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## **Developing Performance Measures for Alcohol and Other Drug Services in Managed Care Plans**

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## Abstract

**Background:** Monitoring the quality and availability of alcohol and other drug services must be a central tenet of any health-related performance measurement system. The Washington Circle Group has developed a core set of performance measures for alcohol and other drug services for public- and private-sector health plans. It also is collaborating with a broad range of stakeholders to ensure widespread adoption of these performance measures by health plans, private employers, public payers, and accrediting organizations.

**Core Performance Measures:** Four domains were identified with specific measures developed for each domain: 1) prevention/education, 2) recognition, 3) treatment (including initiation of alcohol and other plan services, linkage of detoxification and alcohol and other drug plan services, treatment engagement, and interventions for family members/significant others) and 4) maintenance of treatment effects.

**Conclusions:** Performance measures for alcohol and other drugs need to become an integral part of a comprehensive set of behavioral and physical health performance measures for managed care plans.

Addiction is a treatable condition with expectations of success as positive as for other chronic diseases such as diabetes, hypertension, and asthma.<sup>1</sup> Yet, until now, performance measures which have been developed, tested, and used across the nation for medical and mental health services have not been applied for alcohol and other drug services. The Washington Circle Group, whose activities are the subjects of this paper, has begun to fill that gap.

## The Washington Circle Group

As members of the Washington Circle Group (WC), we have joined to share our expertise in alcohol and other drug (AOD) disorders, managed care, and performance management, seeks to improve the quality and effectiveness of AOD prevention and treatment services through the use of performance measurement systems. Our group was convened by the Center for Substance Abuse Treatment (CSAT) Office of Managed Care in March, 1998, and has set two major goals:

- ✚ Develop and pilot-test a core set of performance measures for AOD services for public- and private-sector health plans.
- ✚ Collaborate with a broad range of stakeholders to ensure widespread adoption of AOD performance measures by health plans, private employers, public payers, and accrediting organizations.

The development of performance measures for AOD services is a complex task for several reasons. AOD disorders often manifest as a range of physical and psychological conditions that require their own treatment or intervention; however, they often go

unrecognized and unaddressed in health care settings. Furthermore, many individuals with AOD disorders may minimize the role of alcohol and drug use in their health problems. The illegal nature and stigma of drug use may further inhibit those with the disorder from revealing their problems to their health care provider. Nevertheless, alcohol and drug abuse disorders, once identified, can be successfully treated.

The focus of the WC's efforts is the development of performance measures to track the activities of managed care organizations to prevent, recognize, and treat AOD disorders. We are working with others in the AOD and mental health fields who are developing and implementing performance measures. Through collaboration and dialogue, the WC is building upon existing performance monitoring systems and data sets to ensure more efficient measurement of AOD services.

## Scope of the Problem

AOD disorders exact a terrible toll on individuals and their families, employers, health care providers and payers, the economy, and society at large. Though AOD disorders are readily treatable, most individuals are not getting help.<sup>2</sup>

According to the 1998 National Household Survey on Drug Abuse, conducted by the Substance Abuse and Mental Health Services Administration (SAMHSA),<sup>3</sup> an estimated 14 million Americans over the age of 12 were current users of illicit drugs. About 4 million people met diagnostic criteria for dependence on illicit drugs, including 1 million youth ages 12-17.

Of 113 million Americans ages 12 and older who reported alcohol use in 1998, 33 million engaged in binge drinking and 12 million were classified as heavy drinkers. Nearly 50 percent of underage drinkers (ages 12-20) engaged in binge drinking, and 22 percent were classified as heavy drinkers.

The economic impact of AOD disorders is staggering. In 1995, total costs for AOD abuse were estimated at \$277 billion (\$167 billion for alcohol abuse and \$110 billion for drug abuse).<sup>4</sup> Only 12 percent of these costs were directly related to the cost of treatment. The bulk of the costs was due to additional law enforcement expenditures, AOD-related crime, and lost productivity.

But numbers alone do not tell the complete story. People with AOD disorders often have multiple and complex health and social problems. Co-morbid mental and physical health disorders are common. Suicide, infectious diseases, domestic violence, and child abuse further complicate the picture.

Though AOD disorders are frequently chronic, relapsing conditions, they are readily identifiable and eminently treatable. Research studies have consistently demonstrated the overall effectiveness of AOD treatment in reducing substance use and in improving patient functioning in the family, workplace, and community.<sup>5,6,7</sup> (For a current review of the topic, see *Principles of Drug Addiction Treatment: A Research-Based Guide*, NIDA,

1999.<sup>8</sup> AOD treatment has been found to be as effective as treatments for other complex, chronic illnesses.<sup>1</sup> Only a quarter of the adults diagnosed with chemical dependency, however, receive any treatment at all.<sup>9</sup>

## Mission and Values Statement

From its inception, the WC has developed and refined a set of Value Statements on the provision of care to persons with AOD disorders. A Mission Statement, which incorporates the WC's approach to performance measurement, also has been adopted. The Mission Statement builds upon the earlier work of other performance measures workgroups in the field of AOD disorders, who also recognized that any true measurement of performance must cover all domains in the process of care.

The Value Statements and the Mission Statement have been used to inform the development and selection process of the core measures in this document.

### Mission

*“There is a clear need to promote quality and accountability in the delivery and management of alcohol and other drug abuse services by organized systems of care, both public and private. The WC believes that this is best accomplished through adopting a process of care model and defining a set of measures for each domain within that model. Moreover, the WC believes that accountability for AOD services is best achieved when system performance is compared across all domains of the process of care. The WC is committed to developing evidence-based measures that allow for such comparison.”*

### Value Statements

✚ **Treatment is essential.** People with AOD disorders suffer from conditions that are frequently chronic and relapsing in nature, readily identifiable, and eminently treatable. They should receive professional care for these conditions in a timely and respectful fashion and this professional care should be followed with continuing support through Alcoholics Anonymous (AA), Narcotics Anonymous (NA) or other community support organization.

✚ **Recognition is a key first step.** AOD disorders often go unrecognized and untreated in health care settings. Identifying people in need of AOD services and providing them with access to appropriate care are “first order” responsibilities of managed care organizations.

✚ **Comprehensive treatment is critical to recovery.** People with AOD disorders deserve to have the full range of evidence-based treatment options available to them, including pharmacotherapies and residential care. Self-help and peer support such as provided through AA/NA, although an important component of a comprehensive

treatment plan, is not a substitute for needed treatment delivered by properly trained clinicians.

✚ **Support services for family members are crucial.** Family members of individuals with AOD disorders are often at increased risk for AOD abuse and other problems. Support services to family members are an important component of treatment for the affected individual.

✚ **Quality AOD care yields multiple benefits.** Monitoring the quality and availability of AOD services must be a central tenet of any health-related performance measurement system, because the benefits of quality AOD care accrue not only to the individual and family in need, but to the broader community as well, in terms of improved public health and safety and reduced social welfare costs.

## Framework for Developing Core Measures

### Measurement for External Accountability

The WC's goal is to develop performance measures for the purpose of external accountability. Historically, accrediting bodies and regulatory agencies responsible for ensuring external accountability examined descriptive documentation of health care system structure and process. More recently, performance measurement has become a preferred means of ensuring external accountability.

Measurement for external accountability examines the extent to which a health care system meets a pre-existing, agreed upon standard. As the principal audience for this information, purchasers, payers, and health care consumers use performance measures to compare across different health care organizations. The focus of accountability measurement is on the outputs or results of health care delivery, and does not address how these outputs are achieved or how internal processes need to be changed to improve output.<sup>10</sup> Other approaches to questions of quality and accountability (e.g., quality improvement) may examine and measure the internal processes of production to improve output. Although the core set of measures presented in this document may prove useful in these activities, their primary purpose is to promote external accountability and compare the performance of health care systems.

### Accountability for the Process of Care

To develop effective performance measures that gauge external accountability in AOD services, the WC has considered both whom should be held accountable for such measurement and for what they should be held accountable. Specifically, the WC believes that responsibility for performance measurement rests at the service delivery level, and that organized delivery systems (e.g., managed care plans) should be held accountable for the entire process of care for people with AOD disorders.

**Accountability at the Delivery System Level.** With the major transformations that have occurred in the behavioral health care marketplace, it is clear that responsibility for treatment planning and implementation no longer involves only the clinician and the patient. Health plans, managed behavioral health care organizations, and other forms of organized delivery systems (such as the criminal justice system or social service system) play a significant role in the decisions about what treatment is provided, to whom, and for how long. Moreover, delivery systems have authority over defined populations and all the resources allocated to those populations. With this authority comes responsibility and accountability for performance measurement.

**Accountability for the Entire Process of Care.** The WC believes it is insufficient to hold delivery systems accountable only for AOD services delivered within a particular episode of care. The chronic, relapsing nature of this disorder argues for a system of accountability beyond the confines of a discrete treatment episode. Indeed, how individuals manage their recovery following a particular episode of care is as important to their long-term success as the delivery of the care itself. This has been shown to be true in the treatment and management of other chronic disorders as well. Consequently, how a system of care organizes its services to support individuals' post-treatment sobriety is an important indicator of performance. Furthermore, there is convincing evidence that early recognition and timely prevention and intervention can positively affect the course of an individual's problem with alcohol and other drugs. Organized systems of care must be held accountable for its members through the entire process of care<sup>3/4</sup>from prevention and early recognition services through treatment and post-treatment activities<sup>3/4</sup>if a true measure of their performance is to be realized.

There are several justifications for broadening the base of accountability in the area of AOD treatment. First, responsible stewardship for public and private dollars requires that the impact of these resources be monitored and maximized. To concentrate on only a small segment of the process of care for people with AOD disorders would ignore the body of knowledge that has been developed over the last 25 years about the importance of each phase of that care in achieving positive outcomes for people with AOD problems.

To hold delivery systems clinically accountable for coordination and oversight of the entire care process does not necessarily imply that they must pay for all the care and services provided. They are responsible, however, for assuring that all the required components of the process of care occur with reasonable efficiency and effectiveness over time.

## Underlying Assumptions

In developing its approach to performance measurement, the WC made three assumptions:

**+ Available data collection approaches.** Measures were identified for which data are available in existing administrative data systems or through currently planned consumer surveys. This design decision parallels that for medical and mental health services.

Currently, managed care plans use their administrative data systems to calculate many rate-based HEDIS measures (rate of follow-up visits after hospitalization for depression, for example) and developers of the Experience of Care and Health Outcomes (ECHO) survey, which includes questions for two of the WC measures, are suggesting that it be fielded using a similar protocol to that for the commonly used Consumer Assessment of Health Plan (CAHPS™).

✚ **Initial focus on process measures.** Assessing reduction in the use of alcohol and drugs and their related problems is the ideal standard by which the performance of a substance abuse program can be measured. Due to existing limitations in the science and availability of appropriate databases for outcome measures, however, such assessment of treatment outcomes is not financially or technically feasible for most systems at the present time. Therefore, as an intermediate approach, the WC targeted a set of process measures that research has shown to be related to treatment outcomes. As the field of performance measurement evolves, outcome measures will be added to the core set as well.

✚ **Links to the accreditation process.** Data for some measures identified as important to the process of care framework, e.g., screening, cannot be obtained through current administrative data systems or through patient self-report. Although identification rates, which imply a screening or identification process, can be measured, it is not feasible at present to measure directly important clinical areas such as screening or multidisciplinary treatment planning. Therefore, the WC recommends that the accreditation process incorporate some of these clinical and organizational areas as standards.

## Core Performance Measures

We propose the following seven measures as its initial core set for comparing systems' performance in the delivery of AOD services to adults. These measures fit into four domains representing the continuum of AOD services<sup>3/4</sup>prevention/education, recognition, treatment, and maintenance. Not singularly applied to alcohol and other drug services, these domains are comparable to those used in the management of other chronic illnesses. The four domains and seven measures are listed in the table below.

✚ **Prevention/Education.** This domain encompasses delivery system activities designed to raise the general awareness of substance abuse as a major debilitating disorder affecting individuals, families, and the greater society. Also included are those activities designed to target high-risk individuals and groups for more focused interventions.

✚ **Educating Patients about AOD Disorders.** Percentage of adult patients with primary care visits who are advised or given information about AOD disorders.



✚ **Recognition.** This domain addresses the plan's efforts, in all clinical settings, at case-finding, including screening and assessment. It also includes referral of affected individuals into treatment.

✚ **Identification Rates.** Number of cases per 1,000 members who were diagnosed with AOD abuse or dependence or who received AOD-related plan services on an annual basis.

✚ **Treatment.** This domain encompasses the delivery system activities associated with the rehabilitation of individuals who have a substance abuse disorder diagnosis. This includes a broad range of services associated with an episode of care, including medications, testing, counseling, medical services, psychiatric and psychological services, social services, and coordination with other treatment resources. Detoxification and emergency room care may be viewed as the initiation of a treatment episode but do not by themselves constitute treatment for AOD disorders. In turn, AA/NA and other community support fellowships are clearly important for the continuation of treatment-initiated sobriety and social function. However, by their own charters, AA/NA are not structured to provide professional services that are so often needed to stabilize psychologically and emotionally unstable patients, nor to address the complications of addiction that can interfere with behavioral change.

✚ **Initiation of AOD Plan Services.** Percentage of individuals with an index diagnosis of AOD abuse or dependence who receive any additional AOD services within 14 days.

✚ **Linkage of Detoxification and AOD Plan Services.** Percentage of patients with an index detoxification who initiated AOD plan services within 14 days following detoxification.

✚ **Treatment Engagement.** Percentage of clients diagnosed with AOD disorders that receive three plan-provided AOD services within 30 days of the initiation of care.

✚ **Interventions for Family Members/Significant Others of AOD Clients in Treatment.** Percentage of survey respondents who report using AOD services and who also report that their family member/significant other received preventive interventions.

✚ **Maintenance.** This domain includes those delivery system activities related to sustaining long-term positive outcomes. Included are such areas as self management and peer support strategies to sustain post-treatment abstinence or reduction in use, improvements in role functioning and well being, and lifestyle changes.

✚ **Maintenance of Treatment Effects.** Percentage of clients who report specific services provided and/or monitored by the plan to promote and sustain positive treatment outcomes post-discharge.

## Rationale and Evidence Base for Core Measures

For each core measure, a rationale of its importance and a summary of the supporting literature are presented. Of course, all of the activities we include should be tailored to the needs of the particular patient. Moreover, this core set describes a the floor set of activities that all plans should be striving for in identifying and treating their members with alcohol or other drug problems.

### Prevention/Education

***Educating Patients about AOD Disorders.*** Percentage of adult patients with primary care visits who are advised or given information about AOD disorders.

The provision of general medical care is an excellent opportunity to address issues of alcohol and/or drug abuse. As with other chronic conditions,<sup>11,12</sup> patient education is an important aspect of prevention. Plans should ensure that primary care providers (1) address issues of the use of alcohol and other drugs, either as part of an interview or health risk appraisal, through the distribution of print materials, or as part of other contacts with enrollees; (2) provide information and/or guidance regarding moderate use of alcohol and the risks involved in using other drugs; and (3) recommend follow-up actions when indicated. This measure will permit evaluations of AOD educational efforts in primary care settings.

### Recognition

***Identification Rates.*** Number of cases per 1,000 members who were diagnosed with AOD abuse or dependence or who received AOD-related plan services on an annual basis.

AOD disorders and their associated health problems lead to social and family disruption, as well as to increased medical utilization and costs. Therefore, it is important that managed care plans identify cases among their enrollees and refer them to treatment.

If health plans conducted screening and case finding activities, including the use of validated brief questionnaires, they could identify members with AOD disorders and encourage these individuals to get further help. These activities can also take place in a broad range of settings including emergency rooms, mental health treatment facilities, medical practices (e.g. obstetrics/gynecology, adolescent medicine, or general medicine), and welfare agencies.<sup>13</sup>

By calculating the rate of AOD claims per 1,000 members, and comparing it to current population estimates, this measure will show how successful plans are over time in identifying members who need AOD services. One source of comparison is the regional estimates (and in future years, state-level estimates) included in the *National Household Survey On Drug Abuse*.<sup>3</sup>

## Treatment

***Initiation of AOD Plan Services.*** Percentage of individuals with an index diagnosis of an AOD abuse or dependence who receive any additional AOD services within 14 days.

Studies indicate that only a small fraction of the population with AOD disorders enters treatment.<sup>14</sup> Identification of individuals with AOD disorders is an important first step in the process of care, but one that does not routinely lead to initiation of treatment. Plans must also ensure that individuals with an AOD diagnosis initiate treatment. This measure will permit the comparison of plans' effectiveness in initiating care after the need has been identified by a formal diagnosis of abuse or dependence.

There are many reasons why individuals who are diagnosed with an AOD disorder do not initiate treatment. The primary care provider may avoid confronting the patient due to the stigma associated with AOD disorders, or when a referral is made to AOD treatment, the provider may not always follow through to see if the patient began treatment.<sup>15</sup> In other cases, individuals who were appropriately referred may choose not to enter treatment. Some individuals may still believe that they can control their substance use or deny that there is a problem.<sup>16,17,18</sup> Studies indicate that a lack of "immediately available" treatment services may also pose a barrier to treatment initiation. In one study, a majority of individuals on a waiting list (52 percent) reported that their interest in entering treatment had decreased since they were placed on the list.<sup>19</sup>

***Linkage of Detoxification and AOD Plan Services.*** Percentage of patients with an index detoxification who initiated AOD plan services within 14 days following detoxification.

Detoxification is a medical intervention that manages an individual safely through the process of acute withdrawal. The goals of detoxification are fairly limited. A detoxification program is not designed to resolve the long-standing psychological, social, and behavioral problems associated with alcohol and drug abuse. Detoxification is most effective when it is viewed as a first step to active treatment and is followed by assessment and referral to ongoing alcohol or drug treatment.<sup>8</sup> Without linkage to treatment after detoxification, research has found no significant improvements that are discernable from untreated withdrawal.<sup>1,20,21</sup> This measure will permit evaluation of how often plans successfully link clients to treatment following detoxification.

Detoxification offers an opportunity to recruit clients into treatment; however, the overall completed referral rates are unacceptably low. Discharge data from the 1980 CODAP report indicated that only 14 percent of clients detoxifying from opiates were transferred or referred into treatment. There is also significant variation across the country in successfully linking detoxification clients to treatment. Of the 62 reporting areas, 12 had a transfer/referral rate lower than 5 percent, and only 14 areas had rates greater than 25 percent.<sup>21</sup> More recent data from the period 1991 and 197 from 14 employer groups whose behavioral healthcare benefits are managed by United Behavioral Health showed that 79 percent of patients received formal substance abuse treatment following inpatient detoxification, the majority within one week.<sup>22</sup>

***Treatment Engagement.*** Percentage of clients diagnosed with AOD disorders that receive three plan-provided AOD services within 30 days of the initiation of care.

Engagement in treatment is critical for treatment effectiveness. Treatment engagement is defined as an “intermediate” step between initially accessing care (in a first visit) and completing a full course of treatment. (As noted earlier, detoxification alone does not constitute treatment.) Studies of treatment retention indicate that patients who remain in treatment for a longer duration of time have better outcomes.<sup>5,23,24</sup> However, studies indicate that many clients with substance use disorders leave treatment prematurely. The 1990 Drug Services Research Survey,<sup>25</sup> a study of the drug treatment facilities across the nation, reported that 52 percent of clients who entered treatment did not complete the planned course of treatment. Given the positive association between retention and treatment success, a plan’s ability to engage clients in treatment is an important intermediate measure that is closely related to outcomes.

A review of length of stay studies found that the length of time in treatment is related to post-treatment reduction in drug use, reduced criminal activity, and improved employment status.<sup>26</sup> Studies of alcohol-dependent clients have shown that longer stays in treatment and treatment completion are associated with greater reduction in alcohol use even after controlling for severity at admission.<sup>24</sup> Thus, treatment engagement is positively associated with positive treatment outcomes. Furthermore, intensity of engagement, as measured by how frequently the client attends sessions and how many types of services are provided during treatment, is important to engagement and to treatment outcomes.<sup>24,27,28,29</sup> Engagement in treatment also is important to the reduction of risk for drug-related illnesses.<sup>4,30,31</sup>

It may be asked why simple referral to AA or NA support instead of treatment has been considered not responsive to the treatment engagement criterion. While AA/NA and other community support organizations are essential for the continuation and maintenance of gains following treatment interventions, there are two major reasons why AA/NA by itself cannot be considered treatment. First, these organizations do not consider themselves treatments but rather “support fellowships.” Second, since there are (purposely) no records of activity or even attendance at AA/NA meetings, there is (purposely) no way to monitor patient activity in these organizations. Thus for both conceptual and procedural reasons, referral to AA/NA sessions not accompanied by formal treatment services is not considered responsive to the treatment engagement criterion. However, referral to AA/NA is considered responsive to the Maintenance criterion (see below).

***Interventions for Family Members/Significant Others of AOD Clients in Treatment.*** Percentage of survey respondents who report using AOD services and who also report that their family member/significant other received preventive interventions.

The involvement of family members in the treatment process may be crucial to long-term success because of its effects on the patient and the family in dealing with AOD-related problems. Family members are subject to a host of negative consequences from a

member's alcohol and drug abuse such as lost wages, domestic violence, depression, and inappropriate role modeling for children. For example, research has documented that children of individuals with AOD disorders are more at risk than their peers for alcohol and drug use.<sup>32,33,34</sup> Consequently, interventions for family members are an important addition to the support, education, and counseling provided to the client. This measure is focused on plans' efforts to include family members of individuals undergoing treatment for AOD disorders.

## Maintenance

***Maintenance of Treatment Effects.*** Percentage of clients who report specific services provided and/or monitored by the plan to promote and sustain positive treatment outcomes post-discharge.

As with other chronic disorders, substance abuse requires continued engagement of the patient in psychosocial and/or pharmacological services to maintain the patient's gains after the completion of treatment.<sup>1,35</sup> Thus, plans' activities to maintain their members' recovery after treatment is an important domain to measure.

For many patients, successful recovery post-discharge involves the utilization of self-management strategies and self-help groups such as AA or NA. Self-management strategies include a range of services provided by the treatment program during and immediately following discharge, including referral to AA/NA, relapse prevention training and, follow-up calls/monitoring, etc. Indeed, use of self-help groups and such follow-up techniques as phone calls or reminder letters have been shown to be effective.<sup>36,37,38</sup> Relapse prevention focuses on helping the client to identify high-risk or "trigger" situations that contribute to relapse, and has been shown to be effective for people with AOD disorders.<sup>39</sup> Relapse prevention strategies can help the client develop behaviors to avoid or better manage high-risk situations.<sup>40</sup> Other services which assist in maintaining treatment effects include training in the use of family support mechanisms, coping skills, and employment counseling.

## Continuing Efforts

### Piloting and Testing of Initial Core Set

Pilot testing is being conducted on two parallel tracks. First, the four measures that are based on administrative information from health plans are being calculated using a common set questions and programming instructions across a range of settings including a Medicaid plan that carves out behavioral health services to a managed care vendor, a large group model Health Maintenance Organization, and a major specialty behavioral healthcare vendor. In each setting, the goals of the initial testing are to explore the measurement feasibility, to test the sensitivity of the measures to alternate specifications, and to compare results across plans and with statistics published in the literature. In addition, members of the Washington Circle Group are planning ways to incorporate further validity testing into their ongoing or new research projects.

Second, the two measures that require a consumer survey of behavioral healthcare are being tested as part of the overall testing of the Experience of Care and Health Outcomes (ECHO) survey. Earlier versions of the survey were field tested with 7,000 consumers of behavioral healthcare in five public assistance and five commercial health insurance plans.<sup>41,42</sup> The team of investigators at Harvard Medical School and the Center for Survey Research, University of Massachusetts at Boston, are conducting cognitive testing and pilot tests of the current version with 750 members of public and private health insurance products managed by a behavioral health care organization. They plan to continue their development efforts using a revised version of the survey with approximately 20,000 commercially and publicly insured members of 20 different health insurance plans and managed behavioral health care organizations across the United States with results of the field tests expected to be available by the end of December, 2000.

## Adoption of Additional Measures

In developing its core set of measures, the WC sought to identify candidate measures that had a strong evidence base and that covered the domains of the process of care for addictive disorders. Moreover, the group decided to include only those measures that could be captured from existing administrative data systems or from a consumer survey method. From the WC's perspective, it is essential that national accrediting bodies and plans begin to monitor the delivery of AOD services and compare the performance of managed care plans sooner rather than later.

Given these criteria, several measures across all domains were deferred for development at a future time. Specifically, a recognition measure of co-occurring mental health and addictive disorders and a treatment measure on the use of laboratory tests (such as urinalysis) and medication in treatment were deferred. Other measures of interest included a treatment measure on the reduction of substance use among pregnant women, and a maintenance measure on sustained reductions in substance use post-discharge. As a clearer picture of the performance of managed care plans emerges from the use of the initial core set, the WC hopes to add these and additional measures to its menu of measures. Moreover, as research into the nature and treatment of addictive disorders yields new insights, other measures will be considered for development by the WC.

## Dissemination

The Washington Circle Group also has reached out to a broad range of stakeholders in performance measurement and managed care to acquaint them with the measures and to promote their investigation and adoption. Members of the group have made presentations at the American College of Mental Health Administration (3/99), the annual meeting of the American Public Health Association (11/1999), and the Maryland Task Force to Develop Performance Quality Measures for Managed Behavioral Health Care Organizations (10/1999). In addition, we have initiated discussions with the national accrediting organizations beginning with a presentation to the Behavioral Health Measurement Advisory Panel (BMAP) of the National Committee on Quality Assurance (NCQA). The measures are cited in an inventory of quality measures in behavioral

health care that will soon be available on the web.<sup>43</sup> Moreover, the WC measures relate clearly to Section I of the JCAHO 1999-2000 Accreditation Manual for Behavioral Health Care.<sup>44</sup> The measures focus on assessment, treatment, education, and the continuum of care. If implemented in full they also serve as the basis for continuously analyzing and improving organizational performance of clinical and other processes (Section 2); and for benchmarking the organization's performance against other organizations. Finally, we have earned endorsement from the American Society on Addiction Medicine (ASAM). As results of pilot testing become available, these outreach efforts will continue.

## Conclusion

The WC remains committed to pursuing all promising avenues for developing AOD performance measures. In doing so, we will continue to be guided by our vision of advancing quality and accountability in AOD services through the development and application of evidence-based performance measures across all domains of the process of care. We will have reached our goal when the performance measures for alcohol and other drugs are an integral part of a comprehensive set of behavioral and physical health performance measures for managed care plans.