Frequently Asked Questions About Continuity of Care in Substance Use Disorder Treatment

What does the Continuity of Care Performance Measure require and how does it work?

1. What does the VHA Performance Measure (PM) for continuity in substance use disorder (SUD) treatment require?

The current continuity of care performance measure applies to patients entering specialty treatment for SUDs (inpatient, residential, domiciliary or outpatient, but not opioid substitution). The measure involves 100% review of administrative databases using clinic stop codes or inpatient/residential bedsection codes to determine specialty care for SUDs. The performance period applies to patients completing their 90-day retention period from October through August of the fiscal year.

Indicator Statement: Percent of patients beginning a new episode of treatment for SUD who maintain continuous treatment involvement for at least 90 days after the date of a qualifying event

Numerator: Veterans with a qualifying inpatient/residential or outpatient event for SUD who maintain continuous treatment involvement for at least 90 days as demonstrated by at least 2 visits every 30 days for a total of 90 days in any of the outpatient specialty SUD clinics.

Denominator: Veterans with a qualifying inpatient/residential or outpatient event for a new episode of specialty treatment for SUD.

Continuous Treatment Involvement (Retention period): Continuous treatment involvement for at least 90 days is defined as visits on at least 2 days during every 30 day retention interval for a total of 90 days (three discrete 30 day intervals) in any of the VA outpatient specialty SUD clinics other than 523 (methadone maintenance). The continuous SUD treatment retention period begins the day after the qualifying date and ends 90 days after the qualifying data.

2. *How does a veteran qualify for the PM?*

Cohort: Universe includes all veterans with a SUD outpatient encounter or inpatient discharge from a SUD specialty bed section in VHA.

Veterans beginning a new SUD treatment episode:

To qualify as a new SUD *outpatient* episode, two criteria must be met:

(1) A 90-day history without SUD outpatient or inpatient treatment (i.e., no SUD outpatient visit, telephone 545, inpatient admission or discharge or inpatient SUD encounters) before the date of the 1st of three qualifying SUD outpatient visits, **AND**

(2) Three visits within 30 days to outpatient SUD care. (Clinic stops 513 SA-IND or 514 SA-Home or 519 SA/PTSD or 547 INT-SA TRT, or 560 SA GRP; listed stops are included if paired with other stops as primary or secondary except smoking cessation 707 or methadone maintenance 523. SUD Telephone visits [Stop Code 545] will NOT be used to qualify new SUD treatment episodes.)

The date of the 3rd SUD visit in 30 days is the qualifying date for the outpatient track. The retention period begins the next day.

Patients who accrue outpatient workload while in an inpatient SUD bed section will not qualify for the measure via the outpatient track. A patient who is admitted to a SUD bedsection during the retention period will have his/her retention period reset at the time of discharge.

To qualify as a new SUD *inpatient* episode, a single criterion must be met:

(1) A discharge or transfer from an SUD inpatient bed section. (PTF Discharge Specialty 27 SA Res Rehab or 74 SA HI INT, 86 DOM SA) with a length of stay of at least 4 calendar days.)

The SUD bed section discharge or transfer date is the qualifying date for the inpatient track. The retention period begins the next day.

2a. What if a veteran qualifies by VISITS, and then qualifies again during the retention period by DISCHARGE? If a patient qualifies as an outpatient, but fails the PM (i.e., no visits in Month 1), and then the patient begins inpatient treatment, does this count as a failure or is the patient requalified?

Admission during the retention period: If a veteran has already qualified for the measure (from the inpatient or the outpatient tracks) and, during the retention period has a discharge from one of the SUD inpatient bed sections listed above, and LOS

– < 4 calendar days, will have no effect on the measure.

– At least 4 calendar days, would have their retention period reset at the date of discharge or transfer from that bedsection and the original inpatient/residential or outpatient qualifying event would be dropped from the measure.

3. What counts as a visit?

- VA outpatient continuing care visits or inpatient encounters (if patient is in a non-SUD bedsection, such as General Domiclicary or Acute Psychiatry) with stop codes 513 SA-IND or 514 SA-Home or 519 SA/PTSD or 547 INT-SA TRT or 560 SA GRP

- Visits with stop code 523 (opioid substitution) in either primary or secondary position are ignored by the measure and do not count for qualifying or retention visits.

- Telephone care: SUD clinical care by telephone which meets the same standard as face-to- face visits (e.g., documented clinical encounter with stop code 545; staff qualifications, time spent with the veteran, etc.) will be accepted for continuity of care for visits during the 2nd and 3rd 30-day retention intervals. (Stop code 545 is not used to qualify new veterans into the measure).

4.Is there an easy way for treatment staff to track a veteran's visits after he or she qualifies?

Many programs have developed local tracking systems from the point of first contact with a patient. A number of programs have relied on the VISN 16 Casefinder that is a Class III patch to VISTA available from Pam Croston (Pamela.Croston@va.gov). Note that the Casefinder is based only on local VISTA data, so it is not the definitive source for the measure and may lack information available from multiple facilities in the National Patient Care Database in Austin that is the definitive source of data for the measure.

5. What should treatment staff do in terms of continuing care if a patient leaves their VA facility and goes to another one? How can treatment staff help patients get continuing care at another VA facility?

Veterans seen in multiple facilities will be attributed to the facility where the last retention visit occurred in order to promote timely coordinated transitions between facilities.

- If the veteran is <u>not</u> seen in any substance abuse clinic in VHA during the 1st 30 days of the retention period, s/he fails the measure. The failure will be attributed to the facility where the qualifying event occurred (i.e., where the 3rd visit occurred that qualified the veteran as beginning a new episode of care or where the veteran was discharged from inpatient/residential SUD care).

- If the veteran <u>is</u> seen for a 1st retention visit in a SUD clinic during the 1st 30-day retention period but is not seen again, the patient fails the measure. The failure will be attributed to the facility where the first retention visit occurred.

- If the patient passed the first 30-day retention interval requirement but failed to meet the 2nd 30-day retention interval requirement, the patient fails the measure and the failure is attributed to the facility where the latest retention visit occurred.

- If the patient passed the first and second 30-day retention interval requirement but failed to meet the 3rd 30-day retention interval requirement, the patient fails the measure and the failure is attributed to the facility where the latest retention visit occurred.

What is the evidence for the current PM?

1. Is there evidence that continuing care for veterans with substance use disorders benefits them? If yes, what is the evidence (e.g., less rehospitalization and other additional use of health care; lower ASI scores, higher abstinence rates)?

There are not controlled trials that randomly assign patients to receive or not receive continuing care, so the evidence base relies on observational studies.

Research has shown that good addiction treatment outcomes (i.e., abstinence and improvement in other measures of use or addiction severity) are contingent on adequate lengths of treatment. There is no predetermined length of addiction treatment that assures success, but duration of treatment is the factor most consistently associated with successful addiction treatment outcome (Crits-Cristoph & Siqueland, 1996; Donovan, 1998; Onken et al., 1997; Simpson et al., 1997; Zhang, Friedmann & Gerstein, 2003).

2. Why is the goal three months of treatment, when veterans have a month of treatment when they qualify for the PM? Would it make more sense to focus on three months of treatment (qualification plus two months)?

Many outpatients would receive their 3 qualifying visits within the first week of an intensive outpatient program. Many patients drop out during the initial 90 days of treatment with limited clinical benefit and high rates of relapse. While two contacts per month for three months would rarely be sufficient, most patients require ongoing treatment for **at least** this duration to establish early remission. Many individuals continue to benefit from treatment (e.g., methadone maintenance) over a period of years. AA and other 12-Step programs also emphasize the imnporatance of the first 90 days of recovery.

Consistent with the VHA/DoD Guideline for Treatment of Substance Use Disorders, this performance measure is intended to emphasize the importance of early treatment retention as an essential but not sufficient condition of quality care for addiction. Treatment duration beyond 3 months presents important opportunities to individualize treatment plans consistent with treatment response over time by adjusting the intensity of psychosocial interventions (e.g., frequency of group sessions), pharmacotherapy (e.g., dose amount and monitoring frequency), community recovery support (e.g., promoting Twelve-Step program involvement), and management of comorbid conditions.

3. Why are only two visits per month required?

The initial intensity of treatment should be considered primarily as a means to promote treatment retention, e.g., severely dependent patients typically may require multiple treatment contacts per week in order to stabilize early remission. Patients with insufficient treatment intensity during the early weeks of treatment are unlikely to be retained over subsequent months. However, for many patients following initial stabilization, particularly those with recovery support in the community, it may be appropriate to provide a lower intensity of addiction-focused treatment extending over a longer duration with superior remission rates for those who remain engaged in treatment for 6-12 months (Ritsher et al, 2002).

4. What is the evidence comparing the benefits of face-to-face versus telephone continuing care?

Available evidence from randomized trials in VA supports the effectiveness of telephone follow-up for patients after they have stabilized during the initial weeks of outpatient treatment (McKay, et al., 2004; McKay et al., 2005; a telephone-based relapse prevention manual is also available from James McKay, PhD).

Motivations and mechanisms for increasing CoC?

1. Why is the treatment program held responsible for SUD patients continuing in care? Isn't this decision up to the patient?

Treatment decisions (in the absence of legal pressure) are always up to the patient. Providers, likewise, have options when designing programs and conducting training of staff about best practices. One option open to providers is to create conditions which facilitate patients obtaining an individualized dosage of treatment that, can promote early stabilization and lead to a sustained period of abstinence. Such efforts need not undermine a patient's sense of autonomy in making treatment decisions, but, instead, can convey support and concern for the patient's on-going sobriety.

Consistent with the VA/DoD Clinical Practice Guideline and national consensus standards on evidence-based practices for treatment of SUD from the National Quality Forum, the program is accountable for developing and implementing treatment engagement strategies including attention to patients' co-occurring psychosocial conditions that may interfere with treatment involvement. Evidence over the past several years in VA indicates that programs can improve substantially when retention is monitored. The continuity of care measure is intended to identify patients clinically appropriate for and initially accepting specialty care. Most patients who are considered clinically inappropriate or who reject recommended care are intended to be identified in initial assessment visits.

2. How can treatment staff increase the likelihood that SUD patients will engage in continuing care, i.e., what are the best clinical strategies?

A report completed by the SUD QUERI Retention in Continuing Care Workgroup in 2006 compared continuity of care practices for high and low performing programs. High performing programs were much more likely to identify a number of resources at their stations, such as the presence of on-site housing resources, providing transportation assistance, and staff dedicated to tracking patients. Although the vast majority of facilities reported having a continuity of care coordinator, only programs at high performing stations identified this individual as the key resource in meeting the continuity of care PM. They also were more likely to identify the key role of this person as tracking patients, measuring performance, and providing feedback on performance to providers. Low performing stations were much more likely to note significant barriers to providing continuing care, and as a key barrier noted having a sizable number of patients living far from their facility, homeless patients or having difficulty identifying patients who are eligible for the measure. The report in its entirety can be found at (http://www.chce.research.va.gov/docs/pdfs/CoCFAQ.pdf).

3. Who can treatment staff call for help in solving specific problems in meeting the PM at their VA facility?

In an effort to improve continuity of care performance in the VA as a whole, members of the SUD QUERI Retention in Continuing Care Workgroup have convened a "panel" of SUD continuity of care consultants. The Workgroup's goal is to facilitate communication between staff at programs that are having difficulty meeting the challenges posed by the continuity of care PM and staff who have found ways to achieve high performance. We hope to facilitate contact between programs that offer comparable services and serve similar patient populations (e.g., mix of rural and urban) and help generate relevant solutions for programs that may feel a disheartened by their performance.

An excel file that lists providers who have agreed to participate in this project and attributes of their programs can be found at (http://www.chce.research.va.gov/docs/pdfs/CoCFAQ.pdf). The excel file can be used to find the contact information of a provider whose program attributes are most similar to yours. All individuals listed on the spreadsheet have graciously agreed to act as an informational support person. The easiest way to view the spreadsheet is on your computer which keeps all columns on one page and allows you to see attributes in color. You may find it easiest to save the excel file to your desktop.

Other resources for consultation are the Centers of Excellence in Substance Abuse Treatment and Education (CESATEs) in Seattle (Daniel.Kivlahan@va.gov) and Philadelphia (James.McKay@va.gov).

References

Crits-Christoph, P. and L. Siqueland (1996). "Psychosocial treatment for drug abuse. Selected review and recommendations for national health care." Arch Gen Psychiatry 53(8): 749-56.

Substance abuse and dependence remains an important public health concern because of health-related and other costs to our society. We review selected articles that address questions about the psychosocial treatment of substance abuse disorders; these articles could aid in setting the parameters of a national health care insurance. Data from major program evaluation studies of existing substance abuse treatment programs are presented, followed by reviews of controlled studies of opiate, cocaine, and marijuana abuse and dependence; particular attention is given to studies that have standardized treatment through the use of treatment manuals. Articles about the treatment of substance abuse in adolescents are also reviewed. The existing data suggest that substance abuse treatment should be intensive and should probably involve multiple modalities targeted to various problems encountered in patients with substance use disorders, including comorbid psychiatric problems. However, only a few well-controlled studies have been performed to date; therefore, substantial research is needed before a system truly informed by research can be designed. Suggestions for future research directions are provided.

Donovan, D. (1998). Continuing Care: Promoting the Maintenance of Change. Treating addictive behaviors. W. R. Miller and N. Heather. New York, Plenum: 317-335.

McKay, J. R., K. G. Lynch, et al. (2004). "The effectiveness of telephone-based continuing care in the clinical management of alcohol and cocaine use disorders: 12-month outcomes." J Consult Clin Psychol 72(6): 967-79.

This study of continuing care for substance dependent patients compared a telephone-based monitoring and brief counseling intervention (TEL) with 2 face-to-face interventions, relapse prevention (RP) and standard 12-step group counseling (STND). The participants were graduates of intensive outpatient programs who had current dependence on alcohol and/or cocaine. Self-report, collateral, and biological measures of alcohol and cocaine use were obtained over a 12-month follow-up. The treatment groups did not differ on abstinence-related outcomes in the complete sample (N = 359) or on cocaine use outcomes in participants with cocaine dependence (n = 268). However, in participants with alcohol dependence only (n = 91), TEL produced better alcohol use outcomes than STND on all measures examined and better outcomes than RP on some of the measures.

McKay, J. R., K. G. Lynch, et al. (2005). "The effectiveness of telephone-based continuing care for alcohol and cocaine dependence: 24-month outcomes." Arch Gen Psychiatry 62(2): 199-207.

CONTEXT: Telephone-based disease management protocols have shown promise in improving outcomes in a number of medical and psychiatric disorders, but this approach to continuing care has received little study in alcohol- and drug-dependent individuals. OBJECTIVE: To compare telephone-based continuing care with 2 more intensive face-to-face continuing care interventions. DESIGN: A randomized 3-group clinical trial with a 2-year follow-up. SETTING: Two outpatient substance abuse treatment programs, one community-

based and the other at a Veterans Affairs medical center facility. PATIENTS: Alcohol- and/or cocaine-dependent patients (N = 359) who had completed 4-week intensive outpatient programs. INTERVENTIONS: Three 12-week continuing care treatments: weekly telephone-based monitoring and brief counseling contacts combined with weekly supportive group sessions in the first 4 weeks (TEL), twice-weekly cognitive-behavioral relapse prevention (RP), and twice-weekly standard group counseling (STND). MAIN OUTCOME MEASURES: Percentage of days abstinent from alcohol and cocaine, total abstinence from alcohol and cocaine, negative consequences of substance use, cocaine urine toxicological results, and gamma-glutamyltransferase. RESULTS: Participants in TEL had higher rates of total abstinence over the follow-up than those in STND (P<.05). In alcohol-dependent participants, 24-month gamma-glutamyltransferase levels were lower in TEL than in RP (P = .005). In cocaine-dependent participants, there was a significant group x time interaction (P = .03) in which the rate of cocaine-positive urine samples increased more rapidly in RP as compared with TEL. On percentage of days abstinent or negative consequences of substance use, TEL did not differ from RP or STND. Participants with high scores on a composite risk indicator, based on co-occurring alcohol and cocaine dependence and poor progress toward achieving intensive outpatient program goals, had better total abstinence outcomes up to 21 months if they received STND rather than TEL, whereas those with lower scores had higher abstinence rates in TEL than in STND (P = .04). CONCLUSIONS: Telephone-based continuing care appears to be an effective form of step-down treatment for most patients with alcohol and cocaine dependence who complete an initial stabilization treatment, compared with more intensive face-to-face interventions. However, high-risk patients may have better outcomes if they first receive group counseling continuing care after completing intensive outpatient programs.

Onken, L. S., J. D. Blaine, et al. (1997). "Treatment for drug addiction: it won't work if they don't receive it." NIDA Res Monogr 165: 1-3.

Ritsher, J. B., J. D. McKellar, et al. (2002). "Psychiatric comorbidity, continuing care and mutual help as predictors of five-year remission from substance use disorders." J Stud Alcohol 63(6): 709-15.

OBJECTIVE: In a cohort of 2,595 male patients in VA intensive treatment programs for substance use disorders (SUD), we tested whether psychiatric comorbidity, outpatient care and mutual help group attendance during the first two follow-up years predicted remission status at Year 5, controlling for covariates. METHOD: Logistic regression modeling of longitudinal data was used to test the hypotheses. RESULTS: Dual diagnosis patients were less likely to be in remission at Year 5 than SUD-only patients. Outpatient care was at best only weakly related to Year 5 remission status. By contrast, mutual help involvement substantially improved the chances of substance use remission at Year 5 for both SUD-only and dual diagnosis patients. Mutual help involvement did not, however, offset the poorer prognosis for dual diagnosis patients. CONCLUSIONS: Because mutual help groups specifically targeted to individuals with comorbid substance use and psychiatric disorders are currently rare, further research is recommended to investigate whether they are more effective than standard SUD mutual help groups in facilitating the recovery of persons with dual diagnoses.

Ritsher, J. B., R. H. Moos, et al. (2002). "Relationship of treatment orientation and continuing care to remission among substance abuse patients." Psychiatr Serv 53(5): 595-601.

OBJECTIVES: The authors examined whether continuing outpatient mental health care, the orientation of the treatment program (12-step, cognitive-behavioral, or eclectic), and involvement in self-help groups were linked to substance abuse patients' remission status two years after discharge. METHODS: The data were from a cohort of 2,805 male patients who were treated through one of 15 Department of Veterans Affairs substance abuse programs. Remission was defined as abstinence from illicit drug use and abstinence from or nonproblem use of alcohol during the previous three months. The relationships of the three variables to remission were tested with regression models that controlled for baseline characteristics. RESULTS: About a quarter of the study participants (28 percent) were in remission two years after discharge. Intake characteristics that predicted remission at two years included less severe substance use and psychiatric problems, lower expected disadvantages and costs of discontinuing substance use, and having abstinence as a treatment goal. No significant relationship emerged between treatment orientation and remission status two years later. Involvement in outpatient mental health care during the first follow-up year and participation in self-help groups during the last three months of that year were associated with a greater likelihood of remission at the two-year follow-up. CONCLUSIONS: The results extend previously published one-year outcome findings showing that cognitive-behavioral and 12-step treatment programs result in similar remission rates. Patients who enter intensive substance abuse treatment with polysubstance use, psychiatric symptoms, or significant emotional distress have more difficulty achieving remission. Routinely engaging patients in continuing outpatient care is likely to yield better outcomes. The duration of such care is probably more important than the number of sessions.

Simpson, D. D., G. W. Joe, et al. (1997). "Program diversity and treatment retention rates in the Drug Abuse Treatment Outcome Study (DATOS)." Psychology of Addictive Behaviors 11(4): 279-293.

Stays of 3 months or longer in drug abuse treatment generally predict better follow-up outcomes. In a national sample of community-based programs that participated in the Drug Abuse Treatment Outcome Study, median lengths of stay were 3 months for clients in long-term residential and outpatient drug-free treatments and 1 year for clients in outpatient methadone treatment. However, individual programs within each of these modalities differed widely in how long they kept their clients in treatment as well as their service delivery. Programs treating individuals with heavier cocaine and alcohol use and more psychological dysfunction usually had shorter retention rates. Nonetheless, even after statistically controlling for these client differences, some programs were more effective than others in engaging and retaining clients.

Zhang, Z., P. D. Friedmann, et al. (2003). "Does retention matter? Treatment duration and improvement in drug use." Addiction 98(5): 673-84.

AIM: This study examines whether there is a minimum threshold, continuous or non-linear relationship between the duration of addiction treatment and improvements in drug use. DESIGN: Longitudinal cohort study of 62 drug treatment units and 4005 clients in the US National Treatment Improvement Evaluation Study, fielded from 1993 to 1995. SUBJECTS:

Baseline and 1-year follow-up interviews with clients in methadone maintenance, out-patient non-methadone, short-term residential and long-term residential treatment programs. MEASURES: Improvement in drug use is the difference between the client-reported peak frequency of drug use (in days per month) in the year prior to the baseline interview minus the peak frequency in the year after discharge. Primary drug, and overall use of the major illicit drugs (heroin, cocaine powder, crack cocaine, and marijuana) are considered separately. RESULTS: Controlling for multiple factors, treatment duration had a positive linear relationship with primary drug use improvement among methadone clients and an inverted-U-shaped relationship with overall and primary drug use improvements among out-patient and long-term residential clients. Improvement with longer duration is greatest for long-term residential clients. CONCLUSIONS: Contrary to previous arguments for a sharp retention threshold for onset of treatment effects, we find smooth curves relating treatment duration to drug use improvements in methadone maintenance, out-patient non-methadone and long-term residential modalities. These relationships are effectively linear for durations typically observed in single treatment episodes, but unusually long retention in out-patient non-methadone and long-term residential units appear steadily less predictive of improvement.