**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.

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**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., & Etter, S.

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.
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. (PsycINFO Database Record (c) 2006 APA, all rights reserved)

Title: Defining and Measuring Quality of Care: A Perspective from US Researchers
Authors: Brook, R.H., McGlynn, E.A., & Shekelle, P.G.

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 cost-effective 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. (PsycINFO Database Record (c) 2006 APA, all rights reserved)
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.

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. Overall, 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; x² = 26.02, df= 2, p < .001), they were less likely to initiate (49.1%, 70.7%, and 68.6%, respectively; x² = 59.29, df= 2, p< .001) or continue treatment (39.9%, 63.2%, and 62.2%, respectively; x² = 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. (PsycINFO Database Record (c) 2006 APA, all rights reserved)

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. (PsycINFO Database Record © 2005 APA, all rights reserved)

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

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.

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]