Addressing Measurement Gaps in Continuing Care Management for Substance Use Illness:

The Health Plan Perspective

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November 4, 2009

Current Role of the Health Plan

- Make previsions for health care services for their members
  - Facilitate health care delivery systems involving multiple providers, facilities and services
    - Access to appropriate services
    - Cost effectiveness
    - Assurance of quality and/or evidenced based treatments
  - Coordination of care
  - Provide services to “Fill in the Gaps” in care
    - Care management
    - 24/7 day access to behavioral health professional
    - Care coaching
    - Quality audits of providers
    - Disease management
    - Infusion of technologies, (i.e. web-based tools, Provider/Member reminders)

Changing Health Care Environment: Drivers of Change

- Parity
  - Ideally increases access to treatment
  - No limit barriers
  - Management based more on medical necessity
    - Prudent clinical judgment in accordance with generally accepted practice, (evidenced base practice guideline), most clinically appropriate, not just for convenience.
- Health Care Reform
  - Individual choice
  - Comparative effectiveness
  - Paying for performance/pay for valued based quality

Road Map Back to "Crossing the Quality Chasm"

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- **"Knowing which services are likely to be effective also requires that health care systems continuously monitor the results of the care they provide and use that information to improve care for all patient."**
- **"..Health care practitioners and organization could be far more reflective and systematic in studying their own patterns of care and outcomes...."**

1) IOM 2001. *Crossing the Quality Chasm.*

- Role/Positioning of Managed Care
  - Collector/analysis of data across populations, settings and geographic locations
  - Benchmarking
  - Inform comparative effectiveness
    - Practice/system based analysis
    - Applicable to providers, facilities, communities, treatments, technologies
  - Facilitate transparency
  - Add cost into the analysis

Road Map Back to "Crossing the Quality Chasm"

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- **Berwick (Health Affairs 2003) noted that the report provided an underlying framework for the changes needed in American healthcare at four levels:**
  - **Level A:** the experience of patients
  - **Level B:** the functioning of small units of care delivery (i.e., microsystems or teams and providers)
  - **Level C:** the functioning of organizations that house or support microsystems (e.g. clinics or hospitals)
  - **Level D:** the environment of policy, payment, regulation, accreditation and other factors that influence the organization at Level C

1) IOM 2001. *Crossing the Quality Chasm.*

Using the Data to Deliver Information: The Importance of Standardization and Integration

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- **Consensus** – agreement amongst stakeholders (policy, researchers, practitioner, consumer, purchaser, service delivery administrator) on what are the best measure.
- **Integration –** bringing together data from different sources for the purpose of analysis and creating information
- **Standardization** - measures in each modality are standardized (all data elements are the same in any setting or application) - so that data can be pooled and compared reliably – total quality control.
- **Automation** –collection and outputting data for easy analysis and formulation of information.

Using the Data to Deliver Information

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With the standardized database, large populations, and longitudinal data, powerful cross correlations and Neuro Networking can be performed to drive answers to questions around health care and especially Substance Use Disorder treatment .

	digitot	mazeinit	oddsdrt	rhtapn	spotscor	vi_sco2	wmrt	FAS	ON1TLFz	ON2TLP3	OP2TAPz	OPbTLCz	ECAFz	ECBP4	ECDOz	ECTF3	EOAFrPz	EOBFz	EODCz	EOTF7
digitot	1.00	-0.23	-0.35	0.29	0.46	-0.29	0.23	-0.27	-0.03	0.01	0.28	-0.16	-0.09	-0.18	-0.32	-0.30	0.14	-0.24	-0.34	-0.29
mazeinit	-0.23	1.00	0.26	-0.22	-0.13	0.18	-0.46	0.25	0.02	-0.07	-0.16	0.15	0.01	0.15	0.01	0.03	-0.06	0.15	0.03	0.04
oddsdrt	-0.35	0.26	1.00	-0.33	-0.43	0.27	-0.30	0.52	0.08	0.05	-0.33	0.21	0.07	0.15	0.34	0.36	-0.16	0.25	0.40	0.39
rhtapn	0.29	-0.22	-0.33	1.00	0.34	-0.22	0.24	-0.33	-0.02	0.03	0.27	-0.13	-0.12	-0.19	-0.27	-0.29	0.19	-0.23	-0.29	-0.27
spotscor	0.46	-0.13	-0.43	0.34	1.00	-0.36	0.16	-0.37	0.02	-0.10	0.27	-0.17	-0.15	-0.23	-0.49	-0.48	0.18	-0.31	-0.54	-0.46
vi_sco2	-0.29	0.18	0.27	-0.22	-0.36	1.00	-0.19	0.19	0.00	0.05	-0.19	0.14	0.09	0.11	0.27	0.27	-0.15	0.18	0.30	0.26
wmrt	0.23	-0.46	-0.30	0.24	0.16	-0.19	1.00	-0.29	-0.06	0.05	0.17	-0.19	0.03	-0.08	0.01	0.02	0.05	-0.13	-0.02	-0.02
FAS	-0.27	0.25	0.52	-0.33	-0.37	0.19	-0.29	1.00	0.06	-0.02	-0.28	0.15	0.06	0.14	0.26	0.27	-0.12	0.22	0.30	0.28
ON1TLFz	-0.03	0.02	0.08	-0.02	0.02	0.00	-0.06	0.06	1.00	-0.01	-0.01	0.06	-0.19	-0.18	-0.12	-0.12	0.02	-0.14	-0.07	-0.12
ON2TLP3	0.01	-0.07	0.05	0.03	-0.10	0.05	0.05	-0.02	-0.01	1.00	-0.04	0.09	0.06	0.03	0.20	0.17	-0.01	0.06	0.17	0.15
OP2TAPz	0.28	-0.16	-0.33	0.27	0.27	-0.19	0.17	-0.28	-0.01	-0.04	1.00	-0.12	-0.12	-0.23	-0.32	-0.34	0.13	-0.29	-0.36	-0.35
OPbTLCz	-0.16	0.15	0.21	-0.13	-0.17	0.14	-0.19	0.15	0.06	0.09	-0.12	1.00	0.04	-0.02	0.11	0.11	-0.09	0.07	0.09	0.11
ECAFz	-0.09	0.01	0.07	-0.12	-0.15	0.09	0.03	0.06	-0.19	0.06	-0.12	0.04	1.00	0.51	0.39	0.50	0.02	0.37	0.29	0.34
ECBP4	-0.18	0.15	0.15	-0.19	-0.23	0.11	-0.08	0.14	-0.18	0.03	-0.23	-0.02	0.51	1.00	0.43	0.45	0.05	0.71	0.41	0.41
ECDOz	-0.32	0.01	0.34	-0.27	-0.49	0.27	0.01	0.26	-0.12	0.20	-0.32	0.11	0.39	0.43	1.00	0.75	-0.22	0.43	0.81	0.70
ECTF3	-0.30	0.03	0.36	-0.29	-0.48	0.27	0.02	0.27	-0.12	0.17	-0.34	0.11	0.50	0.45	0.75	1.00	-0.34	0.48	0.73	0.79
EOAFrPz	0.14	-0.06	-0.16	0.19	0.18	-0.15	0.05	-0.12	0.02	-0.01	0.13	-0.09	0.02	0.05	-0.22	-0.34	1.00	-0.02	-0.23	-0.26
EOBFz	-0.24	0.15	0.25	-0.23	-0.31	0.18	-0.13	0.22	-0.14	0.06	-0.29	0.07	0.37	0.71	0.43	0.48	-0.02	1.00	0.50	0.49
EODCz	-0.34	0.03	0.40	-0.29	-0.54	0.30	-0.02	0.30	-0.07	0.17	-0.36	0.09	0.29	0.41	0.81	0.73	-0.23	0.50	1.00	0.73
EOTF7	-0.29	0.04	0.39	-0.27	-0.46	0.26	-0.02	0.28	-0.12	0.15	-0.35	0.11	0.34	0.41	0.70	0.79	-0.26	0.49	0.73	1.00

Quote from the 2008 IOM Workshop Summary on Neurobiological Markers

One successful partnership that was already under way before the creation of the FNIH but that is now funded through FNIH is the Alzheimer's Disease Neuroimaging Initiative (ADNI). This public-private partnership has been extremely useful due to mechanisms set in place that allow for full data sharing in real time. Furthermore, ongoing results are published freely via the Internet. One of the greatest benefits of this partnership comes from the contributions of the special advisory committee members who have created both imaging and cerebrospinal fluid (CSF) protocols to help standardize collection. A major, if not the largest, accomplishment of the advisory committee came about through the push for higher rates of CSF sample collection from the public partners. The result was an increase in collection from 20 percent to 60 percent. However, this creates a new challenge and opportunity to expand ADNI to begin analyzing and categorizing collected biological samples. The success of the ADNI project is that it lies within the precompetitive space, allowing for broad applicability in future clinical trials and, in addition, fostering communication within otherwise proprietary realms in this area of research. Although ADNI is one example of a successful public-private partnership, there are many others that have been established that are also demonstrating similar successes; however, these were not discussed in detail at the workshop.

Valued Based Quality

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- **Value** Based Quality Measurement
  - **Measuring the quality and effectiveness of services for a significant population** that is containing **cost.**
  - $\frac{\text{(quality + effectiveness) x population}}{\text{cost}}$ = Value

- Measuring Domains
  - **Identification – population, gaps in care, intervention opportunities**
  - **Characteristic factors – (diagnosis, functionality, comorbidities, demographics, risk factors and mitigating factors)**
  - **Enrollment** –active agree, those touched by an intervention
  - **Engagement** – demonstrates passive or active behavioral response
  - **Treatment/intervention type –** service, technologies, self help, social networking
  - **Outcomes – clinical improvement, QOL,**
  - **Cost – unit, case, episode**

- Standardized Data sets
  - Claims – behavioral, medical, pharmacy, disability
  - HR – absenteeism
  - Self report – HRA, surveys, outcomes measurement
  - EHR/PHR
  - Assessments

Critical to Goal: Improving Performance

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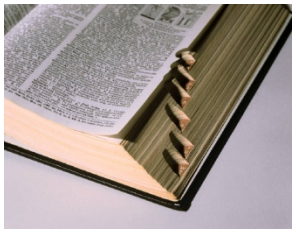
Treatments/Interventions



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Characteristic Factors

Clinical/Functional Outcomes

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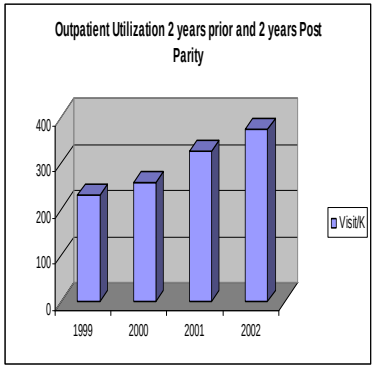
Therapeutic Alliance/ Engagement

Consumer Satisfaction

=

Practice Based Evidence



Critical to Goal: Pay for Performance

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Characteristic Factors

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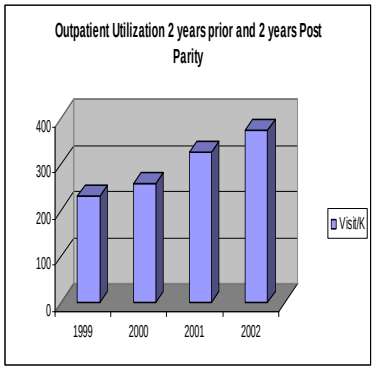
Clinical/Functional Outcomes

Cost

Comparative Effectiveness

+

=



Population Prevalence

Consumer Satisfaction

Critical Gaps in Measuring Substance Use Disorder Episode of Care

- Demographic/Characteristic Factors
  - What are the factors that make up the SUD taxonomy
    - Symptom approach
    - Substance used/amount/duration
    - Risk factors
    - Ethnic/cultural/racial
    - Genetic factors

Critical Gaps in Measuring Substance Use Disorder Episode of Care

- Monitoring Treatment Progress
  - What are the domains that are relevant to identifying and measuring response and treatment remission
    - Abstinence
    - Measurements of other behavior change
    - Measurement of managing carving
    - Measurement of neurocognitive change

Critical Gaps in Measuring Substance Use Disorder Episode of Care

- Definition of and Measurement of Successful SUD Treatment
  - Abstinence only
  - Inclusive factors
  - Change in cognition
  - Effect size level
  - Time frame for making that decision

Critical Gaps in Measuring Substance Use Disorder Care Coordination

- Post level of care follow through
  Many hand offs lead to drop outs
- Drop out rates
- Therapeutic alliance

- Difficult to measure cross communication without EHR or chart audits