

Effectiveness, Quality, Performance :

**What's the Difference?
&
How do you use them?**



Part I

What are these?

- Effectiveness
- Performance
- Quality

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Effectiveness = Results of treatment -
patient symptoms and function

Methods - Patient follow-up 6 – 12
months post discharge.

Measures - Substance use, employment,
crime & health - “Recovery”.

Characteristics – Definitive, but slow,
expensive, not management-relevant.

Performance = System function during treatment, *Indicators* of effectiveness.

Methods - Admin. databases show processes and interim results indicative of effectiveness

Measures – E.G. identification, initiation, engagement, retention

Characteristics - Management-relevant fast, face-valid - but not definitive

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“Indicators” of Quality

Licensing – indicates safety, legitimacy

Accreditation – indicates contemporary standards of care

Credentials – indicates proficiency in accepted practices

Satisfaction – indicates appeal and value

Evidence Based Practices – indicates use of state of the art care

Performance Indicators

Premise 1 – Patients who stay in treatment longer will have better outcomes.

Premise 2 – Programs or Care systems that better engage and retain patients will have better outcomes

Indicators: Easily collected measures of the care system engagement and retention –

Number of visits, linkage between stages.

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Effective Care:

Produces favorable patient
outcomes.

“Recovery”

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Quality Care:

Uses evidence-based methods,
delivered by credentialed staff,
within licensed, accredited programs,
and meets or exceeds patient/payer
expectations.

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High Performance Systems:

Identify those who need care;

Initiate care for those who need it;

Engage and retain those who initiate
across modalities and between
primary and specialty types of care.

Part II

Do We Have "Effective" Treatment Components?

- FDA standards of effectiveness
- Do substance abuse treatments meet those standards?

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An FDA Perspective

A Drug is Approved for “An Indication”

2 -Randomized Clinical Trials:

Often ask for separate investigators



Placebo Control:

Movement to test vs approved medication



FDA-Level Evidence

- **Therapies**

- Cognitive Behavioral Therapy
 - Motivational Enhancement Therapy
 - Community Reinforcement and Family Training
 - Behavioral Couples Therapy
 - Multi Systemic Family Therapy
 - 12-Step Facilitation
 - Individual Drug Counseling
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FDA-Level Evidence

- **Medications**

- Alcohol (Disulfiram, Naltrexone, Accamprosate)
- Opiates (Naltrexone, Methadone, Buprenorphine)
- **Cocaine (Disulfiram, Topiramate, Vaccine?)**
- **Marijuana (Rimanoban)**
- **Methamphetamine – Nothing Yet**

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Part III

Is Performance Measurement Different in Addiction Treatment?

- An Example From Medicine
 - An Example From Addiction
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Project MATCH

Testing Three Versions of the
Rehabilitation Model in
Alcohol Dependence

Project MATCH

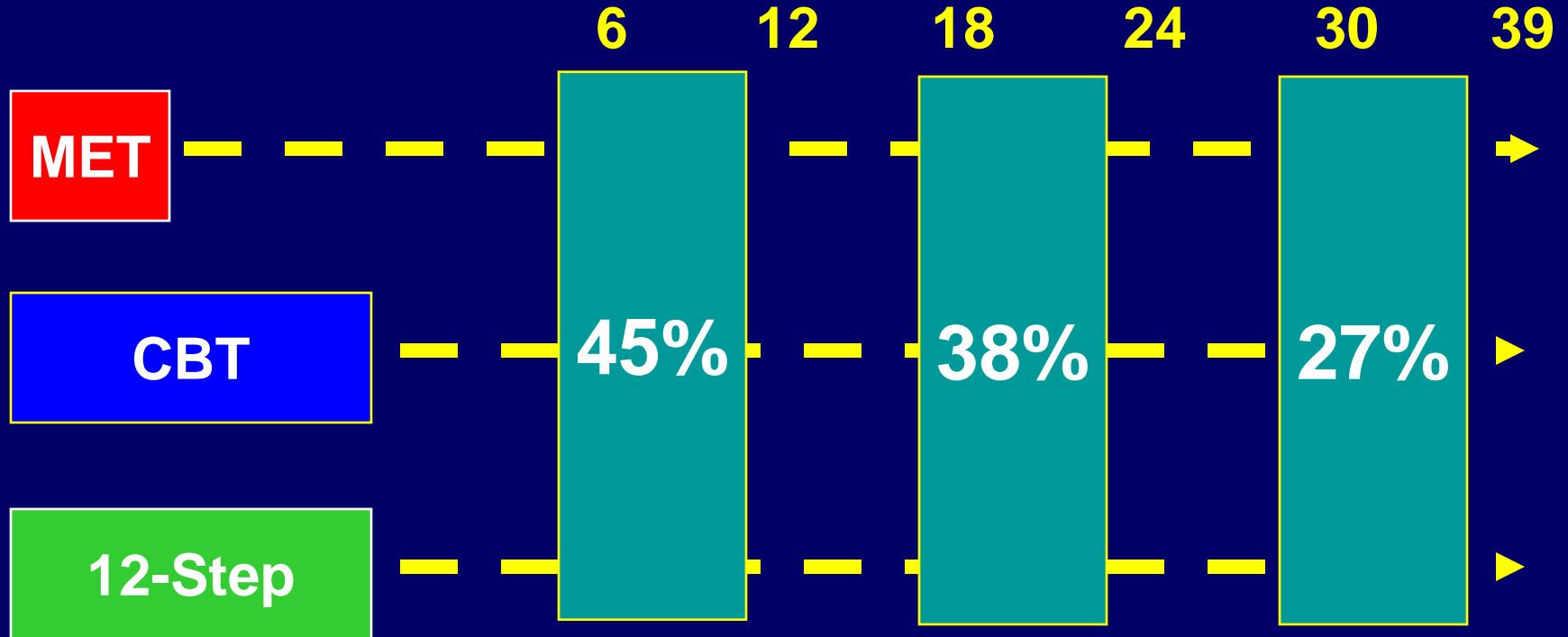
- RCT - 3 Research-Derived Therapies
 - **\$27 Million Dollar NIAAA Study**
- Different Mechanisms of Action
- Fixed Interventions – All Patients
- **Goal** – Achieve Lasting Abstinence
Post Completion

Project Match

Fixed Time - Fixed Content – Rehab Oriented

Treatment
Type

Post Treatment Evaluations



ALLHAT

The Antihypertensive and Lipid-Lowering Treatment to Prevent Heart Attack

ALLHAT

- **\$63 million – 61 sites**
- **Three Groups – Different drug actions, Different drug costs**
 - **Diuretic - \$0.10 / pill**
 - **Calcium Channel Blocker - \$1.50 /pill**
 - **Ace Inhibitor - \$4.00 /pill**
- **Goal – Improvement on Pre-Specified Criterion DURING TREATMENT**

ALLHAT

Pre-Specified Criteria – Adjustment Oriented

Start

27% Control

DURING Treatment Evaluations

Step 1

Step 2

Step 3

Diuretic

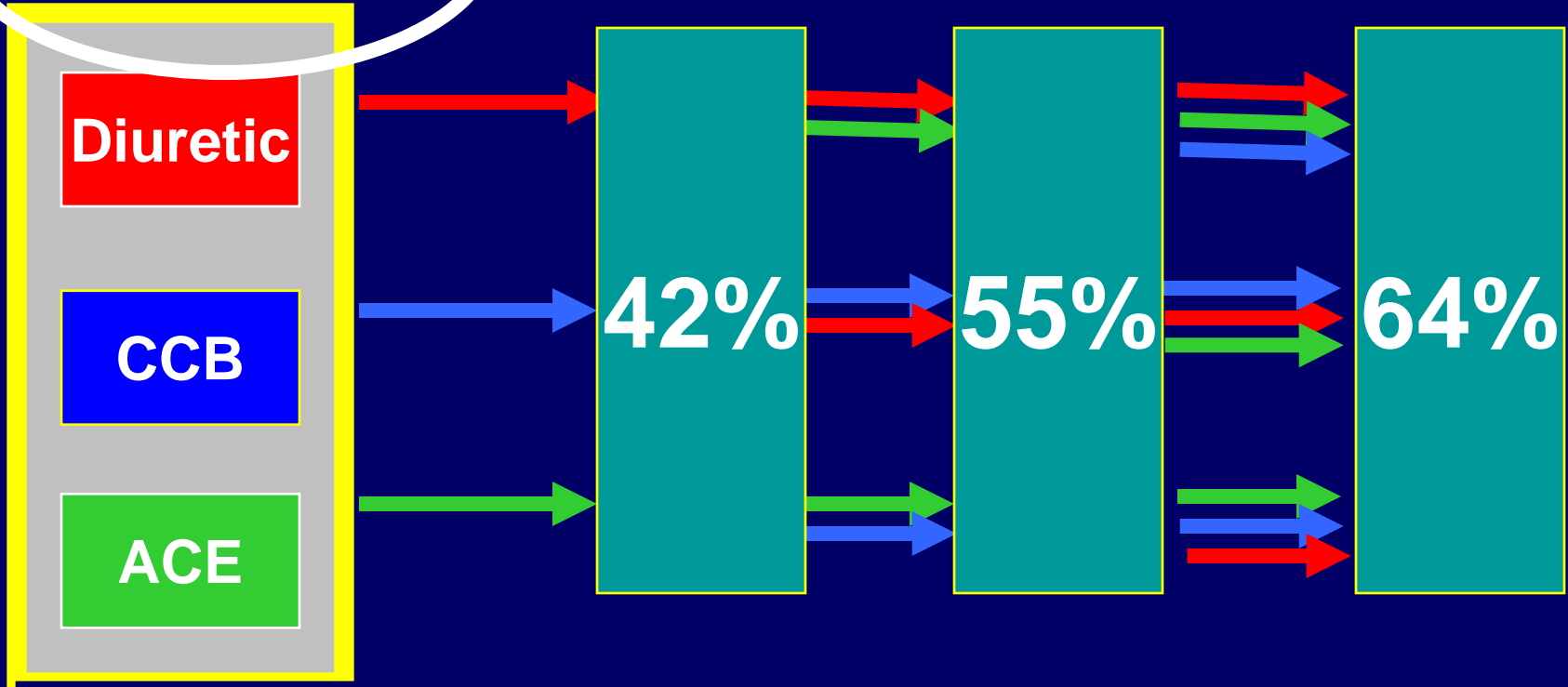
CCB

ACE

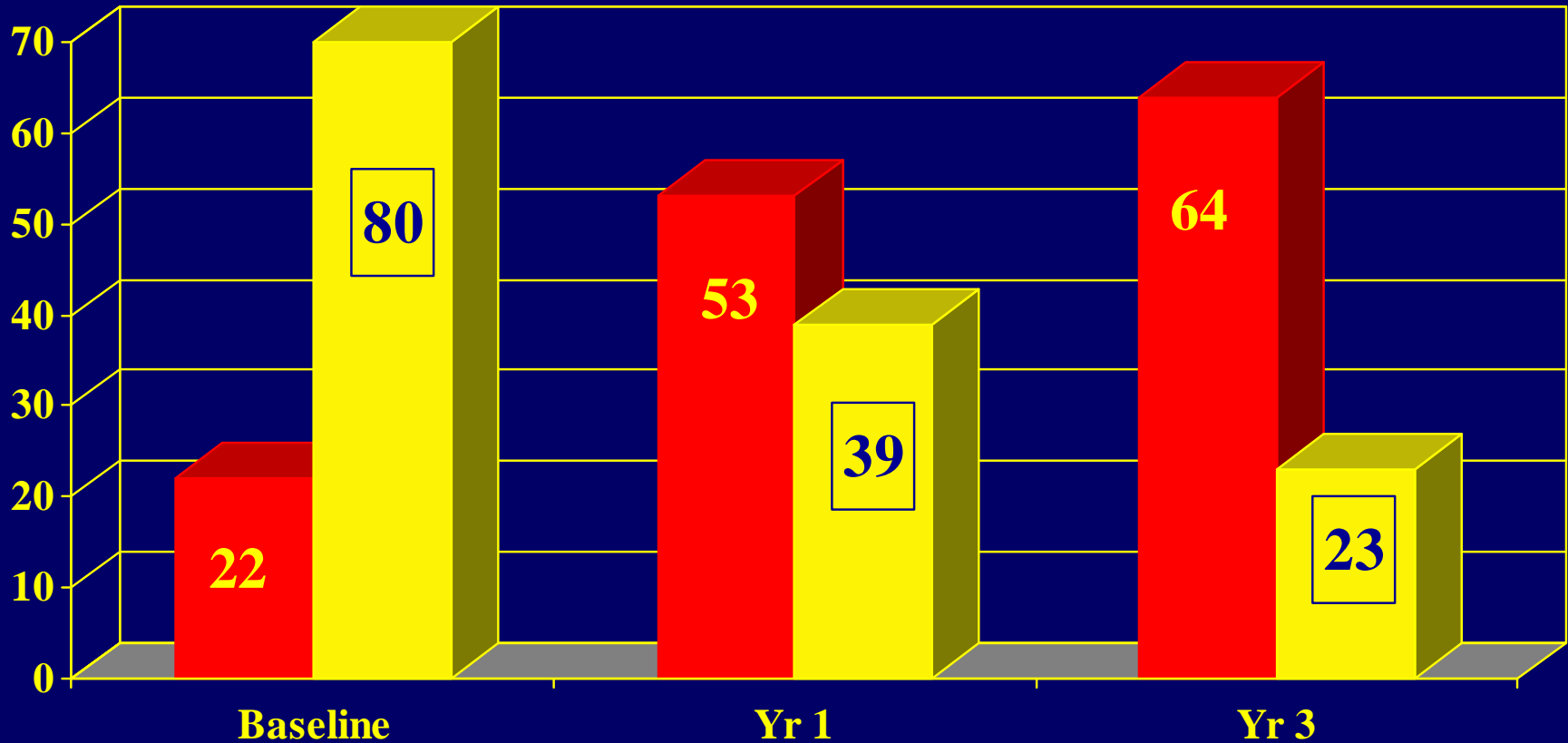
42%

55%

64%



Improvement Comparison



■ ALLHAT ■ MATCH



Part IV

OK – Now What?

How do you use these?

- **Concurrent Recovery Monitoring**
- **Performance Contracting**

Concurrent Recovery Monitoring

A Practical, Clinically Useful
Way to Improve Accountability
and Effectiveness



The Assumptions

- Program is held responsible for Outcomes DURING Treatment
- Evaluation is a Clinical Activity
 - Information will guide care
- Every Patient is Evaluated
- Patient Agrees on Goals/Measures
 - Ultimate goal is Self-Management
- Treatment offers choices!

Concurrent Recovery Monitoring

- From the Start of Outpatient Care
 - Suggest: **Weeks 2, 4, 6, 8**
Monthly thereafter
- Clinician as Evaluator
 - **Brief “Check Up” Starts Sessions**
- Patient works on a few measures



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The Blood Pressure Model



Using **CRM** and **EBP** to Adapt
and Improve Treatment

The Measures

- **Very Few, Simple and Clear**
- **Meaningful to Patient, Program, and Payer**
- **Negotiated with and Agreed upon by the Patient from the Start**
- **Part of “Patient Centered” Care**

The Criteria

The Same Traditional Outcomes

- **Reduce Substance Use**
- **Improved Personal Health**
- **Reductions of Public Health and Public Safety Problems**

Operational Definition of Recovery

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Clinical Considerations

- **Need for Pre-Specified Treatment Goals**
 - **Agreeable to the Patient, Measurable**
 - **Need for Continuing Contact/Monitoring**
 - **Tailored to the severity and needs of the patient**
 - **Telephone and Internet Options**
 - **Need for Multiple Options**
 - **Most First Efforts Will Fail – Hard to Predict**
 - **Sensible Switching or Adding Time Frames**
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The Counselor as Evaluator

- **Evaluation as:**
 - Clinically informative to counselor
 - Structured communication with Pt.
- **Results should modify care plan**
 - Good results: Continue
 - Fair results: Modify
 - Poor results: Consider Alternative

This is not “Paperwork”

The Clinical Process

- Clinical status “Check-Up” each visit
- If Some Progress:
 - **Communicate encouragement**
 - **Ask how they achieved it**
- If No Progress:
 - **Check for effort/activities – explore**
 - **Check for goal importance**
 - **Suggest alternative goals/treatments**

Concurrent Recovery Monitoring

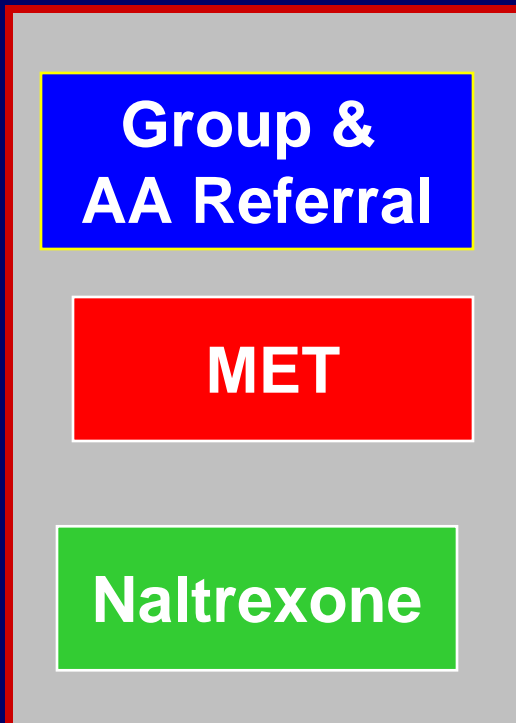
Adaptive Evaluation and Treatment

Check-Ups **During** Treatment

Measure = **Drug Use**

Treatment
Components

1 2 4 6 8 12



Concurrent Recovery Monitoring

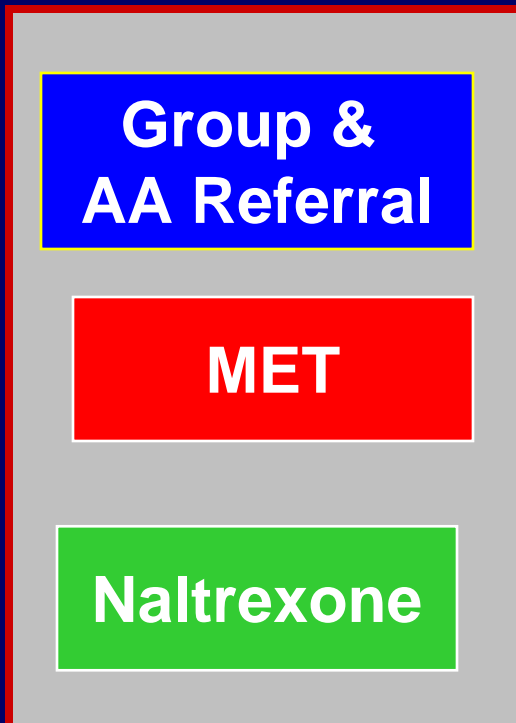
Adaptive Evaluation and Treatment

Check-Ups **During** Treatment

Measure = **Drug Use**

Treatment
Components

1 2 4 6 8 12



***An Example of
Adaptive Care***

**Lessons from
Physician Health Plans**

Physician Health Plans

- **49** PHPs
 - All authorized by state licensing boards
 - Most treat many types of health professionals
- **Continuously Manage treatment**
 - Assess, Intervene, Evaluate, Refer, Monitor, Report and Advocate
 - All under authority of Board

DuPont et al., 2008, (in review).

Formal Treatment

- **Signed contract 3 – 5 years**
 - Protection from adverse actions
 - Diagnostic evaluation – w/Family
 - Monitoring with report to Board – 4 yrs
- **Formal Treatment ~1 yr**
 - Residential 60 days – IOP ~ 6 months
 - Return to practice ~ month 3
 - Aftercare ~ 6 months

Monitoring & Support

- **Monitoring & Support 4 yrs**
 - AA
 - Caduceus Society
 - Worksite visits
 - * Personal Therapist
 - * Family Therapy
- **Urine Drug Screenings**
 - Weekly (random during weekdays)

Results During Contract

**802 Physicians
Consecutively Enrolled into
16 state Physician Health Programs**

Completed

448 - No Longer Being Monitored

67 - Completed but monitored voluntarily

515 (64%)

Continuers

132 - Still being monitored

132 (16%)

Non-Completers (Failed)

85 – Voluntarily stopped / Retired

48 – Failed, License Revoked

22 - Died (6 suicides)

155 (20%)

Results *Through* Five Years

No Positive Urine Over
5 Years

78%

Results Through Five Years

Second Positive Urine
After One Slip

26%

Results After Five Years

Practicing Medicine

Completers 92%

Continuers 73%

Non-Completers 28%

Results After Five Years

Revoked License

Completers 2%

Continuers 11%

Non-Completers 32%

Results After Five Years

Untoward Patient Incidents
~ 500 Physicians 6,000,000 Patients

Recorded incidents **55**

Patient Harm **5**

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Part V

What Could Make this Happen in Addiction Treatment?

- Performance Contracting - Delaware
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New Purchasing Methods

Performance Contracting In Delaware

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Addiction Specialty Care

13,200 programs in US

- **65%** private, not for profit

- **80%** primarily government funded
Private insurance <12%

- **31%** treat less than 200 patients per year

Sources – NSSATS, 2002; D'Aunno, 2004

Delaware Situation 2002

- **11 Outpatient Providers**
- **Limited Budget**
- **No success with outcome evaluation**
- **Providers won't/can't use EBPs**

Delaware's Performance Based Contracting

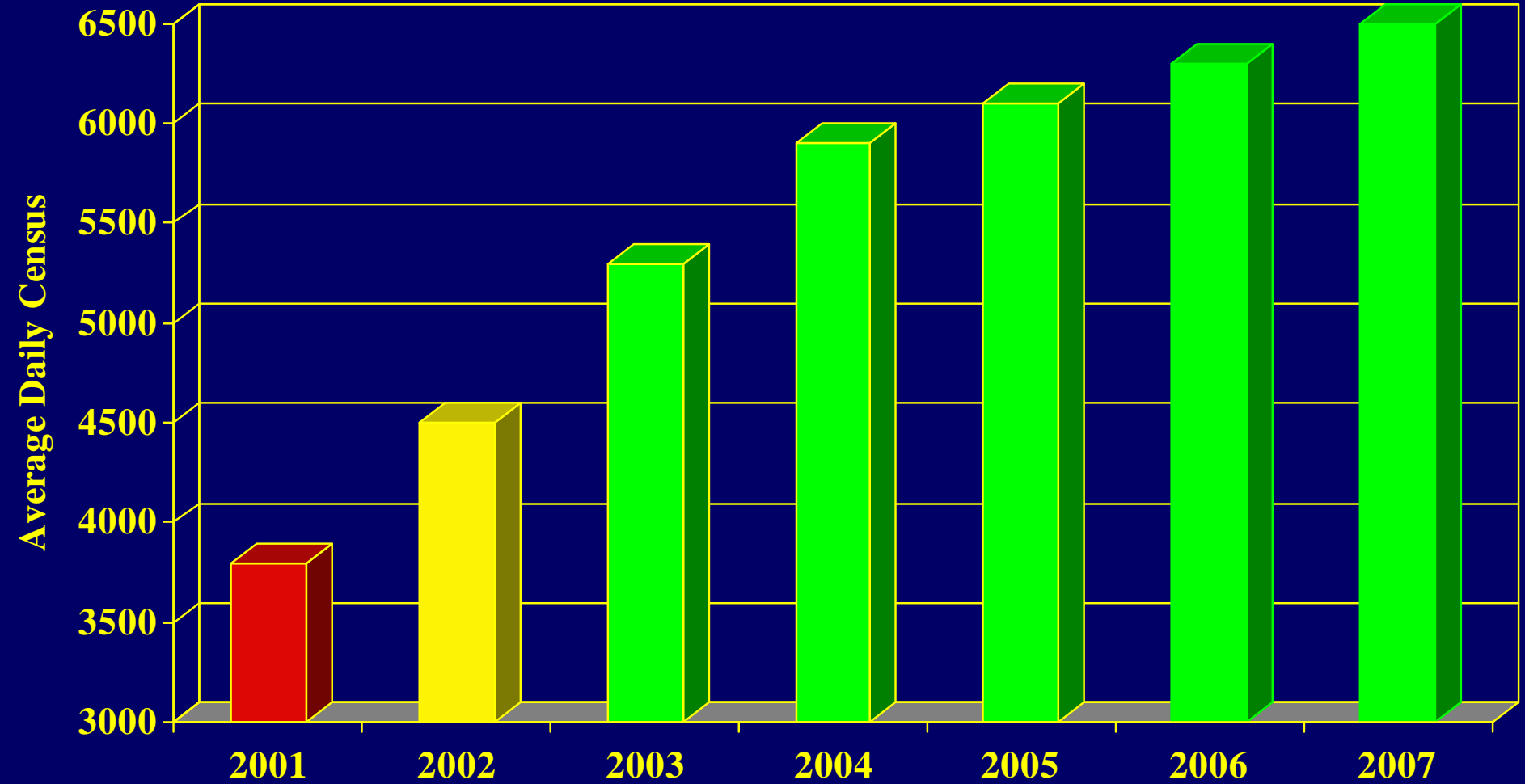
- 2002 Budget – 90% of 2001 Budget
- Opportunity to Make 106%
- Two Criteria:
 - Full Utilization
 - Active Participation
- Audit for accuracy and access

Delaware's Results

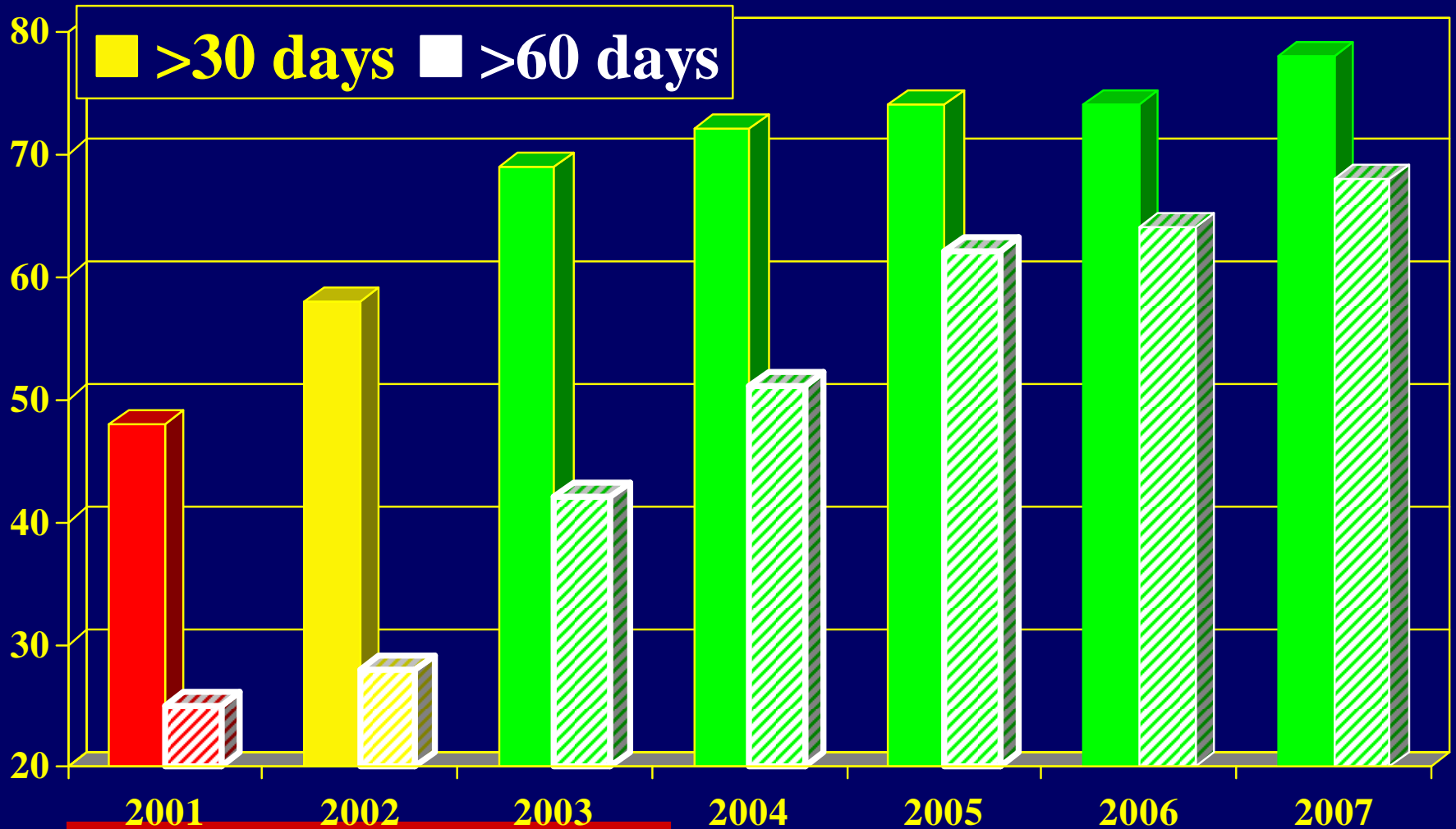
Years 1 & 2

- One program lost contract
- Two new providers entered, did well
 - **Mental Health and Employment Programs**
- Programs worked together
 - **First, common sense business practices**
 - **Second, incentives for teams or counselors**
- 5 programs learned MI and MET

Utilization



% Attending



Delaware Mandate 2005:

Legislature and Drug Courts

- Continue to Manage Addiction Patients

ADD TWO MEASURES

- Reduce Drug/Alcohol Use
- No new arrests



CONCLUSIONS

- **Performance, Effectiveness and Quality**
 - All important – not the same
- **All Require Active Information**
 - Clinical Information Systems a MUST
- **Purchasing Methods Influence Quality**
 - Performance Monitoring and Contacting



- The End -

