

UNDERSTAND THE PURCHASE OF OUTCOME IN SUBSTANCE-ABUSE TREATMENT

If we adopt a system which purchases treatment outcomes – rather than merely counting numbers in undefined ‘treatment’ – what are the policy implications? William Ford calculates the first, major steps to be explored.

DIVERSITY & CULTURAL COMPETENCE.

Outcome data on which an outcome-based purchasing system is built must be comprehensive enough to reflect unique properties of many demographic groupings. In your area, do men have twice the rate of use as women? Are rates of heavy drinking similar or different among different ethnic minorities? How are they different between men and women? When members of a demographic group have differential treatment outcome characteristics, these must be built into the outcome-based purchasing model.

The accumulation of reliable, valid outcome data about these demographic groups can take time. Initially, an outcome-based purchasing system might best fit white males simply because there is a more readily available pool of reliable outcome data about them. But, for the system to be successful, it must reflect the unique outcome characteristics of all sub-groups. For example, there is little point applying to a mainly-female sector a model built on preponderantly male-based outcome data.

COMPLEXITY AND SIZE OF THE TREATMENT SYSTEM.

In the US, the substance-abuse service system treats just under 1 million people a day in about 9,600 substance-abuse programmes. In the UK, the National Treatment Agency puts the figure at 128,000 people in treatment per annum, in about 700 programmes. Most clients receive outpatient services. The services are funded by multiple sources of revenue, from a range of statutory departments to insurance to private pay. Most of these revenue sources require programmes to follow detailed regulations or requirements as a condition of receiving funds.

Also, external accrediting bodies that regulate, but do not fund, services place more requirements on providers concerning medical records, staff qualifications, outcome measures, etc. An outcome-based purchasing system should be consistent with the requirements of every funding/regulating body.

Our emerging outcome-based purchasing system requires continuous monitoring to refine it, and to show outcome rates achieved. One strategy for implementing a uniform system would be to enlist the participation of individual programmes, one by one. While time intensive, this strategy helps to ensure that all regulatory requirements are met.

Convincing a major funding source to adopt a uniform outcome monitoring system also has the practical advantage of affecting multiple programmes at once. But it would not ensure compliance with all the regulatory requirements applicable to each programme funded by it. And implementing an outcome monitoring system could require extra human and financial resources for revenue-limited community-based providers.

Finally, implementation must meet the needs of each treatment programme. For example, some will want to implement it for all admissions, some for only patients whose revenue streams require it. In any case, the implementation process must be sensitive to the unique qualities of each programme if the outcome system is to be accepted and used. This will be labour intensive.

CLIENT OUTCOMES BY FUNDING SOURCE.

Each substance-abuse treatment funder tends to pay for groups with different characteristics. Commercial insurance tends to pay for services for people who, by virtue of their employment, might have less severe substance-abuse disorders. Public funding sources are payers of last resort. They often buy services on behalf of less socially integrated substance users with more severe substance disorders. A different outcome “warranty” should be made to the public purchaser in contrast to the commercial insurance purchaser. Outcome data should be analysed according to demographic characteristics and by funding source.

MULTIPLICITY OF SYSTEMS.

Outcome is one of the most frequently researched topics in substance-abuse literature. Most studies are a project-by-project effort by individual

researchers. Most are not related to ongoing outcome monitoring systems. Many outcome studies rely on a one-time measurement effort. And they are usually studies affecting many providers nationwide. It is unlikely that the National Treatment Agency for Substance Abuse, criminal-justice interests or academia will stop their efforts to better understand the outcomes of substance-abuse treatment. Further, major treatment centres have implemented some form of outcome monitoring to give their clients information on the value of substance-abuse and mental-health treatment. Any effort to introduce a new outcome-based purchasing system must appreciate the plethora of systems in use.

In fact, a new system might have to rely on existing sources of information rather than introducing what will seem to many providers a duplicative effort. This is less than ideal because each study or system uses measures which vary, sometimes significantly, from each other, and from what might be desirable in the new system. It can also introduce error into the outcome measurement effort.

Many monitoring systems and studies measure a wide variety of outcomes, including: use of medical services, crime, return to employment/unemployment costs, welfare costs, absenteeism, substance use and family disruption. To minimise the burden of a new outcome-based purchasing system, all these measures must be incorporated. Agencies with inadequate resources should not be expected to use new measures on top of those they already have. But measures should also be:

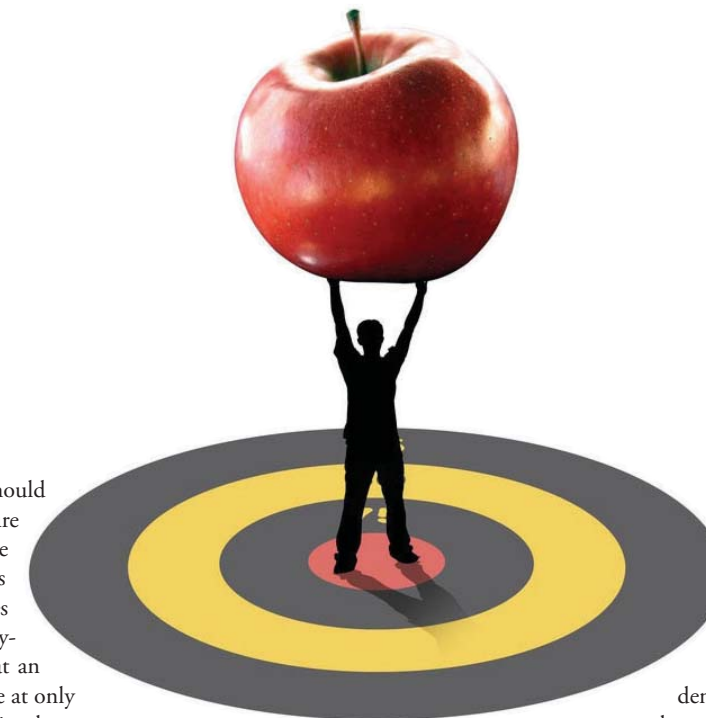
- aimed at specifics and be results oriented
- meaningful and understandable
- supported by data
- feasible and achievable
- rely on currently available data
- sensitive to the populations being served
- supported or accepted by providers
- relevant to consumers
- value based, reliable and valid
- cost- and burden-conscious, and
- current.

Finally, the outcome system should be sophisticated enough to measure the outcome of an individual episode of care. For example, when a client is detoxified in a hospital, then receives residential services in a community-based setting, and receives services at an outpatient clinic, measuring outcome at only one of the sites could give it an unfair advantage or “boost” from the other treatments received by that patient.

OUTCOME MEASURES ARE ONLY ONE MEASURE OF TREATMENT QUALITY.

To some, a system designed to purchase outcome might ignore other, valued characteristics of substance-abuse treatment services. So other performance measures should also be considered. It would be dubious to have outstanding outcome in a programme with no medical records, is discriminatory, has a two-year waiting list, and is in a non-registered facility. An outcomes-based purchasing system should contain a comprehensive set of provider or system performance measures, including outcome measures, such as:

- contracting for network services to take into account provider capacity, network composition and structure, selection and credentialling of providers, provider types, payment requirements and systems, grievance and appeal guidelines, and provisions for monitoring provider services
- requirements for information management, including eligibility, staff credentialling, case management, claims generation, management and clinical reporting, quality-assurance reports, incident reporting, and confidentiality, security, and back-up requirements
- requirements for quality management, including process, structural and outcome measures, accreditation requirements, and internal quality management systems
- requirements for participating in utilisation review/case management, level of care criteria, best practice guidelines and fee schedules. Best-practice guidelines can be derived from the very



outcome data collected for the purchasing system and compiled in a data repository.

BECOME LEARNING ORGANISATIONS.

A system to purchase outcome will be hollow if providers cannot create, acquire, and transfer knowledge from the system to modify their behaviour to reflect new knowledge and insights. Purchasing outcome should not be an end in itself; it should be a process to improve treatment services over time.

Clinicians and staff must find outcome monitoring to be of value or they will see it as externally imposed and having little value other than satisfying external agencies. Data must be collected as a by-product of service delivery and the information gathered must be fed back into clinical processes in real time. One way to achieve this is to collect outcome data through the assessment process while also preparing the data for outcomes measurement. The assessment loop generates information to support treatment decisions on behalf of patients; the outcomes loop generates knowledge on behalf of populations.

The assessment loop informs care delivery: treatment planning, interventions, patient education. The outcomes loop informs and enables care management: outcomes management, credentialling, continuous quality improvement, treatment algorithms. To build an organisation that learns from outcome data requires a cultural shift which must begin at the highest levels of management.

NEED FOR A GOOD TAXONOMY.

To measure the outcome of a service, it is necessary

to define the service so that it can be identified reliably and validly. Not only is this fundamental to good outcome measurement, it is vital for accounting and management purposes. There is no universally accepted taxonomy (classification) of services that meet the demands for reliability and validity in the substance-abuse field. To progress in making more uniform the reporting of service information, this taxonomy must be built.

GIVE PROVIDERS AN INCENTIVE.

Providers in the substance-abuse treatment system are going through major changes. Revenues are down and the rate of increase for behavioural health benefits lags behind that of other sectors of health care. Providers are uncertain about their financial futures, and some have unused capacity in their programmes. Many providers complain of increased accountability demands as their income drops. If providers are to become involved in, let alone enthusiastic about, the purchase of outcome, there must be something in it for them.

They must have incentive to participate in a system which could increase their workload while threatening to reduce their revenue if they do not obtain an acceptable level of outcome, however it is defined. If only the wealthiest of providers can participate in the proposed outcomes initiative, the purchase of outcome could benefit only those recipients who least need it. If a community-based programme cannot participate for lack of financial resources, the neediest clients might be disenfranchised from the benefits of the outcome-based purchasing system. Providers must be convinced that there is benefit to this system and that it will directly accrue to them and their clients. Demonstrating this may be the ultimate obstacle to implementing the new system.

WILLIAM E FORD PhD was commissioned to research this study by C4 Recovery Solutions.

Image: rgbpace