

Regular article

Measuring the quality of substance use disorder treatment: Evaluating the validity of the Department of Veterans Affairs continuity of care performance measure

Alex H.S. Harris, (Ph.D.)^{a,*}, Keith Humphreys, (Ph.D.)^a, Thomas Bowe, (Ph.D.)^a,
Daniel R. Kivlahan, (Ph.D.)^b, John W. Finney, (Ph.D.)^a

^aCenter for Health Care Evaluation, Department of Veterans Affairs Palo Alto Health Care System, and Stanford University School of Medicine, 795 Willow Road (MPD-152), Menlo Park, CA 94025, USA

^bQuality Enhancement Research Initiative – Substance Use Disorder Center, VA Puget Sound Health Care System and University of Washington, School of Medicine, 1660 Columbian Way S. (116 ATC), Seattle, WA 98108, USA

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Abstract

This study examined the patient- and facility-level associations between the continuity of care performance measure adopted by the Department of Veterans Affairs (VA) and improvements in self-administered Addiction Severity Index (ASI) composites and other indicators of problematic substance use. Up to 50 patients from each of a nationally representative sample of 109 VA substance use disorder (SUD) treatment programs at 73 VA facilities were assessed at intake and posttreatment. The continuity of care performance measure specifies that patients should receive at least two SUD outpatient visits in each of the three consecutive 30-day periods after they qualify as new SUD patients. In analyses adjusting for baseline characteristics, meeting the continuity of care performance measure was not associated with patient-level improvements in the ASI alcohol or drug composites, days of alcohol intoxication, or days of substance-related problems. Facility-level rates of continuity of care were negatively associated with improvements in ASI alcohol and drug composites. The continuity of care performance measure derived from prior patient-level evidence did not discriminate facility-level performance as predicted. Translating research into process-of-care quality measures requires postconstruction validation. Published by Elsevier Inc.

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1. Introduction

Increasingly, health care systems evaluate the quality of the services they provide by measuring processes of care

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* Corresponding author. Center for Health Care Evaluation, Department of Veterans Affairs Palo Alto Health Care System, and Stanford University School of Medicine, 795 Willow Road (MPD-152), Menlo Park, CA 94025, USA.

E-mail address: alexander.harris2@va.gov (A.H.S. Harris).

thought to produce positive outcomes or, less frequently, by measuring outcomes directly (AcademyHealth, 2004; Gagnick, Horgan, & Chalk, 2006; Majeed, Lester, & Bindman, 2007). Monitoring strategies based on established quality measures can be used to identify high- and low-performing facilities, to monitor the effects of system-wide initiatives, and to incentivize best practices. The most valid measures of quality, such as pre- and posttreatment assessments of patient symptoms or functioning, are often very expensive and often impractical to obtain. On the other hand, quality measures constructed from administrative data, such as patients' utilization of treatment services and staffing data, are inexpensive and easy to generate but may be of low or unknown validity as proxies for outcomes.

Because of the cost and difficulty of directly monitoring patient outcomes, it is highly preferable to identify treatment process quality indicators that reliably predict subsequent outcomes. However, outcomes can be affected by a large number of factors other than processes of care (Lilford, Brown, & Nicholl, 2007; Moos & Moos, 2007), potentially resulting in no or weak relationships with outcomes. Without knowing the extent to which quality measures constructed from readily available data are correlated with patient outcomes, validity and feasibility cannot be rationally balanced in decisions about which indicators to use. Many widely adopted quality indicators are derived from administrative data, but often, no direct validity evidence is available to support their use. The use of quality measures with unknown or poor validity has serious risks, including incentivizing poor care, promoting overtreatment, or directing clinical energy and attention to a treatment process that is not part of the causal chain by which the treatment produces its intended effects (Heath, Hippisley-Cox, & Smeeth, 2007).

1.1. Measuring the quality of substance use disorder treatment in the Department of Veterans Affairs

The Department of Veterans Affairs' (VA) transformation into a high-quality health care system has been achieved largely through a system of performance measurement and accountability, enabled by an electronic medical record system (Glabman, 2007; Kerr & Fleming, 2007; Oliver, 2007). For most important aspects of care delivery, standards have been established, performance is monitored, and the compensation of system leaders is directly linked to these quality metrics. The VA currently incentivizes two quality measures related to patients' substance use care: (a) annual alcohol misuse screening in all primary care medical settings and (b) continuity of care (CoC) for patients in new episodes of specialty substance use disorder (SUD) treatment. Specialty SUD treatment refers to treatment provided in one of VA's designated SUD treatment programs but excludes SUD-related care (e.g., brief alcohol counseling or pharmacotherapy) that might occur in other settings, such as primary care or psychiatric units.

The CoC performance measure (PM) is the focus of this study. Outpatients meet the CoC PM if they have at least two specialty SUD care contacts in each of three successive 30-day periods after initiating a new episode of care. Patients from SUD inpatient or residential treatment programs meet the PM if they have at least two specialty SUD outpatient contacts in each of three successive 30-day periods following discharge or transfer from the SUD specialty unit.

1.2. The potentially hazardous road from patient-level evidence to facility-level PMs

The evidentiary foundations of the CoC PM are clinical practice guideline recommendations and observational research findings that better SUD treatment outcomes are

associated with longer outpatient treatment length and outpatient follow-up after inpatient treatment (e.g., Moos, Finney, Ouimette, & Suchinsky, 1999; Ouimette, Moos, & Finney, 1998; Simpson, Joe, & Rowan-Szal, 1997; Veterans Health Administration Office of Quality and Performance, 2005; Zhang, Friedmann, & Gerstein, 2003). However, successfully translating research findings (e.g., that more extended treatment involvement is associated with better SUD outcomes) into logistically feasible quality indicators is hampered by at least two major difficulties (Hayward, 2007; Walter, Davidowitz, Heineken, & Covinsky, 2004). First, it is challenging to operationalize a performance indicator in a manner that maps directly onto the empirical literature that supports it. The continuing care literature is nuanced and not uniform in finding positive effects attributed to longer treatment engagement or formal aftercare. In a review of the evidence linking length of treatment engagement and subsequent outcomes in outpatients, McKay (2001) noted consistent positive effects in observational studies and in 7 of 11 randomized trials comparing minimal or no additional treatment to longer treatments or interventions designed to increase continuing care involvement. Among the positive randomized studies, the magnitude of the effects were often modest and found for some outcomes but not others (e.g., Foote & Erfurt, 1991; Lash et al., 2007; McKay et al., 1999). Furthermore, the interventions with positive effects often were very lengthy (e.g., 12 months of nursing home visits; Patterson, Macpherson, & Brady, 1997) and/or employed active efforts to increase continuing care involvement (e.g., contracting, prompting, and reinforcing aftercare; Lash et al., 2007) that are not often used in routine continuing care. Studies such as these are often cited as generic support for longer treatment duration and continuing care, yet their relationship to the specifications of the VA CoC quality indicator is tenuous.

Furthermore, several of the studies supporting a link between lengthier treatment involvement and better outcomes included non-SUD mental health visits (e.g., Moos, Schaefer, Andrassy, & Moos, 2001; Schaefer, Harris, Cronkite, & Turrubiates, 2008) or self-help group participation as a component of continuing treatment involvement. Because self-help group involvement often occurs outside the health care facility or does not result in a clinical progress note, data regarding this kind of continuing care often are not available for use in the calculation of quality measures. In studies that have estimated the independent effects of formal continuing care and informal self-help involvement, formal continuing care has typically been the weaker or a nonsignificant predictor of outcomes. For example, a recent, well-controlled study found among patients in residential treatment or day hospital programs that formal care beyond the index stay imparted no additional benefit, but continuing self-help group involvement was associated with additional improvement (Witbrodt et al., 2007).

Although several interventions have succeeded in improving participation in aftercare and clinical outcomes

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