Workplace Managed Care

Substance Abuse Prevention
and Early Intervention

KNOWLEDGE EXCHANGE WORKSHOP II
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PRESENTATION MATERIAL

Workplace Research in Progress
Snippets From Current Workplace Research at RTI

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Adolescents at Work

- **Risk Factors for Adolescent Drug Use**

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Adolescents at Work

- **Research Question:**

- What is the relationship between substance use and work status among adolescents?

Adolescents at Work

- Analyses of NHSDA data for ages 12-17
- 1995 and 1996 NHSDA samples combined [plan to add 1997 sample]
- Unweighted N = 9,133

Adolescents at Work

- **Risk factors assessed:**
  - Employment status
  - Age
  - Gender
  - Race/Ethnicity [A-A, Hispanic, White, Other]
  - Family receiving any form of public assistance?
  - Region of country
  - Internalizing [psychiatric] syndrome present?
  - Externalizing [psychiatric] syndrome present?

Work and School Participation Estimates

Currently enrolled in school?	
YES	96.8%
Current employment status?	
SCHOOL ONLY	80.2%
EMPL. PART TIME [<35 hrs/wk]	15.3%
EMPL. FULL TIME [35+ hrs/wk]	2.2%
UNEMPLOYED, LAID OFF, OR HOMEMAKER	2.4%

[All youth, N = 9,133]

Adolescents at Work

- Two sets of outcomes studied:

- (1) Any use in past year:
  - **Cigarettes**
  - **Alcohol**
  - **Marijuana use only [no other illicit drug use]**
  - **Any other [illicit] drug use**

Adolescents at Work

- Outcomes studied (continued):

- (2) Heavy use [past 30 days]
  - **Heavy cigarette use [pack/day or more]**
  - **Binge alcohol use [5+drinks at least once]**
  - **Heavy alcohol use [5 +drinks on 5+ occasions]**
  - **Heavy illicit drug use [marijuana daily and/or others at least weekly, or heroin at least once, in past year]**

Basic Prevalence Estimates: *Any Use (%)*

	Cigarettes	Alcohol	Marijuana	Any Other
School only	21.9	29.1	6.4	7.9
Unemp.	54.7	61.4	15.0	26.7
Part time	36.9	51.8	13.2	19.4
Full time	50.4	65.7	19.4	20.2

[All youths, N = 9,133]

Basic Prevalence Estimates: *Heavy Use (%)*

	Heavy Cigarettes	Binge Alcohol	Heavy Alcohol	Heavy Illicit
School only	1.2	5.6	1.9	1.6
Unemp.	11.9	22.4	12.7	13.1
Part time	3.1	12.3	4.9	2.2
Full time	13.1	24.9	11.7	9.6

[All youths, N = 9,133]

Adolescents at Work

- **<u>Details of the analysis</u>:**
  - Logistic regression models
  - Findings presented as *odds ratios*--odds of having a given outcome relative to the reference group ["in school only"]
  - Odds ratios for a given risk factor are "net of all of the others"

Adolescents at Work

- **<u>More details of the analysis</u>:**
  - Findings presented separately by gender
  - Analyses were conducted with and without "dropouts" [those "not in school"]
  - Findings presented are <u>without</u> dropouts--associations are *stronger* with dropouts

Model Based Odds Ratios

Employment Status

	Cigarettes		Alcohol		Marijuana		Any other	
	M	F	M	F	M	F	M	F
Full time	1.97	NS	NS	2.93	2.57	NS	NS	NS
Part time	NS	1.57	NS	1.61	1.41	NS	NS	1.51
Unemp.	NS	NS	NS	3.31	NS	NS	4.00	NS

Reference cell: In school only [not working at all]

Model Based Odds Ratios

Employment Status

	Heavy Cigarette		Binge Alcohol		Heavy Alcohol		Heavy Drug	
	M	F	M	F	M	F	M	F
Full time	3.52	NS	2.59	NS	3.72	...	NS	NS
Part time	NS	NS	NS	1.85	NS	2.80	NS	NS
Unemployed	4.35	NS	NS	3.97	NS	10.31	NS	NS

Reference cell: In school only [not working at all]

Other Findings of Interest

- Externalizing syndrome significant risk factor for *every* substance use outcome for males *and* females
- Internalizing syndrome significant risk factor for use--but not heavy use--in females, but not males
- For most substance use outcomes, A-A and Hispanic youth have significantly *lower* use rates than white

Prevention-Related Behavioral Health Standards in Health Care Accreditation

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Why assess accreditation standards?

- Accreditation is one approach to assessing MCOs' quality of health care
- Public and private payment programs often require accreditation
- MCOs may find accreditation helpful as they compete in the health care market
- Accreditation standards may be used to enhance behavioral health care coverage

Accreditation Organizations Reviewed

- Accreditation Association for Ambulatory Health Care (AAHC)
- Commission on Accreditation of Rehabilitation (CARF)
- Council on Accreditation of Services for Families and Children (COA)
- Employee Assistance Society of North America (EASNA)

Accreditation Organizations (cont.)

- Joint Commission on Accreditation of Healthcare Organizations (JCAHO)
- National Committee for Quality Assurance (NCQA) - Behavioral Health Accreditation Program
- Quality Improvement System for Managed Care (QISMC)

National Report Cards

- Health Plan Employer Data Information Set (HEDIS 3.0)
- Performance-Based Measures for Managed Behavioral Healthcare Programs (PERMS)
- County Behavioral Healthcare Measures (NACBHD)
- Mental Health Statistics Improvement Program (MHSIP)

Findings: National Report Cards

Findings: Accrediting Institutions Examples of Universal Strategies

- Maintain guidelines for prevention and early detection
- Document scientific basis of preventive health guidelines
- Demonstrate expertise of professionals who developed guidelines
- Demonstrate that guidelines have been in place for at least two years and are updated biennially

Examples of Universal Strategies (cont.)

- Distribute guidelines to practitioners and encourage their use
- Distribute guidelines to members annually
- Conduct annual community-based needs assessment
- Increase public awareness of behavioral health issues
- Strengthen individuals' and families' social and psychological functioning

Findings: Accrediting Institutions Examples of Selective Strategies

- Maintain linkages with organizations likely to identify needy individuals and families
- Identify at-risk individuals at risk for specific problems; urge them to use health promotion and prevention services
- Identify and screen families of addicts
- Screen for "life threatening" mental illness among admitted patients

Findings: Accrediting Institutions Examples of Indicated Strategies

- Refer persons in need to appropriate treatment
- Strengthen parent-child relationship

Discussion: Accomplishments

- Some accrediting organizations have incorporated a prevention standards section *into their behavioral health manual*
- A few standards appear actually to tell MCOs what they have to *do* to be accredited

Discussion: Problems

- Many prevention standards appear to be limited to physical health
- Behavioral health-related prevention clearly *not* a priority
- Existing standards are *highly* ambiguous
- Many prevention standards sections are limited to established prevention programs
- Little effort to infuse standards into general behavioral health care services

Discussion: Barriers to be Overcome

- Benefits of prevention slow to accrue
- MCO enrollees turn over frequently
- Less empirical foundation for effectiveness of prevention than treatment
- Perception that costs of prevention outweigh benefits
- Inertia

Optimistic Concluding Remarks

- Decrease of capitation rates, and restrictions on treatment, may increase focus on prevention
- Scarcity of available human capital may induce employers to focus on behavioral as well as physical health needs
- Consolidation may lead to greater MCO stability and thus greater investment in long-term behavioral health of covered lives