and treat in PC if moderate problem
Continue monitoring

Specialty care if needed

Back to PC for monitoring

Continuing care


Helping Patients Who Drink Too Much:
Kaiser’s SBIRT study
NIAAA: PI Jennifer Mertens

Implementation study of effective interventions
Randomization

1/3 of PC modules randomized to PCP Arm

1/3 of PC modules randomized to ‘NPP’ arm

1/3 of PC modules randomized to control condition

PCPs receive SBIRT training with CMEs

MAs are trained to Screen
• BMS/Nurses/CHEs
• Training (with CME/CEUs) to conduct BI and RT

Informational session on how to access and use Alcohol Screener
Performance measurement of primary care and AOD services “during and after” AOD specialty treatment

- AOD patients have high rates of medical and psychiatric problems
- Providing medical care promotes better outcomes and costs
- Chronic medical problems continue after specialty AOD treatment
Importance of Integrated Services During Treatment

Randomized those entering AOD treatment to receiving their primary care in the AOD clinic vs. receiving it as usual care in the clinics.

Those with medical problems receiving integrated services were almost twice as likely to be abstinent at 6 months, and was cost-effective.

There is still an effect at five years.


A Model of Continuing Care Following AOD Treatment: Beginning to Examine Outcomes and Relation to Services

1) Regular primary care as anchor
2) Readmission to AOD treatment when needed*
3) Psychiatric services when needed*

*Need for specialty care: having a non-zero ASI score for the corresponding problem domain at the prior interview time point
Nine-Year Primary Care-Based Observational Study of Continuing Care Outcomes

• Patients receiving continuing care were more than twice as likely to be remitted at each follow-up over 9 years (p<.0001).*

  – Results were consistent by gender, medical and psychiatric severity, and all age groups except those older than 50 years.

* mixed-effects logistic regression model controlling for time/follow-up wave, demographic characteristics, severity, and completion of index AOD treatment

Receiving Continuing Care\(^1\) vs. Remission Over 9 Years, Stratified Analyses\(^2\)

<table>
<thead>
<tr>
<th></th>
<th>Adjusted OR</th>
<th>95% CI</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>2.38</td>
<td>(1.59, 3.57)</td>
<td>&lt;0.0001</td>
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<tr>
<td>Age group</td>
<td></td>
<td></td>
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<tr>
<td>20-29 years</td>
<td>5.11</td>
<td>(1.63, 15.97)</td>
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<tr>
<td>30-39 years</td>
<td>2.52</td>
<td>(1.24, 5.13)</td>
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<td>40-49 years</td>
<td>2.14</td>
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<tr>
<td>≥ 50 years</td>
<td>0.90</td>
<td>(0.30, 2.71)</td>
<td>N.S.</td>
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<tr>
<td>Gender</td>
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<tr>
<td>Female</td>
<td>1.80</td>
<td>(1.03, 3.16)</td>
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<tr>
<td>Male</td>
<td>3.11</td>
<td>(1.70, 5.70)</td>
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<td>Baseline medical severity</td>
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<td></td>
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<td>(1.39, 4.31)</td>
<td>0.0025</td>
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<tr>
<td>Low</td>
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<td>(1.25, 4.16)</td>
<td>0.0031</td>
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<tr>
<td>Baseline psychiatric severity</td>
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<tr>
<td>High</td>
<td>2.80</td>
<td>(1.56, 5.03)</td>
<td>0.0004</td>
</tr>
<tr>
<td>Low</td>
<td>1.67</td>
<td>(1.04, 3.36)</td>
<td>0.0272</td>
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</table>

Note:
1 Received continuing care was defined as having regular PC and receiving both CD and psychiatric services when needed.
2 All models adjusted for the same set of covariates as in the model presented in the previous slide.
Nine-Year Primary Care-Based Continuing Care Costs (Observational Study)

- Those receiving continuing care in the prior interval were less likely to have ER visits and hospitalizations subsequently ($p<.05$).

*Linear mixed model controlling for age, gender, employment and marital status, whether completed treatment

Parthasarathy S, Chi FW, Mertens JR, Weisner C. The role of continuing care on 9-year cost trajectories of patients with intakes into an outpatient alcohol and drug treatment program. *Med Care.* under review.
Average Costs by Number of Continuing Care Components:

<table>
<thead>
<tr>
<th>Number of Continuing Care Components Fulfilled</th>
<th>Other Costs</th>
<th>CD Treatment COst</th>
<th>Psychiatric Services Cost</th>
<th>Primary Care Cost</th>
<th>ER Cost</th>
<th>Inpatient Cost</th>
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<td>0</td>
<td>$0</td>
<td>$250</td>
<td>$150</td>
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<td>$250</td>
<td>$150</td>
<td>$200</td>
<td>$250</td>
<td>$300</td>
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</tbody>
</table>
Summary of Findings

• Those receiving all components of continuing care were more than twice as likely to be remitted at 9 years (across patient characteristics)

• Those receiving all components of CC had lowest overall health care costs (decreased inappropriate utilization)

• Observational study with usual limitations:
  – Intervention study in process
Challenges in Integration and Performance Measurement
Revisiting “Competing Priorities”: What we are up against?

- **CMS 2011 STAR quality measures include:**
  - Staying Healthy: Screenings, Tests and Vaccines - 13 measures, e.g., breast and colorectal cancer screening, cholesterol screening, flu vaccine, pneumonia vaccine, physical activity monitoring,
  - Managing Chronic Conditions - 10 measures, e.g., diabetes monitoring, controlling hypertension
  - Ratings of Responsiveness - 6 measures, e.g., patient satisfaction and ratings)

- **15 CMS core measures of “meaningful use” of Electronic Health Records, e.g., documenting:**
  - Smoking
  - Height, weight, BMI
  - Preferred language, Demographics
  - Drug allergies
  - Updated diagnosis and problem list

- **HEDIS Measures = NCQA ratings = Employer/Purchaser $$$$**

  - These involve **strong incentives** (and some financial sanctions).
  - SBIRT and other integration does not!

Challenges

- Difficulty changing focus from dependence to at-risk drinking for PC and ED (and AOD) physicians
- No sanctions or incentives for SBIRT
- Competing priorities (e.g., Depression Initiative)
- Broad brush screening desired by clinicians
- Telephone visits
- Dynamic measures – static EMRs
- Stigma
- 42CFR
Opportunities

• New information from EMRs in Integrated Health Care Systems
  – Composite measures
  – Care coordination
  – Outcomes (current research – ADVISE and Medical/Health home study)
    • Medication adherence
    • Diabetes, hypertension, cholesterol outcomes
      – (e.g., connect with CMS Star Measures?)
    • Prevention activities
    • Vital signs
Thank you!

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