

# Evaluating Substance Use Disorders Treatment

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The presenter's views and recommendations do not necessarily represent those of the funders, UCLA, or the UCLA Integrated Substance Abuse Programs.

# Who are you?



# The general squishy plan

- Evaluate what?
- Existing data sources
- Measures (lots of 'em)

# What do you want to evaluate?

- System level (e.g. county, state)
- Program level

# What is your goal?

- Patient outcomes?
- Program performance? (Processes)
  - EBP fidelity measurement
- Quality improvement?
- Meet requirements of funders

# What data are you already collecting?

- California Outcomes Measurement System, Treatment (CalOMS-Tx)
- Drug Medi-Cal claims
- Drug and Alcohol Treatment Access Report (DATAR)
- Patient satisfaction surveys?
- Addiction Severity Index
- American Society of Addiction Medicine Criteria
- Other Electronic Health Record Data

**What measures are  
“endorsed”?**



# Initiation and Engagement

## Measure 0004: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) (National Committee for Quality Assurance)

The percentage of adolescent and adult patients with a new episode of alcohol or other drug (AOD) dependence who received the following.

- Initiation of AOD Treatment. The percentage of patients who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis.

- Engagement of AOD Treatment. The percentage of patients who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.

Developed by National Committee for Quality Assurance, included in the Healthcare Effectiveness Data and Information Set (HEDIS), endorsed by the National Quality Forum.

More info: [http://www.qualityforum.org/Measure\\_Specs\\_Table/Behavioral\\_Health\\_SpecsTable.aspx](http://www.qualityforum.org/Measure_Specs_Table/Behavioral_Health_SpecsTable.aspx)

# ASAM Performance Measures

(not to be confused with ASAM Criteria)

1. % patients w/alcohol use disorder prescribed medication.
2. % patients w/opioid use disorder prescribed medication.
3. 7-day follow-up after withdrawal management
4. Presence of screening for psychiatric disorder
5. Presence of screening for tobacco use disorder
6. Primary care visit follow-up
7. All cause inpatient, residential re-admission
8. SUD diagnosis documentation in addiction treatment
9. Psychiatric disorder diagnosis presence.

Source: ASAM Performance Measures for the Specialist Physician

<http://www.asam.org/docs/default-source/advocacy/performance-measures-for-the-addiction-specialist-physician.pdf?sfvrsn=0>

# But beware:

## Are Improvements in Measured Performance Driven by Better Treatment or “Denominator Management”?

*Alex H. S. Harris, PhD<sup>1</sup>, Cheng Chen, MS<sup>1</sup>, Anna D. Rubinsky, PhD<sup>1</sup>, Katherine J. Hoggatt, PhD<sup>2</sup>, Matthew Neuman, PhD<sup>1</sup>, and Megan E. Vanneman, PhD<sup>1,3</sup>*

Study found evidence that “improvement” on a performance measure was driven by reductions in the number of people qualifying for the measure, i.e. “gaming” the system rather than actual improvements in quality.

Harris, H.S., Chen, C., Rubinsky, A.D., Hoggatt, K.J., Neuman, M., & Vanneman, M.E. Are improvements in measured performance driven by better treatment or “Denominator Management”? *Journal of General Internal Medicine*, 31 (Suppl 1): S21-7. DOI: 10.1007/s11606-0153558

# Other measures

# Evidence Based Practices

- Fidelity testing:
  - Motivational Interviewing Treatment Integrity (MITI) for Motivational Interviewing. Requires review of recorded sessions.
  - Not every EBP has a fidelity scale
  - Stay tuned for developments in this area

# Addiction Severity Index

- Addiction Severity Index

[http://www.tresearch.org/wp-content/uploads/2012/09/ASI\\_5th\\_Ed.pdf](http://www.tresearch.org/wp-content/uploads/2012/09/ASI_5th_Ed.pdf)

- ASI Lite

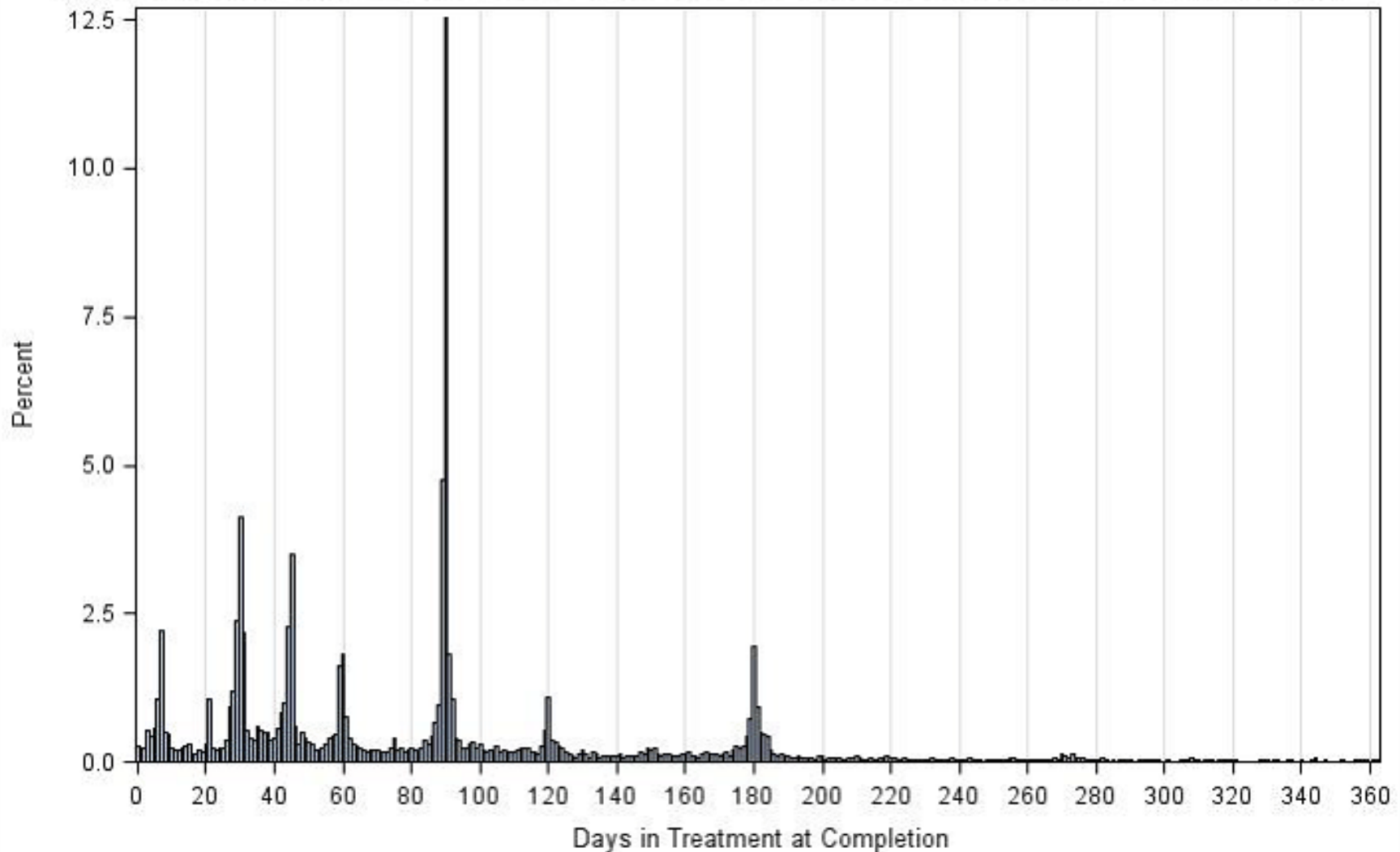
[http://www.tresearch.org/wp-content/uploads/2012/09/ASI\\_Lite.pdf](http://www.tresearch.org/wp-content/uploads/2012/09/ASI_Lite.pdf)

# ASAM Criteria

- Continuum software
- Some counties are developing their own versions for patient placement

# Time in treatment: patient centered, or “one size fits all?”

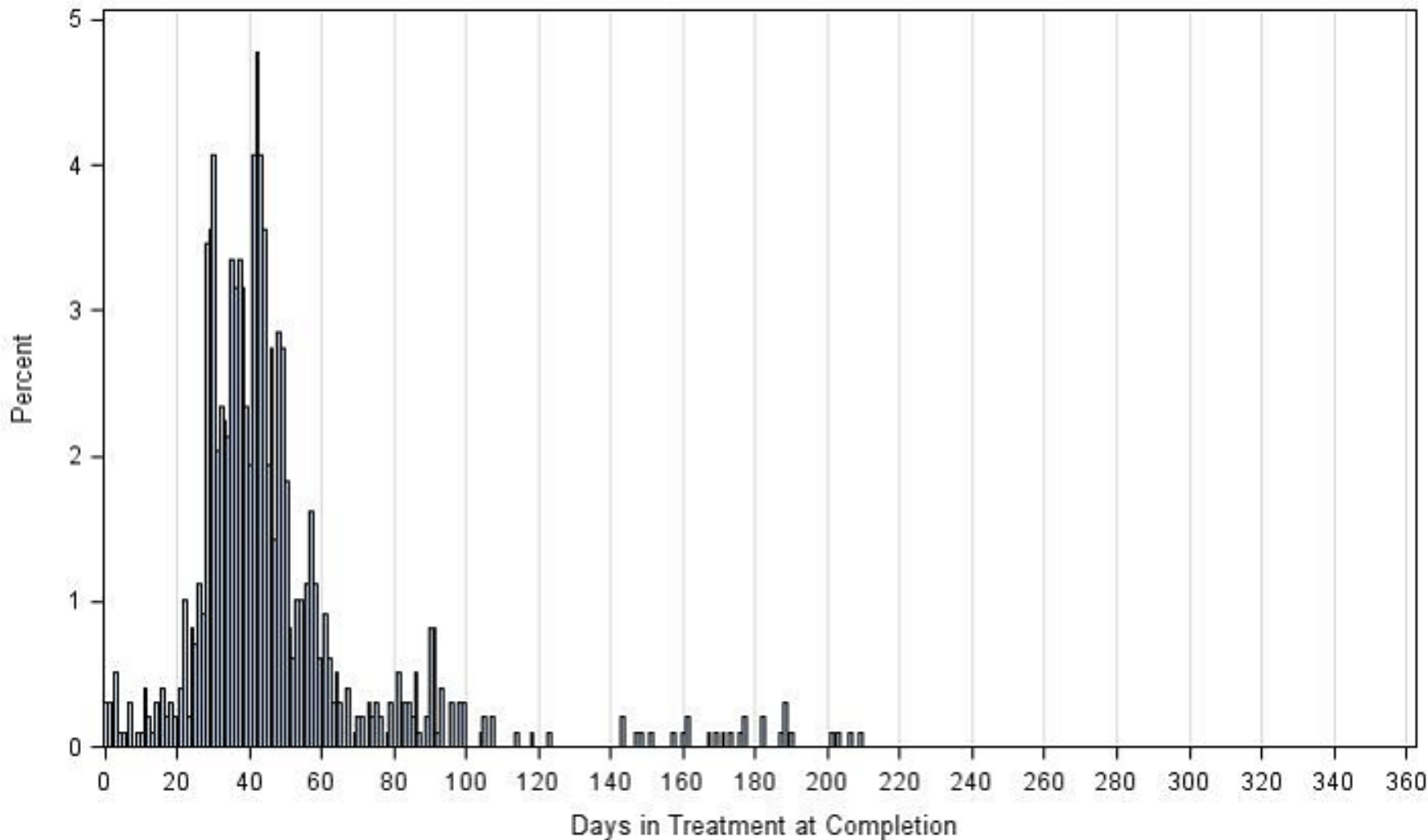
Figure 1.3. Statewide Time in Treatment among Residential Completers (FY 12/13 admissions)



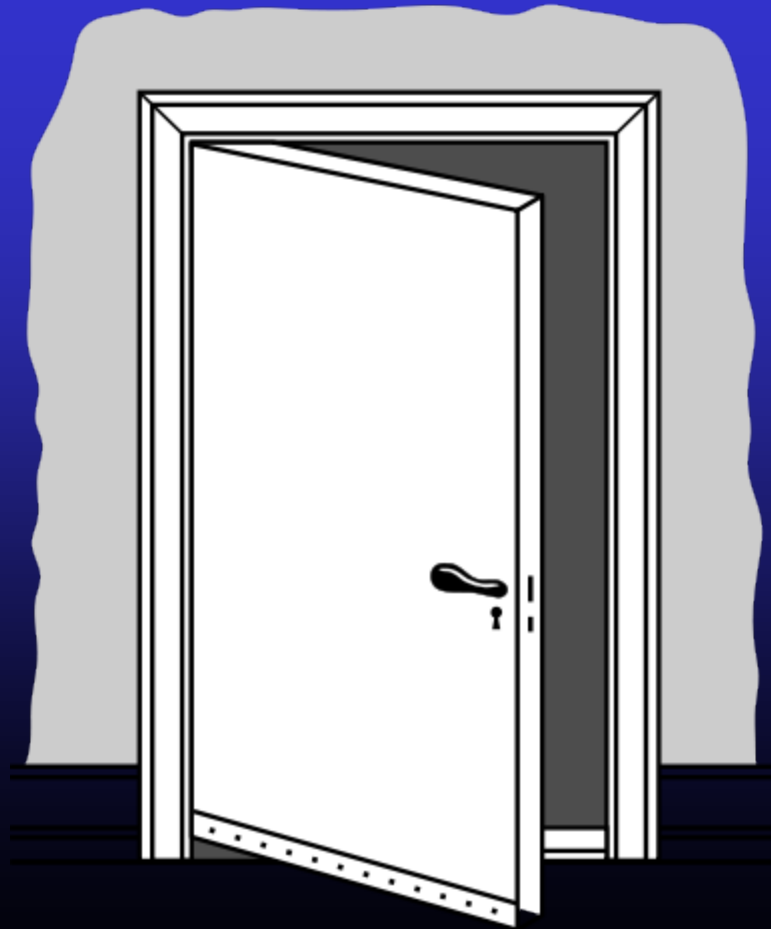


# Time in treatment: patient centered, or “one size fits all?”

Figure 1.4. Santa Clara Time in Treatment among FY 12/13 Residential Completers (FY 12/13 admissions)



# Access



# Measures of Access

- Availability and use of full required continuum of care
- Use of MAT
- Number of Admissions
- Penetration rates
- Availability of first appointments (secret shopper methods)
- Average distance to provider
- Time between assessment and admission.
- Treatment capacity.
- Existence of a 24/7 functioning beneficiary access phone number
- Availability of provider directory to patients
- Patient perceptions of access to care
- **Initiation/engagement**



# Measures of Quality

- Percent of individuals receiving ASAM criteria-based assessment prior to an admission in level of care.
- Comparison of ASAM indicated level of care and actual placement. Analysis of reasons for differences.
- Use of continuing ASAM assessments, appropriate movement
- Successful care transitions - additional services within a 14-day period after discharge from either withdrawal management or residential treatment.
- % of patients who left before completion of treatment with unsatisfactory progress in CalOMS-Tx
- Use and monitoring of evidence based practices
- Patient perceptions of quality of care
- Establishment of quality improvement committees and plans

# Patient Outcomes

- Outcome Measures
  - Alcohol or other drug (AOD) use
  - Social support/social connectedness
  - Living Arrangements (homelessness)
  - Employment
  - Emergency room use
- Grievance reports
- Readmissions to withdrawal management, residential and intensive outpatient treatment

# Costs and Utilization



# Cost/Utilization Measures

- Change in health care costs
- Change in ED utilization and costs
- Change in inpatient utilization and costs
- Change in SUD treatment utilization and costs
- Differences in health care costs that are associated with the use of different treatment modalities in costs
- Differences in health care costs that are associated with the different residential lengths of stay in costs
- Differences in health care costs among patients who receive SUD medications versus patients who do not receive SUD medications, analyzed by type of medication.



# Coordination of Care



# Coordination of Care

- Formalized agreements (MOUs, etc) with other providers.
- Comprehensive SUD, mental health (MH), and physical health screening.
- Beneficiary engagement and participation in an integrated care program as needed.
- Shared development of care plans by the beneficiary, caregivers and all providers.
- Care coordination, effective communication among providers.
- Navigation support for patients and caregivers.
- Facilitation and tracking of referrals between systems.
- Referrals to and from primary care, MH, recovery services
- Identification of SUD in the health care system.
- Follow-up after discharge from the Emergency Department for Alcohol or other drug use.

**Final thoughts...**

# A need to integrate

- As SUD and MH become BH, and as we integrate with the rest of the health system, we need to integrate our measurements as well, where possible.
- We don't want BH providers to have to report similar measures in different ways for each silo.

# While still understanding that SUD is DIFFERENT

- Be careful when using combined behavioral health questions
  - For example MH medications are much more likely to be prescribed than SUD medications. Just asking about prescriptions for BH will obscure this.
- Use caution when adapting health questions. e.g. Readmissions within 30 days is used for hospitals, but is complicated for SUD.
  - Outpatient re-engagement isn't necessarily bad
  - For residential, person could relapse immediately but spend more than 30 days on a waiting list.

# Summary

As we migrate toward “BH”, it will be critical for the MH and SUD fields to draw upon each others’ expertise, both in terms of practice and how to best evaluate those practices.

# Questions? Comments?

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