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Measuring Treatment Goals

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Disclosures

- The following session leader(s) have no relevant financial relationships with ineligible companies to disclose:
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Learning Objectives

- Define a SMART treatment goal
- Identify several standard individual recovery assessment tools
- Identify standard institution level treatment metrics
- Identify stakeholders in treatment measurement
- Explore how to turn measurement into improvement processes

Opening thoughts

- Broad topic
- Controversy: What are our treatment goals? What should they be?
- For whom?
  - Internal improvement
  - Clients
  - Payors
  - Regulators
  - Researchers?
- Measurement dependent on capacity, local issues

SAMSHA Definition: Recovery

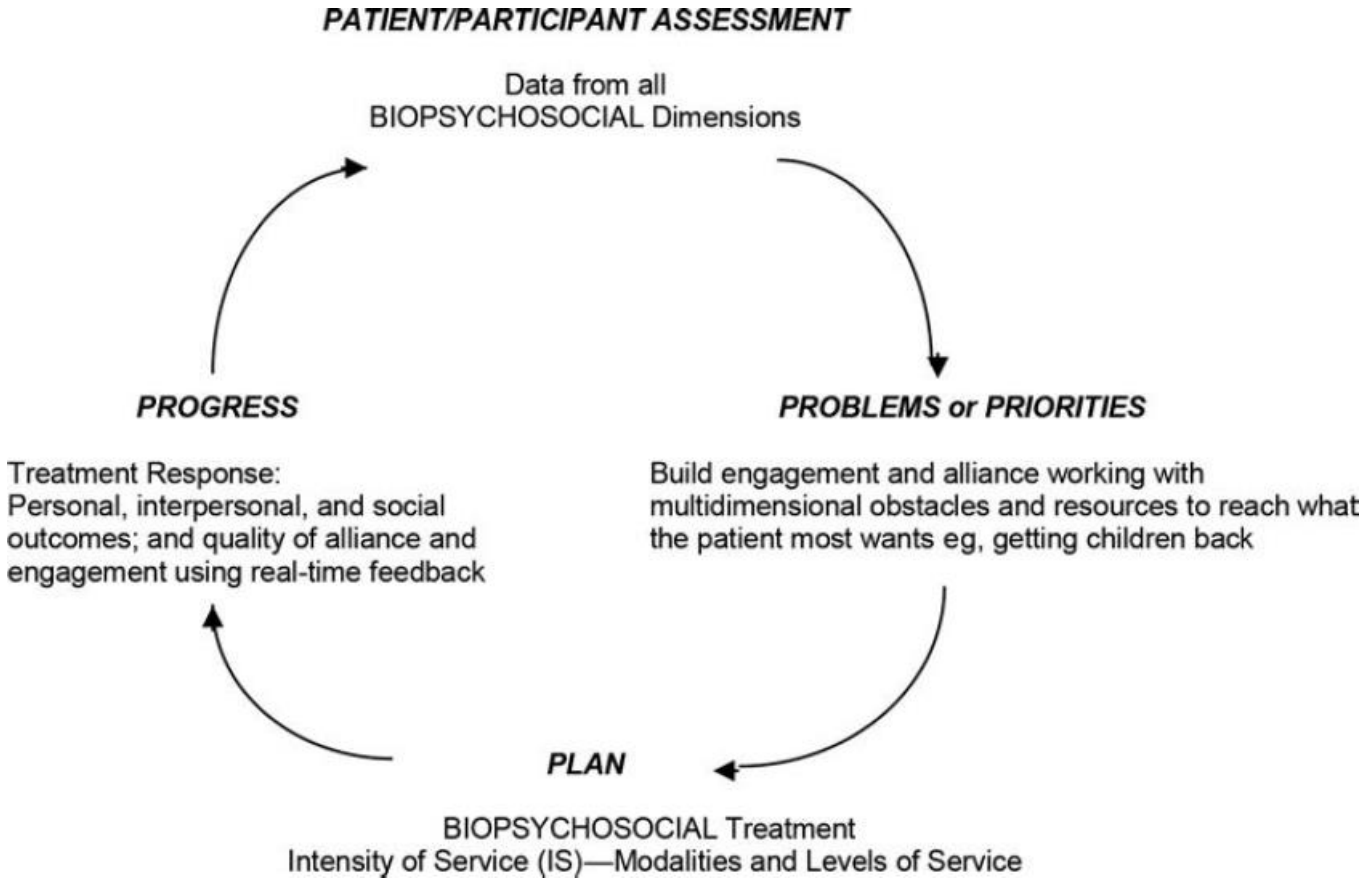
"A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential."

SAMSHA. "Working Definition of Recovery." 2012

Outline

- Client-level
  - How to set and measure SMART treatment goals
  - Standardized treatment measures
- Institution level
  - Why this matters
  - Metrics that matter in substance use disorder care currently
    - Regulators/payors
    - Research
  - How to measure within your own institutions
  - How to turn measurement into improvement

Client-Level: Setting treatment goals



Miller et al. ASAM Principles of Addiction Medicine, 6th Addition

Client-Level: Setting treatment goals

- Name the problem
- Set a SMART goal
- Operationalize action steps
  - Ideally discuss confidence, importance
  - Ideally discuss barrier management
- Set a measurement plan and follow up date

Example: Diabetes

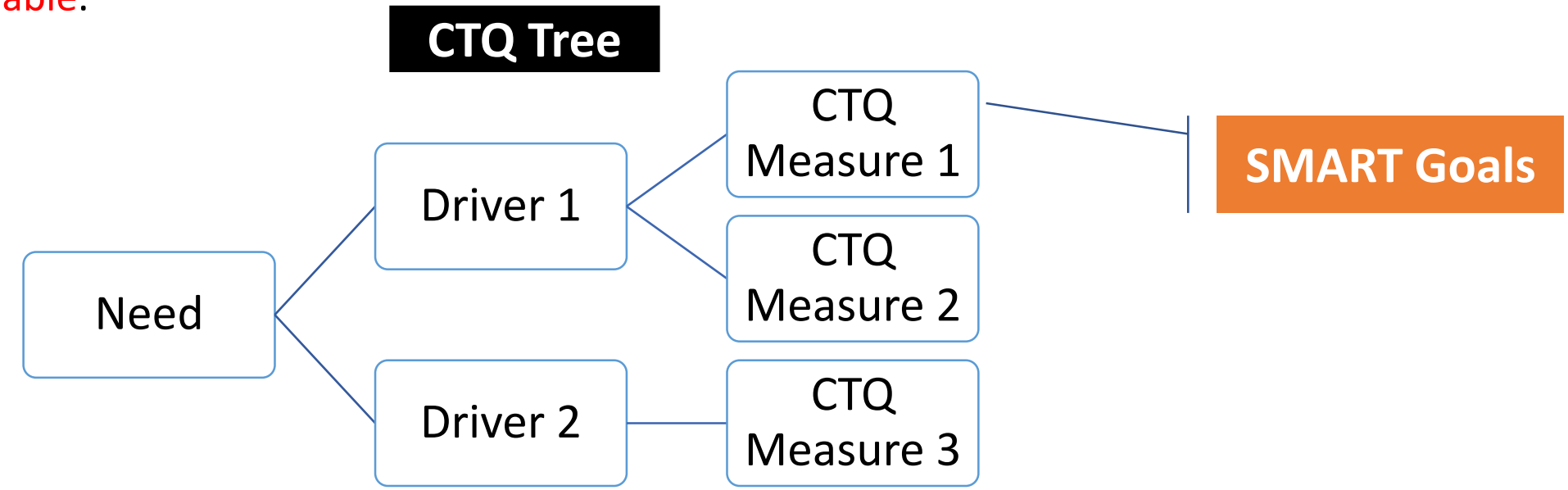
Carla is a 67 year old grandmother coming into your primary care clinic for follow up on her diabetes. Her POC A1C came back at 10.5%, up from 8.5% 3 months ago. She is already on metformin 1000mg BID, and last time told you she didn't want to start a new medication, instead focus on "lifestyle changes." Since then she has been stressed since her granddaughter was born with significant disabilities and she has been helping to care for her, and she hasn't been able to regularly take her medication or make those changes. She has noticed polyuria and polydipsia, and is afraid of losing toes or feet as friends with diabetes have in the past.

Name the problem

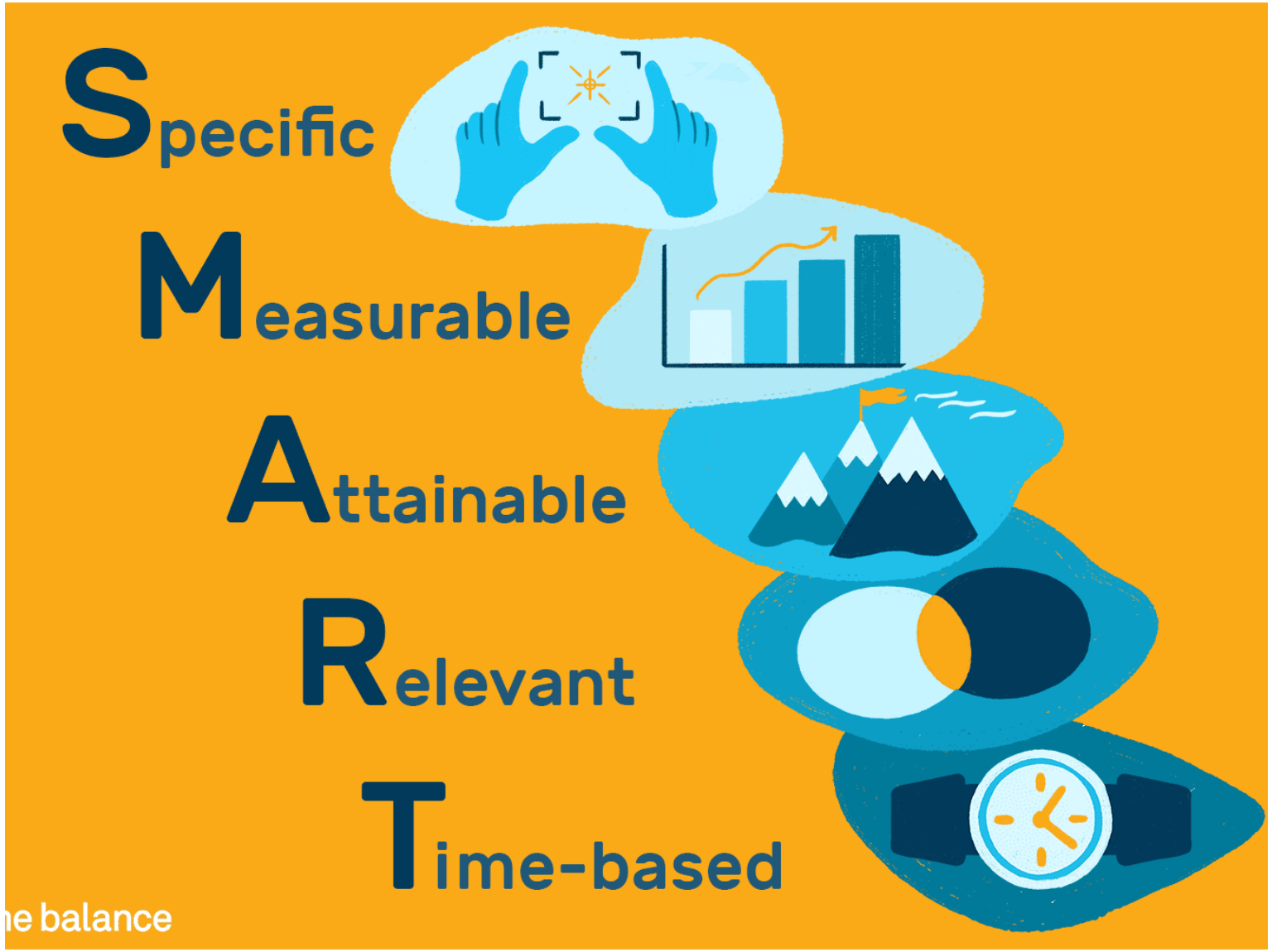
- Use the patient's words
- Can be big picture/vague, but try and make it one problem
- For Carla, she reports:
  - "My blood sugars are too high."

Needs vs. Critical to Quality(CTQ) Measures

- Needs are data collected from stakeholders that give information about what they require or want from your process. Needs are often high-level, vague, and non-specific.
  - "I need a quick response!"
  - "I need accurate information!"
- CTQ measures are stakeholder needs translated into critical process or outcome requirements that are specific and measurable.



Set a SMART Goal



Bailey et al *Am J Lifestyle Med* 2017
Swann et al *Health Psychol Rev.* 2022

SMART Goal

- Example scenario (role play)
- Which one of these is a SMART goal?
    1. I will stop drinking soda.
    2. I will measure and record my blood sugar every morning for the next two weeks, and I will bring the log to my next doctor's visit.
    3. I will take my metformin when I wake up every morning and when I go to bed at night.
    4. I will research recipes for diabetes to use in meal prep.

Measurement

- If you have a good SMART goal, the measurement plan is in the goal
- At time of measurement you can assess progress:
  - Achieved: assess readiness for new goal/level of care
  - Progress: address motivations, barriers, re-structure
  - No progress: address motivations, barriers, re-commit or change goal
- Document in treatment plan
- Next action steps once achieved – work with client, MD on this
  - Lower levels of care?

Standardized Client-Level Measures

- Addiction Severity Index (ASI)
  - 45-60 minutes
- WHOQOL-BREF
  - 15-20 minutes
- ASAM Dimensions of care assessment
  - Variable but on 45-60 minute scale
- Retention in treatment
  - E.g. no show rate
- Urine drug screening

Add citations

Client-Level:
Setting & measuring treatment goals

- Name the problem
- Set a SMART goal
- Operationalize action steps
- Set a measurement plan and follow up date
- Follow up, document
- For treatment level decisions, can also consider incorporating:
  - Standardized treatment scales, re-assessment by physician

Outline

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Institutional Level: Why is this important?

Oliver, John. ”Rehab” *Last Week Tonight.* HBO, 2018.

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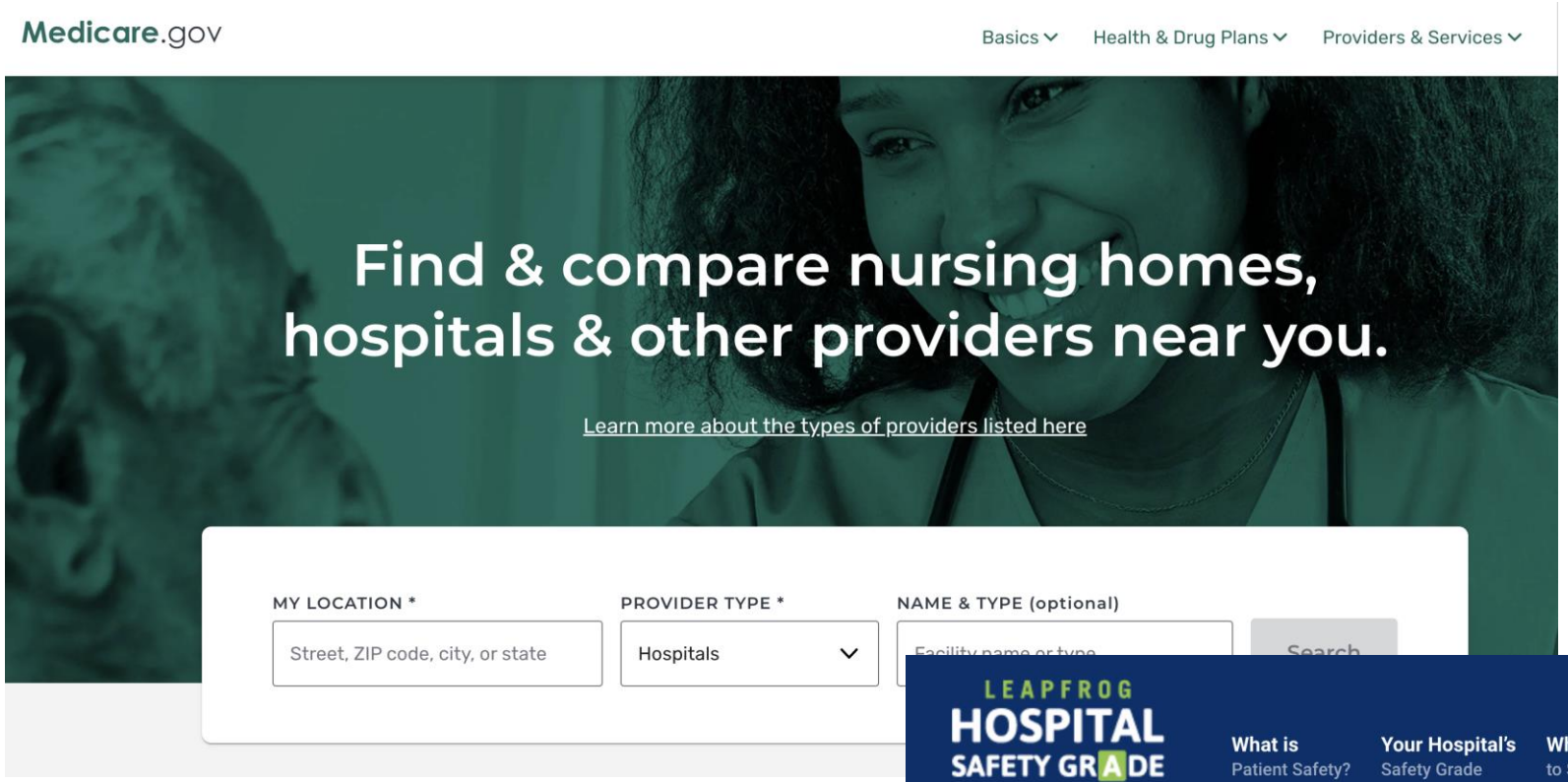
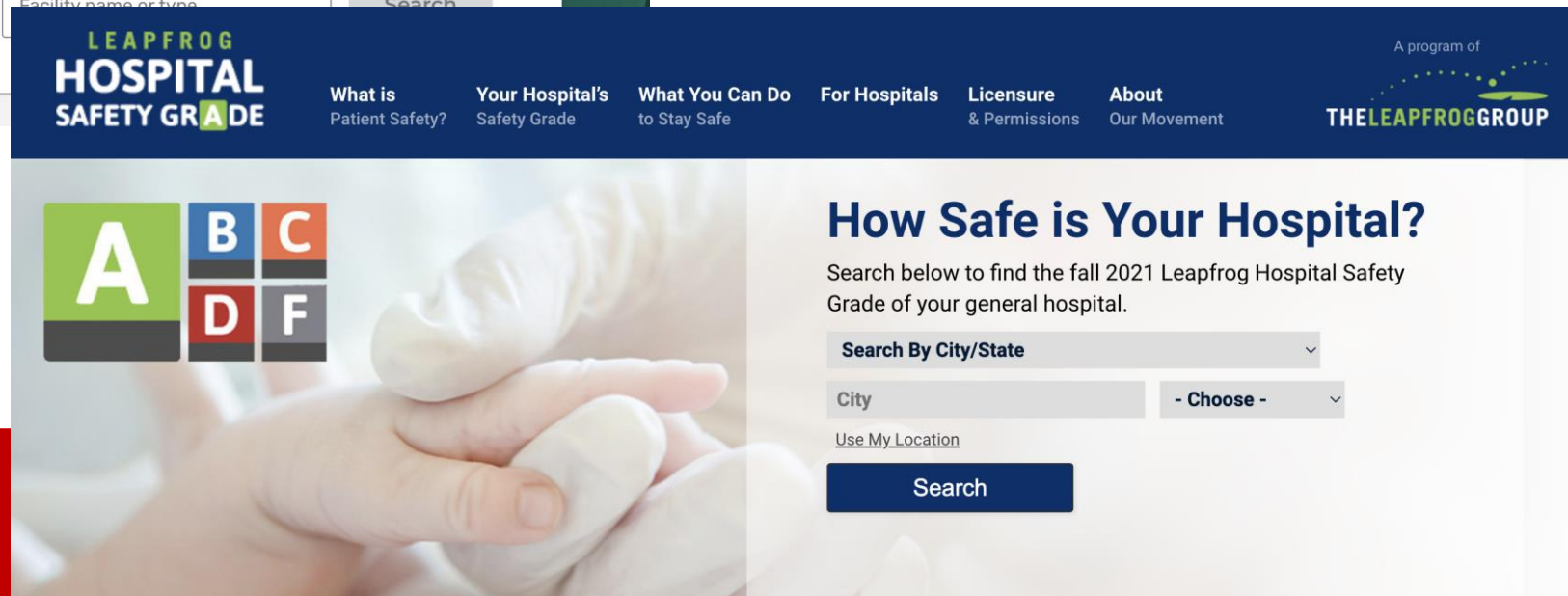
Hospital Compare



Leapfrog



Quality Measures – good, bad, ugly

- Good:
  - Comparative – encourages improvement
  - Enforces basic standards
  - Allow for patient discernment
- Bad:
  - Risk adjustment issues
  - Health disparities – school analogy
- Ugly: Looking for keys under the lamp-post (what do we miss?)

What Standard Quality Metrics Exist?

TABLE 34.2 Washington Circle and National Quality Forum Measure Definitions

WC	**Identification** of alcohol and drug disorders among members is defined as the percent with an alc drug disorder diagnosis.
WC and NQF	**Treatment initiation** is defined as the percent of individuals who entered inpatient or outpatient ca completed another treatment session within 14 d.
WC and NQF	**Treatment engagement** is defined as the percent of individuals who initiated care and completed two additional treatment visits within 30 d.
WC	**Continuity of care after assessment** is defined as percent of individuals who have a positive assessment for substance abuse and received another substance abuse service (other than witho management or crisis care) within 14 d.
WC	**Continuity of care after withdrawal management** is defined as percent of individuals who recei withdrawal management service and received another substance abuse service (other than withd management or crisis care) within 14 d of discharge from withdrawal management.
WC	**Continuity of care in varying residential situations** is defined as percent of individuals, who ha stay that is followed by another service (other than withdrawal management or crisis care) within after discharge (Note: the measure can be calculated for three levels of residential care—short te term, and inpatient).
NQF	**Alcohol Screening and Follow-up for People with Serious Mental Illness** is defined as the percentage of patients 18 y and older with a serious mental illness, who were screened for unhea alcohol use and received brief counseling or other follow-up care if identified as an unhealthy alco
NQF	**Follow-up after Discharge from the Emergency Department for Mental Health or Alcohol or Drug Dependence** is defined as percentage of discharges for patients 18 y of age and older who visit to the emergency department with a primary diagnosis of mental health or alcohol or other dr dependence during the measurement year and who had a follow-up visit with any provider with a corresponding primary diagnosis of mental health or alcohol or other drug dependence within 7 and 30 d of discharge (consist of four distinct measures).
NQF	**Gains in Patient Activation (PAM)** is a 10- or 13-item questionnaire that assesses an individual's knowledge, skill, and confidence for managing their health and health care.
NQF	**HBIPS-1 Admission Screening for Violence Risk, Substance Use, Psychological Trauma History, and Patient Strengths Completed** is the proportion of patients admitted to a hospital-based inpatient psychiatric setting who are screened within the first 3 d of hospitalization for all of the following: risk of violence to self or others, substance use, psychological trauma history, and patient strengths.
NQF	**Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling** is the percentage of patients aged 18 y and older who were screened at least once within the last 24 mo for unhealthy alcohol use using a systematic screening method and who received brief counseling if identifie as an unhealthy alcohol user.
NQF	**SUB-1 Alcohol Use Screening** is the number of hospitalized patients 18 y of age and older who are screened within the first 3 d of admission using a validated screening questionnaire for unhealthy alcohol use.
NQF	**SUB-2 Alcohol Use Brief Intervention Provided or Offered and SUB-2a Alcohol Use Brief Intervention** is an overall rate that includes all hospitalized patients 18 y of age and older to whom a brie intervention was provided, or offered and refused (SUB-2), and a second rate (SUB-2a), a subset of the first, which includes only those patients who received a brief intervention.
NQF	**SUB-3 Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge and SUB 3a Alcohol and Other Drug Use Disorder Treatment at Discharge** is an overall rate which includes all hospitalized patients 18 y of age and older to whom alcohol or drug use disorder treatment was provided or offered and refused, at the time of hospital discharge (SUB-3), and a second rate (SUB-3a), a subset the first, which includes only those patients who received alcohol or drug use disorder treatment at discharge.
NQF	**Tobacco Use Screening and Follow-up for People with Serious Mental Illness or Alcohol or Other Drug Dependence** is the percentage of patients 18 y and older with a serious mental illness or alcohol o other drug dependence who received a screening for tobacco use (Rate 1) and the percentage of adults 18 y and older with a diagnosis of alcohol or other drug dependence who received a screening for tobacco use and follow-up for those identified as a current tobacco user (Rate 2).

Miller et al. ASAM Principles of Addiction Medicine, 6th Addition

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What defines a "quality" treatment program?

- No standard metrics nationwide
- NQF proposed framework here

Miller et al. ASAM Principles of Addiction Medicine, 6th Addition

TABLE 34.3 Summary of NQF Consensus Standards for the Treatment of Substance Use Conditions

Domain #1: Identification of Substance Use Conditions
Screening and Case Finding: During new patient encounters and at least annually, patients in general and mental healthcare settings should be screened for at-risk drinking, alcohol use problems and illnesses, and any tobacco use. To identify patients who use drugs, healthcare providers should employ a systematic method that considers epidemiological and community factors and the potential health consequences of drug use for their specific population.
Diagnosis and Assessment: Patients who have a positive screen for—or an indication of—a substance use problem or illness should receive further assessment to confirm that a problem exists and determine a diagnosis. Patients with a diagnosed substance use illness should receive a multidimensional, biopsychosocial assessment to guide patient-centered treatment planning for substance use illness and any coexisting conditions.
Domain #2: Initiation and Engagement in Treatment
Brief Intervention: All patients identified with alcohol use in excess of the National Institute on Alcohol Abuse and Alcoholism guidelines and/or any tobacco use should receive a brief motivational counseling intervention by a healthcare worker trained in this technique.
Promoting Engagement in Treatment for Substance Use Illness: Healthcare providers should systematically promote patient initiation of care and engagement in ongoing treatment for substance use illness. Patients with substance use illness should receive supportive services to facilitate their participation in ongoing treatment.
Withdrawal Management: Supportive pharmacotherapy should be available and provided to manage the symptoms and adverse consequences of withdrawal, based on a systematic assessment of the symptoms and risk of serious adverse consequences related to the withdrawal process. Withdrawal management alone does not constitute treatment for dependence and should be linked with ongoing treatment for substance use illness.
Domain #3: Therapeutic Interventions to Treat Substance Use Illness
Psychosocial Interventions: Empirically validated psychosocial treatment interventions should be initiated for all patients with substance use illnesses.
Pharmacotherapy should be: 1. Recommended and available to all adult patients with diagnosed opioid dependence and without medical contraindications and, if prescribed, should be provided in addition to and directly linked with psychosocial treatment/support. 2. Offered and available to all adult patients with diagnosed alcohol dependence and without medical contraindications and, if prescribed, should be provided in addition to and directly linked with psychosocial treatment/support. 3. Recommended and available to all adult patients with diagnosed nicotine dependence (including those with other substance use conditions) and without medical contraindications and, if prescribed, should be provided in addition to and directly linked with brief motivational counseling.
Domain #4: Continuing Care Management of Substance Use
Patients with substance use illness should be offered long-term, coordinated management of their care for substance use illness and any coexisting conditions, and this care management should be adapted based on ongoing monitoring of their progress.

What do researchers measure?

- Retention in treatment
  - Time points vary, definitions vary
- Drug/Alcohol use
  - Typically by biometric screening (urine drug screens, e.g.)
  - Some self report (e.g. heavy drinking days)
- Mortality (hard to measure)
- Quality of life (see previous slides)

Accreditation

- Recognition by peers that an organization meets standards of performance that represent safe and competent treatment
  - TJC
  - CARF
  - COA
- Involves extensive internal review process
  - Often process oriented: record keeping, governance, HR
  - Less often outcomes oriented (e.g. performance metrics)

How do we measure?

- No uniform system (as far as I can tell)
- EMR data
  - Varies by EMR, capabilities
  - Data abstraction/aggregation can require specialized training/skills
- Required reporting to monitoring agencies
  - TJC, DEA, SAMSHA etc

Operational Definitions

In relationship to data collection, an operational definition is a clear, concise detailed definition of a measure. It is meant to bring clarity to the measure, how it is captured and subsequently reported in order to reduce measure system variation.

- **Need:** Patients who screen positive for needing SUD follow up should been seen within 14 days
- **Measured Y:** SUD Appointment follow up Lag time
- **Operational Definition:**
  - **What:** SUD Appointment follow up Lag time = The number of days from when a patient screens positive for needing an SUD follow up visit until they are seen by for their follow up SUD visit
  - **How:** The clock starts when the computer attaches the date time stamp at the conclusion of the initial visit where a patient screens positive. The clock stops at the conclusion of the patients Follow up SUD visit. The measure will be calculated by subtracting the day of initial visit from the day of the SUD follow up visit. (Weekends included)

Note that different operational definitions will give different results.

EXHIBIT 1

Average performance rates on Healthcare Effectiveness Data and Information Set (HEDIS) quality measures for behavioral health conditions versus diabetes and hypertension, by payer, 2014

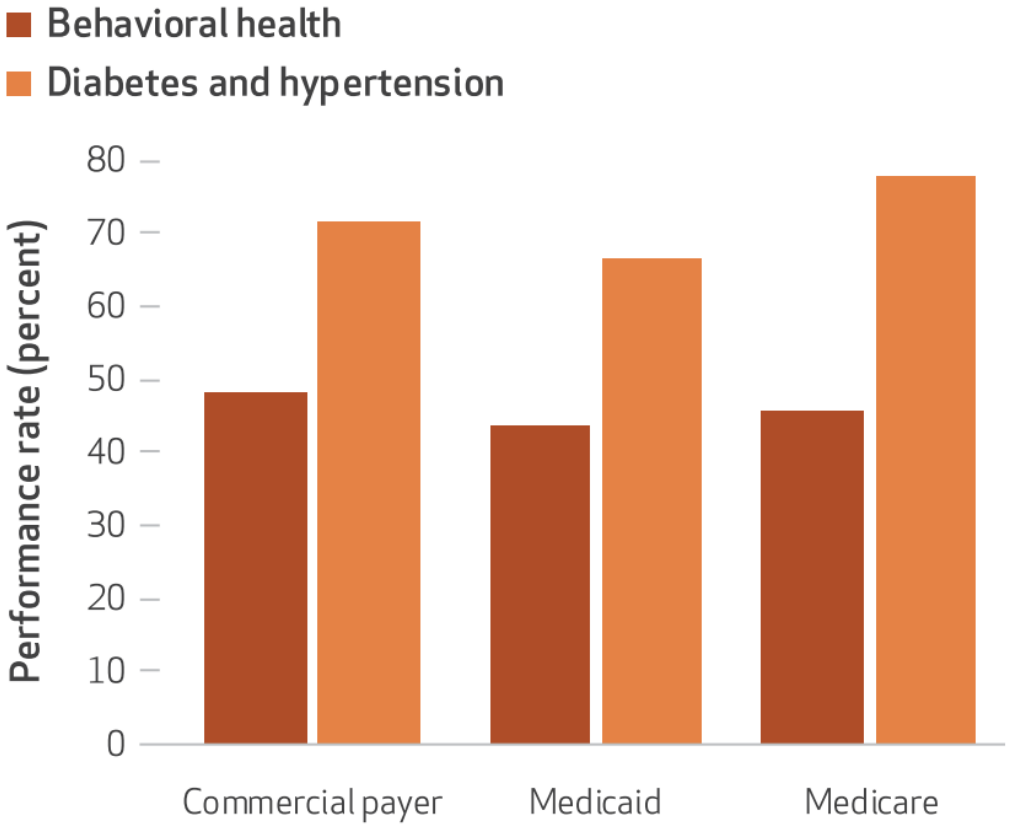
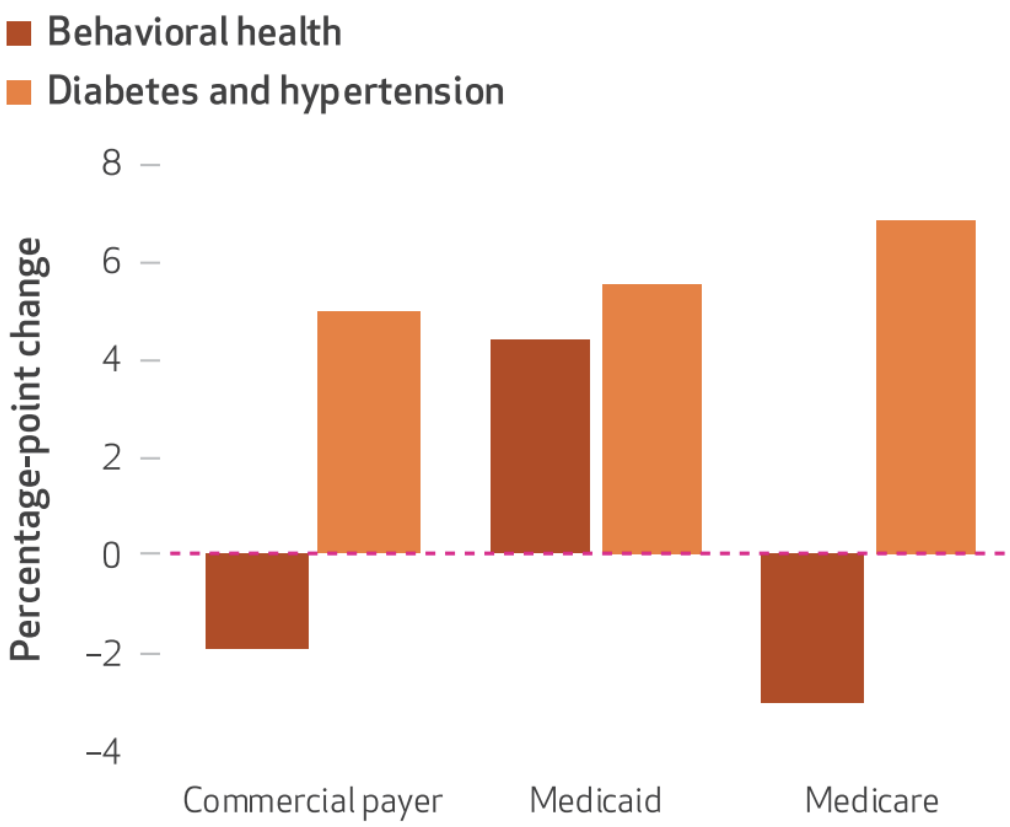


EXHIBIT 2

Average change in performance from 2006 to 2014 on Healthcare Effectiveness Data and Information Set (HEDIS) quality measures for behavioral health conditions versus diabetes and hypertension, by payer



Pincus et al. *Health Affairs* 2016

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How to turn measurement into improvement

- Determine metrics of recovery that are important to you
  - And your regulators/funders
- Automate ways to measure them
  - The EMR can be your friend – use your informatics experts
- Identify areas of deficiency
- Experiment!
  - PDSA cycles, continuous measurement and improvement
- Show your worth!
  - Use outcomes improvements to attract and retain clients

Learning Objectives

- Define a SMART treatment goal
- Identify several standard individual recovery assessment tools
- Identify standard institution level treatment metrics
- Identify stakeholders in treatment measurement
- Explore how to turn measurement into improvement processes

References

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