Ensuring Solutions to Alcohol Problems
THE GEORGE WASHINGTON UNIVERSITY MEDICAL CENTER
Primer 6

Using Performance Measurement to Improve the Quality of Alcohol Treatment

Executive Summary

Businesses, government and health care providers have acknowledged through the adoption of performance measures for addiction treatment that the quality of alcohol treatment matters and that performance measurement can improve quality. Beginning in 2004, the nation's leading health accreditation group will ask health care providers to measure and report their success in engaging people with alcohol and other drug problems in treatment.

Alcohol problems kill 100,000 Americans every year[1] and cost society almost $185 billion annually.[2] Yet until recently, little attention has been paid to the quality of alcohol treatment even though better treatment has the potential to reduce these enormous human and social costs. In fact, according to a 2003 study published in the *New England Journal of Medicine*, the quality of alcohol treatment ranked dead last among the study's assessment of treatment for the nation's 25 leading causes of death, illness, hospitalization and doctors' visits.[3]

The National Committee for Quality Assurance (NCQA), a nonprofit accreditor for managed care organizations, developed and maintains a leading tool to measure health care value and improve quality—the Health Plan Employer Data and Information Set (HEDIS). Almost 90 percent of America's health plans now use HEDIS to measure performance[4] on important dimensions of care and service for many different health conditions, making it possible to compare the performance of health care providers in both the private and public sectors on an "apples-to-apples" basis.

Hope for Improvement in All Sectors

Public reporting on performance by NCQA and other entities has improved the delivery of care for a variety of health conditions. Holding health care providers accountable for their treatment of patients with hypertension, for example, has helped increase blood pressure control efforts substantially.

NCQA's announcement that it will begin to measure performance in treatment for alcohol problems has heightened expectations for quality improvement in addiction treatment. These measures, developed with the Washington Circle, a group focused on performance measurement in addiction treatment, mark a milestone: health plans will be asked for the first time to account for their success at both initiating and engaging treatment for alcohol problems once they have been identified.

The emphasis on performance and quality improvement is not limited to managed care accrediting organizations such as NCQA. The federal government uses performance measures to stimulate quality improvement in addiction treatment for veterans. It will soon begin using them to hold states more accountable for the funding they receive to prevent and treat alcohol and other drug problems. In addition, the National Business Coalition on Health, which represents more than 7,000 employers and 34 million workers and their families, now includes alcohol performance measures in a tool that can be used to drive quality improvement in the private health care benefits offered to employees.

Introduction

In *Crossing the Quality Chasm*, an influential 2000 report from the Institute of Medicine that examined U.S. health care delivery, a panel of experts sounded an alarm: health care harms patients too frequently and routinely fails to deliver its potential benefits.[5] The panel advocated an overhaul of the health care system and included among its primary recommendations a call for a public-private partnership to improve the delivery of evidence-based care.

According to the Institute of Medicine, everyone with a stake in health care can use performance or quality measurement to help achieve this goal.[6] Based on established clinical guidelines, clinical evidence, and/or expert consensus, performance measures offer standard, measurable formulas that can be consistently applied across various health care delivery systems. Public reporting of the results offers consumers and major purchasers of health care, including employers and government programs such as Medicaid and Medicare, a way to hold health care providers in both the private and public sectors more accountable by comparing their performances.

Medical experts have developed performance measures for the prevention and treatment of many diseases, including asthma, diabetes and high blood pressure. According to the National Committee for Quality Assurance (NCQA), they have been highly effective in ensuring that Americans receive clinically proven interventions to help control these chronic conditions. (NCQA, a nonprofit accrediting organization, reports on and works to improve the quality of care provided by organized health care delivery systems.)

Saving Lives (and Business Costs)

Take, for example, the impact of performance measurement on high blood pressure treatment over the past three years. On average, private health plans in 1999 helped just 39 percent of their patients who had been diagnosed with hypertension keep their blood pressure within limits specified by a performance measure; by 2002, that average increased to 58 percent.[7] The best performing health plans assisted 68 percent of their hypertensive patients in controlling their blood pressure. While there still is room for significant quality improvement, if every health plan performed at least this well, researchers estimate that 28,000 lives would be saved and 50,000 fewer Americans would suffer from strokes.

Public reporting of performance measurement is key. NCQA, for example, publishes an annual report on the state of health care in America and provides tools for purchasers and consumers to evaluate health care. Public reporting increases the pressure on health care providers to perform at least as well as their competitors or risk losing market share. This pressure can lead to quality improvement by encouraging heath care providers to identify problem areas and take the necessary administrative or clinical actions to fix them.[8]

Performance measurement also increases purchasers' leverage in negotiating health care contracts. In 1996 the largest business coalition in the nation, the Pacific Business Group on Health, negotiated a contract with 13 of California's largest health plans that put $8 million in premium income at risk if the plans didn't meet specific performance measure targets. Poor performance in childhood immunization resulted in a $2 million refund for the employers on whose behalf the coalition had been negotiating.[9] A financial penalty of this kind provides the strongest possible incentive for a health plan to improve performance and enables employers to get maximum value from their health care investment.

Performance measures for treating alcohol and other drug problems are being incorporated into standard performance measurement tools.

Beginning in 2004, NCQA will ask health care providers to implement new performance measures for treating alcohol and other drug problems, a milestone in the addiction field. The measures will be included in the Health Plan Employer and Data Information Set (HEDIS), a standardized tool developed by NCQA and used by 90 percent of the nation's health plans for performance measurement.

When the results are publicly reported, purchasers will be able to compare, for the first time, how well a health plan has engaged patients with alcohol and other drug problems in the treatment process by examining the plan's success in:

- increasing *identification* of people in need of treatment
- helping such patients *initiate* their treatment, and
- more fully *engaging* patients in their care.

The new HEDIS measures for adults assess treatment initiation and engagement rates—the front end of treatment—by establishing time-sensitive criteria for delivery of services. An updated identification measure will calculate the percentage of enrollees who have been diagnosed with an alcohol or other drug problem and are receiving services. Initiation of treatment will be measured on the basis of how many of these patients received addiction-related services within 14 days of diagnosis—the timeframe when patient motivation, **an active ingredient of effective alcohol treatment**, may be especially strong. Engagement will be measured on the basis of how many of these patients (those who actually have begun the process of treatment) go on to receive at least two additional addiction-related services within the next 30 days.

Changes Increase Specificity

Previously, NCQA asked health care plans to calculate only the percentage of patients who had received treatment for addiction and the average length of stay among patients who had been discharged from inpatient treatment. Though this information is useful for comparing patient utilization of treatment services among health plans, the new measures provide health plans with a better way to measure the processes of care that are integral to the success of long-term treatment for addiction.

One concern about performance measurement in general has been that the existence of a measure can mean that a health plan will pay more attention to this aspect of care than others that aren't being measured, although they may be equally important. The new measures avoid this problem by providing purchasers with a far more complete picture of how well a health plan ushers alcohol dependent patients into the initial phase of treatment. For example, a high identification rate by itself isn't much good if people aren't initiating treatment, just as a high engagement rate for a health plan can be less meaningful if its identification rate of people in need of treatment is low.

Pilot testing of new addiction treatment performance measures demonstrates their feasibility and suggests the need to improve identification, initiation and engagement rates.

Prior to their adoption by NCQA, six health care organizations that provided services to approximately five million people tested the front end performance measures. The results demonstrated both the feasibility of the new measures and the opportunity for quality improvement.

None of the health plans studied identified an alcohol or drug problem in more than 1.45 percent of their adult enrollees.[10] The federal government, however, estimates that 7.4 percent of full-time workers have an alcohol problem.[11] In the field testing, initiation of treatment rates varied significantly: in two health plans nearly half of the patients who had been identified with an alcohol or other drug problem initiated treatment within two weeks of their diagnosis, while in two other

health plans, only one quarter did. Engagement rates were more consistent, but in even the best performing health plan, 71 percent of the patients diagnosed with an alcohol or drug problem who had initiated treatment failed to receive more than two additional services (such as visits to an outpatient clinic) in the following month.[12]

The results of the feasibility study can be used to illustrate how both health plans and purchasers might actively use performance measurement to improve the quality of addiction treatment. Low initiation rates, for example, can prompt a health plan to investigate why more patients diagnosed with an addiction problem aren't receiving treatment. Are motivational interviewing techniques, which research has shown can encourage patients to seek treatment, being used? Similarly, low engagement rates may indicate that some aspect of treatment needs to be "fixed" to keep patients returning. Are counselors establishing strong bonds with their patients? Are outpatient treatment sessions being scheduled at times and in places convenient for patients?

With measurement results like these in hand, purchasers have the information needed to begin to improve the quality of care when their contracts with the health plan come up for renewal. A company could include in the terms of a new contract a negotiated improvement in the alcohol problem identification rate. This improvement might take the form of a better score than the previous year, or it could be tied to the industry-specific estimates for the prevalence of alcohol problems that are available from the federal government. For example, according to the National Household Survey on Drug Use and Health, 11 percent of construction workers and miners have alcohol problems;[13] employers in these industries could use this information to establish a reasonable benchmark for identification when purchasing health care and tie it to benchmarks for initiation and engagement.

Factors unique to treatment for alcohol and other drug problems must be taken into consideration when evaluating performance measurement.

The testing indicated that despite the similarities that addiction shares with other chronic diseases, a number of patient-, provider- and insurance-related challenges can affect its identification and treatment. While these should not be construed as an obstacle to performance measurement for addiction treatment, several factors should be considered when evaluating the results:

- Denial of an alcohol problem, symptomatic of alcoholism, prevents many people from seeking treatment; some actively avoid it.

- Stigma, however, may make people with alcohol problems behave differently when they do seek treatment. They may ask their physicians in their employer-sponsored health plans to omit their diagnoses from their medical records because they fear job repercussions. For the same reason, they may pay for treatment out of their own pockets, use publicly funded alcohol treatment, or substitute support group participation for professional treatment.

- Discriminatory insurance coverage, including higher copays and benefit limitations, discourages people with alcohol problems from seeking treatment at the same time that it encourages health care providers to mask alcohol problems by characterizing them as other medical problems so that patients can get the care they need.

Performance measurement can be used to hold health plans accountable for treating alcoholism as a chronic disease.

The **Washington Circle**, a panel of volunteer experts in addiction, managed care, performance measurement and health care policy, developed and tested the identification, initiation and engagement measures with funding from the Substance Abuse and Mental Health Services Administration (SAMHSA), a federal agency in the U.S. Department of Health and Human Services (HHS). They and other groups working on performance measurement in addiction treatment (such as the Foundation for Accountability) recognized from the outset that effective treatment for addiction, like that for other chronic conditions, must extend beyond the acute stage of the illness.

The Washington Circle also agreed that health plans should be held accountable for the entire process of addiction care. With the **chronic care model** as their guide, the group created a framework comprising four domains—Prevention/Education, Recognition, Treatment and Maintenance. These areas reflect the treatment process from beginning to end. In conjunction with the new HEDIS measures (which fall into the Recognition and Treatment domains), the Washington Circle proposed several additional measures creating, in sum, a core set of performance measures:

- Educating patients about alcohol and other drug problems
- Linkage of detoxification and addiction treatment services
- Interventions for family members/significant others of patients being treated for addiction
- Maintenance of treatment effects

Expense, Data Collection Pose Challenges

Implementation of performance measures, however, is complicated by several factors—cost first and foremost. According to one study, it can cost a health plan $22,000 to $700,000 to implement a single measure.[14] To overcome this obstacle, the Forum on Performance Measurement, another SAMHSA-funded initiative, has convened working groups to create standard sets of evidence-based performance measures (including those developed by the Washington Circle) for both addiction and mental health treatment among adolescents as well as adults. The goal is to ease and ensure implementation by reducing the sheer number of measures and the cost to health plans.

Data limitations are another complicating factor. Performance measurement for any medical procedure depends on the availability and consistency of key data. While a patient's medical records would provide greater detail, these records do not exist in a standardized format and they are seldom computerized. In addition, their release requires patient authorization which is a sensitive issue for patients with a stigmatized condition such as addiction. As a result, performance measurement now relies to a large extent on patient surveys (which require significant response rates) and health insurance administrative data primarily collected from enrollment records and claim forms.

In fact, cognizance of cost concerns and data limitations governed the work of the Washington Circle, leading to the development of performance measures that could be implemented as inexpensively as possible using existing data sources. In practice, new federal regulations mandated by the Health Insurance Portability and Accountability Act (HIPAA) aimed at improving the efficiency and effectiveness of health care are likely to have a positive impact on the collection of new HEDIS measures. Under national standards developed by HHS, any health care provider who electronically transmits individually identifiable health information for which HHS has adopted a standard is required to use a national, uniform set of procedure codes. This will make it easier to more accurately identify the delivery of addiction treatment services using administrative data, a task that has been difficult in the past because of coding inconsistencies among treatment providers.

Public and private purchasers of health care are helping to drive the momentum behind performance measurement for addiction treatment.

The move toward performance measurement in addiction treatment extends well beyond the new HEDIS measures into the public sector, where the majority of individuals with alcohol problems access services. Under the Partnership Performance Grant program, the federal government plans to give the states more flexibility in how they invest $1.72 billion in federal funding (for the 2004 fiscal year) to prevent and treat alcohol and other drug problems. In return, it will hold the states more accountable for how the money is spent by requiring them to collect and report on a number of performance measures.

The proposed treatment performance measures, currently under SAMHSA review, look at two areas: outcomes and how well specific groups of people (those with either tuberculosis or HIV/AIDS, pregnant women and homeless individuals) access services. One outcome measure compares the frequency of self-reported alcohol use 30 days before treatment with reported use 30 days prior to discharge from treatment. Other outcome measures include questions about an individual's employment status and involvement with the criminal justice system before and after treatment.

The idea is not to compare the performance of one state with another but to establish, at the outset, baseline measures in each state. States will then be expected to try to improve performance year after year for each of the outcome and process measures.

Measuring Treatment for the Nation's Veterans

In another indication of the momentum behind performance measurement in the public sector, the Department of Veteran's Affairs (VA) already uses it to assess the quality of addiction treatment delivered in VA hospitals and clinics throughout the country. This makes it possible to compare facilities and regional networks within the nation's largest integrated health care system, and to establish annual goals for addiction treatment.

Like the initiation and engagement measures developed by the Washington Circle, several of the VA measures address the process of care. For example, 45 percent of veterans who were diagnosed with an alcohol or other drug problems in an outpatient clinic during 2001 received at least two additional services within 30 days of their diagnosis. Though no region met the goal of 70 percent of patients "engaged" in treatment, one region reported a 56 percent success rate. The VA also learned that overall, it didn't do as well in engagement as it had in 2000 when 46 percent of the veterans received the additional services.[15]

Performance measurement has consequences in the VA system. Facilities that do better addressing dependence on alcohol, tobacco and other drugs are eligible for a larger slice of the funding pie; those that don't do as well may see their funding cut.

A National Business Initiative

Performance measurement for addiction treatment also has begun to take root in other areas of the private sector, including the **National Business Coalition on Health (NBCH)**. Through its membership of 90 state and regional coalitions, NBCH represents more than 7,000 employers—including several of the nation's largest—who provide insurance for an estimated 34 million workers and their families. Since 1999, NBCH has offered these and other interested groups a Web-based tool called eValue8 that enables them to conduct a uniform, annual assessment of the quality of care for a wide range of health conditions. Independent analysis of the results permits comparison of health plan performance on a local, regional and national basis.

In 2003 eValue8 featured, for the first time, an alcohol module that includes several of the Washington Circle performance measures. This development is significant for two important reasons:

1) Health plans are likely to respond to eValue8 because purchasers use the tool to assess health plan quality directly. For example, when the Pacific Business Group on Health (which uses eValue8 and is the largest business health coalition in the country), requests that a plan complete eValue8, the health plan has a strong incentive to comply because of the coalition's enormous purchasing power.

2) About half of the participating employers offer financial rewards to high performing plans or provide employees with financial incentives to choose these plans for their health care needs. Employers can use these rewards and incentives to drive quality improvement in addiction treatment.

Performance measurement is a first step in quality improvement.

Addiction specialists have made tremendous progress in performance measurement. In just five years, they have developed a core set of measures and incorporated several into tools already familiar to health care purchasers. The inclusion of these measures among those for treating asthma, diabetes and high blood pressure gives addiction to alcohol and other drugs a place on the nation's health care agenda that is commensurate with its devastating impact on individuals, families and communities.

Improving the quality of alcohol treatment serves everyone's interests. Alcohol problems are the third leading cause of preventable death, killing 100,000 Americans annually. They drain $185 billion from the nation's economy by reducing productivity and increasing health care costs. Despite these enormous costs, however, the quality of treatment for alcoholism ranks dead last when compared to treatment for the nation's 25 leading causes of illness, death, hospitalization and doctor's visits. In fact, researchers have found that only 10 percent of Americans with alcoholism receive evidence-based care.[16]

Opportunities for Stakeholders to Improve the Quality of Addiction Treatment through Performance Measurement[17]

Performance measurement can improve the quality of addiction treatment but it will lead to positive change only if everyone with a stake in health care actively looks for ways to accomplish this. The development of a core set of performance measures for addiction treatment is a critical first step. Now that stakeholders at every level of health care delivery have real tools at their disposal, quality improvement in alcohol treatment is moving from theory into practice.

Options for Purchasers:

- Seek health plans that have better scores on performance measures.
- Use performance measures in contracts with health plans, linking them with financial incentives and penalties.
- Work with health plans to improve performance measure scores.

Options for Policymakers:

- Consider the role performance measurement can play in evaluating the effectiveness of public programs to treat alcohol problems.
- Seek input from professional and provider organizations such as the **American Society of Addiction Medicine** and the **Association for Addiction Professionals** to improve performance measurement.

Options for Health Plans:

- Report to the **National Committee for Quality Assurance (NCQA)** on the identification, initiation and engagement performance measures included in HEDIS 2004.
- Provide feedback to individual providers on their performance on measures compared to other providers.
- Design new programs for quality improvement, such as measuring the use of screening tools to identify individuals with alcohol and other drug problems.
- Offer incentives to clinicians to adhere to practice guidelines that will lead to better scores on performance measures.
- Access the **National Quality Measures Clearinghouse**, maintained by the federal Agency for Healthcare Research and Quality for examples of specific performance measurements.

Options for Clinicians/Provider Groups:

- Follow clinical practice and patient placement guidelines for treating individuals with alcohol and other drug problems. Guidelines are available from the **American Psychiatric Association**, the **US Preventive Services Task Force**, the **Center for Substance Abuse Treatment** and the **American Society of Addiction Medicine**.
- Participate in quality improvement initiatives in practice settings.
- Establish recognition programs to honor medical professionals who deliver high quality, research-based addiction treatment.

Options for Researchers:

- Continue to develop and test new performance measures for identifying and treating alcohol problems.
- Evaluate the implementation of performance measures.
- Train health plans and treatment providers to use performance measures.

Option for Consumers:

- Use the Quality Compass and other consumer-oriented tools developed by **NCQA** to learn how well your health plan scored on addiction treatment performance measures.

EXPERT CONSULTANT

Constance M. Horgan, ScD is a professor at the Heller School for Social Policy and Management, Brandeis University and director of the Center for Behavioral Health within its Schneider Institute for Health Policy where, in 1990, she founded the Substance Abuse Group. She has more than 25 years of experience in health policy analysis and services research in both academic and government settings, and has been involved in numerous health surveys. She studies how substance abuse and mental health services are financed, organized, and delivered in the public and private sectors.

Dr. Horgan directs a National Institute for Alcohol Abuse and Alcoholism doctoral training program at Brandeis. She also leads several studies on managed behavioral healthcare and directs the Brandeis/Harvard Center on Managed Care funded by the National Institute on Drug Abuse.

Dr. Horgan is the lead author of *Substance Abuse: the Nation's Number One Health Problem*. She has written numerous articles and served on expert panels and advisory committees for federal agencies, professional associations, and academic and community task forces.

CONTRIBUTIONS

Special thanks to Bob Anderson at the National Association of State Alcohol and Drug Abuse Directors; John Bartlett at the Forum on Performance Measurement; Mady Chalk at the Substance Abuse and Mental Health Services Administration; Don Christensen, MD at Value Options; Deborah Garnick, ScD at Brandeis University; Eric Goplerud, PhD at Ensuring Solutions to Alcohol Problems; Pamela Greenberg at the American Behavioral Health Care Association; Keith Humphreys, PhD at Stanford University; Frank McCorry, PhD at the New York State Office of Alcoholism and Substance Abuse Services; Delia Olufokunbi, PhD at Ensuring Solutions to Alcohol Problems; Sarah Sampsel at the National Committee for Quality Assurance; Sarah Wattenberg at the Substance Abuse and Mental Health Services Administration; and Lynora Williams at Ensuring Solutions to Alcohol Problems for their thoughtful contributions to this material.

Using Performance Measurement to Improve the Quality of Alcohol Treatment was researched and written by Ensuring Solutions to Alcohol Problems Senior Research Scientist Jeffrey Hon.

January 2003

2021 K St. NW
Suite 800
Washington, DC 20006
Phone: 202.296.6922
Fax: 202.296.0025
info@ensuringsolutions.org
www.ensuringsolutions.org

Ensuring Solutions to Alcohol Problems
THE GEORGE WASHINGTON UNIVERSITY MEDICAL CENTER

Ensuring Solutions to Alcohol Problems (Ensuring Solutions) at The George Washington University Medical Center in Washington, DC, seeks to increase access to treatment for individuals with alcohol problems. Working with policymakers, employers and concerned citizens, Ensuring Solutions provides research-based information and tools to help curb the avoidable health care and other costs associated with alcohol use and improve access to treatment for Americans who need it. The project is supported by a grant from The Pew Charitable Trusts.

SUGGESTED READING

Babor, T.F. & Higgins-Biddle, J.C. 2003. Quality Measurements for Alcohol Misuse and Dependence. Prepared for The Foundation For Accountability.

Berwick, D.M., Brent, J. et al. 2003. Connections Between Quality Measurement and Improvement. *Medical Care* 41(1) Supplement.

Eddy, D.M. 1998. Performance Measures: Problems and Solutions. *Health Affairs*. (17) 4: 7-25.

Garnick, D.W., Lee, M.T. et al. 2002. Establishing the Feasibility of Performance Measures for Alcohol and Other Drugs. *Journal of Substance Abuse Treatment*. 23: 375-385.

Gordis, E. 1999. Monitoring the Performance of Alcohol Treatment Systems. *FrontLines: Linking Alcohol Research and Practice*, a publication of the Association for Health Services Research.

Hodgkin, D., Horgan, C.M. et al. 2002. Quality Standards and Incentives in Managed Care Organizations' Specialty Contracts for Behavioral Health. *Journal of Mental Health Policy and Economics*. 5:61-69.

Institute of Medicine. 1997. *Managing Managed Care: Quality Improvement in Behavioral Health*. Washington, DC: National Academy Press.

McCorry, F., Garnick, D.W. et al. 2000. Developing Performance Measures for Alcohol and Other Drug Services in Managed Care Plans. *Journal on Quality Improvement*. 26(11):633-643. SIHP-234.

McGlynn, E. 2003. Selecting Common Measures of Quality and System Performance. *Medical Care*. 41(1) Supplement.

McGuire, T., Duby, L. & McGuire, L. 1999. Performance-Based Contracting in Maine Spurs Upward Trends in Service Effectiveness and Efficiency. *Frontlines: Linking Alcohol Research and Practice*, a publication of the Association for Health Services Research.

McLellan, A.T. & McKay, J.R. 1999. Monitoring the Effectiveness of Alcohol Treatment: Strategies for Linking Performance Measures to Outcomes. *Frontlines: Linking Alcohol Research and Practice*, a publication of the Association for Health Services Research.

Merrick, E.L., Garnick, D.W. et al. 1999. Use of Performance Standards in Behavioral Health Carve-Out Contracts Among Fortune 500 Firms. *American Journal of Managed Care*. 5(Special Issue):SP81-SP90. SIHP-156.

Merrick, E.L., Garnick, D.W. et al. 2002. Quality Measurement and Accountability for Substance Abuse and Mental Health Services in Managed Care Organizations. *Medical Care*. 40(12): 1238-1248.

Miller, J. 1999. Establishing Performance Measures and Standards for Alcohol Services. *Frontlines: Linking Alcohol Research and Practice*, a publication of the Association for Health Services Research.

National Association of State Alcohol and Drug Abuse Directors. 2001. A Summary of the Third NASADAD State Data Advisory Workgroup on Treatment Performance Measurement.

Ross, E.C. 1999. Performance Quality and Patient Protection: One Set of Standards for All Patients. *Frontlines: Linking Alcohol Research and Practice*, a publication of the Association for Health Services Research.

Solberg, L.I. Mosser, G. & McDonald, S. 1997. The Three Faces of Performance Measurement: Improvement, Accountability, and Research. *Journal on Quality Improvement*. 23(3), 135-147.

LINKS

Agency for Healthcare Research and Quality
http://www.ahcpr.gov/

American Society of Addiction Medicine
http://www.asam.org/

Association for Addiction Professionals
http://www.naadac.org/

Foundation for Accountability
http://www.facct.org/facct/site/facct/facct/home

Institute of Medicine
http://www.iom.edu/

National Business Coalition on Health
http://www.nbch.org/

National Committee for Quality Assurance
http://www.ncqa.org/index.asp

National Quality Measures Clearinghouse
http://www.qualitymeasures.ahrq.gov/about/about.aspx

Pacific Business Group on Health
http://www.pbgh.org/

Substance Abuse and Mental Health Services Administration
http://www.samhsa.gov/

Washington Circle
http://www.washingtoncircle.org/

Sources

1 McGinnis, J. & Foege, W. 1993. Actual Causes of Death in the United States. *Journal of the American Medical Association*. (270) 18: 2208.

2 National Institute on Alcohol Abuse and Alcoholism. 2000. Eighth Special Report to the US Congress on Alcohol and Health.

3 McGlynn, E.A., Asch, S.M. et al. 2003. The Quality of Health Care Delivered to Adults in the United States. *New England Journal of Medicine*. 348:2635-45.

4 National Committee for Quality Assurance. Accessible on the World Wide Web: **http://www.ncqa.org/index.asp**.

5 Institute of Medicine. 2000. *Crossing the Quality Chasm: A Health Care System for the 21st Century*. Washington, DC: National Academy Press.

6 Institute of Medicine.

7 National Committee for Quality Assurance. 2003. *The State of Health Care Quality: Industry Trends and Analysis*. p. 12. Available from the World Wide Web: **http://www.ncqa.org/index.asp**.

8 National Committee for Quality Assurance. 2003.

9 Schauffler, H.H., Brown, C. & Milstein, A. 1999. Raising the Bar: The Use of Performance Guarantees by the Pacific Business Group on Health. *Health Affairs*. (18) 2: 134-142.

10 Garnick, D.W., Lee, M.T. et al. 2002. Establishing the feasibility of performance measures for alcohol and other drugs. *Journal of Substance Abuse Treatment*. 23: 375-385.

11 Substance Abuse and Mental Health Services Administration. 2001. *National Household Survey on Drug Abuse 2000*. Washington, DC: Department of Health and Human Services.

12 Garnick, D.W., Lee, M.T. et al. 2002. Establishing the feasibility of performance measures for alcohol and other drugs. *Journal of Substance Abuse Treatment*. 23: 375-385.

13 Substance Abuse and Mental Health Services Administration. 2001. *National Household Survey on Drug Abuse 2000*. Washington, DC: Department of Health and Human Services.

14 Eddy, D.M. 1998. Performance Measures: Problems and Solutions. *Health Affairs*. (17) 4: 7-25.

15 Lie, C-C., Poon, K.Y.T. & McKellar, J.D. 2002. VA Care for Substance Use Disorder Patients: Indicators of Facility and VISN Performance (Fiscal Years 2000 and 2001). Palo Alto, CA: Program Evaluation and Resource Center and HSR&D Center for Health Care Evaluation. VA Palo Alto Health Care System and Stanford University School of Medicine. Available from the World Wide Web: **http://chce.info**.

16 McGlynn, E.A., Asch, S.M. et al. 2003. The Quality of Health Care Delivered to Adults in the United States. *New England Journal of Medicine*. 348:2635-45.

17 Horgan, C., McCorry, F. & Garnick, D. 2003. Creating Policy Relevant Information: The Case of Washington Circle. Nashville, TN: Presentation to the annual meeting of AcademyHealth. Available from the World Wide Web: **http://www.washingtoncircle.org**.