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Journal of Substance Abuse Treatment 41 (2011) 97–103

Journal of Substance Abuse Treatment

Brief article

The impact of pay-for-performance on therapists' intentions to deliver high-quality treatment

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Received 6 July 2010; received in revised form 10 January 2011; accepted 12 January 2011

Abstract

This article examined the extent to which assignment to a pay-for-performance (P4P) experimental condition impacted therapists' intentions to deliver high-quality treatment and the extent to which therapists' intentions could be explained by the theory of planned behavior. Data were collected from 95 therapists who agreed to participate in a P4P experiment related to their implementation of an evidence-based treatment (EBT) for adolescents with substance use problems. Relative to those in the control condition, therapists in the P4P condition reported significantly greater intentions to achieve monthly competence ($B = 1.41$, $p < .001$) and deliver a targeted threshold level of treatment to clients ($B = 1.31$, $p < .001$). In addition, therapists' intentions could be partially explained by the theory of planned behavior. Meta-analyses have found intentions to be one of the best predictors of behavior; thus, these findings provide initial support for using P4P approaches as a method of increasing the quality of substance use treatment.

Keywords: Adolescents; Intentions; Pay-for-performance; Substance use treatment

1. Introduction

According to the Institute of Medicine (IOM; 2007), existing payment systems are not currently aligned with providing high-quality care and have limited the success of prior quality improvement efforts. Indeed, early attempts to improve quality of care within substance abuse treatment, which focused on disseminating treatment manuals for evidence-based treatment (EBT; Budney, & Higgins, 1998; Carroll, 1998; Mercer & Woody, 1999), have not had a significant impact on the adoption and implementation of these EBTs (Garner, 2009). Among the potential reasons for this is the lack of financial incentives for adopting and implementing these EBTs. To promote better alignment of payment systems and quality care, the IOM (2007) has recommended examining pay-for-performance (P4P; i.e., providing financial incentives for achieving predefined quality targets) as one promising method to encourage innovation, performance improvement, and better outcomes.

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0740-5472/11/$ – see front matter
doi:10.1016/j.jsat.2011.01.012

Using data from a large randomized P4P experiment called Reinforcing Therapist Performance (RTP; Garner, Godley, Dennis, Godley, & Shepard, 2010), this article examines the extent to which P4P methods impacted therapists' intentions to achieve two quality care targets, as well as the extent to which therapists' self-reported intentions to achieve these quality targets could be explained by the theory of planned behavior (TPB; Ajzen, 1991). As described by Garner et al. (2010), these quality targets included demonstrating monthly competence (i.e., delivery of treatment procedures at or above the level prescribed in the training manual) and delivering a targeted threshold level of treatment (i.e., at least 10 of 12 specific treatment procedures delivered in no less than seven sessions) found to be significantly associated with better posttreatment client outcomes.

1.1. Research on P4P

Despite little research experimentally testing the effectiveness of P4P methods to improve quality of health care (Dudley et al., 2004), the number of P4P programs in the United States is well over 100 and quickly rising (Greene & Nash, 2009). Within the behavioral health treatment field,

however, P4P has been less common, with only 13 P4P programs having been identified that targeted either behavioral health specialists or substance abuse treatment providers (Bremer, Scholle, Keyser, Houtsinger, & Pincus, 2008). In general, behavioral health P4P programs have focused on increasing rates of client engagement and retention in treatment and have provided incentives at the level of the treatment program. As one example, McLellan, Kemp, Brooks, & Carise (2008) describe the State of Delaware's initiative to replace traditional cost–reimbursement contracts with performance-based contracts for all 11 of its outpatient addiction treatment programs. After making program reimbursement contingent on successfully maintaining specific client capacity utilization rates, the average rate increased from 54% in 2001 to 95% in 2006. In addition, when monetary bonuses were provided for programs meeting specific threshold rates of client participation and completion, the average program rate of clients meeting the participation requirements increased from 53% in 2001 to 70% in 2006. Only two prior studies have used therapist-level P4P methods to improve treatment quality. For example, Andrzejewski, Kirby, Morral, and Iguchi (2001) found that providing therapists with graphical performance feedback and drawings for monetary incentives increased contingency management implementation by 69% and 93%, respectively. In addition, a study by Shepard et al. (2006) found that providing therapists with a $100 bonus appeared to be an effective approach to improve the percentage of clients who attended at least five treatment sessions. A limitation of these two P4P studies, however, has been the lack of random assignment to experimental and control conditions, which limits the ability to make causal inferences regarding the P4P programs' impact on outcomes.

1.2. The TPB

As an extension of the theory of reasoned action (Fishbein & Ajzen, 1975), Ajzen's (1991) TPB is one of the most widely tested theories of behavior change (e.g., Armitage & Conner, 2001; Eccles et al., 2006; Godin, Belanger-Gravel, Eccles, & Grimshaw, 2008; Godin & Kok, 1996; Webb & Sheeran, 2006). According to this theory, an individual's *intention* to perform or engage in a particular behavior is a key predictor of his or her actual behavior. The TPB also postulates that behavioral intentions are determined in part by three constructs: (a) attitudes toward the behavior (i.e., positive or negative evaluations of behavior), (b) subjective norms (i.e., social pressure from significant others to engage or not to engage in a behavior), and (c) perceived level of control (i.e., perceived ease or difficulty of performing a behavior). Relative to the larger literature that has used theories such as TPB to study behavior change, only an extremely limited number of studies have applied theories of behavioral change to better understand and change the behavior of staff in medical and other behavioral health care fields (Perkins et al., 2007). One exception is a recent study by Rieckmann, Daley, Fuller, Thomas, and McCarty (2007), which found that therapists' attitudes and subjective norms were significantly associated with their intentions to recommend specific medications to clients for the treatment of opioid dependence. Thus, consistent with recommendations for more theory-driven research to understand therapist behavior (Perkins et al., 2007), this study also examined the extent to which the TPB measures could explain therapists' intentions to achieve two indicators of high-quality treatment.

2. Method

2.1. Study context

All participants in this study, which is one piece of a larger study, were therapists hired to treat adolescents with substance use problems as part of a service project funded by the Center for Substance Abuse Treatment (CSAT) to implement the Adolescent Community Reinforcement Approach (A-CRA) and Assertive Continuing Care (ACC). Based upon the Community Reinforcement Approach (CRA), which was originally developed for treating substance abuse with adults (Azrin, Sisson, Meyers, & Godley, 1982; Higgins et al., 1991; Hunt & Azrin, 1973; Meyers, Dominguez, & Smith, 1996; Meyers & Smith, 1997; Smith, Meyers, & Delaney, 1998), A-CRA/ACC are adolescent adaptations of CRA that have been found to be both effective and cost-effective (Dennis et al., 2004; Garner, Godley, Funk, Dennis, & Godley, 2007; Godley et al., 2010; Godley, Godley, Dennis, Funk, & Passetti, 2002, 2007; Slesnick, Prestopnik, Meyers, & Glassman, 2007). Importantly, in contrast to session-based EBTs, which deliver treatment procedures to all clients in the same prescribed order, A-CRA/ACC are procedure-based interventions that require therapists to be able to not only deliver the treatment procedures but also determine which procedure(s) are most appropriate based on what the adolescent says during each treatment session. As part of this CSAT project, treatment agencies each received financial resources of approximately $300,000 per year (for up to 3 years), as well as free A-CRA/ACC training and technical assistance for their therapists during the 3-year project period. As described by Godley, Garner, Smith, Meyers and Godley (in press), the training includes several components identified by Carroll, Kadden, Donovan, Zweben, and Rounsaville (1994) to ensure that therapists are trained to maximize treatment fidelity (e.g., treatment manual, 3.5-day initial workshop, and ongoing individual performance feedback and coaching based on review of recorded therapy sessions). Participants for this study were therapists working for agencies who received funding from CSAT and who agreed to participate in the RTP experiment during January and February 2009. The RTP experiment was funded by the National Institute of