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Performance Measurement for Systems Treating Alcohol and Drug Use Disorders

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Widespread skepticism about treatment for alcohol and drug use disorders demands that counselors and treatment centers document the quality and effectiveness of care. One response is to argue, debate the merit of treatment services, and resist change. A more effective response is to see opportunities to construct state-of-the-art performance measurement systems that facilitate program management and generate evidence of service quality and effectiveness. Agencies and systems investing in performance measurement systems are leading system change and their leaders are converting challenge to opportunity.

Two papers in this issue of the *Journal of Substance Abuse Treatment* illustrate information system strategies and provide examples of innovative performance measures and outcome monitoring systems. The papers offer different perspectives on building and using performance measurement systems. The analyses test the Washington Circle measures initially developed to monitor health plan performance (Garnick et al. 2002; McCorry et al. 2000): 1) identification (the percent of patients with a diagnosis of substance use disorder), 2) initiation (the percent of patients with an index outpatient service and one more service within 14 days), and 3) engagement (the percent of patients with an index service and two or more additional services within 30 days).

Harris, Humphreys and Finney analyze data from the Department of Veterans Affairs' (VA) Outcomes Monitoring Project. VA treatment programs ($n = 110$) located in 73 VA facilities provided baseline data from 5,723 admissions and follow-up data for 3,733 (65%) individuals about 7 months after admission. Randomly selected patients completed self-administered Addiction Severity Index interviews at intake and follow-up. The analysis examines facility-level variation on the Washington Circle measures and the influence of better performance on mean client improvement on the Addiction Severity Index scores for alcohol and drug impairment. Only one significant relationship was found – facilities with higher initiation rates had slightly greater improvements on ASI Drug composite scores (but not on the ASI Alcohol score). The authors suggest that the Washington Circle measures are necessary but insufficient to affect facility level treatment outcomes - when measured following treatment discharge.

Garnick, Horgan, Lee, Panas, Ritter, Davis, Leeper, Moore & Reynolds collaborated with the Oklahoma Department of Mental Health and Substance Abuse Services and assessed the influence of treatment initiation and engagement on arrests and incarceration. Admission records from clients with a new episode of outpatient treatment during 2001 ($n = 5,169$) were matched to state data bases for the Department of Corrections (incarcerations), Department of Public Safety (drunken driving convictions), and the Oklahoma State Bureau of Investigation

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(arrests from felonies and serious misdemeanors). About half of the clients ($n = 2,651$; 51%) met criteria for engagement (intake plus two services within 30 days); 874 clients (17%) initiated care but did not engage and the remainder ($n = 1,644$; 32%) did not initiate care. Clients who engaged in treatment were less likely (hazard ratio = 0.73) to be arrested or incarcerated than those who did not initiate care or initiated but did engage in care. Risk of arrest and incarceration declined for older clients and women and, conversely, increased for African Americans, individuals who reported frequent marijuana and methamphetamine use (3 or more times in the past week) and individuals with arrests in the past year. The authors comment that the association between the process measure of treatment engagement and the outcome measure of arrests and incarceration supports the use of the Washington Circle process measures as proximal measures that can guide efforts at improving treatment quality and enhancing distal outcomes.

The apparent conflict in these conclusions (i.e., Washington Circle measures are insufficient versus Washington Circle measure are important indicators) may be more methodological than real. The two investigations tested different facets of performance measurement systems. The Oklahoma study replicated prior research findings that criminal justice involvement declines following treatment for alcohol and drug use disorders. The finding that treatment engagement was sufficient for reductions in arrests is a useful extension of prior research that primarily compared treatment completers with non-completers. The VA investigation, on the other hand, took the analysis of process measures to the next level comparing outcomes among participating treatment facilities. Facility level differences on measures of identification and engagement were not associated with differential post treatment client improvements on the ASI alcohol and drug scales.

Consistent associations between treatment center performance on the initiation and engagement measures and improvements in patient outcomes are likely to be difficult to observe until systems of care achieve better initiation and engagement rates. Rates of initiation (35%) and engagement (10%) for the VA system suggest a need for more attention to these processes system wide. Nonetheless, the rates are similar to those reported from the Health Plan Employer Data and Information Set (HEDIS). The 2006 NCQA State of Health Care Quality report (available at: http://www.ncqa.org/Communications/SOHC2006/SOHC_2006.pdf) notes wide variation across health plans and presents 2005 summary data for three groups of health plans: commercial (initiation = 44.5%; engagement = 14.1%), Medicare (initiation = 50.9%; engagement = 4.7%), and Medicaid (initiation = 40.7%; engagement = 9.7%) (National Committee for Quality Assurance 2006). The overall impression, therefore, is that rates of initiation and engagement are disappointingly low. In health plans across the nation less than 15% of the patients diagnosed with a substance use disorder receive at least 2 sessions of care within 30 days of initial treatment. The rates in Oklahoma were much higher presumably because the programs are specialty drug and alcohol treatment centers and the patients have greater needs for treatment (initiation = 68%; engagement = 51%). Even a 51% engagement rate in Oklahoma, however, suggests that specialty treatment systems can improve their performance on these indicators.

The future is here. Performance measurement systems will be used to monitor and improve treatment center and treatment system performance and participants (either the counselors in a treatment center or the treatment centers in a county or state) will be compared to identify more effective providers. Ultimately, performance measures will facilitate comparisons among those treatment centers and counselors; and research will help identify the useful limits of those comparisons. Proactive states (like Oklahoma) and treatment systems (like the VA) are participating in and leading the development of these measures.

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