Performance Measures for the Treatment of Substance Use Disorders: Opportunities for the CTN

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Today’s Presentation

• Background on the Brandeis/Harvard NIDA Center
• Current Context of Performance Measurement
• New Initiatives in Measure Development
• Implementation Issues – EHRs and Beyond
• Looking to the Future – Opportunities for the CTN
NIDA Center Investigators

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Conceptual Framework: Key Relationships in Health System Reform

Payment & Delivery System Reform

Payment approach
Organizational influences

Eligibility rules
Benefit design
Utilization management

Provider Organization

Payment approach
Organizational influences

SUD treatment

Preferences
Readiness for change

Patient

Training, preferences
Treatment options available

Clinician

System Performance:
Access, Quality, Cost

Center Research Questions & Activities
CURRENT CONTEXT OF PERFORMANCE MEASUREMENT
Premise

Performance measures are tools, and as such, do not lead to improvements unless they are well designed, appropriately used and applied in a system or organization that is equipped to implement change.

(Horgan and Garnick, 2005)
Importance of Performance Measurement

• Clients entering SUD treatment may not receive recommended services
• Performance measures are key for accountability and quality improvement
• Process measures are focused on providing the right services at the right time
• Strong research evidence on association of longer treatment and improved outcomes
National Organizations Focused On Quality - Then

Health Care Financing Administration (HCFA)

Joint Commission on the Accreditation of Healthcare Organizations (JCAHO)

National Committee for Quality Assurance (NCQA)

Institute of Medicine (IOM)

Adapted from NCQA
Organizations Focused On Quality - 2015

National Committee for Quality Assurance (NCQA)
Center for Medicare and Medicaid Services (CMS – formerly HCFA)
National Quality Forum (NQF)
State & Regional Quality Programs
The Joint Commission (TJC – formerly JCAHO)
American Medical Association/Physician Consortium on Performance Measurement (PCPI)
American Board of Medical Specialties (ABMS)
Office of National Drug Control Policy (ONDCP)
Institute of Medicine (IOM)
Washington Circle
Benefit Consultants
Office of the National Coordinator (ONC)
Measurement Software Vendors
Medical Specialty Groups
Researchers
Leapfrog Group
Foundations
Employer Coalitions
Agency for Health Care Research and Quality (AHRQ)
Substance Abuse and Mental Health Services Administration (SAMHSA)
Health Resources and Services Administration (HRSA)
State of Quality Measurement - 2015

• Quality measures are lacking for key areas of MH/SUD treatment

• Donabedian framework of structure, process and outcomes measures offers useful model

• Priority research areas include:
  – Measurement of access and outcomes
  – Development and testing of measures incorporating patient-reported outcomes
  – Processes to capture data that can be used for risk adjustment

• Support use of health information technology for quality measurement and improvement of access and outcomes

(IOM 2015)
New Imperatives

• **Health care reform and parity** – even greater focus on development and adoption of well-vetted performance measures to drive accountability and quality improvement

• **Measuring and rewarding performance** – key to increasing effective health care delivery

• **Information technology** – greater use of EHRs, automated databases and computer-based IT (e.g., clinical decision-making, patient monitoring/reminders)

• **Movement toward integrated care** – “no wrong door”
Quality Measurement – Evolution

• Drive toward higher performance
• Shift toward composite measures
• Measure disparities in all we do
• Harmonize measures across payers and providers
• Promote shared accountability and measurement across patient-focused episodes of care:
  – Outcome measures, especially patient-reported outcomes
  – Appropriateness measures
  – Cost/resources use measures coupled with quality measures
  – High-leverage process measures linked to outcomes
NEW INITIATIVES IN PERFORMANCE MEASUREMENT
Two Current Initiatives in Measure Development

• Quality Measure Development and Maintenance for CMS Programs Serving Duals and Medicaid-Only Enrollees – Measure Instrument Development and Support (MIDS)
  – Substance use disorders
  – Beneficiaries with high needs/high costs
  – Improved community integration through long-term services and supports
  – Physical health and mental health integration

• American Society of Addiction Medicine (ASAM) Performance Measures for the Addiction Specialist Physician
  Three measures being tested (2015)
  – % of patients prescribed a medication for alcohol use disorder (AUD)
  – % of patients prescribed a medication for opioid use disorder (OUD)
  – 7-day follow-up after withdrawal management

(ASAM 2014; Thomas et al. 2013)
NIDA Center – Research Applications of Performance Measures

**Washington**

**Goal:** Determine impacts on SUD treatment agency performance:
- Financial incentives to agencies
- Client-specific alerts about whether clients are meeting performance measures
- Combination of both incentives and alerts

**Measures**
- Engagement in outpatient treatment
- Continuity after detox stay or residential treatment

**Maine**

**Goal:** Determine effects of measuring and paying for performance:
- Incentive-based contract to outpatient and IOP agencies, with rewards and penalties
- Incentives (via research) directly to clinicians in outpatient and IOP agencies

**Measures**
- Access to treatment (i.e., waiting time)
- Engagement in treatment
- Retention in treatment
Conceptual Framework of Nested Identification, Initiation and Engagement Measures

- **Population prevalence** – Substance dependence or abuse in the past year
- **Identification** – % with alcohol and other drug (AOD) claim with inpatient, IOP or partial hospitalization, and outpatient or ED
- **Initiation** – % of patients who initiate treatment through an inpatient AOD admission, OP visit, IOP encounter or partial hospitalization within 14 days of the diagnosis.
- **Engagement** – % of patients who initiated treatment and who had two or more additional services with an AOD diagnosis within 30 days of the initiation visit.
Medicaid HMO 2013 Initiation and Engagement Rates

Eligible Population Prevalence → Identified → Initiated 38.2%* → Engaged 10.6%* (denominator = identified)

Exclusions

Engaged 27.9% (denominator = initiated)

*NCQA approach – 60 day clean period, rates from Medicaid managed care HMO 2013
Medicaid 2009
AOD Prevalence vs. AOD Identification Rates

<table>
<thead>
<tr>
<th>State</th>
<th>AOD Prevalence, NSDUH</th>
<th>AOD Identification Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kentucky</td>
<td>10.8</td>
<td>3.4</td>
</tr>
<tr>
<td>Louisiana</td>
<td>7.9</td>
<td>1.7</td>
</tr>
<tr>
<td>Michigan</td>
<td>10.1</td>
<td>3.9</td>
</tr>
<tr>
<td>Minnesota</td>
<td>12.1</td>
<td>4.4</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>12.1</td>
<td>1.1</td>
</tr>
<tr>
<td>Texas</td>
<td>6.6</td>
<td>1.5</td>
</tr>
<tr>
<td>Washington</td>
<td>10.4</td>
<td>3.6</td>
</tr>
</tbody>
</table>
### Using Engagement Rates for Treatment Agency Alerts

**Washington Incentive Project – Outpatient and IOP**

**Generated: 04/17/13**

**Sunrise House**

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**Clients Pending Engagement**

**Engagement Criteria:** Within 30 days of initiation, at least two days with any of the following:

- In-person client attendance of an OP individual, group, or conjoint (with client) treatment session
- Case management activity with client in attendance
- Individual, group, or conjoint "Brief Therapy" support activity

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<table>
<thead>
<tr>
<th>Name</th>
<th>Admission Date</th>
<th>Initiation Date</th>
<th>Engagement Deadline</th>
<th>Days to Engagement Deadline</th>
<th># Services Needed to Engage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Julie Nash</td>
<td>3/26/13</td>
<td>4/2/13</td>
<td>5/2/13</td>
<td>15</td>
<td>2</td>
</tr>
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</table>
Using Performance Measures to Reward Performance: Maine Project

REPORT: How did your program do in this quarter?

<table>
<thead>
<tr>
<th></th>
<th>Access</th>
<th>Early Retention</th>
<th>Retention</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2013 BASELINE</strong></td>
<td>7 days</td>
<td>97%</td>
<td>67%</td>
</tr>
<tr>
<td><strong>THIS QUARTER</strong></td>
<td>1.5 days</td>
<td>95.24%</td>
<td>71.43%</td>
</tr>
<tr>
<td><strong>$ for Target:</strong></td>
<td>$50</td>
<td>$30</td>
<td>$50</td>
</tr>
<tr>
<td><strong>$ for Improvement:</strong></td>
<td>$30</td>
<td>$0</td>
<td>$20</td>
</tr>
<tr>
<td><strong>Total $</strong></td>
<td>$80</td>
<td>$30</td>
<td>$70</td>
</tr>
</tbody>
</table>

Available award = $80 + $30 + $70 = $180
Adjusted for your FTE = $180
Split between your OP & IOP work = $90
YOUR REWARD = $90
14-Day Continuity After Detoxification

Washington State Public Sector – July – September 2015

![Bar chart showing 14-day continuity after detoxification by treatment agency in Washington State Public Sector from July to September 2015. The chart includes data for agencies labeled A through I, with varying percentages of clients showing continuity.]
IMPLEMENTATION ISSUES – ELECTRONIC HEALTH RECORDS AND BEYOND
Performance Measurement Challenges

• Nature of service delivery system
  – Multiple settings of treatment
  – Often unintegrated
  – Confidentiality
  – Provider/institutional capacity to invest in measurement

• Data quality
  – Completeness/accuracy of clinical data, patient surveys

• Population issues
  – Comorbidity (MH and SUD conditions, general medical)
  – Risk adjustment
  – Small numbers

(Data Sharing Challenges)

(Horgan and Garnick, 2005)
EHRs: The Goals

• Facilitate quality and safety of individual patient care
• Population health management
• Clinical research
  – Medical record review
  – Augment prospective clinical research
Examples of EHR Tools to Facilitate Performance Measurement and Research

• Information sharing across programs
• Structured data fields
• Clinical decision support
  – Alerts
  – Order sets
• Patient portals (PROMs, other clinical info)
• Registries and reports
EHR Challenges

• Data completeness
  – Implementation details (workflow, usability) important
  – Alerts, forcing functions & structured data fields can be disruptive to clinical care
  – Build content requires institutional resources
  – Clinical data sharing and 42 CFR Part 2

• Interoperability limited
  – Common Data Elements
  – Customization of EHR by institutions is the norm

• Data retrieval requires institutional resources
  – Report building
  – Data warehousing for dataset building/analysis
LOOKING TO THE FUTURE – OPPORTUNITIES FOR THE CTN
Looking to the Future - Issues

• Emphasis on:
  – Integration of behavioral health and medical care
  – Health information technology
  – Workforce development

• Measures that can be used across conditions, settings and purposes

• Measuring disparities

• Shift toward composite measures

• Linking measurement to performance

• Implications for performance measurement of “no wrong door”
Looking to the Future - Context

• Multi-faceted implementation strategies targeting multiple levels of service provision are most effective
  – Consumers
  – Providers
  – Organizations
  – Payers
  – Regulators

• Consider quality as existing within a complex context
  – **not** as binary, static characteristic
  – **but** as part of a cycle of actions leading to implementation of quality improvement by multiple stakeholders involved in care delivery

(IOM, 2015)
Premise

Performance measures are tools, and as such, do not lead to improvements unless they are well designed, appropriately used and applied in a system or organization that is equipped to implement change.

(Horgan and Garnick, 2005)
Thank you!

Questions?

For more information about the Brandeis/Harvard NIDA Center:
http://nidacentral.brandeis.edu
References


