Assuring Safe and Stable Outcomes Within the Limited Resources of Addiction Treatment

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A freestanding addiction treatment department GARC, Glendale Adventist Residential Center was opened by Glendale Adventist Medical Center in 1984. Glendale Adventist Medical Center (GAMC), formerly the Glendale Sanitarium, opened in 1905 and today is a full service 450-bed facility with a team of 11 who specialize in organizational performance. The medical staff includes over 700 physicians. The non-physician staff is comprised of more than 2,300, with 120 working in Behavioral Medicine Services. The Behavioral Medicine Services include Psychiatric Services of 60 beds and Outpatient Behavioral Health Services. The smallest segment of GAMC Behavioral Medicine Services is Glendale Adventist Alcohol & Drug Services, including a multi-disciplinary team of 17, though less than 13 full time equivalents.

GARC, Glendale Adventist Residential Center, opened with a dedication to the cost effective treatment of alcohol and drug dependencies and as an alternative to costly inpatient care. At the time, there were an abundance of hospital addiction treatment departments in the foothill communities where the medical center is located and throughout Los Angeles. Cedar Sinai, Providence St. Joseph, Valley Presbyterian, Northridge, Glendale Memorial, St. Luke, St. Johns, Brotman, Washington and many others had addiction treatment departments. In recovery meetings one might overhear a person say, "I got a thirty thousand dollar big book at that hospital!" Those departments closed. Most, it appears, closed in relation to cost containment as influenced by managed care organizations and were replaced by outpatient levels of care and office based therapies.[1] The evolution of addiction treatment under the pressure of managed care morphed GARC into a full set of services beyond residential care. The name changed to Glendale Adventist Alcohol & Drug Services in 1992, signaling the addition of outpatient services in the late 1980s.

Addiction treatment has never fit with ease into acute hospital models for reasons financial, organizational and cultural.[2] If the regional market of services available for the treatment of addiction is any measure, the cost of inpatient models of addiction treatment appear to have been excessive with the exception of providing care for persons suffering medical or psychiatric conditions. A review of the California Department of Alcohol and Drug Programs on line licensees shows over 7,000 beds for addiction services in Los Angeles County alone. There are more than 20 services in Malibu with prices from twenty thousand to over fifty thousand dollars per month. Most of the licensee beds are very low cost, providing shelter, non-medical services, twelve step recovery resources and referral relationships to clinics of other care providers. GAADS has 24 non-medical beds licensed by the California Department of Alcohol and Drug Programs and accredited by the Joint Commission. GAADS provides residential addiction care for about ten thousand dollars for 30 days. More than two thirds of GAADS patients care is paid through their private health insurance that is overwhelmingly managed behavioral "carve outs" from larger managed care enterprises. The remaining fewer than one third pay for services themselves, out of pocket.

As long ago as 1993, after less than ten years of operation GAADS engaged in its first third party administered outcome study. Already by the early 1990s there was a significant number of hospital based addiction treatment programs in the region that closed. Resources then were limited for contracting with managed care. Glendale Adventist had joined Calnet, Inc. in 1986. Calnet is a member

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1 McNeese-Smith, D., & Nyamathi, A. et al. (2007). Processes and outcomes of substance abuse treatment between two programs for clients insured under managed care *American Journal Alcohol Drug Abuse,* 33(3), pages 439–446.

2 Hunsicker, R. J., *An Acute Care Hospital Challenge,* The Terraces, July 1992, page 49.

services organization that provides contracting for managed behavioral care and other member services. The available managed care and contracting departments and other medical center resources were allocated in alignment with the medical center strategic plan and in correlation with revenue and volumes. Addiction treatment is a tiny part of the entire medical center operation. The group of addiction treatment providers banded together in Calnet. Calnet served as the content experts and "strength in numbers" in the emerging area of negotiating with managed care. Insurance payment and accreditation both demanded measures of safety, quality and outcomes that most of the regional hospital based providers of addiction treatment failed to demonstrate.

GAADS first outcome study was administered by New Standards, Inc. of St. Paul, MN. Calnet served as the conduit between New Standards and Glendale Adventist along with 11 other Calnet related addiction treatment providers. In total there were only 392 patients in the study from March 1993 until October 1994, and only 43 from GAADS.[3] The study included a review of admission and discharge records, coupled with a follow-up phone call from a researcher. The level of attrition from admission to follow-up made the results of that study interesting only on demographic information. The low proportion of follow up resulted in the Calnet addiction treatment programs declining a second iteration. The first study was high cost and resulted in low volume of useful data.

GAADS second group of studies was conducted under the leadership of Dr. Donna McNeese-Smith of the graduate school of nursing at UCLA. The second group of studies at GAADS were paid for by a UCLA faculty Grant and several NIDA grants. The studies resulted in 8 publications in peer reviewed journals to date coupled with useful data that confirmed the clinical directions of GAADS programming. The second group of studies cost GAADS only staff hours and resulted in dense and useable data. Sadly, it is difficult to find dedicated researchers who are willing and able to propose and find funding to conduct research. In addiction treatment there appears to be a bias toward study in public sector and Veterans Administration treatment providers.

GAADS third wave of study appears to be a balance between being low cost and repeatable. A voluntarily, self-administered behavior and symptom identification scale results in dense usable data that assures the continuation of safe services and is the primary set of outcome data from treatment. In 2001 a group of Calnet member program directors clamored for another foray into shared outcome measures. Many of the Calnet programs are free standing facilities, not related to hospitals. Few quality and outcome resource experts exist compared with the resources of large medical centers. The team of 11 members of the Organizational Performance Department at GAMC is a wildly rich resource in the view of any addiction treatment entity! Again, Calnet, Inc. served as a conduit between very dissimilar addiction treatment providers and a larger organization with outcomes data processing capacity.

With payment for residential addiction treatment services being about 25% of what payment is for other inpatient care at a medical center, GAADS is not going to develop research expertise internally. Instead, GAADS participated with the group of Calnet member addiction treatment programs in the use of the BASIS 32®.[4]

The BASIS-32® measures the change in self-reported symptom and problem difficulty over the course of treatment. A brief yet comprehensive instrument, BASIS-32® cuts across diagnoses by identifying a wide range of symptoms and problems that occur across the diagnostic spectrum. Validated and found reliable in both inpatient and outpatient settings, BASIS-32® assesses treatment outcomes from the patient perspective. Typically, BASIS-32® is given at admission and discharge for hospital-based episodes of care, and at intake/initiation of treatment and then periodically thereafter in ambulatory care settings.

Scoring the 32 items provides summary indicators of how patients feel before and after receiving care. The survey measures the degree of difficulty experienced by the patient during a one-week period on a five-point scale ranging from no difficulty to extreme difficulty. The survey is scored using an algorithm that gives an overall score with five subscales for

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3 New Standards, Inc., *ComprehensiveReport – CALNET; Glendale Adventist Medical Center All Programs,* St. Paul, MN, March 1995.

4 Eisen SV, Wilcox M, Leff HS, Schaefer E, Culhane MA. Assessing behavioral health outcomes in outpatient programs: Reliability and validity of the BASIS-32. *The Journal of Behavioral Health Services & Research,* 1999;26:5-17.

the following domains of psychiatric and substance abuse symptoms and functioning: Relation to Self and Others, Depression and Anxiety, Daily Living and Role Functioning, Impulsive and Addictive Behavior, Psychosis.

The survey has received several outcomes and quality assessment awards, including the:

- Blue Ribbon Award, New England Healthcare Assembly, 1996
- Partners in Excellence Award, Partners Healthcare System, Inc., 1996
- Medical Outcomes Trust Scientific Advisory Committee and Board of Trustees, 1997. Incorporated into the Trust's library of internationally available outcomes measurement instruments.[5]

The data contained in each of the following graphs is the result of GAADS' monthly submission of voluntarily, patient self-administered BASIS-32® questionnaires to Mental Health Outcomes, CQI+ of Horizon Health in Lewisville,Texas, our vendor.

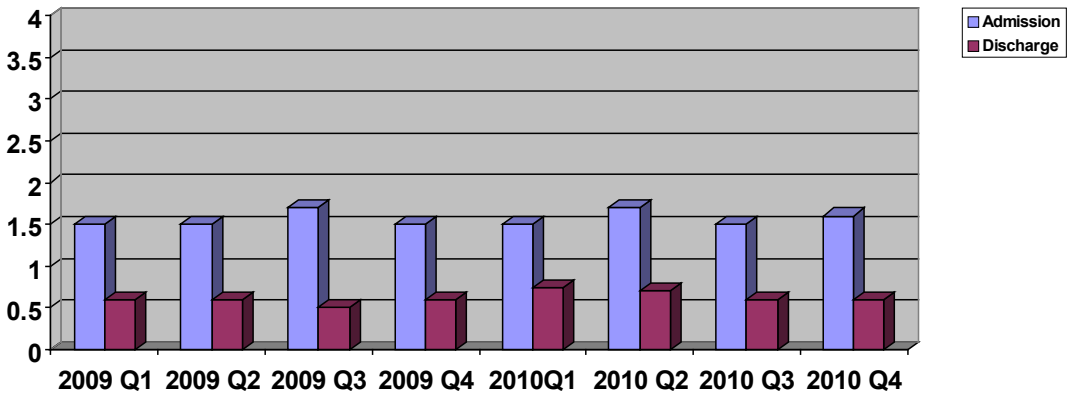
In the following graph, the Behavior and Symptom Identification Scale is measured on a scale from 0 to 4, where a higher score indicates greater difficulty with self-reported symptomatology. In order to protect GAADS patients from researcher or score bias, the individual results are never seen by anyone at the facility. Only the aggregated data is used by GAADS clinical team. The data is used and reviewed each quarter. GAMC also uses the same vendor to score patient satisfaction questions at GAADS. The results of the Basis 32® patient satisfaction score are published on the web at www.glendaleadventist.com/gaads and clicking on "Patient Satisfaction and Quality."

The following graph is an indication from patient self-scoring of how much difficulty our patients are having at the time they are admitted and how they see themselves at the time of discharge. The length of stay for the residential program is less than 20 days. This graph only is the result of blending the 5 subscales: relation to self and others, daily living skills, depression/anxiety, addictive/impulsive behavior and psychosis. From an anecdotes:

- Patients and families report an increase in trust that GAADS demonstrates effects of treatment.
- Prior to admission, many patients and families seek data about the success rates for addiction treatment.
- Proof that treatment does something is beneficial for employers and family members who can experience.
- Trending the reduction in self-reported symptoms allows all GAADS stakeholders, patient, families, alumni, licensing and accrediting bodies and GAADS staff to understand the stability and consistency of the services.
- Public posting of the data in the department and online demonstrate transparency, especially when there is a small decline in perceived performance.
- In patient lectures, we jokingly call this scale the "sick-o-meter."

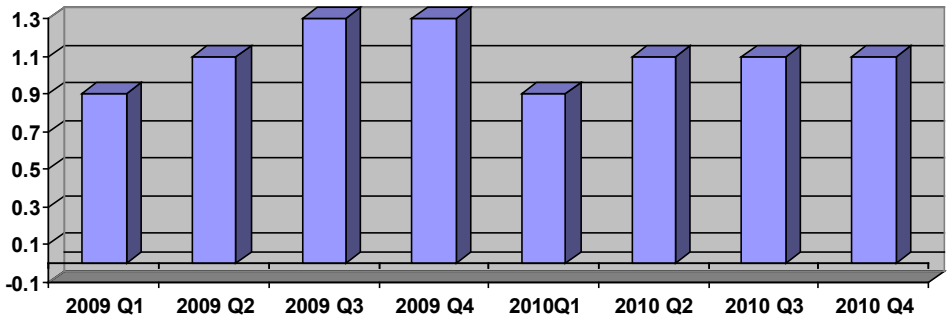
The following five graphs show changes made during treatment according to the patient. The Change in Behavior and Symptom Identification Scale Subscale scores are measured on a scale from -4 to +4, where a higher score indicates greater improvement in symptoms.

Patient Self Reported Difficulty and Functioning at Admission and Discharge

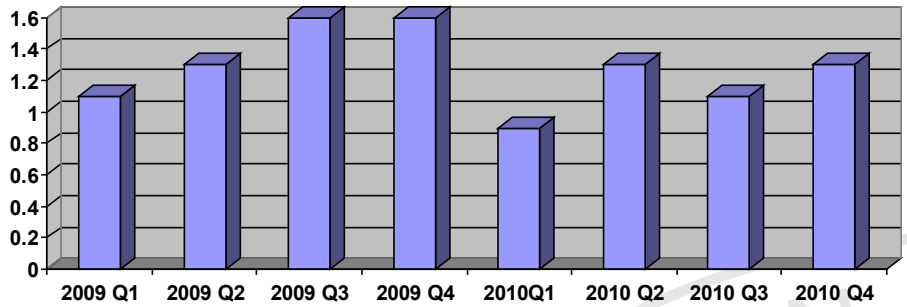


[5] http://www.basissurvey.org/basis32/

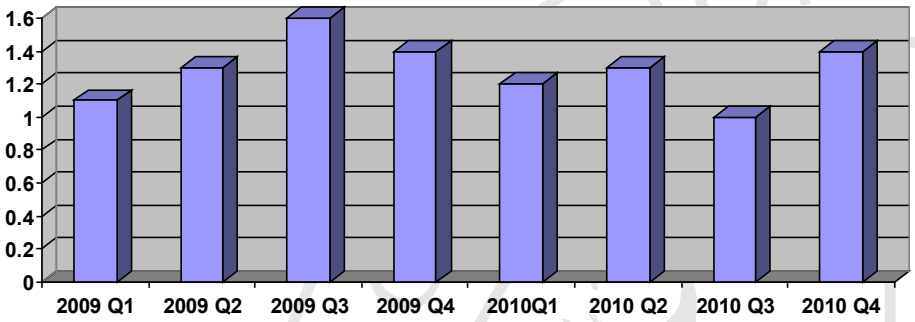
Patient Reported Relationship to Self and Others Change Score From Admission to Discharge



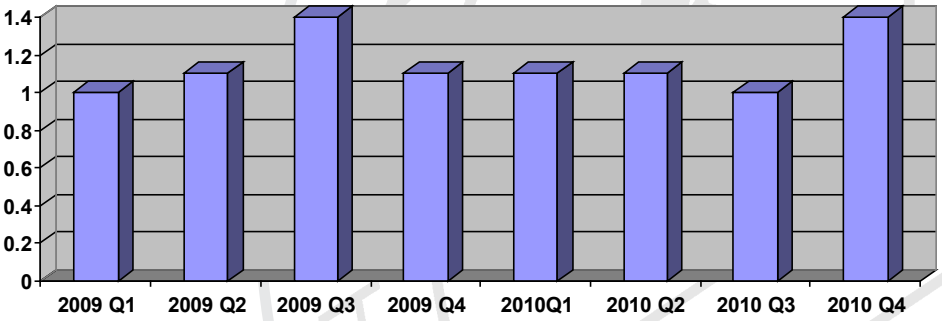
Patient Reported Daily Living Skills Change Score From Admission to Discharge



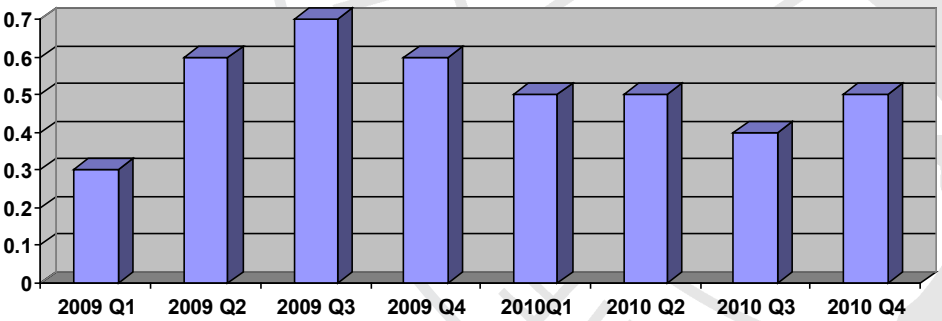
Patient Reported Depression/Anxiety Change Score From Admission to Discharge



Patient Reported Impulsive/Addictive Behavior Change Score From Admission to Discharge



Patient Reported Psychosis Change Score From Admission to Discharge



The cost and time associated with the use of this tool have been very low. GAADS will soon have 10 years worth of trended data. In GAADS first wave of outcome measurement there were 43 of GAADS patients in a study of less than 400 patients in California. The second wave of outcome study, with the help of UCLA, included 114 from GAADS into an overall study population of fewer than 250. In GAADS current use of the BASIS 32® in the services of an excellent vendor, over 449 GAADS patients were included in the past two years. More than 1,000 GAADS patients have contributed to the growing database nearly a decade in development. The BASIS 32® affords a cost effective way to assure the depth and quality of initial and subsequent assessment skills as a group. This simple outcome measure demonstrates that treatment changes patient lives. The treatment team contribution is demonstrable, in that they provide a stable, consistent treatment experience when the outcome measure data is aligned with required chart audits, performance improvement, performance appraisal, and continued patient and family rapport with GAADS team. And CAHQ Journal reader who is interested in more detail or collaboration, please send a note to RobertS1@ah.org.