



Maintenance of Access as Demand for Substance Use Disorder Treatment Grows



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ABSTRACT

Due to the Affordable Care Act and other recent laws and regulations, funding for substance use disorder (SUD) treatment is on the rise. In the 2000s, the Veterans Health Administration (VA) implemented several initiatives that increased funding for SUD treatment during a period of growth in demand for it. A key question is whether access to and intensity of treatment kept pace or declined. Using VA SUD treatment funding data and patient-level records to construct performance measures, we studied the relationship between funding and access during the VA expansion. Overall, we observed an increase in access to and intensity of VA SUD care associated with increased funding. The VA was able to increase funding for and expand the population to which it offered SUD treatment without diminishing internal access and intensity.

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1. Introduction

Due to the Patient Protection and Affordable Care Act (ACA; Pub. Law 111-148) and other recent laws and regulations, the U.S. is entering a period of expansion of financial support for health care in general and for mental health and substance use disorder (SUD) treatment in particular (Buck, 2011). Given that SUD treatment has historically been underprovided (Substance Abuse & Mental Health Services Administration, 2011), increased coverage for SUD treatment services will likely lead to more demand on the delivery system. The extent to which the delivery system can sufficiently respond to greater demand – maintaining or improving access, recommended intensity, and adequate quality – is an open question and a growing concern, particularly in light of the fact that hiring and retaining qualified SUD treatment staff are recognized challenges (Humphreys & McLellan, 2011).

In this context, we studied a period of expansion in demand for SUD treatment within the Veterans Health Administration (VA) (2005–2010). Commensurate with that growth in demand, the VA increased resources for VA SUD treatment, designed to maintain or expand access to care, intensity, and quality. In the decade of the 2000s, the VA collected considerable data on SUD treatment programs and spent \$152 million in centrally administered funds targeted to hiring additional SUD treatment staff. Though characteristics of the VA – a national, integrated health system that employs clinical providers and serves a defined population – differ from those of the rest of the U.S.

health care system, the observed relationship between the increase in SUD treatment resources and access and intensity of care within the VA is potentially germane. In particular, the VA must hire SUD treatment counselors from the same labor market as do non-VA provider organizations (Gugliotta, 2013). Therefore, the question of how well the VA can scale up operations – relative to the level and nature of care it provided previously – to expand provision of SUD care could be relevant beyond the VA. We return to the threats to generality of our findings in the concluding discussion.

Increasing financial support for SUD treatment could affect delivery performance in a variety of ways. On the one hand, it could increase quality by providing greater resources per patient. For instance, it could facilitate the hiring of more highly credentialed staff that are more receptive to provision of evidence-based treatment (Humphreys & McLellan, 2011). On the other hand, if the patient population grows as fast or faster than new funding, access, intensity, or quality could decline. This could happen if, for example, the system was already using resources (available workforce, space, and other inputs) efficiently and new resources were added unevenly. If, for instance, space was not expanded, then the new resources would be deployed in increasingly crowded conditions, diminishing efficiency and quality. Therefore, the effects of increasing SUD treatment delivery performance are empirical questions, which we investigate.

1.1. SUD treatment funding in the VA

Substance use is a common problem among users of the VA, which provides care for U.S. military veterans through an integrated delivery system with salaried clinicians. In the month prior to the date of

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interview, 23% of veterans responding to the National Survey on Drug Use and Health (NSDUH) had consumed five or more alcoholic drinks on the same occasion, 8% had done so at least five times, 4% had used marijuana, and 2% had used other drugs (Wagner et al., 2007). These figures could understate veterans' substance use because the NSDUH may underrepresent populations that include more prevalent users, e.g., poor, vulnerable, and homeless veterans that are difficult to survey.

Recognizing the gap between SUD treatment need and capacity, in the decade of the 2000s the VA collected considerable data on SUD treatment programs. Over the same period, the VA initiated several programs to direct funds toward SUD and broader mental health treatment. Under provisions of the Veterans Millennium Health Care and Benefits Act of 1999 (Pub. Law 106-117), Congress directed about \$30 million between 2000 and 2002 to hiring additional VA SUD treatment staff. Several years after the Millennium Act, the Veterans Health Administration Comprehensive Mental Health Strategic Plan, adopted in 2004, aimed to remove identified gaps in the VA's provision of mental health services (Ekstrand, 2006). As part of the VA's Mental Health Enhancement Initiative, which commenced in 2005, the department enhanced funding of mental health programs generally and SUD-specific treatment in particular. This was followed up in 2008 by the VA Mental Health and Other Care Improvement Act (Pub. Law 110-387) and the adoption of the VA Uniform Mental Health Services Handbook (Katz, 2010).

In total, between 2002 and 2010, the VA directed about \$152 million in centrally administered funds toward hiring additional SUD treatment staff. This represents about \$16.9 million per year, on average, which is 4.3% of overall VA spending on drug treatment in 2010 (Executive Office of the President of the United States, 2010). These centrally administered funds supplemented resources already allocated to SUD treatment from general funds routinely distributed to VA medical centers. If successful, centralized funding dedicated to SUD treatment would increase the resources devoted to it. Across many settings, economists have found that, relative to unrestricted resources, centrally administered, dedicated funds have a much larger effect on spending for the services to which they are targeted, including SUD treatment. Funds "sticking where they hit" or where they are targeted are known as a "flypaper effect" in the public finance economics literature (Inman, 2008). However, the flypaper effect may vary in strength because some dedicated funds may not stick and funding is fungible; general funds may be withdrawn to offset dedicated funds. Outside the VA, the flypaper effect for SUD treatment funding has been found to be large: the vast majority of funds are put to the use for which they are intended (Gamkhar & Sim, 2001; Huber, Pope, & Dayhoff, 1994; Jacobsen & McGuire, 1996; Ma, McGuire, & Weng, 2002).

Two prior studies investigated the use of these centrally administered funds in the VA. US Government Accountability Office (2006) examined the use of 2005 and 2006 funding associated with the 2004 VA Mental Health Strategic Plan, finding that some of the funding was not applied to its targeted use. Frakt, Trafton, Wallace, Neuman, and Pizer (2013) studied the flypaper effect by examining the extent to which these directed funds actually increased SUD treatment spending by VA medical centers. They found that between 2002 and 2008, the directed funds displaced pre-existing SUD treatment resources, leading to no net increase in spending for SUD treatment. However, in 2009 and 2010, 39% and 60%, respectively, of directed funding translated into increased VA medical center spending on SUD specialty treatment. VA SUD specialty treatment staffing levels increased almost 50% over the decade and were concentrated among more highly credentialed staff—graduate level counselors and medical management staff.

Our study complements prior work by relating centrally directed SUD treatment spending to measures of access and intensity of care. We focus on the years 2005–2010, which include the period during which VA directed funding for SUD treatment peaked and the years

during which Frakt et al. (2013) found that it led to a net increase in SUD treatment spending by VA medical centers.

1.2. VA SUD process quality measurement

The Institute of Medicine's (2001) report "Crossing the Quality Chasm: A New Health System for the 21st Century" helped propel a dozen years of vigorous development and evaluation of access and quality measurement for physical health. Though less attention has been paid to mental health and SUD treatment (Pincus, Spaeth-Ruble, & Watkins, 2011), the VA has been among the leaders in studying (Harris, Bowe, Finney, & Humphreys, 2009; Harris, Kivlahan, Bowe, Finney, & Humphreys, 2009), implementing (Garnick, Lee, Horgan, Acevedo, & Washington Circle Public Sector Workgroup, 2009), and evaluating (Watkins et al., 2011) a suite of performance metrics consistent with the Washington Circle paradigm. That paradigm decomposes early engagement of SUD treatment into a sequence of three related phases – identification, treatment initiation, and treatment engagement – each of which can be associated with one or several performance metrics (Simpson, 2004). Some work within the VA has questioned the association of performance on metrics of early engagement with subsequent outcomes. However, sufficient engagement is likely to be at least a necessary condition for good treatment results (Harris, Humphreys, & Finney, 2007).

Beginning in 2010, the VA Office of Mental Health Operations (OMHO) implemented the Mental Health Information System (MHIS) Dashboard (Trafton et al., 2013). The Dashboard is populated with performance metrics that overlap with the Washington Circle conceptualization of early engagement with treatment and consistent with the goals of the VA's Uniform Mental Health Service Handbook (Department of Veterans Affairs, 2008). The Handbook describes required mental health treatments that must be available at VA facilities. The purpose of the MHIS Dashboard is to monitor and report on the state and variation of VA mental health and SUD programs and to help OMHO target resources (Trafton et al., 2013). The Dashboard domains span measures of staffing, access, screening and service delivery, as well as measures focused on specific populations such as those with a serious mental illness, post-traumatic stress disorder, or a SUD. In the SUD domain, the Dashboard includes measures of diagnosis and treatment rates, duration of care, rates of follow-up after detoxification, and pharmacotherapy use (Trafton et al., 2013). Additional details on the metrics of focus in our study are provided in the following section.

2. Materials and methods

We estimated the effects of dedicated funding with fixed effects, ordinary least squares (OLS) regression models on measures of access and intensity as dependent variables and dedicated funding amounts as the key independent variable, controlling for variations in the broader medical center budget. This is a potentially important control because an increase in total resources available to local policymakers could influence the quantity or quality of SUD care. Fixed effects controlled for permanent differences between localities (VA medical centers in our application). Additionally, we had six years of data, so we included year effects and interacted them with dedicated funding amounts to assess whether dedicated funds had different effects through time.

The equation below specifies the model, where the unit of analysis is the medical center-year:

$$\begin{aligned} (\text{performance measure})_{m,y} = & \alpha(\text{unrestricted medical center budget allocation}) \\ & + \beta_y(\text{SUD specialty clinic dedicated funding})_{m,y} \\ & + \gamma_m + \delta_y + \varepsilon_{m,y}. \end{aligned}$$

The variables in the equation – performance measure, unrestricted medical center budget allocation, SUD specialty clinic dedicated

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