OCTOBER ATTC MESSENGER

LEARN TO LOVE YOUR DATA

Burdensome, irrelevant, repetitive, not meaningful, detracts from client care – all of these reflect the feelings of many addiction counselors about the collection and use of data in clinical practice. It is understandable, of course, for many reasons, but addiction treatment is entering an era in which collection and use of data is going to become more and more important, even essential for agency survival.

"Addiction treatment agencies need to be able to collect, manage and share data so that they can bill for services, develop appropriate treatment plans, monitor patient progress across inpatient and outpatient settings, test promising clinical practices and track quality improvements efforts." (Menehan, K., 2010). It is the latter two, testing promising clinical practices and tracking quality improvement efforts that this feature article will explore, looking at the forces for and against the better use of data in addiction treatment agencies, as well as what has been shown to work in helping agency staff become more data-fluent. This is an overview article and more specific and practical information will be provided in the webinar described at the end.

Current situation

Unfortunately, there are more barriers to good use of data than there are supports at this point in time. A couple of notable studies have described the situation as follows:

- *"Many substance abuse treatment agencies have inadequate data management systems in place and lack ways to transfer data from one level of care to another. As a result, they often collect the same data several times in the course of a patient's treatment. Many agencies also lack the infrastructure to aggregate data about patients, thwarting efforts to evaluate clinical strategies adequately. Even those agencies that have good information technology (IT) may not use it optimally."* (Menehan)
- Treatment agencies with more integrated health IT were able to expedite and improve the flow of information. Strengths of integrated systems include enhanced productivity, improved communication among intake, clinical and administrative staff, and an increased focus on data that allows information to be shared among stakeholders. "*Yet, most did not use their systems as much as they could have to look at data across all of their clients and conduct quality improvement activities."* (Menehan)
- *"Addiction treatment agencies typically do not prioritize data collection, management, and analysis, and these agencies may have barriers to integrating data in agency quality improvement."* (Wisdom, et al.)
- Despite finding that addiction treatment agencies have extensive reporting requirements to managed care organizations and state agencies, McLellan et al. noted that only 30% of 175 surveyed agencies reported access to well-developed information systems and concluded that treatment agencies are "choking" on data collection requirements. *"They observed little use of data for clinical decision making or program planning; for most agencies, data collection was just "paperwork." Fundamental opposition to data collection as demeaning to individuals or counter to the goals of recovery, a belief system that is part of the culture of many agencies, can*

inhibit staff support of performance improvement projects that require data collection." (Wisdom et al.)

Ironically, the glut of data that is required to be collected may serve useful purposes, but it may also not be providing the information needed to guide best clinical practice. Or, if data of that nature is there, agency and staff cultures that are not data-friendly may not be using the data they have as well as they could for improving clinical practice.

Enter An Effective Data-Supportive Model: NIATx

One way to encourage staff to embrace data collection and analysis is to help them see its relevance, to make it as user-friendly as possible, to have staff input and buy in, and to use data to make changes that are visible and successful. The Network for the Improvement of Addiction Treatment, aka NIATx, offers a model for this kind of interaction. A detailed description of the project aims and outcomes is available at www.niatx.net.

Wisdom et al. describe the project and its outcomes related to data fluency, as follows:

- *"NIATx members implement process improvements to reduce days to admission and enhance retention in care. Participants learn to use limited resources more efficiently and share strategies and tools for improving access and retention in addiction treatment. NIATx process improvement coaches guide organizations into creating cultures of improvement, in which patients and staff from all levels help drive treatment changes. The process improvement coaches assist agencies in identifying executive sponsors and agency change leaders, who lead change processes (with coaching) to improve services and outcomes. Change efforts have four aims: (1) reduce waiting time between first request for service and first treatment session; (2) reduce the number of patients who do not keep an appointment; (3) increase the number of people admitted to treatment; and (4) increase the period that patients stay engaged in treatment."*
- *"A cross-site evaluation examined the first 15 months of NIATx impacts on days to treatment and retention in care. Participating programs reduced days to treatment 37% from nearly 20 days in October 2003 to slightly more than 12 days in December 2004. Retention in care improved 18% from 72% to 85% of the treatment admissions completing at least two units of care. Moreover, the completion rate for three units of care improved significantly from 62% to 73% (a 17% improvement). NIATx, therefore, appears to help alcohol and drug abuse treatment centers facilitate changes in treatment process. (McCarty et al., 2007; Hoffman et al., 2008)*
- *"The NIATx intervention to improve access and retention also provided a unique opportunity to assess agencies' ability to use data to measure the impact of change."*

The same study posed and answered questions that are highly relevant to our present topic. The findings below are enlightening as we consider how to encourage better use of data in looking at clinical practice and outcomes (Wisdom et al.):

*B**efore NIATx participation**, "data systems were underutilized for quality improvement activities, in part because the information systems were designed for client payment and accounting, not client outcome tracking or quality improvement activities. Quality improvement data were generally limited to client feedback, satisfaction questionnaires, and treatment completion rates."*

- *Agencies differed in their dissemination of data.* ***In general, agencies that disseminated data more broadly were more likely to develop a capacity to explain the data and increased an agency focus on making data-driven improvements.***
- *Although agencies greatly increased their ability to collect data, analysis and interpretation of data remained challenging for most. Some agencies developed the capability to collect high- quality data and relied on external programming assistance to extract, analyze, and interpret the data results. High-performing agencies progressed in their ability to collect, extract, analyze, and interpret data and conducted more complex analyses, such as the effect of interventions on subgroups of clients (e.g., gender or funding source). Many agencies significantly changed staffing in response to a new data focus. Several changed the focus of a staff member (usually the change leader) to provide authority and time to manage data. Others hired an external consultant or internal staff member to assist with data collection.*

What barriers were encountered developing data expertise and focus?

Resistance to data collection often was associated with an agency culture that did not value data-based decision making. Many agencies experienced considerable resistance from staff at all levels to increasing a focus on data. Some staff indicated that any effort toward data tracking detracted from their primary mission of clinical care. Other leaders and staff indicated they were afraid of what more rigorous data tracking might reveal, or whether poor results could jeopardize their funding.

A middle manager at one agency sympathized with staff concerns about developing a data focus: Staff are much more interpersonal here, rather than data savvy. Most people work in this agency because they want to work with people, not because they want to work with numbers. ... The management information system is new, and is quite cumbersome, so many staff have difficulty with it, and are a bit afraid of it ... There has been an adaptation: people try to get by without data as best they can.

Wisdom et al. also addressed factors that helped improve agency and staff ability to use data effectively:

Agency leadership valued data and provided resources. *Agency leadership designated data and data-based decision making as a priority for the agency. This was accomplished in a number of ways. In agencies with stronger data management capabilities, agency leaders established data- based decision making and the development of a strong data-based management team as a goal for the agency and they committed resources to developing a strong infrastructure. Leaders in agencies with less strong data management capabilities stressed the importance of data, invited program staff or other experts to speak with their staff about data, and designated specific data managers who had responsibility and authority on data issues.*

Staff received training on data collection and use*. Training reinforced the leadership's focus on data and served to overcome staff resistance. In addition, training helped overcome "math anxiety" present in many staff who tended to avoid data, preferring to focus only on direct client care. Learning why the data were being collected, how the data were used, and how the data directly related to improving client care resulted in more buy-in from staff.*

It seems clear that pre-service training is another area upon which to focus if we are going to promote data literacy. It is interesting to note that addiction counselors who take the National Counselor Examination for licensure and certification score lowest on the section called Research and Evaluation (an average passing rate of 57%); this is the lowest rate among the 13 areas examined. Addiction counselors are not trained in skills vital for contributing to a quality-improvement-focused addiction treatment agency.

Wisdom et al. describe the importance of sharing change results:

> *Leaders who regularly shared the results of data collection and analysis with staff emphasized the value of data and reinforced training. Agencies managed sharing differently, by sharing results only within the change team, posting results on a project-related bulletin board, sending emails to some or all staff, and discussing the latest results at monthly meetings attended by all staff. As noted in the article, "Everyone knows at the end of the month about why people are leaving [against medical advice]—it's posted in the lunchroom. It's interesting to see the data, and sometimes they sit down and say, "It seems like we've been having a lot of this lately. Does anyone know what's happening?" ... That's helpful. Sometimes it's subjective, from memory, but they are having the conversations."*
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> *One key in developing the culture needed to sustain and replicate data-based performance improvement methodologies is the constant communication and training regarding data. Agencies that trained their staff members about data use had better adoption of data-focused processes. Those that communicated routinely to staff about data had more success in diffusing data-driven decision making than those agencies that did not communicate. Communication and training regarding data use and usefulness to inform decisions appears critical."*

Demonstrating the value of data to staff in real-world applications may help increase their buy-in to actively participate in data collection activities. A good example comes from an interview with NIATx coach Janet Bardossi, who worked with agencies offering supported employment programs. Increasing the agency staff's capacity to gather and use data resulted in regular measuring of the agency success rates against the state averages. According to the coach, "it has inspired staff to try and do better—we used a visual data board to display results and keep the data in front of the staff…as the numbers got better, morale increased and people got even more goal-oriented." (Bardossi)

Another insight from a NIATx coach is also worth noting: working with too much data or trying to make it too perfect can be a deterrent to staff and agency engagement in the data process. The coach advises picking the top "X" number of indicators that can improve treatment and concentrate on looking at just those. Define the indicators, identify how the data will be pulled, identify who will pull it and how it will be analyzed (as a group is recommended), and finally determine who will follow up on problems and acknowledge people who are doing well. Below are some indicators from which agency staff could select a few upon which to focus data analysis:

- How long does it take to get an appointment?
- How many people drop out?
- What is the average length of care?
- Do we have a financial dashboard we can look at?

- What changes in problem behavior are occurring? What level of treatment progress is taking place?
- Do we have high utilizers? (in particular, this measurement may align well with primary care integration efforts)
- What are our staff retention rates?
- What do our clients think of our services?
- Can we measure fidelity on at least one of our programs? (Bardossi)

Another big reason to gear up: integrated care systems

Since healthcare reimbursement systems are moving toward integrated HIT systems with certified, standards-based Electronic Health Records (EHR), providers who are unable to conform both claims and quantitative patient information to national data standards of these systems may become increasingly marginalized. (Ghiza)

Parity for SUD treatment is now federal law, but will be implemented in the context of these emerging EHR and national data standards. Therefore, specialty SUD treatment providers need to proactively initiate efforts to equip themselves with the necessary infrastructure to implement data standards consistent with those supported by the Federal Government. (Ghiza et al.)

Certainly, creating agency cultures supportive of data, helping staff learn to interpret and use data to improve clinical practice, and implementing other data-supportive measures such as are outlined in this article are precursors to being able to remain both effective and competitive in the emerging health care system.

Author:

Wendy Hausotter, MPH
Research Associate
Northwest Addiction Technology Transfer Center

Sources

Personal interview with Janet Bardossi, LCSW, on September 10, 2013.

Ghitza, U., Sparenborg, S., & Tai, B. (2011). Improving Drug Abuse Treatment Delivery Through Adoption Of Harmonized Electronic Health Record Systems. Substance Abuse And Rehabilitation, 2, 125-131.

Hoffman KA, Ford JH, et al. (2008) Replication and sustainability of improved access and retention within the Network for the Improvement of Addiction Treatment. Drug and Alcohol Dependence, 98 (1-2); 63-9.

McCarty, D. et al. (2007) The Network for the Improvement of Addiction Treatment: enhancing access and retention. Drug and Alcohol Dependence 2007; 88(2-3): 138-45.

Menehan, K (2010). Addiction Treatment Programs Manage Data Inefficiently. Robert Wood Johnson Foundation Program Results.

Wisdom JP, Ford JH 2nd, Hayes RA, Edmunson E, Hoffman K, McCarty D. Addiction treatment agencies' use of data: a qualitative assessment. J Behav Health Serv Res. 2006; 33:394–407.

Wisdom JP, Ford JH 2nd, Wise M, Mackey D, Green CA. Substance abuse treatment programs' data management capacity: an exploratory study. J Behav Health Serv Res. 2011; 38:249–264.