

Chronic Care & Quality

Addiction Prevention & Treatment

Critical Health Areas Project (CHAP)

Healthcare Access

Providers & Workforce

The Outcomes of Addiction Treatment and Approaches to Measuring Performance

**Third in a Four-Part Series on
The Elements of a Quality Health Care System**

Friday, November 2, 2007, 1:00 pm EDT

Supported by the Robert Wood Johnson Foundation

As part of the NCSL Critical Health Areas Project

Speakers

- ◆ **Adam Brooks, Ph.D, Scientist,**
Treatment Research Institute
- ◆ **Kim Johnson, Former Director,**
Maine Office of Substance Abuse

What Happens In State-Funded Treatment?

Outcomes, Performance, and Care Monitoring

Adam C. Brooks, Ph.D.
Treatment Research Institute

The Bad Rap on Addiction Treatment

- Addiction Treatment Often Seen as Ineffective
 - Patients Relapse
 - Require Multiple Episodes of Care
- Addiction is Very Similar to Other Chronic Medical Conditions (Diabetes, Hypertension)
- Costs of Treatment Need to Be Compared to the Costs of No Treatment

New Views, New Methods

- Why is Treatment Valuable?
- The Continuing Care Model (Outcomes vs. Performance)
- Recovery Monitoring
- Performance Based Contracting: The Delaware Experiment

A Note On Terminology

Outcomes, Performance, Quality

(What's the Difference?)

Calls for Better “Accountability” and
“Performance” Coming from many Disciplines

Each Discipline Approaches the Goal Differently

Some Definitions

- **Outcomes**: Changes in patient symptoms, behavior, and function that can be attributed to treatment
 - Measured across several domains
 - “Recovery” is the ultimate goal
- **Recovery**: Patients are not drinking/using, they have sound physical health, and they have regained functioning in important life areas

Some Definitions

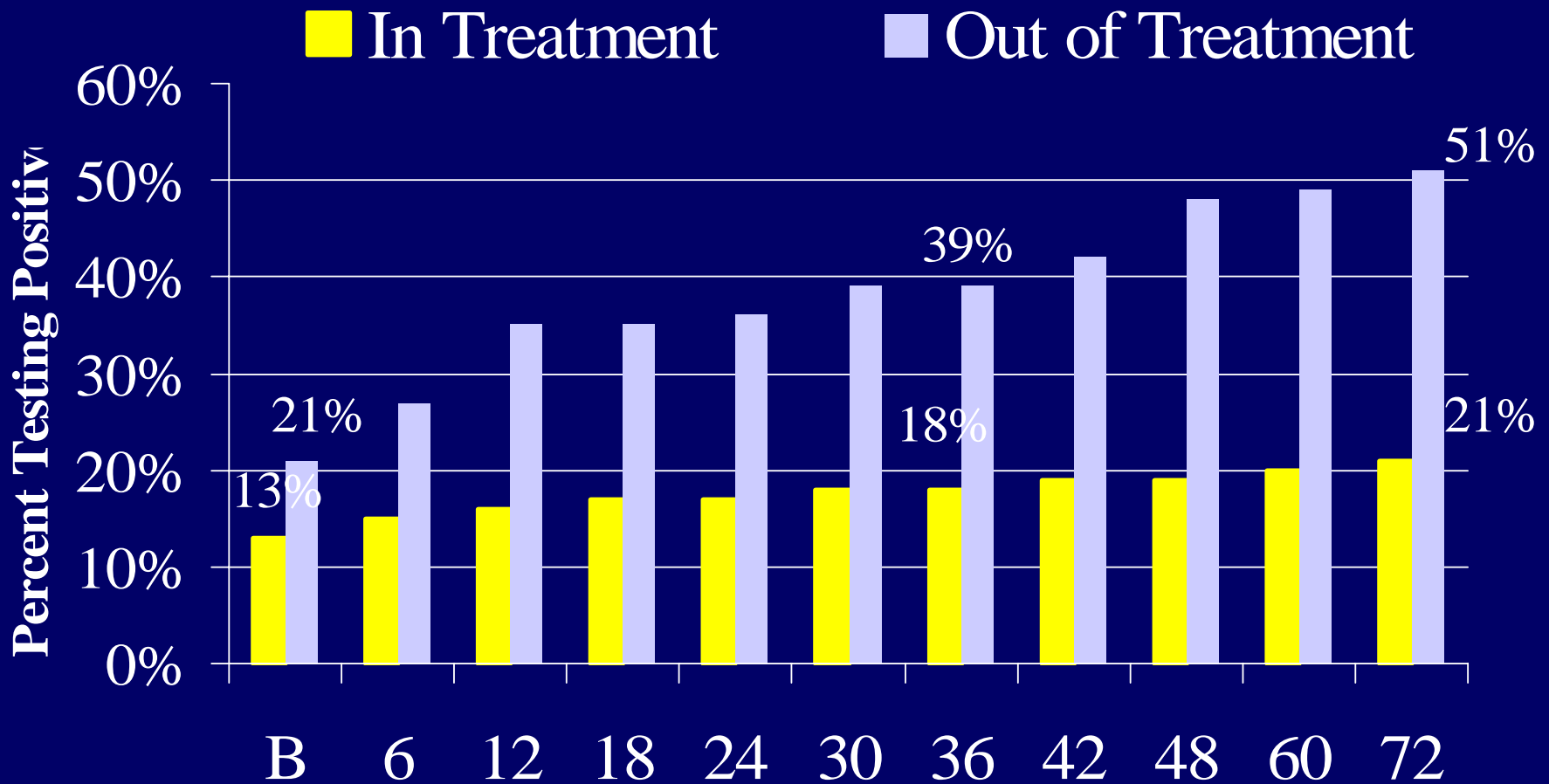
- **Quality Care:**
 - Evidence-Based Treatments
 - Accredited or Licensed Practitioners
 - Core Competence of Practitioners
 - Monitored and Regulated Program- and System-Level Indicators
- **Performance and Quality Indicators:**
Organizational level measures to indicate whether a system or provider conforms to best practices

Is Treatment Worth it?

- California Treatment Outcome Project
- Average costs of treatment: \$1,583
- Average societal benefit/savings: \$11,487
- Societal costs savings due to:
 - Decreased crime/criminal justice costs (65%)
 - Increased employment (29%)

Costs are in 2001 Dollars

Six Year HIV Infection Rates by Treatment Status at Time of Enrollment



Baseline through 72 Months

Costs of Treatment

- Average monthly per patient cost of methadone treatment: \$364
- Average monthly per-patient costs of treating HIV infection: \$2,100
- Average lifetime per-patient costs of treating HIV infection range from \$385,000 to \$619,000

Costs are in 2004 Dollars

Why Does Addiction Treatment Seem Ineffective?

The Continuing Care Model

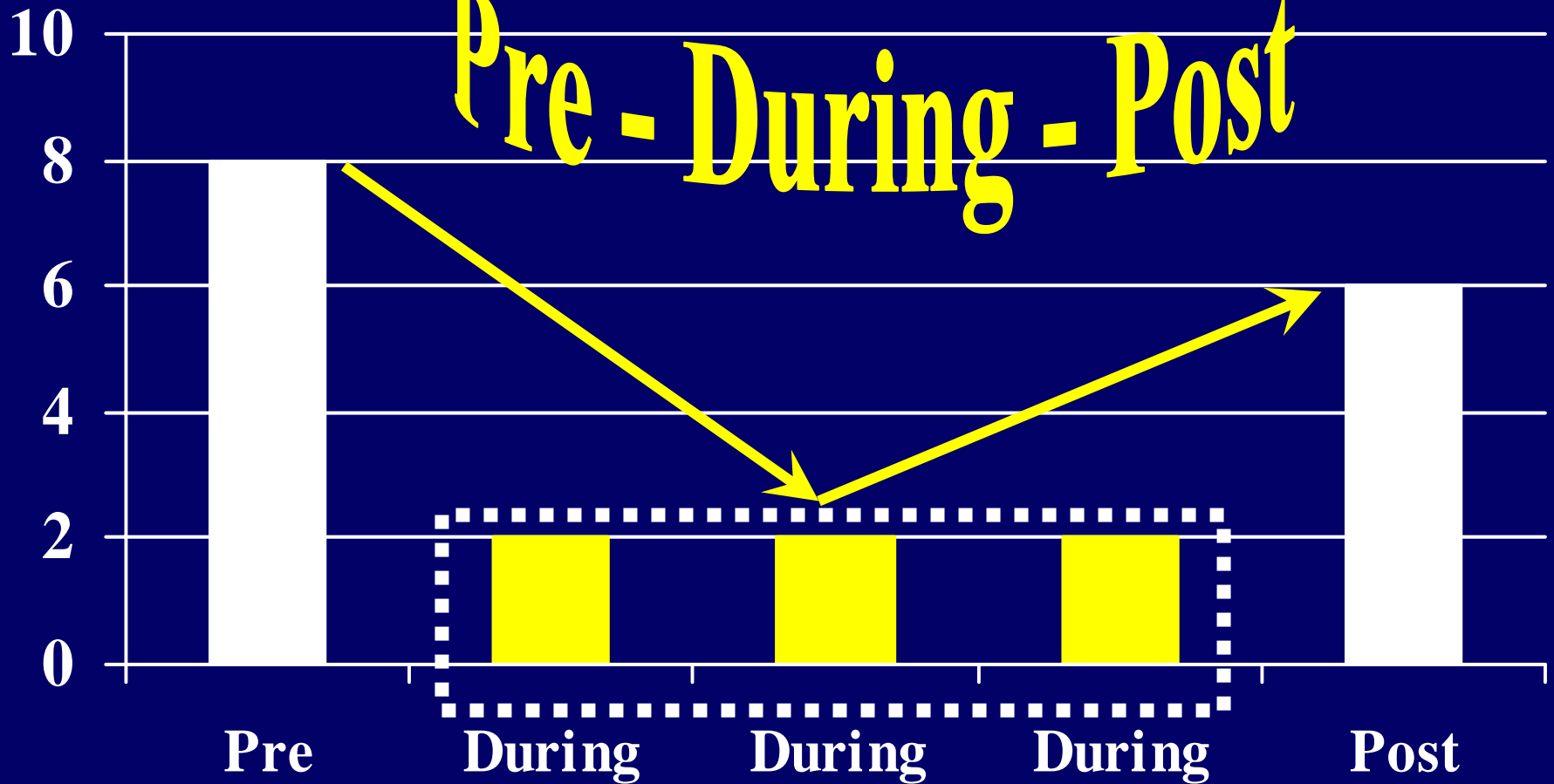
Implications for Evaluating Outcome

Treatment of Chronic Illness: The Continuing Care Model

- Evidence of Success
 - Retention in Treatment
 - Reductions in Emergent or Acute Care
 - Improved Functional Status
- Outcome is evaluated
DURING TREATMENT

Outcome In Chronic Illness

Pre - During - Post

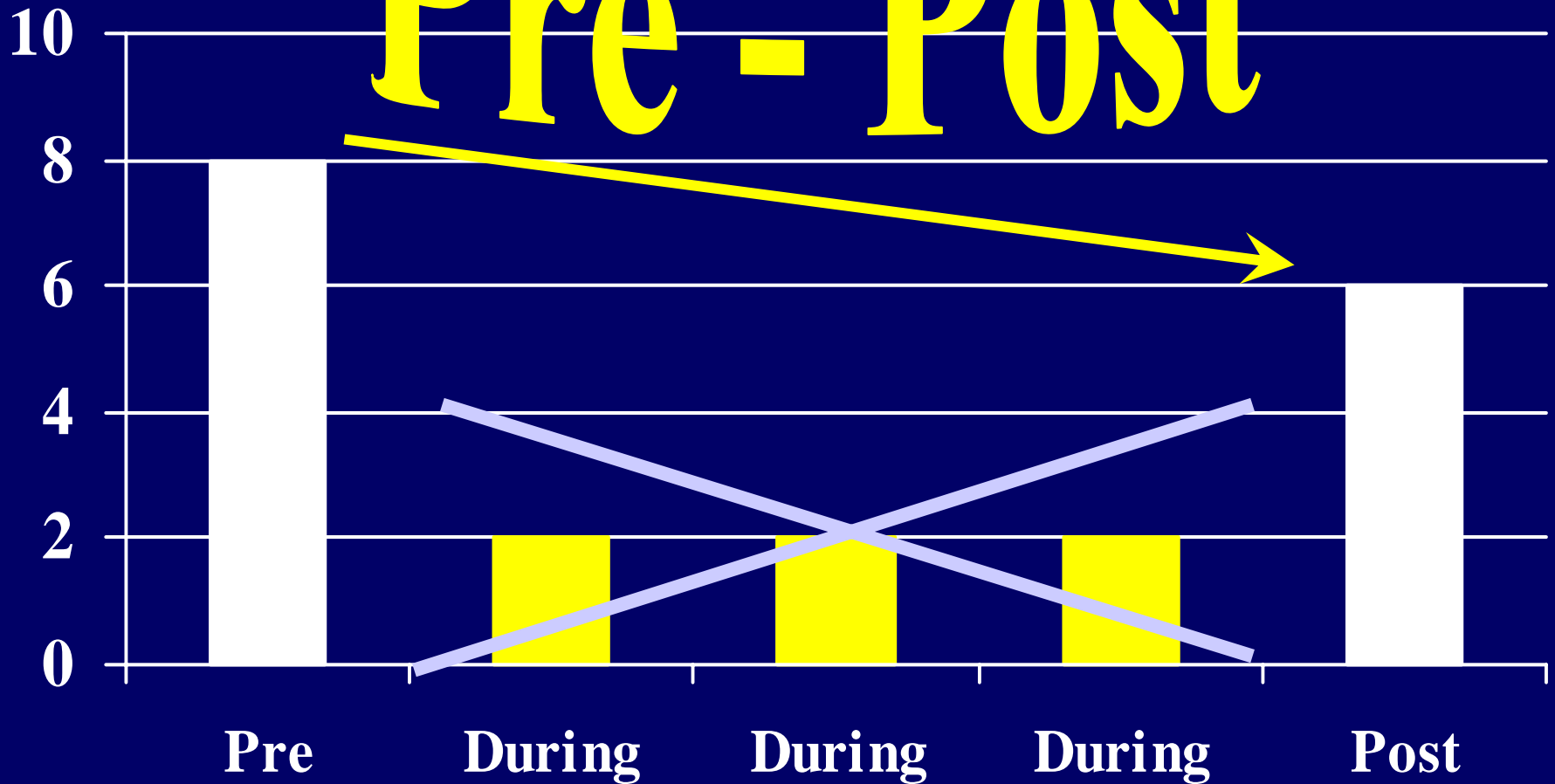


Treatment in Addictions: Rehabilitation Model

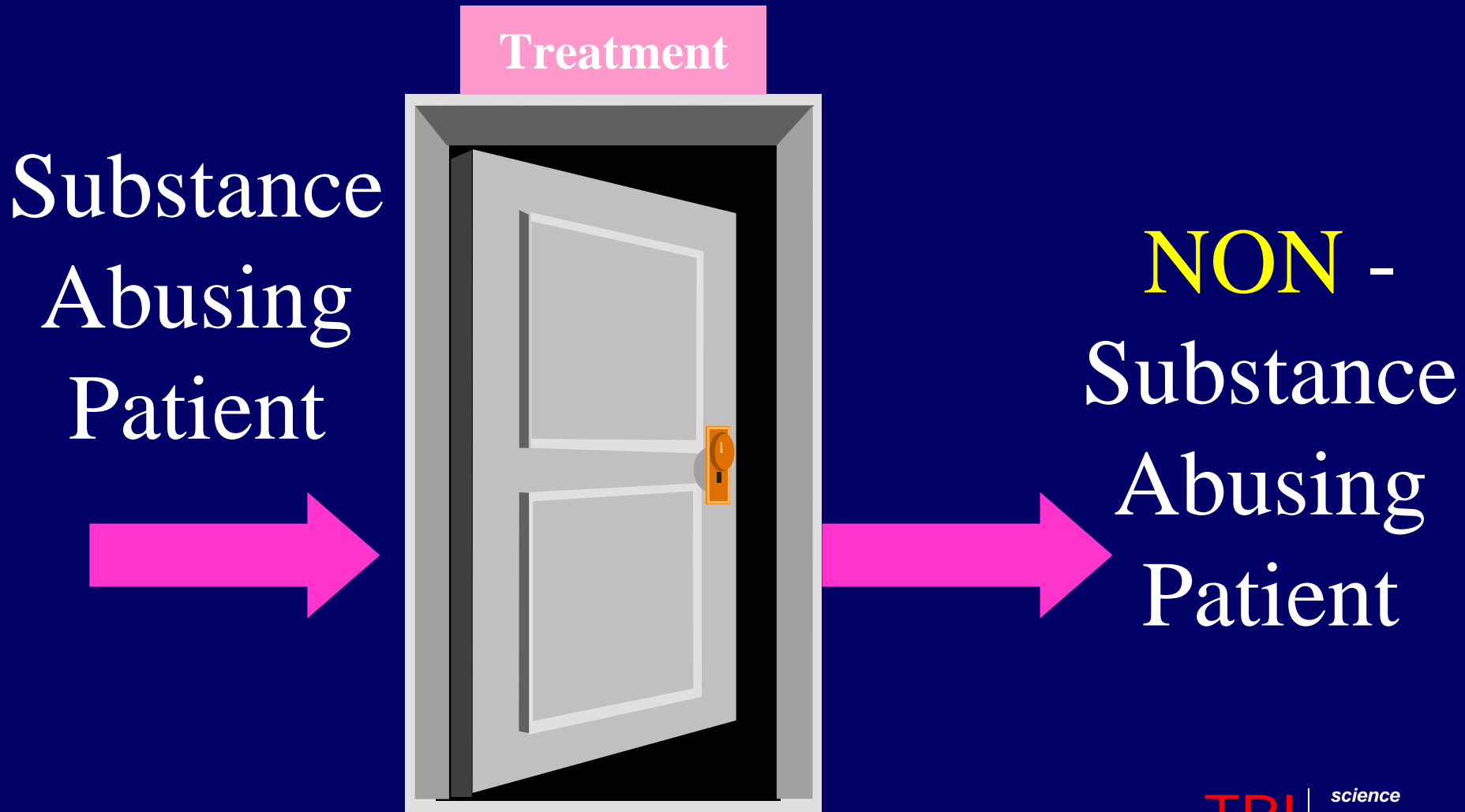
- Evidence of Success
 - Completion of Treatment
 - Successful Acquisition of New Behaviors
 - Resumption of Function
 - Sustained Elimination of Symptoms
- Outcome is evaluated
FOLLOWING TREATMENT

Outcome In Addiction

Pre - Post



A Nice, Simple Treatment Model



Assumptions

- Some fixed amount or duration of treatment should resolve the problem
- Clinical efforts put toward matching treatment and getting patients to complete treatment
- Evaluation of effectiveness following completion
 - **Poor outcome means failure**

New Continuing Care Model

Substance Abusing Patient

Detox

Duration
Determined by
Performance
Criteria

Rehab

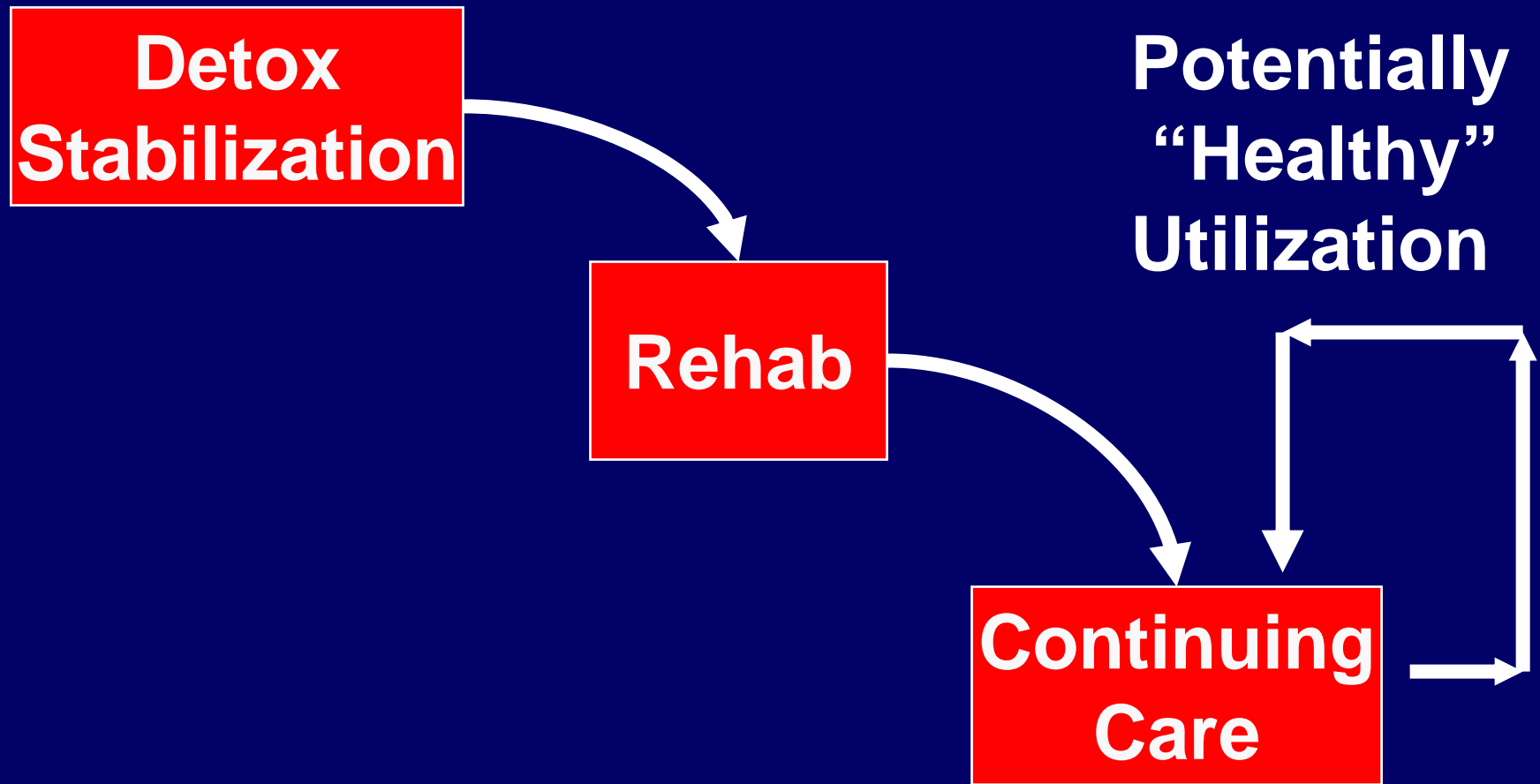
Duration
Determined by
Performance
Criteria

**Continuing Care
Self-Management
Recovery**

Assumptions

- 1) Patient will continue in treatment
- 2) There are agreed upon clinical targets at each stage of treatment
- 3) Achieving the clinical targets is preparation for the next stage
- 4) No rush to discharge – just reduced intensity of care leading to self-maintenance

Evidence of Success



Measuring In-Treatment Outcomes: Concurrent Recovery Monitoring

- Monitor patient at regular intervals during treatment
- Use a brief, standardized measure

Measuring of Treatment Outcomes: Concurrent Recovery Monitoring

- Available to all key decision makers
- Data used for guiding care

Standardized Data Collection: The Blood Pressure Model



An Example of Non-Standardized Reporting: Currently SA-type

Blood Pressure

Nurse 1 – It's getting better (better than what??)

Nurse 2 – It's much lower than before (too low??)

Nurse 3 – The patient is in denial (???)

Nurse 4 – The patient is non-compliant, lets not treat him until he's really ready

An Example of Standardized Reporting

Blood Pressure

Nurse 1 – It's 120/80

Nurse 2 – It's 116/78

Nurse 3 – It's 122/82

Nurse 4 – The patient is non-compliant, lets not treat him until he's really ready

The “Blood Pressure” of Substance Abuse Treatment

- Recurrence of Substance Use
- Patient Risk Factors
- Patient Protective Factors

How Can This Data Be Used?

- Adapt Care for the Individual
- Tailor System for the Population
- Share Information Across Systems

The Delaware Experiment

Improving Public Addiction Treatment Through Performance Contracting

A.T. McLellan, J. Kemp,
A.C. Brooks, D. Carise

Performance Based Contracting

- 29 State Medicaid Offices Have Some Form of Performance Based Contracting
- Usually applied to the management of chronic, high-cost illnesses (diabetes, cardiovascular illness)
- Few states applied PBC to addiction services

The Delaware Contract

- DSAMH in Delaware had struggled to get providers to adopt evidence based procedures
- Beginning FY 2001, renegotiated outpatient contracts to provide incentives for:
 - Attracting and engaging their full complement of patients (capacity utilization)
 - Keeping patients engaged at a minimal level

Innovative Aspects

- Provided both incentives (additional dollars) and penalties (loss of base dollars) for hitting targets
- Providers helped set performance targets
- Contract payments were dispersed monthly (not semi-annually or annually)
- Participating providers received consistent, monthly feedback with financial impact (positive or negative)

What Were the Targets?

- **Census Targets**
 - Monthly reporting on active utilization
 - Providers earned 1/12th of 100% of their negotiated contract if they served a minimum of 80% of utilization target
 - If the target was 100 served monthly, and they served 80 patients, they were paid 100%!

Census Target Penalties

- Serve 70-80% of census target, suffer a 10% deduction to monthly payment
- Serve 60-70% of census target, suffer a 30% deduction to monthly payment
- After one year, the census minimum for full payment was raised to 90% utilization

Active Patient Participation

Treatment Phase	Time In Treatment	Participation Level	Compensation
Orientation	< = 30 Days	50 % of Patients 8 Sessions Per Month	1%
Treatment 1	31- 90 Days	60% of Patients 4 Sessions Per Month	1%
Treatment 2	91 – 180 Days	70% of Patients 4 Sessions Per Month	1%
Community Reintegration	180 + Days	80% of Patients 2 Sessions Per Month	1%
Bonus for all four targets			1%

Successful Graduation

- Programs were paid an additional \$100 bonus for each successful treatment graduation
- SO . . .
A program who met at least 80% of their census, and hit all four participation targets, could earn 105% of their negotiated contract

Services???

- Full, standardized assessment
- Provision of group, individual, family counseling
- Evidence of cultural competence
- Adopt one evidence-based practice (trainings offered by DSAMH)

What Happened???

The Kick-Off

- DSAMH hosted regular meetings to foster a working relationship with providers
- Providers encouraged to share strategies for meeting goals
- DSAMH perfected data collection system
- DSAMH provided trainings in evidence based practices

What Happened???

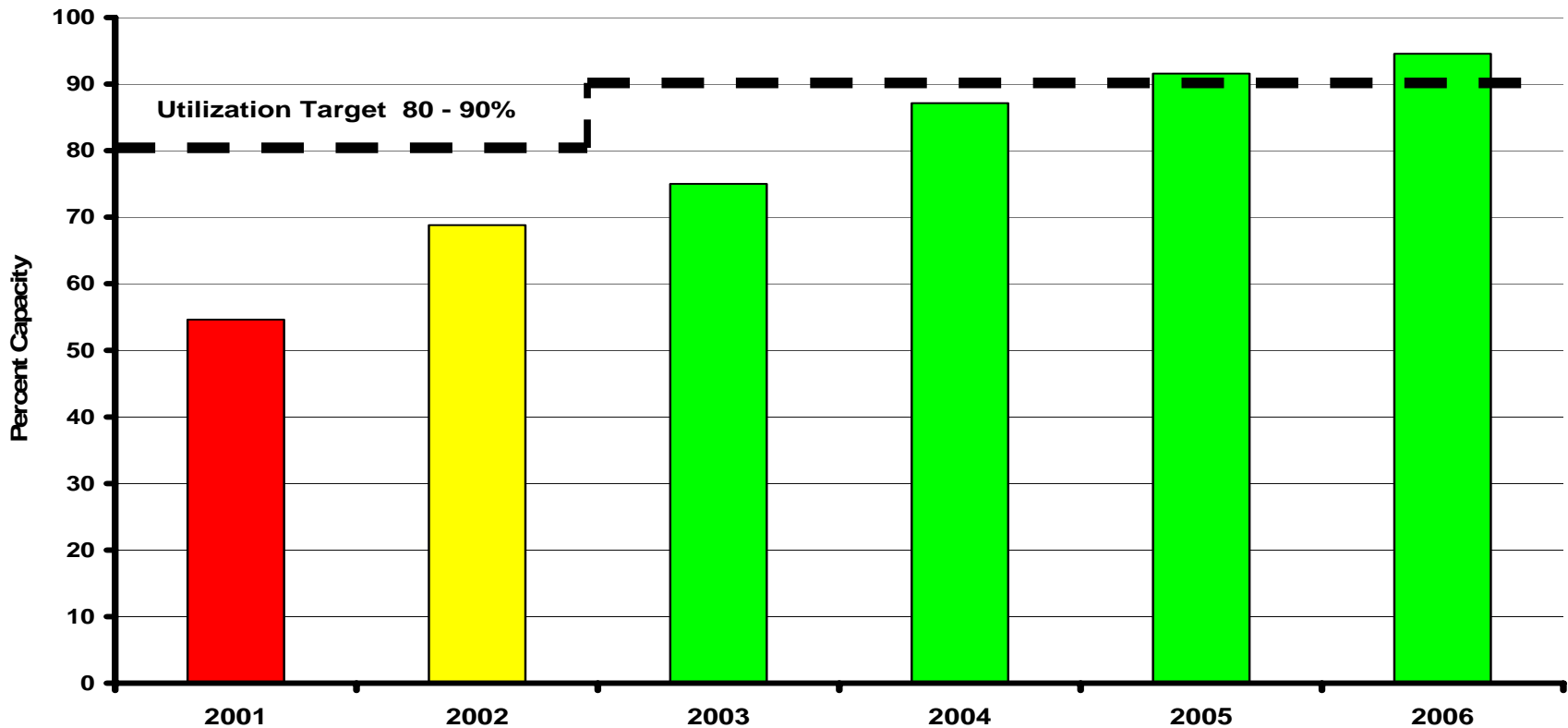
Provider Changes

- Increased Patient Access
 - Streamlined Admissions Procedures
 - Patient Friendly Hours (Mornings and Evenings)
 - Physical Changes in Facilities
- Three Providers Opened Satellite Offices in Underserved Areas
- Some Providers Shared Bonuses with Staff
- All Providers Learned Evidence Based Treatments

What Happened???

Patient Changes

Figure 1
Percent Capacity Utilization, By Fiscal Year



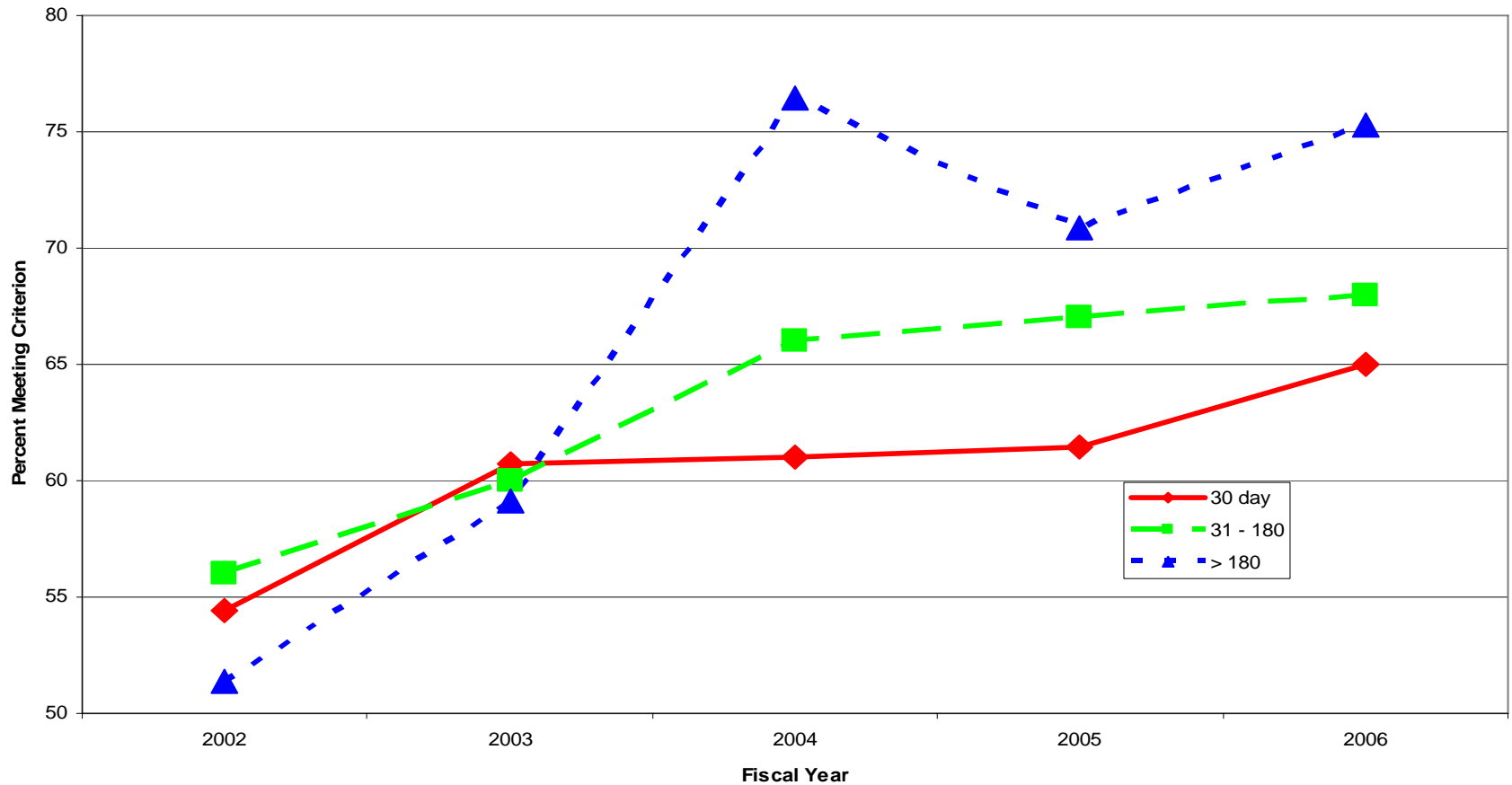
What Happened???

Full Houses

	2001 Capacity	2001	2002	2003	2004	2005	2006	2006 Capacity
Provider 1	175	43%	51%					
Provider 2	125	69%	94%	87%	89%	91%	107%	130
Provider 2a				61%	92%	98%	89%	60
Provider 3	135	48%	56%	89%	88%	89%	90%	130
Provider 3a				65%	90%	92%	90%	110
Provider 4	125	47%	64%	82%	83%	82%	83%	125
Provider 5	300	66%	79%	90%	88%	90%	92%	300
Provider 5a				51%	80%	99%	111%	60
	860	54%	69%	75%	87%	92%	95%	915

What Happened???

Patient Participation



Percent of Clients Meeting Participation Criteria, By Fiscal Year **TRI**

Performance Based Contracting

- All State Outpatient Providers Collaborating and Sharing Retention Strategies
- No Significant Increase in State Spending
- Significant Gains in System Utilization and Patient Participation

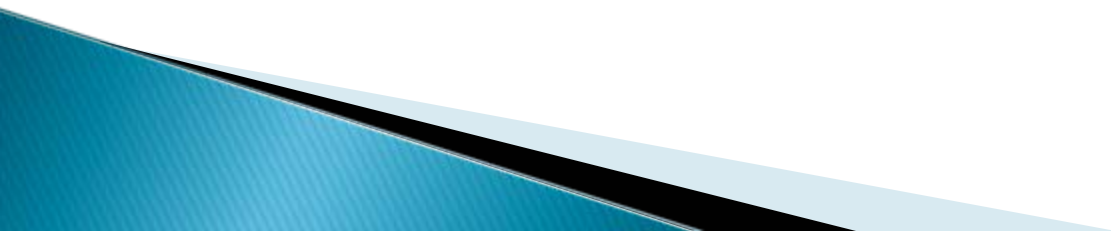
- The End -

Performance Based Contracting: Some Things to Consider

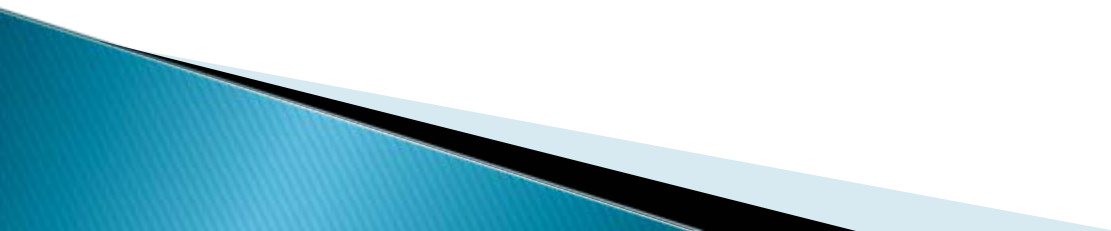
Kimberly Johnson, MEd, MBA



Maine's Experience

- ▶ P.L. 1983 c. 464 creating the Treatment Data System (TDS)
 - ▶ Federal Mandate to provide treatment data
 - ▶ Developed and set performance indicators
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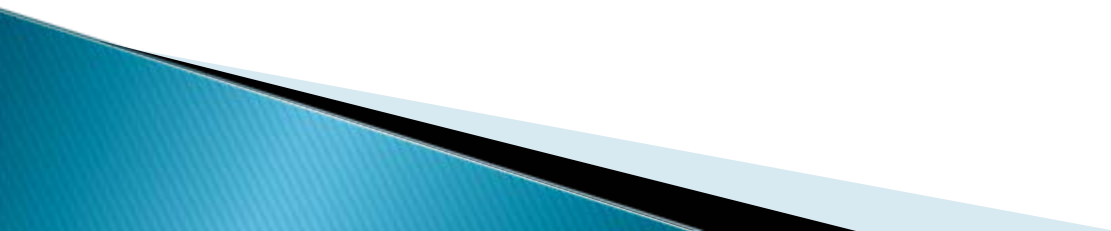
Maine's Experience

- ▶ Focused on two categories of outcome: efficiency and effectiveness
 - Efficiency focused on meeting contracted number of units
 - Effectiveness focused on meeting a set standard for client outcomes based on data that is required to be submitted to SAMHSA
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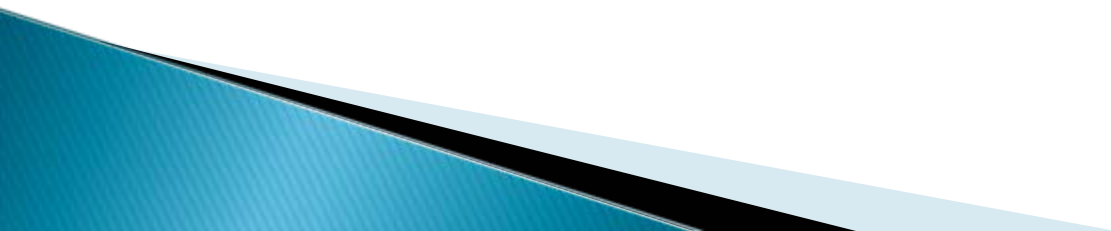
Maine's Experience

- ▶ Reports shared with providers on a quarterly basis regarding whether or not they were meeting their contractual obligations.

Key Elements

- ▶ Good data collection system
 - Who is required to submit data
 - What data elements are collected
 - At what point in time is data collected
 - ▶ Clear definitions for data elements
 - Everyone needs to understand and agree
- 

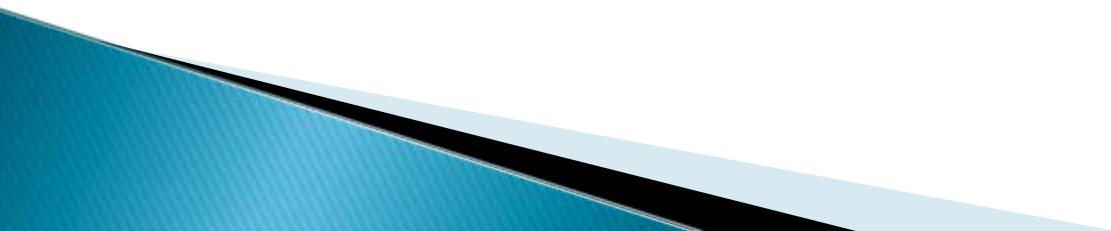
Maine's Experience

- ▶ Problems with system:
 - Historically could only punish not reward
 - Standards arbitrary
 - Standards out of provider's control
 - Cost based reimbursement system
- 

Key Elements

- ▶ Must Have agreed upon performance standards
 - What are the outcomes you want to achieve?
 - How will contracting structure help or hinder change?
 - Are the standards supported by the practices that you are promoting in the field?

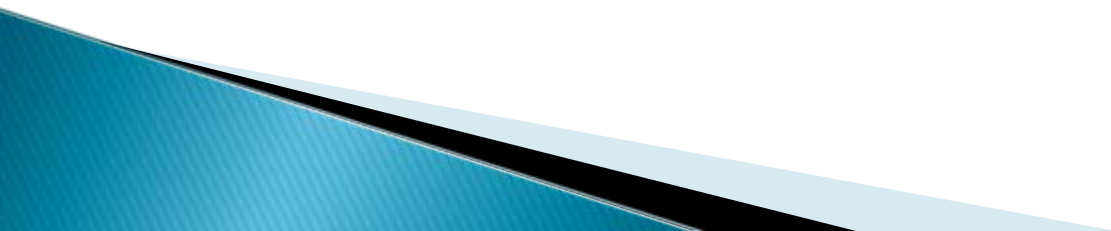
Maine's Experience

- ▶ For two years have been working with treatment agencies to improve access and retention
 - ▶ Used this experience as the basis for changing the performance standards
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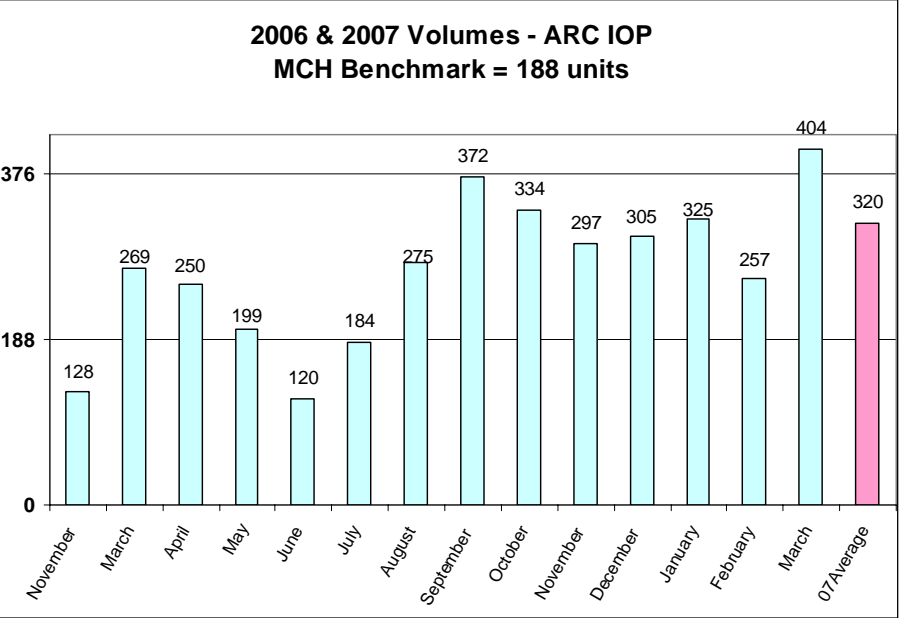
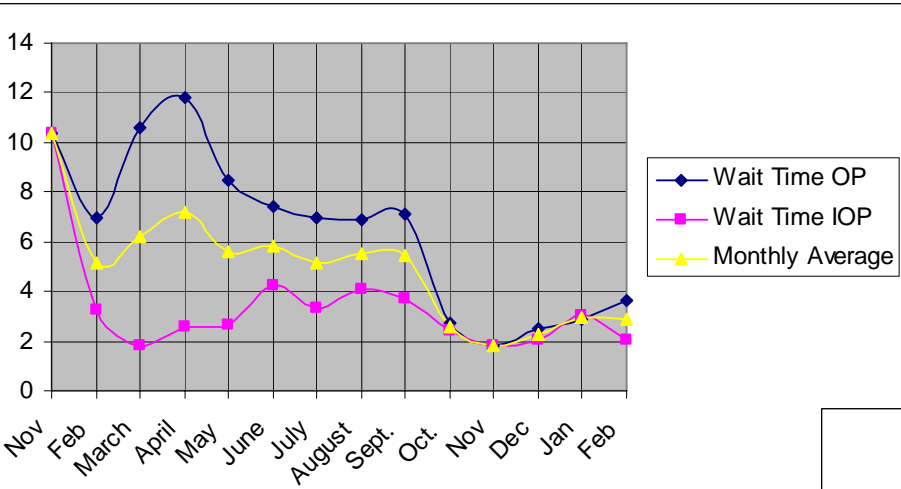
Acadia Hospital – Open Access to IOP

- ▶ Clients who fit the clinical profile over phone or at local ED are offered an evaluation the following morning at 7:30 a.m.
- ▶ All evaluated clients started program same day.

IMMEDIATE RESULTS

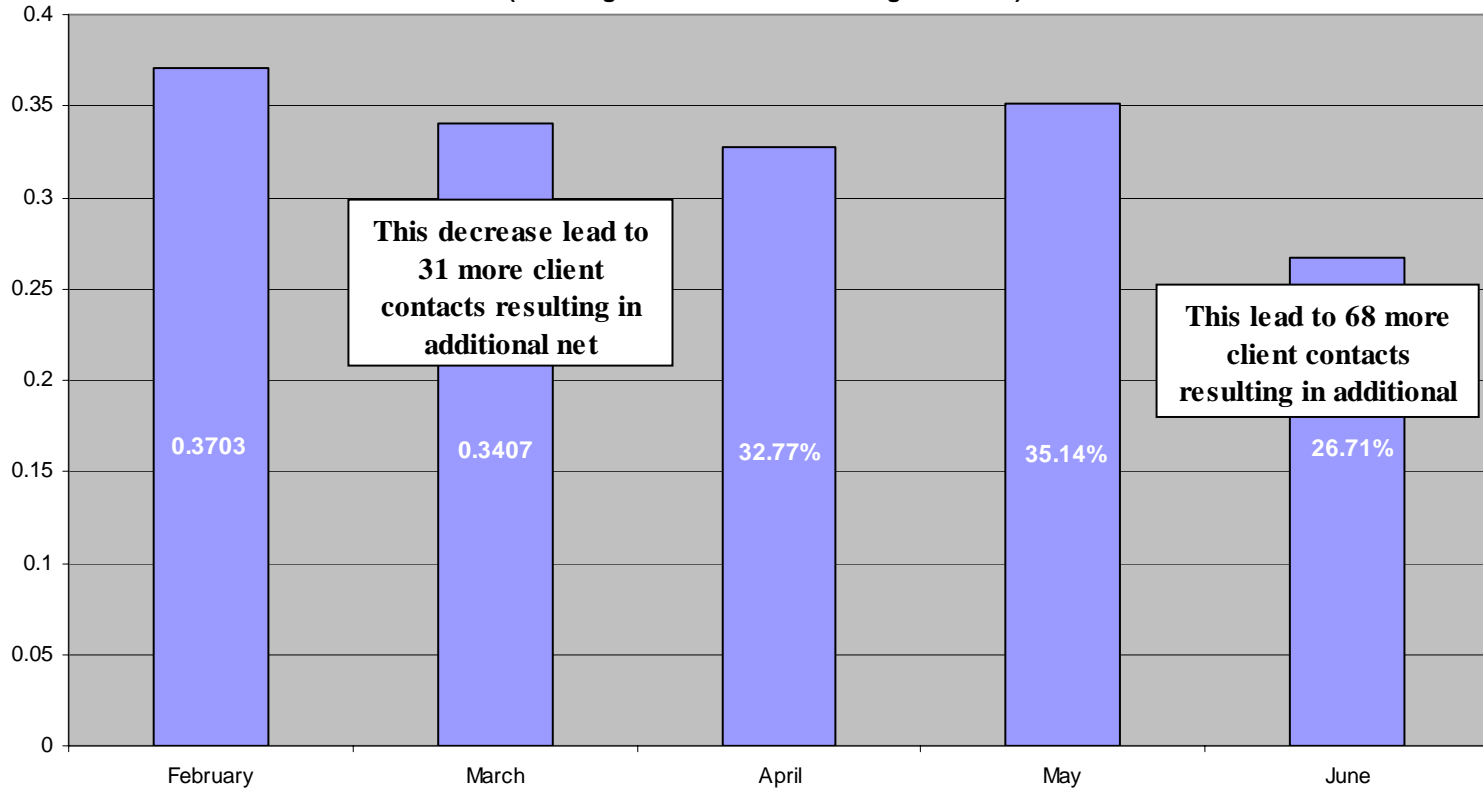
- ▶ Time between initial contact and screening dropped from 16 – 4.1 days to 1.3 days.
 - ▶ Clients seeking treatment who were retained in treatment rose from 19 percent to 53 percent.
 - ▶ Retention increased to 67 percent by March 2005.
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Addiction Resource Center

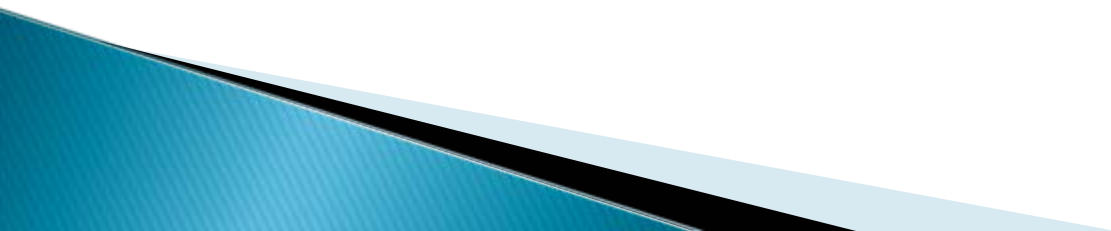


Aroostook Mental Health Center

**Caribou Substance Abuse
No-Show/Cancellation
(including clients with co-occurring disorders)**



Maine's Experience

- ▶ For the current contract year a new performance based contract was implemented that provided rewards for exceptional performance and penalties for performance below standard
 - ▶ Reimbursement mechanism: Grant plus or minus incentive payment
- 

Maine's Experience

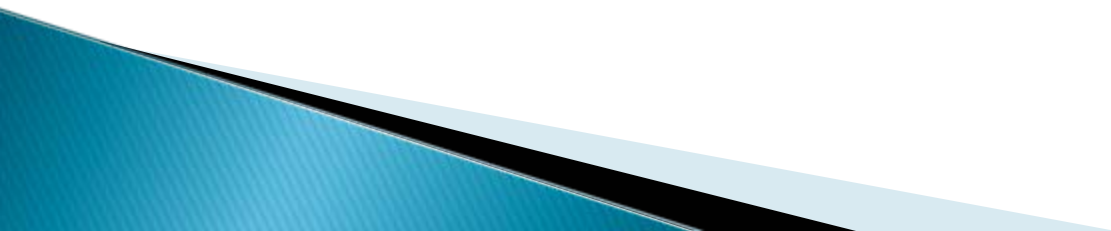
- ▶ Performance Standards are:
 - Timely Access:
 - Intake within 5 days
 - Admission with 14 days
 - Retention in Treatment:
 - Four sessions
 - Twelve weeks
 - Number of Units provided: Based on prior year contract

Maine's Experience

- ▶ Client Outcomes are still tracked, but payment is not based on client outcomes

OSA						
Effectiveness Indicator Report						
For: Substance Abuse - Co-Existing						
Period: 07/01/2006 To 06/30/2006						
Indicators	State Average %	Minimum Standard %	Program Actual %	Applicable Clients	Total Clients	State Met
SHORT-TERM (90 DAYS OR LESS)			Crossroads for Women, Inc. -26014.2		Total Clients	175
EFFECTIVENESS INDICATORS						
ABSTINENCE	90	85	90.9	175	175	1
COMPLETED TREATMENT	74.5	75	74.8	150	172	1
EMPLOYABILITY	55.9	5	61.8	99	161	1
REDUCTION OF USE	87.7	80	88.8	133	139	1
REFERRAL	70.6	75	81.1	145	179	1
SELF HELP	90.5	80	100	179	179	1
Minimal Level of Performance: 4 of 6 Indicators				TOTAL STANDARDS MET: 6		
INFORMATIONAL TRACKING						
Info Standards Met						
Avg. TIME IN TREATMENT	11		6		130	
CRUG AND ALCOHOL EDU.	97.2		89.9		177	179
FUNCTIONAL SKILLS	32.3		48.1		88	179
SELF IMPROVEMENT	10.6		7		130	
HEALTH SERVICES	99.1		100		179	179
<small>The Average Length of Stay is the average stay in weeks for all service settings except for detoxification and detox which are the average stay in days</small>						
Page 6				Based on the data loaded as on: 07/05/2006		

Next Steps

- ▶ Delaware rewards agencies for meeting a standard for successful level of care transitions
 - ▶ Need to track client outcomes to be sure that assumptions are accurate
 - ▶ Data system that tracks people through episodes of care (TX)
- 

Any Questions

- ◆ Among the Panelists?
- ◆ From the audience?
 - Use Q and A option in your web-assisted audioconference.
- ◆ After the call
 - Health.chaps@ncsl.org

To follow up

- ◆ Feel free to contact us for more information at Health.chaps@ncsl.org
- ◆ For more program information and related links, and to see past programs: <http://www.ncsl.org/programs/health/webcast2.htm>
- ◆ This program was recorded and will be made available on line.

Additional resources

- ◆ Treatment Research Institute
<http://www.tresearch.org>
- ◆ Network for the Improvement of
Addiction Treatment
<http://www.niatx.net>
- ◆ Maine Office of Substance Abuse
<http://www.maine.gov/dhhs/osa>

Resources from NCSL

- ◆ The Outcomes of Addiction Treatment and Approaches to Measuring Performance

<http://www.ncsl.org/programs/health/satmeasure.htm>

- ◆ Forum for Health Policy Leadership
Critical Health Areas Project

<http://www.ncsl.org/programs/health/forum/chap/index.htm>