Title: Inconsistencies in self-reported drug use by adolescents in substance abuse treatment: Implications for outcome and performance measurements.
Authors: Harris, K. M.; Griffin, B. A.; McCaffrey, D. F.; & Morral, A. R.
Source: Journal of Substance Abuse Treatment, 34(3), Apr 2008, pp. 347-355

This article presents an analysis of logical inconsistencies in adolescents' reporting of recent substance use to assess the potential effect of inaccurate reporting on measures of treatment outcomes and program performance. We used data on 1,463 clients from 10 adolescent treatment programs to assess the relationship between inconsistent reports and various factors that contribute to program assignment and treatment outcomes. Our results suggest that inconsistencies do not arise at random. Instead, inconsistencies are associated with program assignment and factors widely considered to influence treatment outcomes, including age at first use, living situation, race/ethnicity, and mental distress. We also found a positive relationship between level of inconsistent reporting of drug use and self-reports of improvement over time on several well-established treatment outcome measures. Our study highlights the need for greater awareness on the potential impact of inaccuracies in the reporting of substance use on outcome and performance measurements and that for the development of methodologies to improve accuracy.

Title: Interventions in organizational and community context: A framework for building evidence on dissemination and implementation in health services research.
Author: Mendel, P.; Meredith, L. S.; Schoenbaum, M.; Sherbourne, C. D.; Wells, K. B.
Source: Administration and Policy in Mental Health and Mental Health Services Research. Special Issue: Improving mental health services, 35(1-2), Mar 2008, pp. 21-37.

The effective dissemination and implementation of evidence-based health interventions within community settings is an important cornerstone to expanding the availability of quality health and mental health services. Yet it has proven a challenging task for both research and community stakeholders. This paper presents the current framework developed by the UCLA/RAND NIMH Center to address this research-to-practice gap by: (1) providing a theoretically-grounded understanding of the multi-layered nature of community and healthcare contexts and the mechanisms by which new practices and programs diffuse within these settings; (2) distinguishing among key components of the diffusion process--including contextual factors, adoption, implementation, and sustainment of interventions--showing how evaluation of each is necessary to explain the course of dissemination and outcomes for individual and organizational stakeholders; (3) facilitating the identification of new strategies for adapting, disseminating, and implementing relatively complex, evidence-based healthcare and improvement interventions, particularly using a community-based, participatory approach; and (4) enhancing the ability to meaningfully generalize findings across varied interventions and settings to build an evidence base on successful dissemination and implementation strategies.

Title: Driving with roadmaps and dashboards: Using information resources to structure the decision models in service organizations.
Authors: Chorpita, B. F.; Bernstein, A.; Daleiden, E. L.
Source: Administration and Policy in Mental Health and Mental Health Services Research. Special Issue: Improving mental health services, 35(1-2), Mar 2008, pp. 114-123.

This paper illustrates the application of design principles for tools that structure clinical decision-making. If the effort to implement evidence-based practices in community services organizations is to be effective, attention must be paid to the decision-making context in which such treatments are delivered. Clinical research trials commonly occur in an environment characterized by structured decision making and expert supports. Technology has great potential to serve mental

health organizations by supporting these potentially important contextual features of the research environment, through organization and reporting of clinical data into interpretable information to support decisions and anchor decision-making procedures. This article describes one example of a behavioral health reporting system designed to facilitate clinical and administrative use of evidence-based practices. The design processes underlying this system--mapping of decision points and distillation of performance information at the individual, caseload, and organizational levels--can be implemented to support clinical practice in a wide variety of settings.

Title: Applying the institute of medicine quality chasm framework to improving health care for mental and substance use conditions.
Author: Keyser, D.J.; Houtsinger, J. K.; Watkins, K.; Pincus, H. A.
Source: Psychiatric Clinics of North America, 31(1), Mar 2008, pp. 43-56.

This article describes the two major phenomena that shaped the overall findings of the Institute of Medicine report Improving the Quality of Health Care for Mental and Substance Use Conditions and that informed its overarching recommendations. These phenomena are (1) the co-occurrence of mental health, substance use, and general health conditions; and (2) differences in the delivery of services for mental health/substance use and general health care. It describes efforts currently underway that address these differences and might significantly improve delivery and outcomes of mental health/substance use services.

Title: Changing mental health gatekeeping: Effects on performance indicators.
Authors: Merrick, E. L.; Hodgkin, D.; Horgan, C. M.; Garnick, D. W.; McLaughlin, T. J.
Source: The Journal of Behavioral Health Services Research, 35(1), Jan 2008, pp. 3-19.

This study evaluated how a change in gatekeeping model at a health maintenance organization affected performance indicators for specialty outpatient mental health care. Gatekeeping in one division changed from in-person evaluations to a call center with routine authorization for the first eight visits. Using 1996-1999 claims data (including 2 years pre- and 2 years post-intervention), the study compared performance indicator results in the affected division and another where the model did not change. Subjects included 122,751 continuously enrolled persons. Dependent variables were mental health emergency room use, treatment initiation, treatment engagement, and family treatment for child patients. After controlling for secular trends at the other division and enrollee characteristics, the division that changed gatekeeping experienced no significant impact on most indicators and an increase in family treatment for children. The move to call-center gatekeeping did not appear to have a negative impact on treatment process as reflected in these indicators.

Title: Veterans affairs facility performance on Washington Circle indicators and casemix-adjusted effectiveness.
Authors: Harris, A. H. S.; Humphreys, K.; Finney, J. W.
Source: Journal of Substance Abuse Treatment, 33(4), Dec 2007, pp. 333-339.

Self-administered Addiction Severity Index (ASI) data were collected on 5,723 patients who received substance abuse treatment in 1 of 110 programs located at 73 Veterans Affairs facilities. The associations between each of three Washington Circle (WC) performance indicator scores (identification, initiation, and engagement) and their casemix-adjusted facility-level improvement in ASI drug and alcohol composites 7 months after intake were estimated. Higher initiation rates were not associated with facility-level improvement in ASI alcohol composite scores but were modestly associated with greater improvements in ASI drug composite scores. Identification and engagement rates were unrelated to 7-month outcomes. WC indicators focused on the early stages of treatment may tap necessary but insufficient processes for patients with substance use

disorder to achieve good posttreatment outcomes. Ideally, the WC indicators would be supplemented with other measures of treatment quality.

Title: Are Washington Circle performance measures associated with decreased criminal activity following treatment?.
Authors: Garnick, D. W.; Horgan, C. M.; Lee, M. T.; Panas, L.; Ritter, G. A.; Davis, S.; Leeper, T.; Moore, R.; Reynolds, M.
Source: Journal of Substance Abuse Treatment, 33(4), Dec 2007, pp. 341-352.

This study examines the association between adherence to during-treatment process measures of quality (defined as initiation and engagement in treatment as developed by the Washington Circle) and outcome measures (defined as arrests and incarcerations) in the following year. The data come from the Oklahoma Department of Mental Health and Substance Abuse Services administrative data system linked to data from state criminal justice agencies. Clients who initiated a new episode of outpatient treatment and who engaged in treatment were significantly less likely to be arrested or incarcerated in the following year. Initiation of substance abuse treatment alone, without engagement in treatment, was not significantly associated with arrests or incarcerations. These findings validate the clinical importance of the Washington Circle performance measures of initiation and engagement. Applying the "process-of-care" measures can make a difference when they are used as a target for quality improvement in treatment facilities.

Title: Performance measurement for systems treating alcohol and drug use disorders.
Author: McCarty, D.
Source: Journal of Substance Abuse Treatment, 33(4), Dec 2007, pp. 353-354.

Comments on the original articles "Veterans Affairs facility performance on Washington Circle indicators and casemix-adjusted effectiveness," by A. H. S. Harris, K. Humphreys, and J. W. Finney (see record 2007-17867-003) and "Are Washington Circle performance measures associated with decreased criminal activity following treatment?" by D. W. Garnick, C. M. Horgan, M. T. Lee, et al (see record 2007-17867-004). While offering different perspectives on building and using performance measurement systems, both articles illustrate information system strategies and provide examples of innovative performance measures and outcomes monitoring systems.

Title: A feasibility study of a web-based performance improvement system for substance abuse treatment providers.
Authors: Forman, R.; Crits-Christoph, P.; Kaynak, Ö.; Worley, M.; Hantula, D. A.; Kulaga, A.; Rotrosen, J.; Chu, M.; Gallop, R.; Potter, J.; Muchowski, P.; Brower, K.; Strobbe, S; Magruder, K.; Chellis, A. H.; Clodfelter, T.); Cawley, M.
Source: Journal of Substance Abuse Treatment, 33(4), Dec 2007, pp. 363-371.

We report here on the feasibility of implementing a semiautomated performance improvement system--Patient Feedback (PF)--that enables real-time monitoring of patient ratings of therapeutic alliance, treatment satisfaction, and drug/alcohol use in outpatient substance abuse treatment clinics. The study was conducted in six clinics within the National Institute on Drug Abuse Clinical Trials Network. It involved a total of 39 clinicians and 6 clinic supervisors. Throughout the course of the study (consisting of five phases: training period [4 6weeks], baseline [4 weeks], intervention [12 weeks], postintervention assessment [4 weeks], sustainability [1 year]), there was an overall collection rate of 75.5% of the clinic patient census. In general, the clinicians in these clinics had very positive treatment satisfaction and alliance ratings throughout the study. However, one clinic had worse drug use scores at baseline than other participating clinics and showed a decrease in self-reported drug use at postintervention. Although the implementation of the PF system proved

to be feasible in actual clinical settings, further modifications of the PF system are needed to enhance any potential clinical usefulness.

Title: Measuring performance of brief alcohol counseling in medical settings: A review of the options and lessons from the veterans affairs (VA) health care system.
Authors: Bradley, K. A.; Williams, E. C.; Achtmeyer, C. E.; Hawkins, E. J.; Harris, A. H. S.; Frey, M. S.; Craig, T.; Kivlahan, D. R.
Source: Substance Abuse, 28(4), Dec 2007, pp. 133-149.

Brief alcohol counseling is a top US prevention priority but has not been widely implemented. The lack of an easy performance measure for brief alcohol counseling is one important barrier to implementation. The purpose of this report is to outline important issues related to measuring performance of brief alcohol counseling in health care settings. We review the strengths and limitations of several options for measuring performance of brief alcohol counseling and describe three measures of brief alcohol counseling tested in the Veterans Affairs (VA) Health Care System. We conclude that administrative data are not well-suited to measuring performance of brief alcohol counseling. Patient surveys appear to offer the optimal approach currently available for comparing performance of brief alcohol counseling across health care systems, while more options are available for measuring performance within health care systems. Further research is needed in this important area of quality improvement.

Title: Outcomes, performance, and quality--What's the difference?.
Authors: McLellan, A. T.; Chalk, M.; Bartlett, J.
Source: Journal of Substance Abuse Treatment, 32(4), Jun 2007, pp. 331-340

Calls for greater accountability within the addiction treatment field have led to a wide range of efforts designed to improve treatment performance, quality, and outcomes. However, efforts with conceptually and methodologically different approaches have used the same umbrella terms such as "quality," "performance indicators," and "outcome domains," causing substantial confusion among providers and policymakers. This article provides operational definitions of the terms used in discussing quality, performance, and outcomes, as well as a discussion of ways to integrate efforts to measure treatment system performance and quality during treatment with patient outcomes during and following treatment. This article thus helps build a common understanding about how these efforts to bring greater accountability can be combined and integrated to improve the attractiveness and effectiveness of addiction treatments.

Title: The Network for the Improvement of Addiction Treatment (NIATx): Enhancing access and retention.
Author: McCarty, D.; Gustafson, D. H.; Wisdom, J. P.; Ford, J.; Choi, D.; Molfenter, T.; Capoccia, V.; Cotter, F.
Source: Drug and Alcohol Dependence, 88(2-3), May 2007, pp. 138-145.

The Network for the Improvement of Addiction Treatment (NIATx) teaches participating treatment centers to use process improvement strategies. A cross-site evaluation monitored impacts on days between first contact and first treatment and percent of patients who started treatment and completed two, three and four units of care (i.e., one outpatient session, 1 day of intensive outpatient care, and 1 week of residential treatment). The analysis included 13 agencies that began participation in August 2003, submitted 10-15 months of data, and attempted improvements in outpatient (n=7), intensive outpatient (n=4) or residential treatment services (n=4) (two agencies provided data for two levels of care). Days to treatment declined 37% (from 19.6 to 12.4 days) across levels of care; the change was significant overall and for outpatient and intensive outpatient services. Significant overall improvement in retention in care was observed for the second unit of care (72-85%; 18% increase) and the third unit of care (62-73%; 17%

increase); when level of care was assessed, a significant gain was found only for intensive outpatient services. Small incremental changes in treatment processes can lead to significant reductions in days to treatment and consistent gains in retention.

Title: Prospective validation of substance abuse severity measures from administrative data.
Authors: McCamant, L. E.; Zani, B. G.; McFarland, B. H.; Gabriel, R.M.
Source: Drug and Alcohol Dependence, 86(1), Jan 2007, pp. 37-45.

Background: Severity measures for clients in substance abuse treatment programs are becoming increasingly important as funders adopt payment systems linked to agency performance. Recently, two severity measures based on administrative data have been developed. This study validated these measures using prospective data.
Methods: Subjects were participants in the Drug Abuse Treatment Outcomes Study (adult or adolescent components) or the Substance Abuse and Mental Health Services Administration Medicaid Managed Behavioral Healthcare and Vulnerable Populations project (adult or adolescent chemical dependency components). Severity measures were calculated based on data obtained at entry into substance abuse treatment. The baseline severity measures were included along with age, gender, and race/ethnicity in logistic regression models predicting abstinence at follow-up for alcohol use, marijuana use, cocaine use, or heroin use.
Results: For adults, the severity measures were highly statistically significant (p < 0.001) for all models in both data sets, indicating that adults with higher severity were more likely (and much more likely in many cases) to use alcohol, marijuana, cocaine, or heroin at the follow-up interview than were those with lower severity. For adolescents, the severity measure was highly statistically significant (p < 0.001) for marijuana in both data sets and for alcohol in the Medicaid data set.
Conclusions: Baseline severity measures were powerful predictors of abstinence at follow-up. These measures, derived from routinely available electronic records, appear to have noteworthy predictive validity. The severity indicators can be used for administrative purposes such as risk-adjustment when examining treatment agency performance.

Title: Acute Pain Management for Patients Receiving Maintenance Methadone or Buprenorphine Therapy
Authors: Alford, D.P., Compton, P., & Samet, J.H.
Source: Annuals of Internal Medicine, 144(2), January 2006, 127-134.

More patients with opioid addiction are receiving opioid agonist therapy (OAT) with methadone and buprenorphine. As a result, physicians will more frequently encounter patients receiving OAT who develop acutely painful conditions, requiring effective treatment strategies. Undertreatment of acute pain is suboptimal medical treatment, and patients receiving long-term OAT are at particular risk. This paper acknowledges the complex interplay among addictive disease, OAT, and acute pain management and describes 4 common misconceptions resulting in suboptimal treatment of acute pain. Clinical recommendations for providing analgesia for patients with acute pain who are receiving OAT are presented. Although challenging, acute pain in patients receiving this type of therapy can effectively be managed.

Title: Benefit–Cost in the California Treatment Outcome Project: Does Substance Abuse Treatment "Pay for Itself"?
Authors: Ettner, S. L.; Huang, D.; Evans, E.; Rose Ash, D.; Hardy, M.; Jourabchi, M.; & Hser, Y.
Source: Health Services Research, 41 (1), February 2006, pp. 192-213.
Publisher: Blackwell Publishing

Objective: To examine costs and monetary benefits associated with substance abuse treatment.

Data Sources: Primary and administrative data on client outcomes and agency costs from 43 substance abuse treatment providers in 13 counties in California during 2000–2001.

Study Design: Using a social planner perspective, the estimated direct cost of treatment was compared with the associated monetary benefits, including the client's costs of medical care, mental health services, criminal activity, earnings, and (from the government's perspective) transfer program payments. The cost of the client's substance abuse treatment episode was estimated by multiplying the number of days that the client spent in each treatment modality by the estimated average per diem cost of that modality. Monetary benefits associated with treatment were estimated using a pre–posttreatment admission study design, i.e., each client served as his or her own control.

Data Collection: Treatment cost data were collected from providers using the Drug Abuse Treatment Cost Analysis Program instrument. For the main sample of 2,567 clients, information on medical hospitalizations, emergency room visits,

earnings, and transfer payments was obtained from baseline and 9-month follow-up interviews, and linked to information on inpatient and outpatient mental health services use and criminal activity from administrative databases. Sensitivity analyses examined administrative data outcomes for a larger cohort (N=6,545) and longer time period (1 year).

Principal Findings: On average, substance abuse treatment costs $1,583 and is associated with a monetary benefit to society of $11,487, representing a greater than 7:1 ratio of benefits to costs. These benefits were primarily because of reduced costs of crime and increased employment earnings.

Conclusions: Even without considering the direct value to clients of improved health and quality of life, allocating taxpayer dollars to substance abuse treatment may be a wise investment.

Title: Evaluating risk -adjustment methodologies for patients with mental health and substance abuse disorders in the veterans health administration
Authors: Rosen, A.K., Christiansen, C.L., Montez, M.E., Loveland, S., Shokeen, P., Sloan, K., & Ettner, S.
Source: International Journal of Healthcare Technology and Management, 7 (1-2), 2006, p 43-81.

Although the difficulties in applying existing risk-adjustment measures to mental health
populations are increasingly evident, the need for adequate risk-adjustment methodologies
continues to increase due to the ongoing pressures of the need to constrain costs and allocate
resources equitably across key population sub-groups. The performance of several riskadjustment measures in predicting total healthcare costs and Mental Health/Substance abuse (MH/SA) costs was compared with a national sample of patients with MH/SA disorders receiving healthcare services in the Department of Veterans Affairs (VA). Differences in the performances of the models in predicting both total and MH/SA costs were small; mean absolute prediction errors and predictive ratios did not demonstrate any clear ranking of model performance. Inequitable allocation of resources may result when models that have been developed specifically for general patient populations are applied to unique populations with different healthcare needs.

Title: Longitudinal patterns of alcohol, drug, and mental health need and care in a national sample of U.S. adults
Author: Stockdale, S.E., Klap, R., Belin, T.R., Zhang, L., Wells, K.B.

Source: Psychiatric Services, 57(1), January 2006, pp. 93-99.

Objective: Use of longitudinal data can help clarify the extent of persistent need for services or persistent problems in gaining access to services. This study examined the level of transient and persistent need and unmet need over time among respondents to a national survey and whether need was met by provision of mental health services or resolved without treatment.

Methods: Data from the longitudinal Health Care for Communities (HCC) household telephone survey were used to produce joint distributions of need status and care for two periods (wave 1 data collected in 1997 to 1998 and wave 2 data collected in 2000 to 2001; N=6,659). Perceived need was measured as self-report of need for help with a mental or substance use problem. Probable clinical need was assessed with the Composite International Diagnostic Interview, the Alcohol Use Disorders Identification Test, and the 12-item Short Form Health Survey.

Results: High levels of persistent unmet need for care (44 to 52 percent) were found among respondents who had probable clinical need in wave 1. Although a majority of those with need received some care, an equal proportion (about 30 percent) of those with perceived need only or probable clinical need in wave 1 did not receive any care. A substantial portion of need (22 to 26 percent) appears to have resolved without treatment, which may suggest high levels of transient need.

Conclusions: Persistent patterns of unmet need represent important targets for policy and programs that can improve utilization, including outreach, education, and improved insurance coverage.

Title: Defining and Measuring Quality of Care: A Perspective from US Researchers

Authors: Brook, R.H., McGlynn, E.A., & Shekelle, P.G.

Source: International Journal for Quality in Health Care, 12(4), 2000, pp. 281-295. For reprints contact Robert_Brook@Rand.org.

The modern quality field in medicine is about one-third of a century old. The purpose of
this paper is to summarize what we know about quality of care and indicate what we can do to improve quality of care in the next century. We assert that quality can be measured, that quality of care varies enormously, that improving quality of care is difficult, that financial incentives directed at the health system have little effect on quality, and that we lack a publicly available tool kit to assess quality. To improve quality of care we will need adequate data that will require patients to

provide information about what happened to them and to allow people to abstract their medical records. It also will require that physicians provide patient information when asked. We also need a strategy to measure quality and then report the results and we need to place in the public domain tool kits that can be used by physicians, administrators, and patient groups to assess and improve quality. Each country should have a national quality report, based on standardized comprehensive and scientifically valid measures, which describes the country's progress in improving quality of care. We can act now. For the 70-100 procedures that dominate what physicians do, we should have a computer-based, prospective system to ensure that physicians ask patients the questions
required to decide whether to do the procedure. The patient should verify the responses.
Answers from patients should be combined with test results and other information obtained from the patient's physician to produce an assessment of the procedure's appropriateness and necessity. Advanced tools to assess quality, based on data from the patient and medical records, are also currently being developed. These tools could be used to comprehensively assess the quality of primary care across multiple conditions at the country, regional, and medical group level.

Title: Cost -Effectiveness of Case Management in Substance Abuse Treatment
Authors: Saleh, S.S., Vaughn, T., Levey, S., Fuortes, L., Uden-Holmen, T., & Hall, J.A.
Source: Research on Social Work Practice, 16(1), January 2006, pp. 38-47

Objective: The purpose of this study, which is part of a larger clinical trial, was to examine the cost-effectiveness of case management for individuals treated for substance abuse in a residential setting. Method: Clients who agreed to participate were randomly assigned to one of four study groups. Two groups received face-to-face case management and one telecommunication case management, and the fourth was the control group. Results: Using a ratio of cost to days free from substance abuse, the case management groups were less costeffective than the control group at 3 months, 6 months, and 12 months. The telecommunication case management was least cost-effective of the three case management conditions.

Conclusion: Results from the analysis revealed case management is not cost-effective as a supplement to traditional drug treatment over a 12-month follow-up period.

Title: Quality of care for substance use disorders in patients with serious mental illness
Authors: Kilbourne, A.M., Salloum, I., Dausey, D., Cornelius, J.R., Conigliaro, J., Xu, X., & Pincus, H.A.
Source: Journal of Substance Abuse Treatment. Special Issue: Heroin maintenance treatment for chronic heroin-dependent individuals: a Cochrane systematic review of effectiveness, 30(1), January 2006, pp. 73-77.

We assessed the quality of care for substance use disorders (SUDs) among 8,083 patients
diagnosed with serious mental illness from the VA mid-Atlantic region. Using data from the National Patient Care Database (2001-2002), we assessed the percentage of patients receiving a diagnosis of SUD, percentage beginning SUD treatment 14 days or earlier after diagnosis, and percentage receiving continued SUD care 30 days or less. Ove rall, 1,559 (19.3%) were diagnosed with an SUD. Of the 1,559, 966 (62.0%) initiated treatment and 847 (54.3%) received continued care. Although patients diagnosed with bipolar disorder were more likely to receive a diagnosis of SUD than those diagnosed with schizophrenia or schizoaffective disorder (22.7%, 18.9%, and 17.7%, respectively; $x^2 = 26.02$, df= 2, $p < .001$), they were less likely to initiate (49.1%, 70.7%, and 68.6%, respectively; $X^2 = 59.29$, df= 2,$p< .001$) or continue treatment (39.9%, 63.2%, and 62.2%, respectively; $X^2 = 72.25$, df= 2, $p <. 001$). Greater efforts are needed to diagnose and treat SUDs in patients with serious mental illness, particularly for those with bipolar disorder.

Title: Early Experience with Pay-for-Performance: From Concept to Practice
Authors: Rosenthal, M.B., Frank, R.G., Li, Z., & Epstein, A. M.
Source: Journal of the American Medical Association, 294 (14), October 2005, pp. 1788-1793

CONTEXT: The adoption of pay -for-performance mechanisms for quality improvement is growing rapidly. Although there is intense interest in and optimism about pay-for-performance programs, there is little published research on pay-for-performance in health care.

OBJECTIVE: To evaluate the impact of a prototypical physician pay-for-performance program on quality of care.

DESIGN, SETTING, AND PARTICIPANTS: We evaluated a natural experiment with payforperformance using administrative reports of physician group quality from a large health plan for an intervention group (California physicians group) and a contemporaneous comparison group (Pacific Northwest physician groups).

Quality improvement reports were included from October 2001 through April 2004 issued to approximately 300 large physician organizations.

Main Outcome Measures: Three process measures of clinical quality: cervical cancer screening, mammography, and hemoglobin A-sub (1c) testing.

RESULTS: Improvements in clinical quality scores were as follows: for cervical cancer screening, 5.3% for California vs. 1.7% for Pacific Northwest; for mammography, 1.9% vs. 0.2%; and for hemoglobin A-sub (1c), 2.1% vs. 2.1%. Compared with physician groups in the Pacific Northwest, the California network demonstrated greater quality improvement after the payforperformance intervention only in cervical cancer screening (a 3.6% difference in improvement [p = .02]). In total, the plan awarded 3.4 million dollars (27% of the amount set aside) in bonus payments between July 2003 and April 2004, the first year of the program. For all 3 measures, physician groups with baseline performance at or above the performance threshold for receipt of a bonus improved the least but garnered the largest share of the bonus payments.

CONCLUSION: Paying clinicians to reach a common, fixed performance target may produce little gain in quality for the money spent and will largely reward those with higher performance at baseline.

Title: Payment for Quality: Guiding Principles and Recommendations. Principles and Recommendations
Source: The American Heart Association’s Reimbursement, Coverage, and Access Policy
Development Workgroup, January 9, 2006
Authors: Bufalino, V., Peterson, E.D., Burke, G.L., Labresh, K.A., Jones, D.W., Faxon, D.P., Valadez, A.M., Brass, L.M., Fulwider, V.B., Smith, R., & Krumholz, H.M.

Payment-for-quality programs are emerging in the wake of rising healthcare costs and a
demonstrated need for quality improvement in healthcare delivery in the United States. These programs, also known as "pay-for-performance" or "pay-for-value" programs, attempt to realign financial incentives with the quality of care delivered. The American Heart Association's Reimbursement, Coverage, and Access Policy Development Workgroup provides in this statement a set of principles and recommendations for the development, implementation, and evaluation of these programs. The statement also suggests future areas for research around the realignment of financial incentives to improve both the quality of care delivered and patient outcomes. PMID: 16401766 [PubMed - as supplied by publisher]

Title: Improving Care for Depression in Patients with Comorbid Substance Misuse.
Authors: Watkins, K.E., Paddock, S.M., Zhang, L., & Wells, K.B.
Source: American Journal of Psychiatry, 163 (1), January 2006, pp. 125-132

OBJECTIVE: The authors investigated whether quality improvement programs for depression would be effective among substance misusers and whether there would be a differential program by comorbidity effect.

METHOD: A group-level randomized controlled trial (Partners in Care) compared two quality improvement programs for depression with usual care. Consecutive patients (N=27,332) from six managed care organizations in five states were screened, and 1,356 were enrolled: 443 received usual care while the rest entered a quality improvement program involving either medication (N=424) or therapy (N=489). Multiple logistic regression was used to test hypotheses and compute standardized predictions of the adjusted rates of depression and use of psychotherapy and antidepressants.

RESULTS: Under usual care conditions, depressed patients with substance misuse had an
increased probability of ongoing depression despite higher rates of overall appropriate treatment. Among clients with comorbid substance misuse, the quality improvement programs were associated with improved depression outcomes at 12 months and increased antidepressant use at 6 months. Among clients with no substance misuse, the quality improvement programs improved depression outcomes at 6 months and were associated with increased treatment utilization.

CONCLUSIONS: Co-occurring substance misuse is associated with depression and with
increased risk for poorer depression treatment outcomes under usual care conditions. Quality improvement programs can significantly reduce the likelihood of probable depressive disorders in depressed patients with and without comorbid substance misuse. No consistent evidence was found for a differential program-by-comorbidity effect except for a suggestion of greater increase in psychotherapy among individuals with no substance misuse. PMID: 16390899 [PubMed - as supplied by publisher

Title: Economic Modeling of Methods to Stimulate Quality Improvement
Author: Eggleston, K.
Source: International Journal for Quality in Health Care, 17 (6), December 2005, pp. 521-531

OBJECTIVE: This paper uses an economic model to compare three methods for stimulating quality improvement: payment incentives, competition for patients, and emphasis on professional ethics.

DESIGN: Use an economic model to simulate the impact on quality distortions (risk selection) of differences in payment incentives, competition for patients, and emphasis on professional ethics.

SETTING: Health care policymakers in many countries seek to use incentives and competition to spur quality improvement. However, strong incentives often promote risk selection: insurers and providers financially benefit from distorting quality to attract profitable patients.

RESULTS: The analysis suggests that intense competition for patients and strong financial rewards for cost control can exacerbate quality distortions and compromise social solidarity.

CONCLUSIONS: Carefully regulated competition and mixed forms of provider payment (risk sharing) appear to be the best options. Moreover, designing competition, regulation, payment, and other forms of health policy to promote suppliers' professional ethics can help society to reap the quality and efficiency benefits of competition and incentives without sacrificing social solidarity. PMID: 16141247 [PubMed - indexed for MEDLINE]