

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

The Provider Perspective

Arthur Schut
Deputy Director/COO
Arapahoe House, Inc
Colorado
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- Multiple settings of specialty care with largely discontinuous service delivery system
- More indigent clients than resources resulting in rationing and truncated care
- Challenges in conceptualizing and providing continuing care management

- Recovery-oriented systems of care under-adopted
- Coerced and forensic clients with minimum stay requirements that become maximum stays - few engage in continuing care
- Evidence-based practices under-adopted without ongoing fidelity measures

- Little meaningful gathering of patient input and feedback - particularly post-treatment and early termination
- Little meaningful assessment of quality of care or value of care
- Provider performance self-measurement of process and outcome - not system-wide. Largely unique to specific providers or research projects

- Few meaningful relationships with primary care systems by clients and/or providers pre- or post-specialty treatment
- Many clients without a primary health home (other than hospital emergency departments)
- Regulatory requirements fragment care episodes. Continuous episodes required to be broken into discrete admissions/discharges.
- Continuing care may be accessed “outside the system” - not recorded

- Lack of claims-based billing systems (Medicaid, Private Insurance, etc.) in the specialty provider system
- Rudimentary, unsophisticated state (and provider) data systems cannot link discrete admission/discharge segments into an episode, or have great difficulty in linking segments.
- Services provided a patient throughout an episode of care may not be available.

- Coding of services delivered may be creative and not reflect the actual level of care: 24-hour detox billed un-bundled as: detox assessment, safety assessment, motivational treatment, daily living skills
- Free-standing inpatient billed as: “Intensive Outpatient with a bed”; or “day treatment” where patient or other funds pay for room and board; or fee for service unit billing with multiple payers

- Claims data of Medicaid and private payers do not reliably report services delivered, nor episodes of care, because of discontinuous and erratic: eligibility, enrollment, authorization, care management, benefit structure; plus single services have portions paid by multiple unrelated payers and systems
- Reliable naturally occurring administrative data is currently a challenge.

- “Continuing care management?” defined in an operational way that is clear to, and executable by, providers.
- Services recorded by providers in a way that is sufficiently disaggregated that most billing and reporting options are open.
- Results driven service delivery - what does the customer want as deliverables?
- Who are the customers?

- Organize provider data around business and performance management requirements, rather than local, state, and federal encounter reporting requirements
- Make provider performance self-measurement ubiquitous - process and outcome
- Reliable accurate data (internal)

Large numbers of coerced patients compared to other health enterprises.

- Should we separate forensic patients ?
- Should we separate coerced child welfare custody referrals?

- Mandate fidelity procedures with EBP implementation
- Require basic inter-rater reliability techniques and verification
- Target to create reliable naturally occurring administrative data.
- Benchmarking - an opportunity to facilitate reliable data gathering?

- In the publicly funded specialty system, the challenges with the existing data gathering and reporting systems are so immense that attempts to craft an episode of care model should probably by-pass that system and its data.
- Creation of an alternative system or a national sample may actually be a simpler proposition