PAYER–PROVIDER CHANGE BULLETIN

SOUTH CAROLINA DEPARTMENT OF ALCOHOL AND OTHER DRUG ABUSE SERVICES

The South Carolina Department of Alcohol and Other Drug Abuse Services (DAODAS) is the cabinet-level agency charged with ensuring the provision of quality services to prevent or reduce the negative consequences of substance use and addictions. DAODAS partners with public, private, and social sector organizations to provide quality prevention, intervention, and treatment services for the citizens of South Carolina.

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PARTNERS: Aiken Center for Alcohol and Other Drug Services
Axis I Center of Barnwell County
Colleton County Commission on Alcohol and Drug Abuse
Georgetown County Alcohol and Drug Abuse Commission
Keystone Substance Abuse Services
LRADAC: The Behavioral Health Center of the Midlands
The Phoenix Center
Spartanburg County Alcohol and Drug Abuse Commission

PROJECT AIM: Reduce paperwork

STATEWIDE AIM: The short-term aim is to improve access and, through increased retention, produce better outcomes.

The long term aims are:

- Reduce no-shows for assessments by 25 percent for separate intakes and assessments.
- Increase the continuation rate by at least 25 percent for combined intakes and assessments.
- Increase number of admissions by at least 2.5 percent.

GOALS AND MEASURES

Input from providers and from DAODAS Change Team walk-throughs indicated that excessive paperwork at intake is a major barrier to access and retention. Too much paperwork may unnecessarily lengthen the intake process and "turn off" the client, thus contributing to no-shows for assessment appointments or, if intake and assessments are combined, to continuation rates. The goals of the pilot project were to reduce intake paperwork by at least 33 percent (from 6 forms to 4 forms) and to reduce the duration of intake by at least 20 percent.

The state Change Team included members of the STAR–SI staff and provider representatives to the Uniform Clinical Records (UCR) Committee. The team looked at several possible changes to achieve the objective. These included:

- Combine forms in the short term.
- Move to electronic records in the long term.
- Collect some intake data over the telephone.
- Institute a waiver to allow providers to deviate from normal timelines in completing selected forms.
- Enhance front-line staff's abilities to engage clients.

OVERALL IMPACT

The state level Change Team developed a waiver to allow providers to experiment with the timing of paperwork during the intake process. Training of front-line staff in Motivational Interviewing to enhance client engagement was completed. So far we only have anecdotal and positive results from these facilitating changes made at the state level.

The Change Team's primary project was to reduce intake paperwork and the time needed for clients to go through the intake process.

The first two change cycles field tested two consolidated intake forms. The results were:

- The number of intake forms was reduced by 67 percent.
- The length of the intake process was reduced by 50 percent when intake is face-to-face and 5 percent when intake is part of a group orientation.

Next, the Change Team further squeezed the intake forms into just one form, coordinated it with the Legal Action Center; and field tested it during July 2007. Not unexpectedly, the number of intake forms was reduced by 85 percent, and we obtained some marginal improvements on the length of the intake process.

The business case impact is probably centered on the reduction in the length of the intake process. We forecast that at least 15 of our 33 providers will experience a reduction of 50 percent in the length of intake. While we have not run a study on how this reduction impacts the bottom line, it is apparent that we will realize roughly a 25 percent savings in this area.

LESSONS LEARNED

While the PDSA cycle at the state level is not as rapid as at the provider level, the SSA's continuous quality improvement approach changed for the better with the adoption of the NIATx model. The SSA has become much more flexible, responsive, and proactive in addressing state-level barriers.

As a result of this change and participating in the STAR–SI program, the relationship between the SSA and local providers has been improved as well. All participants have become more eager to share and learn from each other's experiences.

By inviting the participation of staff at all levels and nurturing a team approach, which featured contributions of front level staff, the Change Project broke down hierarchical organizational barriers.

Another consequence of this change project, in deed a general impact of the NIATx model, was a reduction of unproductive time and effort spent on correcting miscommunications.

PLANNED CHANGES

We are now in the process of further coordinating the consolidated form with CARF, after which we will revise our Uniform Clinical Records Manual, train our providers to use the new form, and implement the consolidated form state wide (probably by January 2008).

Because of the lessons learned during the field trials, our long-term plan includes analyzing client access and retention data, as well as client outcomes, to see if group orientation/intake and face-to-face intake processes have differing impacts.