Expanding Performance-Based Contracting in Delaware

Statewide Science-based Concurrent Recovery Monitoring (CRM)

Jack Kemp
Deni Carise
Adam Brooks
Kim Lucas
Amy Camilleri
Meghan Love
Mady Chalk

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Delaware CRM Project

Aim:

To extend the performance–based contracting system already in place by selecting and testing a small number of additional performance indicators for feasibility of use in future PBC.

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Delaware Phase 1

The Paperwork Burden Review

Evaluate current data collection in an effort to minimize paperwork burden

"A good faith effort"

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Paperwork Burden Step 1

A systematic evaluation of multiple, competing data collection demands (state, grant, contract, managed care, credentialing agencies, etc.) through continuum of care (screening, intake & assessment, discharge, etc.) all of which require paperwork

Paperwork Burden Step 1

- Paperwork Burden evaluation is a service for providers who are interested.
  - No provider declined to participate; in fact, they were very appreciative, welcoming and participatory.

Paperwork Burden Step 2

- Connect with each provider, assure them that their site's needs and unique situations are being taken into consideration.
  - In this case, 2 staff from TRI conducted five-hour site visits at each outpatient treatment program

Paperwork Burden Step 2

At the site visits:

1. TRI staff met with numerous treatment provider staff and conducted a paperwork “walk through”.

2. All paperwork forms and requirements for patient activity were documented and discussed.

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Paperwork Burden Step 3

Be Comprehensive:

All paperwork completed, for any reason, from the first phone call through transfer or discharge from treatment was discussed and all forms were collected.

Paperwork Burden Step 3

Paperwork demands were discussed and forms collected for the following activities:

Screening

Intake

Assessment

Treatment Planning

Discharge

Transfer and

Follow-up

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Paperwork Burden Step 4

Documentation and Comparability:
Forms were logged into spreadsheets by type of information documented and how each provider collected the information.

Paperwork Burden Step 4

	Program # 1	Program # 2	Program # 3	Required?
DISCHARGE				
State Discharge Form Used	Yes	Yes	Yes	Yes
Discharge Summary	Hand Written	In special Progress note	"SOAP" Format	Yes
Discharge ASI	No	Yes (When Possible)	No	Yes – Why?
Discharge ASAM	Yes	No	No	Yes – Why?
Prescription Documentation	Verbal list from client	Makes copies of bottle	Note from Physician	No

Results:
Forms fell into 12 categories

1. Organizing forms,
2. Applicant Intake Packet
3. Biopsychosocial forms
4. Addiction Severity Index (ASI)
5. American Society of Addiction Medicine (ASAM) paperwork,
6. Treatment Planning
7. Physical Exam forms
8. Medicaid Only paperwork
9. During Treatment forms
10. Discharge
11. Post-Discharge forms
12. Transfer forms.

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Paperwork Burden Step 5

- Confirm: We reviewed our master list of paperwork requirements and forms from all sites to ensure that we had collected everything.
  - Common issue: Same form, different name.

Recommendations: Delete

1. Written Assessment Summary (covered by ASI narrative report)
2. ASAM at intake for all OP programs (lowest level of care)
3. MAST (few alcohol only clients)
4. 90 Day ASAM updates
5. Full SOGS (use 2-question screener)
6. ASI and ASAM at discharge

Recommendations: Standardize

Standardize Forms:

1. Consent (2-way)
2. Treatment Planning
3. DFS, TASC and PO Status Reports
4. Physical Exam form
5. Physical Exam Refusal form

Results

1. Standardized, consolidated forms
   - Decreased redundancy
   - Transfer between program easier
   - Everyone “talking the same language”
2. Non-required paperwork identified
   - Many site were completing “required” paperwork that hadn’t been required for years
3. Increased good-will between treatment programs, state and research staff.

Results

Required paperwork reduced by

2 hours per client

What made this successful?

Extensive commitment and ongoing involvement by State Director:

- Involved of State licensing staff
- State Director was willing to be open-minded and consider all suggestions
- Trusted knowledge of researchers
- But, made his own decisions in service of the state.

What made this successful?

- Dedicated, patient "research" staff
  - Repeat visits to sites
  - Ongoing telephone contact
  - Willingness to listen repeatedly to program staff's "gripes" even when we couldn't effect change (Medicaid forms)
- Collaborative nature of work between researchers, state and treatment programs staffs.

How might this be done in your state?

Notice we didn't pick New York, California or Texas….

But – there are many options!

How might this be done in your state?

- At the County or Regional level
- Using a survey tool that requires only Yes/No checkmarks and is validated with phone calls
- Finally will always require a State-level meeting of all agencies that require paperwork to reach agreement on final number of forms