Policies, Practices, Factors and Unintended Consequences Associated with Monitoring Substance Use Disorder Treatment Continuity of Care within the Veterans Health Administration

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By

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As the largest provider of healthcare and substance use disorder (SUD) services in the US, the Veterans Health Administration (VHA) strives to maintain the highest standards of care in order to adequately serve those who served in the nation’s armed services. A series of major reforms in the late ‘90s transformed the VHA into a highly decentralized but fully integrated health system. The overall availability of SUD services declined steadily in the post-reform period. However, between fiscal years (FYs) 2003 and 2009 there was an influx of Federal funds generally aimed at expanding veterans’ access to high-quality SUD treatment options systemwide. The majority of the monies from these initiatives went towards additional full-time SUD staff being hired at VHA facilities (Tracy, Tavakoli, Stolpner, & Trafton, 2011).

The VHA assesses the quality and efficiency of healthcare services using performance measures/indicators, and rewards SUD program personnel and facility leadership through reputational incentives and performance-based contracts. This dissertation focuses on the SUD treatment continuity of care performance measure (CoC PM), a longstanding metric used to assess VHA SUD treatment process quality. The continuity of care measure monitors whether veteran SUD patients with a new episode of treatment have at least two outpatient visits per month within their first 90 days of treatment. Scores are reported at the facility-level and compared to national benchmarks.

Using VHA administrative and survey data from the period between FYs 2003 and 2009, as well as contemporaneous qualitative accounts from SUD program staff, this study had three primary aims: 1) Determine what policies, practices and factors affected SUD treatment CoC PM scores; 2) Establish if facility-level policies, practices and factors were associated with the need for and/or receipt of SUD treatment; and 3) Find out if CoC PM enhancing policies, practices and factors were associated with certain unintended consequences.

The study’s hypotheses were guided by measurement reactivity theory, and also drew from Blau’s theory of decentralization in bureaucracies. Several models were estimated using weighted generalized least squares regression. This study’s findings indicate that facilities with more SUD personnel per unique SUD patient had higher CoC PM scores. In addition, poor facility-level CoC PM performance tended to be enduring (i.e., persisted from one FY into the next). Consistently low CoC PM scores were found to be associated with facilities providing SUD care to an increased proportion of alcohol and/or drug use disorder diagnosed homeless patients in a subsequent FY. In other words, persistently poor performing facilities served a disproportionate share of high-severity patients, and likely did not engage in cream-skimming (i.e., preferentially enrolling low-risk patients into treatment). Increases in the amount of SUD
staff-per-patient were found to be associated with VHA facilities treating fewer SUD patients more intensively. Moreover, this relationship was stronger when analyses were limited to the homeless veteran population. These findings point toward a potential unintended consequence of VHA leadership allocating funds for additional SUD staff while concurrently focusing on facility-level SUD treatment continuity of care. Specifically, that these supplemental SUD personnel were dedicated to activities aimed at improving facility-level CoC PM scores (i.e., tracking and scheduling CoC PM eligibles) and not treating additional patients.

The VHA gives priority to providing veterans access to SUD care, in addition to meeting the health care needs of veterans who are homeless. This study’s findings provide insights into several facility-level policies, practices and factors, as well as potential unintended consequences associated with the CoC PM. In light of these findings, researchers and policy makers should examine whether adjustments to the CoC PM are in order so that valid/fair comparisons of SUD treatment process quality can be made among VHA facilities. In addition, since thus far policies targeting improved patient access to SUD care have tended to result in funding outlays being dedicated to hiring more full-time treatment personnel, it is important to better understand how SUD staff are utilized at VHA facilities. This information may be particularly important if additional SUD personnel are devoted to activities aimed at meeting continuity of care performance targets for a smaller volume of patients, in lieu of providing SUD care to additional veteran beneficiaries.

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