Program and Patient Factors that Influence Continuity of Care Performance Measure Outcomes in VA Substance Use Disorder Treatment Programs

Department of Veterans Affairs

HSR&D Center for Health Care Evaluation and
Program Evaluation and Resource Center
VA Palo Alto Health Care System
Menlo Park, CA 94025

Jeanne Schaefer, PhD, John McKellar, PhD, Simona Stolpner, BA,
Patricia Turrubiartes, MS

In Collaboration with:
Substance Use Disorder QUERI
Retention in Continuing Care Workgroup

February 2007

Executive Summary

The objectives of this project were to: (1) identify the clinical practices and services that VA substance use disorder (SUD) treatment programs use to keep patients engaged in continuing care, (2) identify the barriers program staff face in meeting the continuity of care (CoC) performance measure and the resources that help them successfully meet it, and (3) determine if SUD programs at stations with high scores on the performance measure differ from those with low scores on program characteristics, CoC practices, and barriers and resources to meeting the performance measure.

Programs from stations with high or low CoC performance measure scores were selected based on size (> 100 patients), location (urban vs. rural), and the distribution of inpatient/residential, intensive outpatient, and non-intensive outpatient sites. Directors/coordinators of 35 of the 36 randomly selected SUD programs completed a brief telephone survey. Survey data were used to compare programs at high and low performing stations.

Continuity of Care Practices

High performing stations were somewhat more likely to provide continuing care appointments before discharge from specialized care, and they tended to provide more appointment reminders. High performers also were more inclined to offer patients incentives or rewards for engaging in continuing care, to have them sign contracts to remain in treatment, and to provide transportation assistance. Surprisingly, low performing stations reported they were more likely than high performers to contact patients who missed continuing care appointments.

Resources and Barriers

Programs at high performing stations were much more likely to identify system resources, such as the presence of on-site housing resources and staff dedicated to tracking patients. Although the vast majority of facilities reported having a CoC coordinator, more staff at high performing stations identified the key roles of the coordinators as tracking patients, measuring performance, and providing feedback to providers. Program coordinators at low performing stations were much more likely to report significant barriers to meeting the performance measure, including difficulty in identifying patients who meet inclusion criteria for the CoC measure.

Conclusions/Implications

In summary, the pattern of results identified no single factor that uniformly differentiated programs at high and low performing stations on CoC practices, but there were substantial differences in the CoC coordinator role and smaller differences on a number of other variables reflecting CoC practices. The challenge for the SUD QUERI is now to help low performing sites overcome barriers and develop the resources needed to provide high-quality SUD continuing care.

Background

Many VA SUD programs have found it difficult to meet the Office of Quality and Performance's Continuity of Care (CoC) performance measure (PM). The measure requires that patients entering a new episode of specialty SUD treatment receive at least two VA substance abuse clinic visits for each of three successive 30-day periods after qualifying as a new patient. Patients "qualify" for the CoC care measure as a new patient once they have more than 2 outpatient SUD clinic visits or enter inpatient/residential SUD treatment.

The Retention in Continuing Care Work Group of the Substance Use Disorder Quality Enhancement Research Initiative (SUD QUERI) has a strong interest in helping SUD treatment program staff improve their scores on the CoC performance measure. In an effort to gain a better understanding of the factors that influence programs' performance on the measure, members of the Work Group surveyed a sample of VA SUD treatment programs. The purpose of the survey was to identify the SUD programs' organizational characteristics, CoC practices, and other system factors (i.e., barriers or resources) that were associated with their CoC PM outcomes.

The project objectives were to: (1) identify the clinical practices and services that VA SUD programs use to keep patients engaged in continuing care, (2) identify the barriers program staff face in meeting the CoC PM and the resources that help them successfully meet it, and (3) determine if SUD programs at stations with high CoC PM scores differ from those with low performance scores on program characteristics, continuity of care practices, and barriers and resources to meeting the performance measure.

Methods

We surveyed the directors/coordinators of SUD treatment programs at VA stations that varied in their CoC PM scores which are calculated at the parent station level. As a first step, we ranked all VA stations by their CoC PM scores from highest to lowest based on performance in the first quarter of FY06. Then, we randomly selected 18 SUD programs from the highest ranking stations (top third) and 18 from the lowest ranking stations (bottom third) that were roughly balanced by whether they were an inpatient/residential, intensive outpatient programs or regular outpatient program. Methadone maintenance programs were excluded. Program selection was based on size (> 100 patients) and stratified by location (urban-rural) and treatment type (inpatient/residential, intensive outpatient, non-intensive outpatient). The directors/coordinators of 35 of the 36 randomly selected SUD programs completed a brief telephone survey.

The limited size of the sample precluded significance testing of differences between high and low programs. However, we include graphs to compare CoC

practices, features, and patient populations that appear to differentiate programs at high and low performing stations.

Program Sample

The program sample included 11 inpatient/residential programs, 19 intensive outpatient programs (5 with a residential component), and 5 non-intensive outpatient programs (1 with a residential component).

Eighteen programs were categorized as being at "high" performing stations; 17 were classified as being at "low" performing stations. The mean CoC PM score for the high performing facilities was 49% of patients receiving the required continuing care, with a range of 40% to 88%. Among the low performing programs, the mean score was 23%, with a range of 8% – 31%.

Most outpatient programs (88%) had a defined start and end point, with a median recommended length of stay of 35 days (range 14 – 214 days). Nearly all inpatient/residential programs (91%) had a standard recommended length of stay, with a median length of stay of 35 days (range 28 – 130 days).

Results

Access to Continuing Care

Throughout this report, figures are broken down into low and high where low = bottom third and high = to two thirds. When figures are in thirds, low = bottom third, medium = middle third, and high = top third.

Length of Continuing Care. The PM requires continuing care over 3 months. However, programs may recommend patients remain in continuing care for other periods of time. We examined whether programs with recommended periods of continuing care that exceeded the 90-day period for the PM had better PM performance. The median length of time that patients were asked to stay in continuing care was 13 weeks (range from 6 – 52 wks)

As seen in Figure 1, 63% of programs at low performing stations recommended 3-6 months of continuing care compared with only 37% of high performing stations. However, 43% programs at high performing stations recommended greater than 6 months of continuing care compared with 22% of lower performing stations.

Evening and Weekend Access to Continuing Care. Patients treated at high performing stations were slightly more likely to have access to continuing care services during the evening and on weekends. Among the high performing stations, 78% offered evening and weekend continuing care services versus 69% at low performing stations.

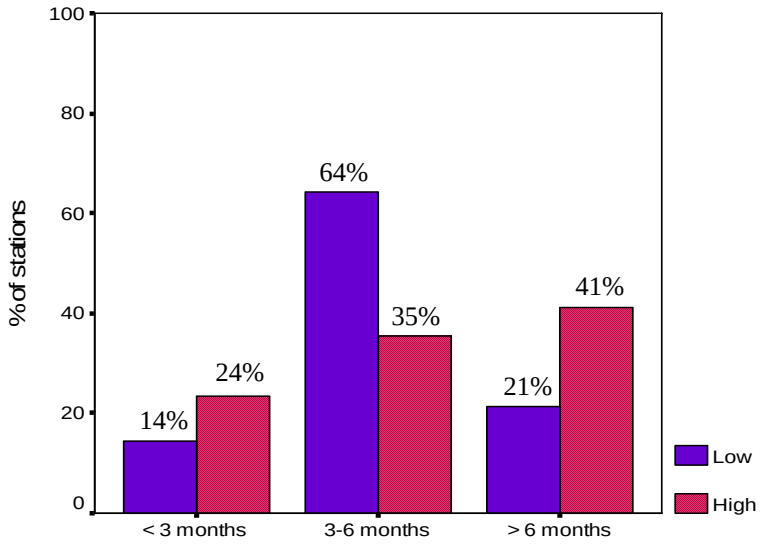

Figure 1. Percent of low and high performing stations by recommended duration of continuing care

Continuing Care Appointments. High performing stations were more likely (94%) to give continuing care appointments to a high proportion of their patients prior to discharge than were low performing stations (75%; see Figure 2).

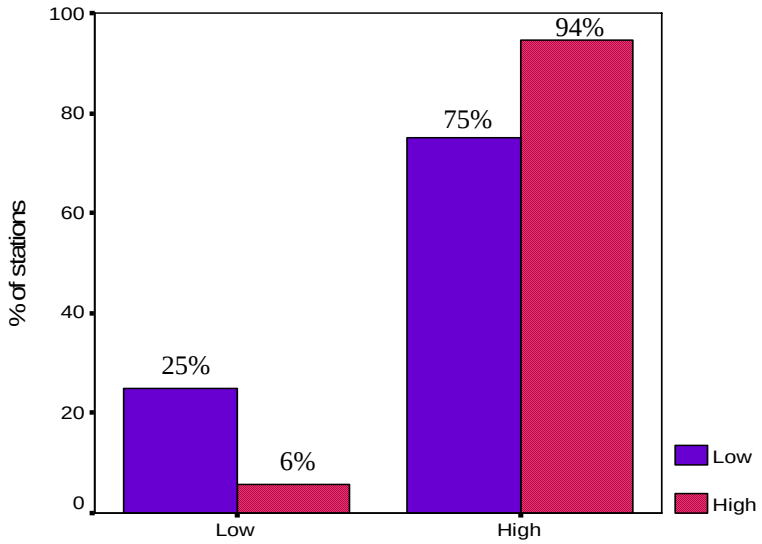

Figure 2. Percent of low and high performing stations by the proportion of patients given continuing care appointments prior to discharge from intensive treatment

Clinical Practices to Enhance Retention of Patients in Continuing Care

Appointment Reminders Figure 3 illustrates marginally greater use of appointment reminders at high performing stations. Among high performers, 61% of stations reported that a medium to high proportion of their patients received reminders as compared to 50% at low performing stations.

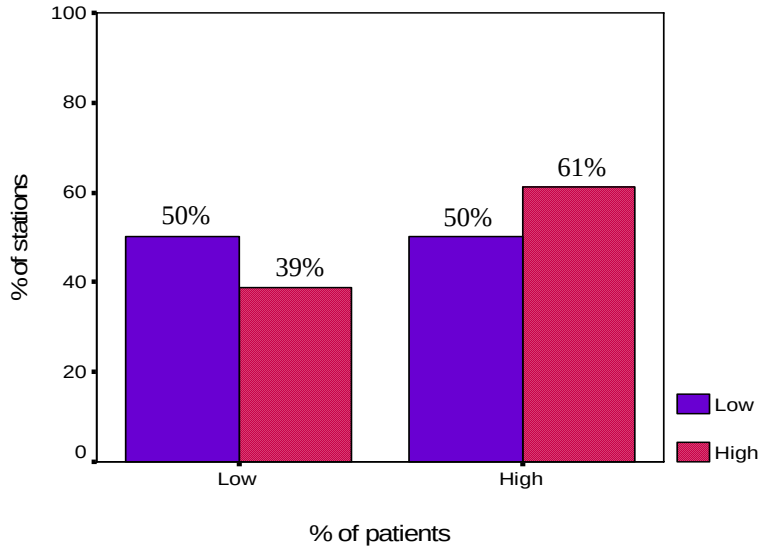

Figure 3. Percent of low and high performing stations by the proportion of patients given appointment reminders prior to continuing care appointments

Missed Appointment Follow-Up Surprisingly, SUD treatment staff at low performing stations reported following-up with a greater proportion of patients who missed continuing care appointments than did staff at high performing stations (Figure 4). Two-thirds of the low performing stations indicated that staff followed a high portion of patients who missed appointments; this was the case at only half of the high performing stations. This finding may reflect a higher percentage of patients missing initial appointments at low performing sites, leading to more attempts to follow-up on missed appointments.

Transportation Patients at high performing stations were more likely than those in low performing stations to arrange transportation assistance to continuing care appointments (e.g., bus tokens, van service). As Figure 5 shows, 22% of high performing stations offered transportation assistance to a high proportion of their patients, while only 13% of the low performing stations did so. In contrast, at the majority (81%) of low performing stations, small numbers of patients received help with transportation; the percentage of high performing stations that furnished transportation to a small portion of their patients was somewhat less (72%).

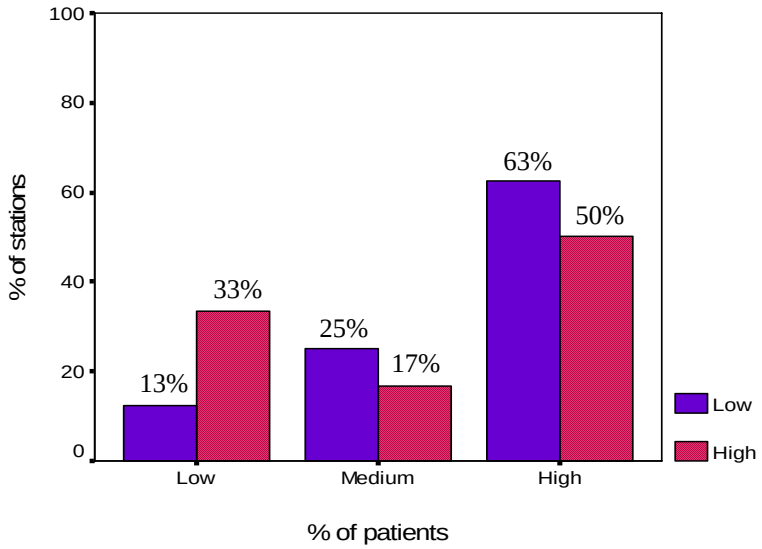

Figure 4. Percent of low and high performing stations by the proportion of patients followed up by staff if they missed an appointment

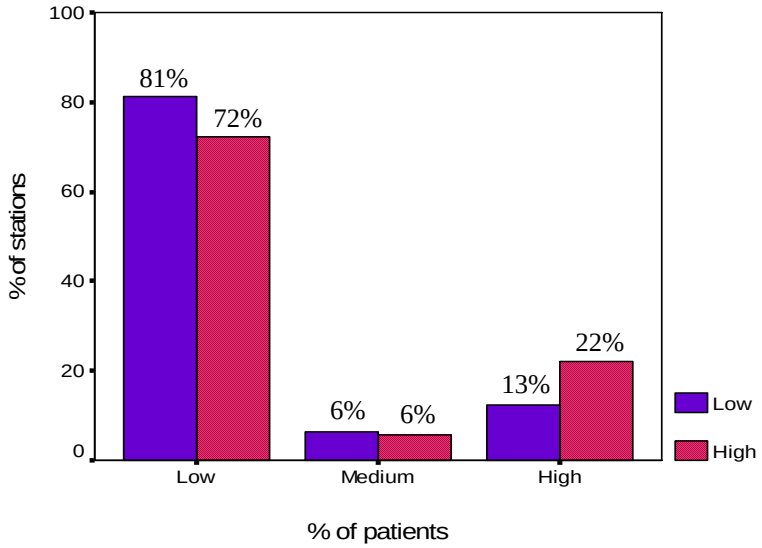

Figure 5. Percent of low and high performing stations by the proportion of patients provided transportation assistance to attend continuing care

Incentives, Recognition, Rewards Patients at high performing stations were offered incentives and rewards for attending continuing care appointments much more often than were patients at low performing stations. Among high performing stations, 41% provided incentives or rewards to a high proportion of their patients; this was the case at only 12% of low performing stations (Figure 6).

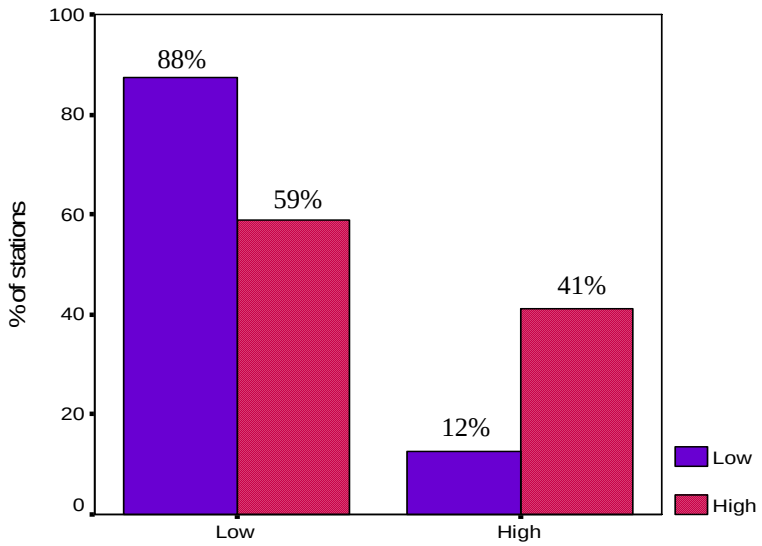

Figure 6. Percent of low and high performing stations by the proportion of patients provided with incentives or rewards for attending continuing care

Contracts for Attendance at Continuing Care As seen in Figure 7, high performing stations were more likely to ask patients to sign contracts agreeing to attend continuing care than were low performing stations. Among high performing stations, 39% used contracts with a high portion of their patients. In comparison, 27% of low performing stations used contracts with a high proportion of their patients.

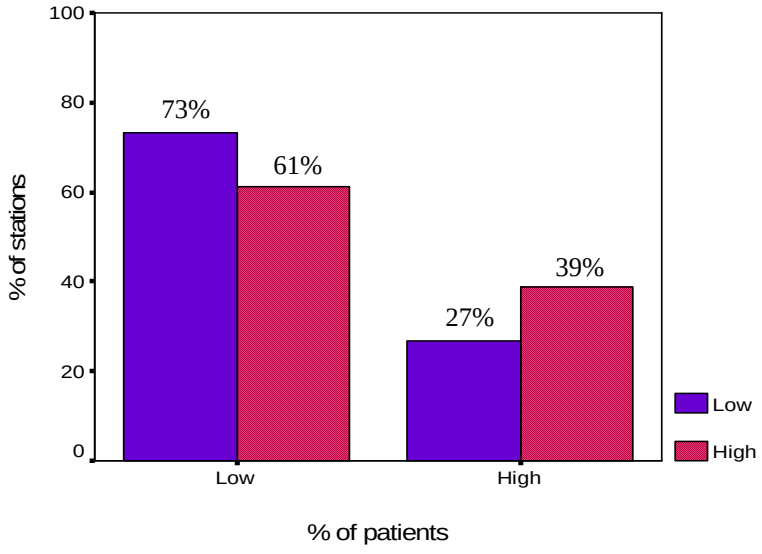

Figure 7. Percent of low and high performing stations by the proportion of patients asked to sign contracts agreeing to attend continuing

SUD Continuity of Care Coordinators

Most stations (80%) reported that they had an individual who served as their SUD CoC coordinator. Table 1 shows the key roles that program directors/coordinators reported for the CoC coordinators. SUD program directors/coordinators at high performing stations were more likely (61%) than those at low performing stations (17%) to see the coordinator's key role as tracking patients, measuring performance, and providing feedback on performance to providers. Staff at high performing stations also were more than three times as likely to report that their CoC coordinator follow-up with patients who qualified for the PM than did staff at low performing stations.

Table 1. Key Roles of CoC Coordinators at Stations with Low and High CoC Performance Measure Scores

CoC Coordinator Roles	Stations with High PM Scores (N = 18)	Stations with Low PM Scores (N = 17)
Track patients who are eligible for performance measure; track performance measure statistics and provide data to staff	61% (11)	18% (3)
Do follow ups of patients who are eligible for performance measure	33% (6)	12% (2)
Remind staff of patients who qualify for the PM and make sure staff follow up with these patients	17% (3)	41% (7)
Emphasize the importance of continuing care to staff and patients	11% (2)	18% (3)
Develop strategies to improve CoC and work on process of care issues	11% (2)	12% (2)

Key System Resources Influencing Retention in Continuing Care

SUD program directors/coordinators reported on the key system resources that influenced their stations' CoC performance scores. This line of inquiry uncovered fairly sharp differences between high and low performing stations. High performing stations identified resources that influenced their performance, such as having on-site housing for patients during or after intensive treatment, having a staff person dedicated to monitoring performance, and having an emphasis on long-term sobriety goals throughout treatment (Table 2). Low performers, on the other hand, did not identify any resources. Although the vast majority of high and low performing facilities reported having a CoC coordinator, only at the high performing stations did staff view this individual as a resource.

Table 2. Key System Resources at Stations with High and Low CoC PM Scores

Key System Resources	Stations With High PM Scores (N=18)	Stations With Low PM Scores (N=17)
No resources noted	11% (2)	100% (17)
On-site housing during/after treatment	28% (5)	0
Staff dedicated to tracking patients	28% (5)	0
Other (e.g., program emphasizes long-term sobriety goals)	33% (6)	0

Key System Barriers Influencing Retention in Continuing Care

SUD program staff also reported on the key system barriers they believed influenced their CoC PM scores. Again, fairly sharp differences between high and low performing stations were evident (Table 3). Low performing stations (100%) were much more likely than high performing stations (22%) to identify key barriers to meeting the CoC PM. Barriers identified at low performing stations included long travel distances for patients, difficulty identifying when patients qualify for the measure, and difficulty in transitioning patients who return to a home facility and/or go to other facilities for care during the continuing care period.

Patient Barriers To Engagement in Continuing Care

To gain a better understanding of the patient barriers that may influence stations' scores on the CoC PM, we asked SUD program directors/coordinators if there were particular types of patients or patients in certain circumstances whom they found especially difficult to keep engaged in continuing care. As shown in Table 4, homeless patients were, overall, the group most often cited as difficult to engage in continuing care. Low performing stations (53%) were considerably more likely than high performers (22%) to identify problems in engaging such patients. On the other hand, high performers reported more often than did low performers that dually diagnosed patients and court ordered patients who completed mandated treatment prior to the 90-day continuing care period were difficult to follow.

Table 3. Key System Barriers at Stations with High and Low CoC PM Scores

Key System Barriers	Stations With High PM Scores (N=18)	Stations With Low PM Scores (N=17)
No Barriers noted	77% (14)	0%
Difficulty identifying patients who are eligible for the PM	6% (1)	12% (2)
Patients live at distance/ problems getting transportation to continuing care	6% (1)	41% (7)
Difficulty in transitioning patients who return to home facility and/or go to other facilities	0%	18% (3)
Other (e.g., poor staff attitudes towards continuing care)	11% (2)	29% (5)

Table 4. Types of Patients Whom SUD Program Staff Reported Were the Most Difficult to Engage in Continuing Care

Type of Patient	Stations with High PM Scores (N=18)	Stations with Low PM Scores (N=15)
Patients who are difficult to track, e.g., homeless, transients, those in shelters	22% (4)	53% (8)
Patients who are dually diagnosed (seriously mentally ill)	28% (5)	13% (2)
Patients with little motivation, e.g., early treatment dropouts	11% (2)	13% (2)
Patients whose court mandates completed prior to 90-days	17% (3)	0%
Patients who live out of area; are discharged to another facility, e.g., CBOCs	11% (2)	13% (2)
Other (e.g., employed and unable to make weekly appointments)	11% (2)	7% (1)

Summary

This project surveyed directors/coordinators of VA SUD treatment programs about CoC practices at their facilities and the resources and barriers that influenced their stations' scores on the CoC PM. The overall response rate of providers was high (97%) and the sample of programs appears representative of VA SUD care.

A number of CoC practices appeared to differentiate high and low performing stations. High performing stations were more likely to provide continuing care appointments before discharge from an index episode of care and were more likely to issue appointment reminders. High performers also were more inclined to provide rewards and incentives for engagement in continuing care, to have patients complete contracts or agreements to remain engaged in treatment, and to provide transportation assistance to attend continuing care. Surprisingly, respondents at low performing sites more often reported that attempts were made to contact patients who missed their initial continuing care appointment than did respondents at high performing stations. That difference may reflect a higher percentage of patients missing initial appointments at low performing sites, leading to more attempts to follow-up on missed appointments.

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 and staff dedicated to tracking patients. Although the vast majority of facilities reported having a CoC coordinator, only programs at high performing stations identified this individual as the key resource in meeting the CoC 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 homeless patients, patients living far from their facility, or having difficulty identifying patients who are eligible for the measure.

In summary, the pattern of results identified no single factor that uniformly differentiated programs at high and low performing stations on CoC practices, but there were substantial differences on the role of the CoC coordinator and smaller differences on a number of other variables reflecting CoC practices. Thus, "quality" as reflected in CoC performance does not appear, to depend on any discrete CoC practice as much as a coordinated approach to continuity. With regard to key system barriers or resources, the pattern of results is consistent with what would be expected: substantial differences in perceived difficulty of overcoming patient retention barriers such as distance and residential instability. The challenge for the SUD QUERI is now to help low performing sites overcome barriers and develop the resources needed to provide high-quality SUD continuing care.

The authors would like to acknowledge the assistance of members of the SUD QUERI Retention in Continuing Care Workgroup who provided feedback in all stages of this project.

Daniel Kivlahan, PhD, Seattle VA (Workgroup Chair)
John Finney, PhD, VA Palo Alto Health Care System
Jay Ford, Center for Health Systems Research and Analysis, University of Wisconsin, and Network for the Improvement of Addiction Treatment (NIATx)
Dean Krahn, MD, Madison VA
Steven Lash, PhD, Salem VA
James McKay, PhD, Philadephia VA
Jefferson Parker, PhD, Jackson VA
Christine Timko, PhD, VA Palo Alto Health Care System