VA Quality Enhancement Research Initiative for Substance Use Disorders

Daniel Kivlahan, Ph.D
VA Puget Sound & University of Washington
APA, New Orleans
August 11, 2006
Veterans Health Administration (VA)

- US largest integrated healthcare system
- 4.8M veterans served in FY05
- 157 medical centers
- 721 community-based outpatient clinics
- 21 regions
  - Veterans Integrated Service Networks (VISNs)
Articles About VA’s Quality Culture

Overall, VHA patients receive better care than patients in other settings.

Improving Patient Care is a special section within Annals supported in part by the U.S. Department of Health and Human Services (HHS) Agency for Healthcare Research and Quality (AHRQ). The opinions expressed in this article are those of the authors and do not represent the position or endorsement of AHRQ or HHS.

Comparison of Quality of Care for Patients in the Veterans Health Administration and Patients in a National Sample

Steven M. Asch, MD, MPH; Elizabeth A. McGinn, PhD; Mary M. Hogan, PhD; Rosalyn A. Hayward, MD; Paul Shekelle, MD, MPH; Lisa Rubenstein, MD; Juannie R. Elsayy, BA; John Adams, PhD; and Eve A. Kerr, MD, MPH

21 December 2004 | Volume 141 Issue 12 | Pages 1381-85

Background: The Veterans Health Administration (VHA) has introduced an integrated electronic medical record, performance measurement, and other quality improvement initiatives. Comparisons of these initiatives with other systems have been limited to small sets of indicators.

Objective: To compare the quality of VHA care with that of care in a national sample by using a comprehensive quality-of-care measure.

Design: Cross-sectional comparison.

Setting: 12 VHA health care systems and 12 communities.

Patients: 598 VHA patients and 962 patients identified through random-digit dialing. All were men older than 35 years of age.

Measurements: Between 1999 and 2000, quality was measured by using a chart-based quality instrument consisting of 346 indicators targeting 26 conditions. Results were adjusted for clustering, age, number of visits, and medical conditions.

Results: Patients from the VHA scored significantly higher for adjusted overall quality (87% vs. 51%, difference, 36 percentage points [95% CI, 14 to 18 percentage points]), chronic disease care (72% vs. 59%, difference, 13 percentage points [0.10 to 17 percentage points]), and preventive care (64% vs. 44%, difference, 20 percentage points [0.12 to 26 percentage points]), but not for acute care. The VHA advantage was most prominent in processes targeted by VHA performance measurement (86% vs. 43%).

The Veterans Health Administration: Quality, Value, Accountability, and Information as Transforming Strategies for Patient-Centered Care

Jonathan B. Perlin, MD, PhD, MSHA; Robert M. Kolodner, MD; and Robert H. Roswell, MD
Infrastructure Advantages of VA

- National systems for administrative data
- Integrated electronic health record
- Incentivized performance monitoring
- Evidence-based treatment guidelines
- QUERI
SUD QUERI Leadership

Research Coordinator – Tom Kosten
(recently succeeded John Finney)
Clinical Coordinator – Dan Kivlahan
Implementation Coordinator – Hildi Hagedorn
Executive Committee Members from Division 50
  John Finney
  Keith Humphreys
  Rudy Moos
  Jon Morgenstern
QUERI Steps

1. Select patient populations
   high prevalence / high disease burden
2. Identify E-B Guidelines/Recommendations
3. Assess Performance Gaps
4. Design/Implement Improvement Programs
5. Evaluate impact on clinical outcomes
6. Evaluate impact on health-related quality of life
## FY05 Hierarchical Categories of SUD Dx*

<table>
<thead>
<tr>
<th>Category</th>
<th>~n</th>
<th>%</th>
<th>per 1000 patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opioid Dependence</td>
<td>26,800</td>
<td>9%</td>
<td>6</td>
</tr>
<tr>
<td>SUD+Axis I MH Dx**</td>
<td>175,000</td>
<td>57%</td>
<td>36</td>
</tr>
<tr>
<td>SUD Alone</td>
<td>105,000</td>
<td>34%</td>
<td>22</td>
</tr>
<tr>
<td>Total SUD dx</td>
<td>306,800</td>
<td>100%</td>
<td>64</td>
</tr>
</tbody>
</table>

* SUD diagnoses **exclude** nicotine dependence

**Dual diagnosis = any DSM Axis I psychiatric disorder and either substance abuse or dependence
Substance Use Disorders (SUD)
Clinical Practice Guidelines
Office of Quality and Performance

Guideline Reference

<table>
<thead>
<tr>
<th>View Online</th>
<th>Download Center</th>
</tr>
</thead>
<tbody>
<tr>
<td>View Online</td>
<td>Download Center</td>
</tr>
<tr>
<td>OVERVIEW</td>
<td></td>
</tr>
<tr>
<td>Information about the SUD guideline</td>
<td></td>
</tr>
<tr>
<td>GUIDELINE</td>
<td></td>
</tr>
<tr>
<td>Complete SUD (Interactive site)</td>
<td></td>
</tr>
<tr>
<td>ALGORITHMS</td>
<td></td>
</tr>
<tr>
<td>The SUD-CPG algorithms</td>
<td></td>
</tr>
<tr>
<td>Module A - Primary Care</td>
<td></td>
</tr>
<tr>
<td>Module C - Care Management</td>
<td></td>
</tr>
<tr>
<td>Module R - Rehabilitation - Specialty Care</td>
<td></td>
</tr>
<tr>
<td>Module P - Pharmacotherapy</td>
<td></td>
</tr>
<tr>
<td>Module S - Stabilization</td>
<td></td>
</tr>
<tr>
<td>SUMMARY</td>
<td></td>
</tr>
<tr>
<td>Summary of recommendations:</td>
<td></td>
</tr>
<tr>
<td>- Primary Care</td>
<td></td>
</tr>
<tr>
<td>- Specialty Care</td>
<td></td>
</tr>
<tr>
<td>POCKET CARD</td>
<td></td>
</tr>
<tr>
<td>SUD-Pocket Cards:</td>
<td></td>
</tr>
<tr>
<td>- Primary Care</td>
<td></td>
</tr>
<tr>
<td>- Specialty Care</td>
<td></td>
</tr>
<tr>
<td>- Pharmacotherapy</td>
<td></td>
</tr>
<tr>
<td>KEY POINTS</td>
<td></td>
</tr>
<tr>
<td>The key points addressed in the SUD guideline</td>
<td></td>
</tr>
<tr>
<td>- Primary Care</td>
<td></td>
</tr>
<tr>
<td>- Specialty Care</td>
<td></td>
</tr>
<tr>
<td>REMINDERS</td>
<td>II/A</td>
</tr>
<tr>
<td>ARCHIVE</td>
<td>II/A</td>
</tr>
</tbody>
</table>
Goals of SUD QUERI

(1) Improve detection and mgmt of alcohol misuse in primary care
(2) Improve retention of patients in continuing specialty care for SUD
(3) Implement effective smoking cessation treatment
(4) Improve detection and mgmt of patients with SUDs and SUD-related co-occurring disorders seen in primary care and other medical settings

(1) infectious disease (i.e., HIV, Hepatitis C)
(2) psychiatric co-morbidity
From Guidelines to Performance Measures

- Practices recommended by VA Guidelines
- Strongest and most consistent evidence
- Documented variation from desired performance
- Measurable with explicit criteria
Goals of SUD QUERI

1. Improve detection and mgmt of alcohol misuse in primary care
2. Improve retention of patients in continuing specialty care for SUD
3. Implement effective smoking cessation treatment
4. Improve detection and mgmt of patients with SUDs and SUD-related co-occurring disorders seen in primary care and other medical settings
   - infectious disease (i.e., HIV, Hepatitis C)
   - psychiatric co-morbidity
The Spectrum of Alcohol Use

- Abstinence
- Lower risk
- Problem
- Risky
- Harmful, abuse
- Alcoholism
- Dependence

Alcohol Use Disorders

Unhealthy alcohol use
Screening Measure: AUDIT-C

1. How often did you have a drink containing alcohol in the past year?
   Never (0 points), less than monthly (1 point), 2-4 times a month (2 points), 2-3 times a week (3 points), 4 or more times a week (4 points)

2. On days in the past year when you drank alcohol how many drinks did you typically drink?
   0 drinks (0 points), 1-2 drinks (0 points), 3-4 drinks (1 point), 5-6 drinks (2 points), 7-9 drinks (3 points), ≥10 drinks (4 points)

3. How often do you have 6 or more drinks on an occasion in the past year?
   Never (0 points), less than monthly (1 point), monthly (2 points), weekly (3 points), daily or almost daily (4 points)

(Score 0-12; screen+ ≥ 4 for men; ≥ 3 women)
Alcohol Screening FY04-05
Alcohol Screening Q3 FY06
Data Source Matters

Prevalence of Screen+ (n=21 VISNs)

Patient Survey: 34% (95% CI 32-35%)
Chart review: 25% (95% CI 24-27%)

Discordance

+patient / -chart 13%
+chart / -patient 5%
Goals of SUD QUERI

(1) Improve detection and mgmt of alcohol misuse in primary care
(2) Improve retention of patients in continuing specialty care for SUD
(3) Implement effective smoking cessation treatment
(4) Improve detection and mgmt of patients with SUDs and SUD-related co-occurring disorders seen in primary care and other medical settings
(1) infectious disease (i.e., HIV, Hepatitis C)
(2) psychiatric co-morbidity
# Substance Use Disorders

## Module R: Assessment and Management in Specialty Care

![Table of Contents](#)

## Evidence Table

<table>
<thead>
<tr>
<th>Recommendations</th>
<th>Sources of Evidence</th>
<th>QE</th>
<th>R</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Indicate to the patient that treatment is effective.</td>
<td>Gerstein &amp; Harwood, 1990</td>
<td>I</td>
<td>A</td>
</tr>
<tr>
<td></td>
<td>IOM, 1990</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Respect patient preference for the initial psychosocial intervention approach.</td>
<td>Carroll &amp; Schottenfeld, 1997</td>
<td>I</td>
<td>A</td>
</tr>
<tr>
<td></td>
<td>Crites-Cristoph &amp; Siqueland, 1996</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Finney &amp; Moos, 1998</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Consider behavioral marital therapy.</td>
<td>Stanton &amp; Shadish, 1997</td>
<td>I</td>
<td>A</td>
</tr>
<tr>
<td></td>
<td>O’Farrell, 1993</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Consider cognitive-behavioral coping skills training.</td>
<td>Beck et al., 1993</td>
<td>I</td>
<td>A</td>
</tr>
<tr>
<td></td>
<td>Carroll, 1998</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Kadden et al., 1992</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Monti et al., 1989</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Meyers &amp; Smith, 1995</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Silverman et al., 1996</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Consider individual and group drug counseling.</td>
<td>Mercer &amp; Woody, 1999</td>
<td>I</td>
<td>A</td>
</tr>
<tr>
<td>7. Consider motivational enhancement.</td>
<td>Miller et al., 1992</td>
<td>I</td>
<td>A</td>
</tr>
<tr>
<td>8. Consider Twelve-Step facilitation training.</td>
<td>Nowinski et al., 1992</td>
<td>I</td>
<td>A</td>
</tr>
<tr>
<td></td>
<td>Ouimette et al., 1997</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tonigan et al., 1996</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Emphasize retention in formal treatment or community support.</td>
<td>Finney &amp; Moos, 1998</td>
<td>I</td>
<td>A</td>
</tr>
<tr>
<td></td>
<td>Simpson, 1997</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Promote active involvement in Twelve-Step programs.</td>
<td>Humphreys, 1999</td>
<td>II-2</td>
<td>A</td>
</tr>
</tbody>
</table>

*QE = Quality of Evidence; R = Recommendation (See Introduction)*
Initiate Psychosocial Treatment

Focus on promoting initial engagement and maintaining retention over time.

This includes attention to appropriate housing and access to treatment.
3-Month Treatment Retention

% Continuity

FY03 | FY04 | FY05 | FY06
--- | --- | --- | ---
30 | 30 | 30 | 30

FY03 | FY04 | FY05 | FY06
Treatment Retention Variation Remains

FY06 YTD
Lessons Learned

- Top down *and* bottom up
- Local latitude on “how” – customizing
- Measure carefully
  - Unintended consequences
  - Gaming
Challenges

- Funding implementation
  - Mixed research/management review panels
  - Balance rigor and relevance
- Career path for junior colleagues?
- Identifying “essential components”
  - Mechanisms of behavior change
- Integrated care vs. condition specific
- Sustainability
  - Workload limits – panel sizes
2 Simple principles

(1) Clear and accurate feedback on performance

(2) Accessible guidance from a supervisor/coach with greater expertise and proficiency

Miller, Sorensen, Selzer, Brigham. JSAT, 2006;21:25-39