

UNDERSTANDING THE PURCHASE OF OUTCOME IN SUBSTANCE ABUSE TREATMENT

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Executive Summary

This document is designed to provide the context in which the National Council on Alcoholism and Drug Dependence Committee on Benefits has been working to develop an outcome-based system for the purchase of substance abuse treatment services. In order to understand why a new approach is needed, it is important to understand the current substance abuse treatment system and the environment in which it operates. This document presents a review of the effect of substance abuse in America, as well as what the societal response to it has been, particularly focusing on treatment. The funding of the treatment system is analyzed. Current outcome measurement activities are described, as are current performance indicators. This is followed by a review of managed care. Finally, this document discusses issues related to the purchase of treatment outcome and its policy implications.

Key policy implications and considerations related to the outcome-based purchasing of substance abuse treatment presented in this document are:

- **Diversity and Cultural Competence-** The majority of current drug users are white, yet the rate of use is highest among blacks. Men have nearly twice the rate of use as women. The rates of heavy drinking are similar among white, blacks, and Hispanics. Men are nearly five times as likely to be heavy drinkers as are women. People living in metropolitan areas are more likely to be drug users. These findings suggest that the outcome data upon which an outcome-based purchasing system is built must be sufficiently comprehensive to reflect unique properties of many demographic groupings. That is, when members of a demographic cohort have differential treatment outcome characteristics, these must be built into the outcome-based purchasing model. Yet, because the number of non-white male substance abusers can be relatively small, the accumulation of reliable and valid outcome data about these other demographic groups may take some time. Initially, then, the outcome-based purchasing system may be best suited for white males from whom a larger pool of reliable and valid outcome data would be more readily available. Purchasers will be buying an outcome-based system for a diverse demographic group. For the system to be successful, it must reflect the unique outcome characteristics of all sub-groups within the covered population. For example, the Medicaid-covered population is primarily female. There would be little point in attempting to sell to a state Medicaid agency a model built on preponderantly male-based outcome data. To do so would risk mismatching available outcome data and the needs of the entire covered population, a clinically and financially risky situation.
- **Keeping what works currently-** The estimated costs to society of substance abuse are based, in part, on calculations of the costs to collateral systems of dealing with substance abusers. Such collateral systems include general health care, welfare, criminal justice, etc. It

is important to remember that no matter how well designed the outcome-based purchasing system might eventually be, substance abusers affect everyone's lives in many different ways. A good purchasing system will not obviate the need for all of the other systems currently in place that help society deal with substance abuse and the substance abuser. Thus, employee assistance, criminal justice, welfare, and medical systems will continue to be needed to help society cope with substance use. To the extent that an outcome-based purchasing system can improve treatment outcomes, some collateral costs may be reduced. Nevertheless, it is important to remember that most substance abusers do not want nor seek treatment. It would be perilous to oversell the potential general societal benefits of an outcome-based purchasing system.

- **The complexity and size of the substance abuse treatment system-** The substance abuse service system treats a little less than a million persons daily in approximately 9600 substance abuse programs. The vast majority of clients on any given day are receiving outpatient services. The services are funded by multiple sources of revenue, including: commercial insurance, Substance Abuse Prevention and Treatment Block Grant (SAPT) funds; Medicaid; Medicare; state general revenue; local tax revenue; donations; and private pay. Most of these revenue sources require programs to follow detailed regulations or requirements as a condition of receiving funds. Further, external accrediting bodies that regulate, but do not fund, services place additional requirements on providers concerning medical records, staff qualifications, outcome measures, etc. Any proposed outcome-based purchasing system should ensure that the outcome measurement system is consistent with the requirements of every funding/regulating body. The mix of funding sources will vary from program to program. The emerging outcome-based purchasing system requires that measures be taken in order to establish outcome rates. It also requires continuous outcome monitoring in order to refine the system, and to demonstrate to the purchaser the outcome rates achieved. One strategy for implementing a uniform outcome monitoring system would be to enlist the participation of individual programs, program-by-program. While time intensive, this strategy would help to ensure that all regulatory requirements are being met. On the other hand, convincing a major funding source to adopt a uniform outcome monitoring system would have the practical advantage of affecting multiple programs at once. It would not, however, ensure compliance with all of the regulatory requirements that apply to each program funded by the single major funding source. Further, given the sometimes-limited revenue base of many community-based providers, the implementation of an outcome monitoring system may require additional human and financial resources. Finally, implementation of an outcome monitoring system will of necessity have to meet the needs of each program. For example, some programs would want to implement it for all admissions and some would want to implement it for only for those revenue streams that would require it. In any case, the implementation process must be sensitive to the unique qualities of each program if the outcome system is to be accepted and used. This too will be a labor-intensive undertaking.
- **Client populations by funding source-** Each of the substance abuse treatment revenue sources tend to pay for services for groups with different characteristics. Commercial insurance tends to pay for services for individuals, who, by virtue of their employment, may have less severe substance abuse disorders. Public funding sources, especially the SAPT

Block Grant and Medicaid, are payers of last resort. They often purchase services on behalf of less socially integrated substance users who frequently have more severe substance disorders. A different outcome “warrantee” should be made to the public purchaser in contrast to the commercial insurance purchaser. Thus, outcome data should be analyzed not only according to demographic characteristics, but also by funding source if the emerging outcome-based purchasing system is to be financially viable.

- **The multiplicity of outcome measuring/monitoring systems-** Substance abuse treatment outcome is one of the most frequently researched topics in the substance abuse literature. The majority of these studies are based on a project-by-project effort by individual researchers. Most are not related to ongoing outcome monitoring systems. Many of the federally funded outcome studies rely on a one-time measurement effort. In addition, they are usually large studies affecting many providers nationwide. It is unlikely that the National Institute on Alcohol Abuse and Alcoholism, the National Institute on Drug Abuse, and the Center for Substance Abuse Treatment will stop their efforts to better understand the outcomes of substance abuse treatment. Further the major managed behavioral health organizations have implemented some form of outcome monitoring to provide their customers with information about the value of substance abuse and mental health treatment. In fact, MCC Companies has already implemented a form of outcome-based treatment purchasing. Any effort to introduce a new outcome-based purchasing system must appreciate the plethora of outcome measurement systems in use. In fact, a new system may have to rely on already existing sources of information rather than introducing what will seem to many providers as a duplicative effort. This is less than ideal because each study or system uses measures that vary, sometimes in significant ways, from each other, and from what might be desirable in the new system. It can also introduce error into the outcome measurement effort. Many of the monitoring systems and studies measure a wide variety of outcomes, including:

- Use of medical services;
- Crime;
- Return to employment and unemployment costs;
- Welfare costs;
- Absenteeism;
- Substance use; and
- Family disruption.

In order to minimize the burden of a new outcome-based purchasing system, all of these measures must be incorporated. Agencies that struggle with inadequate resources cannot, and should not, be expected to use new measures in addition to those they already are. Outcome measures should also be:

- Aimed at specific objectives 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, because substance abuse services, particularly in the public health system, are often provided to one client through a continuum of settings in various facilities, the outcome system should be sophisticated enough to measure the outcome of an episode of care. That is, 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 only at the one of the sites may give that site an unfair advantage or “boost” from the other treatment received by that patient. Given today’s state-of-the-art, this may be a very tall order.

- **Outcome measures are only one measure of the quality of treatment system output -** To some, a system designed to purchase outcome might ignore many other characteristics of substance abuse treatment services that are valued. The various performance measurement systems presented in this document take a broad view of all of the characteristics that are considered important by experts measuring the output of the substance abuse treatment system. In the design of a system to purchase outcome, it is important that many other performance indicators be incorporated. In other words, outcome measures may be most important (at least in a system that purchases outcome), but many other performance measures should also be considered. It would be a dubious proposition to have outstanding outcome in a program that has no medical records, is discriminatory, has a two year waiting list, and is located in a non-licensed facility. An outcomes-based purchasing system should contain a comprehensive set of provider or system performance measures, including outcome measures.
- **Managed care has a track record-** Any new system of purchasing services should not ignore the valuable contributions of managed care systems in improving the quality of, access to, and affordability of health care. The proposed outcome-based purchasing system should include managed care-like arrangements such as:
 - Contracting for network services that take into account concerns for provider capacity; composition and structure of the network; selection and credentialing of providers; provider types; provider payment requirements and systems; provider grievance and appeal guidelines; and provisions for the monitoring of provider services.
 - Requirements for information management, including the management of eligibility information; staff credentialing information; utilization and case management functions; claims generation; clinical and management 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 utilization review/case management; level of care criteria; best practice guidelines; and fee schedules. Note that best practice guidelines can be derived from the very outcome data collected for the outcome-based purchasing system and compiled in a data repository.

All of these managed care techniques can assist the outcome-based purchasing system to contain costs, ensure quality, and improve access.

- **Provider agencies must become learning organizations-** The creation of a system to purchase outcome will be hollow if providers cannot create, acquire, and transfer knowledge from the system to modify their behavior to reflect new knowledge and insights. That is, purchasing outcome should not be an end in itself; it should be a process to actually improve treatment services over time. Clinicians and staff must find outcome monitoring to be of value or they will simply see it as externally imposed and having little value other than satisfying the requirements of external agencies. The collection of outcome data should be added into the clinical workflow, rather than onto it. 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 accomplish this is to collect outcome data through the assessment process. The system must feed outcome data into the assessment process while also preparing the data for outcomes measurement. Clinical impact requires that outcomes data drive two feed back loops. The assessment loop generates information from the data to support treatment decisions on behalf of a particular patient, whereas the outcomes loop generates knowledge on behalf of populations. The assessment loop informs the care delivery process (treatment planning, interventions, patient education). The outcomes loop informs and enables the care management process (outcomes management, credentialing, continuous quality improvement, treatment algorithms). By feeding into this double loop system, the data gathered provides information to support decisions on behalf of individual patients and of populations. To build an organization that learns from outcome data requires a cultural shift that must begin at the highest levels of management. Structural changes must reflect management's belief in the importance of organizational learning.
- **The need for a good substance abuse service taxonomy-** In order 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 essential for accounting, and management purposes. There does not appear to be a universally accepted taxonomy of services that meet the demands for reliability and validity in the substance abuse field. Before any progress can be made in making more uniform the reporting of service information, this taxonomy must be established.

- **Providers must have an incentive to be involved in outcome-based purchasing-** Providers in the substance abuse treatment system are going through major changes due in large part to the influence of managed care. Revenues are down and the rate of increase for behavioral 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 programs. 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 that may increase their workload while concomitantly threatening to reduce further 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 may benefit only those recipients who least need it. If a community-based program cannot participate for lack of adequate financial resources, the most needy of clients may 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.

The goal of this document is to provide the reader with sufficient information to gain an understanding of the complexity of the substance abuse treatment system, not only from a size and structural point of view, but also from a financing perspective. The complexities of the system must be understood in order to appreciate the challenges and opportunities for an outcome-based system of purchasing substance abuse services.