Vermont Association of Addiction Treatment Providers

System of Care

White Paper

January 15, 2015

Executive Summary

In March of 2014 the Vermont Association of Addiction Treatment Providers (VAATP) undertook a state-wide assessment of the current system of care to identify opportunities for improvement. A broad range of stakeholders including the treatment providers, officials of state agencies, and clients of the current system provided input. For the purpose of this assessment the system of care was defined as all treatment and support services for individuals with substance use disorders and their families,.

Current and former patients reported high levels of satisfaction with the care they receive. However, in seeking treatment many did not know what services and supports were available or how to access them. Accessing the addiction services system for the first time was often difficult and time consuming. In addition, patients who had accessed the system at one point experienced difficulties when seeking services later.

The primary opportunity for improvement addressed in this White Paper is the need for an integrated and easy to use system for accessing care. A review of leading practices, both within addiction treatment and beyond, identified an "integrated service delivery model" as the best solution. Such systems are commonly used in both the public and private sector as a means for providing fast and efficient access to a wide array of services.

Examples of such systems include technology help desks (e.g., Apple Computer, Comcast, Verizon) and local systems such as the Vermont Department of Motor Vehicles (http://dmv.vermont.gov/online_services). In the latter system users can perform transactions on-line (e.g., renew registration, pay fees, register for courses), view up-to-date travel information and download forms. For customers requiring further assistance there is an "800" number which connects them to an automated phone-tree with keypad and voice recognition technology that routes them to the appropriate (recorded) information or customer service representative.

For Vermont's system of care, the future service delivery model is envisioned as a state-wide shared system providing a single resource for accessing addiction treatment. It is anticipated that development of this system will be a joint venture of the State and the service providers working together through the VAATP. As part of this process all aspects of the "customer experience" (e.g., ease of access, information and transactions provided, level of assistance provided by customer service representatives) will be designed to be consistent with the needs of State Agencies, the treatment system, and clients.

However, development of a new service delivery system will incur associated costs and Vermont has budget constraints. It is essential that funding not be reduced from existing services. Therefore, this project should be low cost or cost-neutral, with funding from a combination of State money and external funding sources. Initial discussions with both treatment providers and state officials indicated an interest in, and willingness to, pursue external funding sources. A variety of potential funding sources have been identified that could support an innovative public-private healthcare partnership.

Background

In March of 2014 the Vermont Association of Addiction Treatment Providers (VAATP) undertook a state-wide assessment of the current system of care to identify opportunities for improvement. A broad range of stakeholders including treatment providers, officials of state agencies, and clients of the current system provided input. For the purpose of this project the system of care is defined as all treatment and support services for individuals with substance use disorders and their families.

Current System of Care

Vermont's Addiction treatment system of care offers residential and community-based outpatient treatment programs throughout the State. Together with the mental health treatment system it forms an comprehensive and coordinated support system of specialty services within the overall healthcare system. For people receiving addiction treatment services in Vermont, those services are generally robust and of high quality. Services are provided by licensed professionals who are well trained and committed to delivering quality care.

Vermont has seen an alarming growth of opioid addiction in recent years, and has made significant and rapid changes in response. This has put the system of care under significant pressures and there are a number of areas where improvements can be made.

Current and former patients reported high levels of satisfaction with the care they receive. However, in seeking treatment they did not know what treatment programs were available or how to access them. Friends or family members assisted some patients in this process; others simply went to the emergency room. In many cases, accessing treatment for the first time was not experienced as fast or easy. Typically, once patients have been in treatment they tend to return, as needed, to programs already known to them.

Opportunity for Improvement

The primary opportunity for improvement addressed in this White Paper is the need for fast and efficient access to treatment services. The current process of identifying and accessing initial treatment and the subsequent process of transitioning patients between treatment programs is generally not easy, fast or efficient. There are a number of reasons for this including system capacity and the administrative burdens of transferring patients within the system of care. Despite this, patients are typically well shielded from the complexity and they experience a high level of coordination and care.

The issue of access to services is typically an issue for three groups of stakeholders, and the proposed system would improve services for all three groups. The first group are first-time patients and their primary treaters such as PCPs and therapists: this group may be unfamiliar with available addiction treatment programs and are looking for a program with availability that is a good fit for their needs. Typically, once a client or referring provider has found a program that meets their needs, they return to (or refer others to) that program in the future. However, when people are returning for treatment and their preferred program is not the best match they often are unaware of other treatment options. This is the second group that will be served - people returning for treatment and looking for a new treatment program. Finally, this system will provide ready access for people seeking detailed and specific information about treatment outside of normal operating hours. This will provide patients an opportunity to begin the process

of finding services when they need it, regardless of time of day, day of week, or where in Vermont they choose to live. It is anticipated this will decrease the large number of people who consider getting help but who never enter treatment.

Leading Practices

A review of leading practices in addiction treatment services revealed that Vermont's current system is typical of systems nation-wide. There are no States with a well-integrated and efficient system for addiction treatment. For the most part, States are moving slowly towards this goal due to a number of impediments such as lack of collaboration between treatment providers, a lack of collaboration between treatment providers and state government, and limited funding.

Identifiable leading practices that have been implemented are limited in both number and scope. For instance, New Hampshire has instituted an integrated patient information system (utilizing capabilities of their WIC information system) where some of the information collected by an initial treatment program is available to all subsequent treatment providers. However, this shared information is basic (e.g., name, age, address, medical history) and must be supplemented with a clinical screening by all subsequent treatment providers.

An examination of leading practices outside of addiction treatment was conducted to identify other solutions. This led to the identification of service delivery models which route the majority of information inquiries and transactions through self-service applications, supplemented by a help desk. These are used by a number of public and private organizations to improve access to services while reducing costs.

Examples include technology help desks (e.g., Apple Computer, Comcast, Verizon) and local systems such as the Vermont Department of Motor Vehicles (http://dmv.vermont.gov/online_services). In the latter system users can perform transactions on-line (e.g., renew registration, pay fees, register for courses), view up-to-date travel information and download forms. For customers requiring further assistance there is an "800" number which connects them to an automated phone-tree with keypad and voice recognition technology that routes them to the appropriate (recorded) information or a customer service representative.

The actual implementation of service delivery models that provide access to multiple services is typically referred to as a **shared services center**. One of the primary design criteria for these centers is the principle of "one call does it all." In a properly designed and operating shared services center approximately 95% of all inquiries are handled via a single phone call or visit to the website (see the sample model and escalation process in Appendices A and B for more details).

Briefly, a typical shared services center consists of four levels or "tiers" of service, with oversight provided by a governance board (see Appendices A and B for further details). The basic levels, in order of access, are as follows:

Tier 0 *Self-Service* **–** *web and/or phone based* entry point for end-users of the system, (e.g., clients, physician's offices, courts) seeking information on services (e.g., treatments provided, availability of treatment slots, costs of treatment) and carrying-out transactions (e.g., initiating intake process for a treatment program). Access is available 24 hours a day, seven days a week.

Tier 1 *Service Desk* **–** The first level of escalation for inquiries and transactions that end-users cannot complete via self-service. Service desk personnel are available by phone, email and web-chat. This function provides *live*, end-to-end support for routine requests, questions, issues and services. Access is typically available during normal business hours.

Tier 2 *Subject Matter Experts: Escalation & Resolution* **-** Supports service desk personnel on more complex requests, typically involving unusual problems and exceptions. The personnel at this level are experts in their field and may support the service center on an "as-needed" basis while carrying out the full-time duties of another role (e.g., managing a treatment program, directing a state office). As a result issues requiring resolution at this level may take several hours and require a return call to the client. It is typically the responsibility of the Service Desk staff member who took the original call to escalate an issue to the appropriate subject matter expert and contact the client regarding the resolution.

Tier 3 *Leadership* **–** Dedicated staff responsible for providing day-to-day oversight and direction of the service center, resolving complex issues, and tracking and reporting on performance metrics.

Governance Board – made up of selected members of stakeholder organizations. The Board provides strategic direction and guidance to the leadership team.

Proposed Solution

It is envisioned that a single shared services center could be designed, implemented and operated as a joint venture of the State and the addiction treatment system. Essentially, this will be a shared resource that is supported by, and in turn supports, the State and the treatment system. As such all aspects of the service delivery model and "customer experience" (e.g., ease of access, information and transactions provided, level of assistance provided by customer service representatives) will be designed to be consistent with the needs of State Agencies, service providers and clients.

For instance, people who are familiar with their treatment options could continue to access treatment by contacting a treatment provider directly. In addition, they will now have the option of going through a centralized system to access treatment. As previously discussed, this will be especially beneficial for people accessing treatment for the first time, seeking a new treatment program, or seeking treatment, outside of normal operating hours.

In essence, customers (e.g., patients, parole officers, medical professionals) would access the system via either phone or Internet in order to identify appropriate and available treatment programs. Once connected to either a service desk operator, or the website, users will be able to obtain program information, identify appropriate treatment programs with availability, and begin the initial "registration" process. The information to be collected during the initial "registration" will be determined during the design phase of the system implementation. At a minimum, it is suggested that sufficient information be collected (e.g., basic demographic and clinical information) that treatment providers can assess whether they can meet the needs of a client referred to them via the system. The system will also provide a process for efficiently

escalating and resolving requests which cannot be addressed via an initial call or visit to the website (see Appendix D: Illustrative Scenario, for an example of this process).

Because all information regarding access to treatment will be centralized, there will be the ability to generate real-time, State-wide performance metrics that are agreed upon during the design phase. For instance, at any given time it will be possible to create a report on wait times for treatment, the number of people waiting for treatment, the number of open treatment slots and other information of interest. In addition, this data can be parsed by a variety of demographic variables (e.g., location, age, gender). This will significantly improve the State and the treatment providers' access to accurate data and to track and report on critical information across the entire continuum of the treatment system.

Finally, as this is a shared resource it should reduce operating costs for participating agencies and service providers by eliminating duplicative services and functions. Admittedly, a significant investment is required to pay for the design, implementation and staffing of the shared services center. But it is anticipated that the needed funding is available. In a post-healthcare reform world, with an ever-decreasing uninsured population, partial funding could come from the use of a portion of the State's annual SAMHSA block grant which has historically paid for care for the uninsured. We believe that SAMHSA would find this an innovative solution that promotes their goal of funding "activities that prevent and treat substance abuse and promote public health." The following section provides suggestions on potential additional funding sources.

Potential Concerns and Challenges

It is anticipated that enhanced access to information about, and entry to the treatment system will increase demand for services. There is some concern that in certain areas of the State that increased ease of access could create a strain on the addiction treatment system's capacity. Solutions to this issue would need to be considered in tandem with implementation of such a project, including workforce development and attention to areas already under a capacity strain. Access barriers, however, are not a solution to problems with system capacity: these must be solved through sustainable growth, innovation and collaboration with State partners.

Those familiar with other types of service center models might raise the objection that many have experienced poor service from one or more service centers (e.g., long wait times on hold, service desk operators who were unable to help). However, it is important to note that all aspects of the "customer experience" (e.g., ease of access, wait times, level of assistance provided by customer service representatives) can be designed to be consistent with the needs of State Agencies, service providers and clients. For example, a well-designed virtual service center, such as Apple Computer's, is easy to use and quickly and efficiently meets the needs of the vast majority of customers. Conversely, many systems provide unsatisfactory service; in some cases this is intentional, and in some cases it is due to poor design or execution. *The bottom line is that if properly designed and managed a shared service center will provide high levels of service and create high levels of customer satisfaction.*

Finally, as this report is being written, the State faces a growing deficit and will certainly be taking further action in response. Therefore, any new system must be low cost or cost neutral to the State, and not take funding away from existing programs.

Funding

There are, of course, costs associated with the development of a new service delivery system, and Vermont's current budget constraint underscores the needs for additional funding sources. Initial discussions with both treatment providers and State officials indicated an interest in, and willingness to, pursue alternate funding sources. However, if available, public investment in an integrated system that promotes access is a worthwhile investment strategy: many studies have shown that access to addiction services substantially reduces overall costs to the system. Tragically, as many as 90% of those who need some level of treatment are not receiving it today, and the costs of this are seen in both human lives and hidden costs across the spectrum of State spending. The simple truth is that treatment is effective and treatment not only saves lives but saves money.

One potential federal funding source is the CMS Innovation Awards established under the Affordable Care Act (http://innovation.cms.gov/initiatives/Health-Care-Innovation-Awards/Round-2.html). One of the (four) target areas for awards is "Models that improve care for populations with specialized needs" – a category that clearly fits many patients with substance use disorders. So far twenty-seven states have been granted initial awards, in 2014, ranging from $2M to $23.8M. For example, New Hampshire is part of a $7.1M grant made to five states to develop an on-line system to enable Physicians to request and provide consultations and referrals. So far, Vermont has not received any grants.

Grants may also be available from leading charitable organizations that support innovations in health care such as the Kresge Foundation (http://kresge.org/grants-social-investments), the Arthur Vining Davis Foundation http://www.avdf.org/FoundationsPrograms/HealthCare.aspx), and the Robert Wood Johnson Foundation (http://www.rwjf.org/en/grants/what-we-fund.html).

Further, as it is likely that the future service delivery model will be significantly enabled by information technology, another potential funding source is the technology industry. For instance, at the beginning of 2014 Eric Schmidt, the CEO of Google, provided $1M in grants to organizations using technology "…to solve some of our most pressing problems." While this grant money has been disbursed it is anticipated that technology companies will continue to be interested in publicly supporting the innovative use of (their) technology to address pervasive medical and social problems such as addiction.

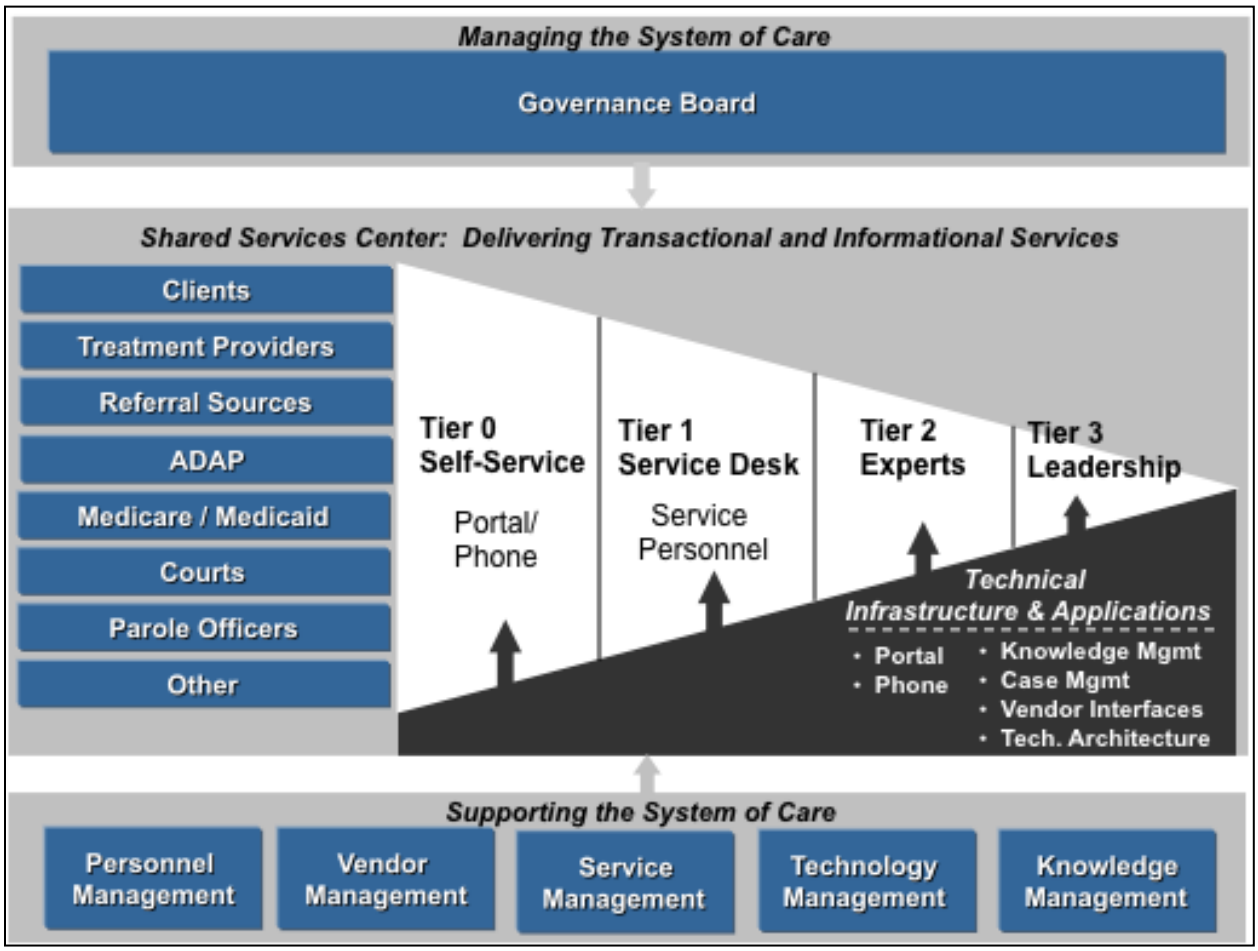
Next Steps

It is anticipated that implementation of this plan will require a major change effort. Neither the State nor the treatment system alone currently has sufficient resources to carry out a project of this scope. Therefore, once a strategy has been developed, the State and VAATP can jointly issue an RFP for consulting services to firms with a proven track record of working with both State Governments and Health Care providers on large scale changes to organizational structures, policies and technology. The RFP should require submission of a plan and cost estimates for delivery of consulting services, which are to include an implementation plan, governance model, technology integration (i.e., hardware, software) and business case.

Based on cost estimates provided by the consulting firms a project budget can be developed and funding obtained (e.g., Governor's Office, Capital Budget, CMS Incubator). Following this a full-time project manager should be appointed to oversee the project and a consulting firm hired to carry-out the project

Appendix A: Sample Future System of Care Infrastructure - Overview

The following graphic illustrates the primary components of the proposed future system of care. A brief description of the components is provided below.



The primary components of this model are as follows:

Tier 0 *Self-Service* **–** *web-and/or phone based* entry point for end-users of the system, (e.g., clients, physician's offices, courts) seeking information on services (e.g., treatments provided, availability of treatment slots, costs of treatment) and carrying-out transactions (e.g., initiating intake process for a treatment program). Available 24 hours a day, seven days a week.

Tier 1 *Service Desk* **–** The first level of escalation for inquiries and transactions that end-users cannot complete via self-service. Service desk personnel are available by phone and web-chat on the Tier 0 website. This function provides *live*, end-to-end support for routine requests, questions, issues and services. Access is typically available during normal business hours.

Tier 2 *Subject Matter Experts: Escalation & Resolution* **-** Supports service desk personnel on more complex requests, typically involving problems and exceptions. The personnel at this level are experts in their field and may support the service center on an "as-needed" basis while carrying out the full-time duties of another role (e.g., managing a treatment program, directing a state office). As a result issues requiring resolution at this level may take several hours and require a return call to the client. It is typically the responsibility of the Service Desk staff member who took the call to escalate an issue to the appropriate subject matter expert and contact the client regarding the resolution.

Tier 3 *Leadership* **–** Dedicated staff responsible for providing day-to-day oversight and direction, resolving complex issues, and tracking and reporting on performance metrics.

Governance Board – made up of selected members of stakeholder organizations. The Board provides strategic direction and guidance to the leadership team.

Support Services

Personnel Management **–** Responsible for hiring, developing and managing service center employees.

Vendor Management **–** Manage and monitor service center suppliers' contracts and performance.

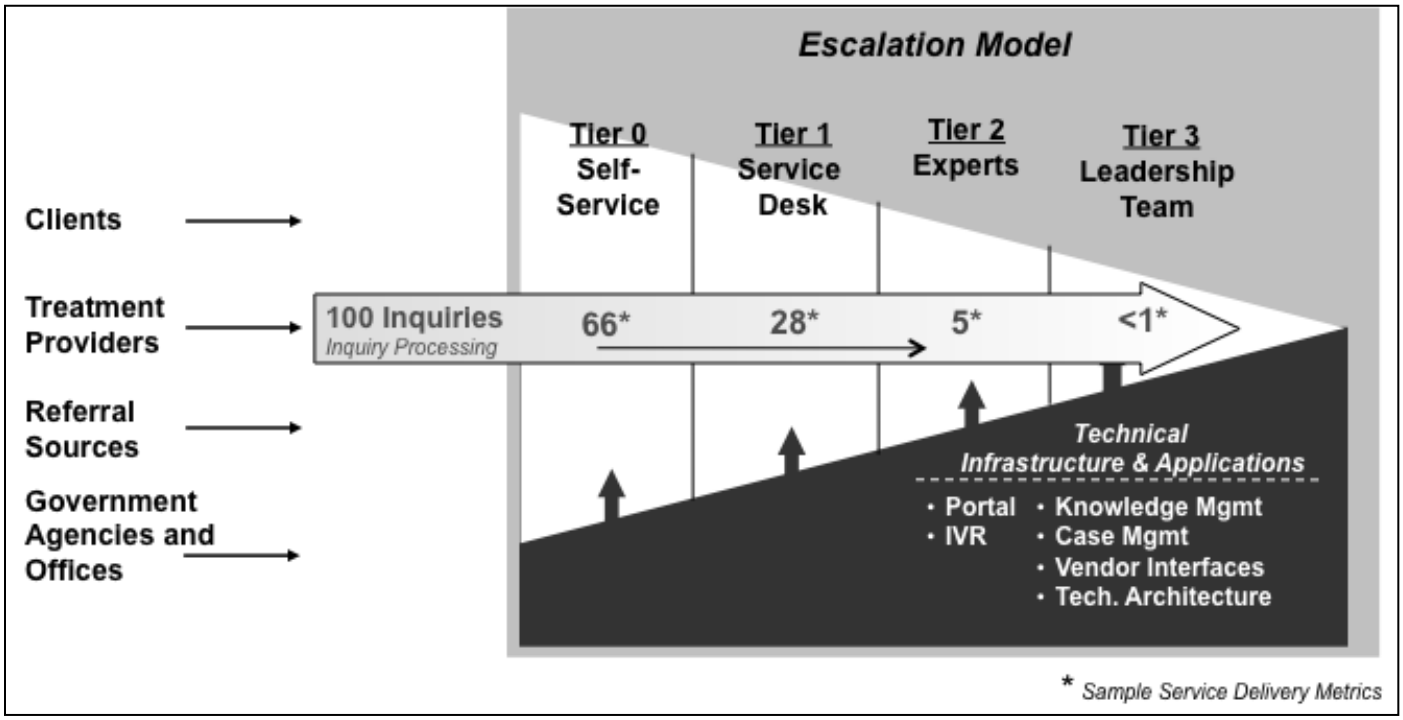
Service Management **–** Lead data gathering efforts to develop and populate performance reports and scorecards; own the preparation and distribution of performance reports and scorecards; monitor continuous improvement activities based on performance scorecards.

Technology Management **–** Manage and support existing technology, and develop and deploy technology required for new services.

Knowledge Management **–** Monitor information repository to ensure data integrity; identify reusable information to create frequently asked questions (FAQs); coordinate with other groups to share knowledge; develop processes and tools to capture and utilize knowledge.

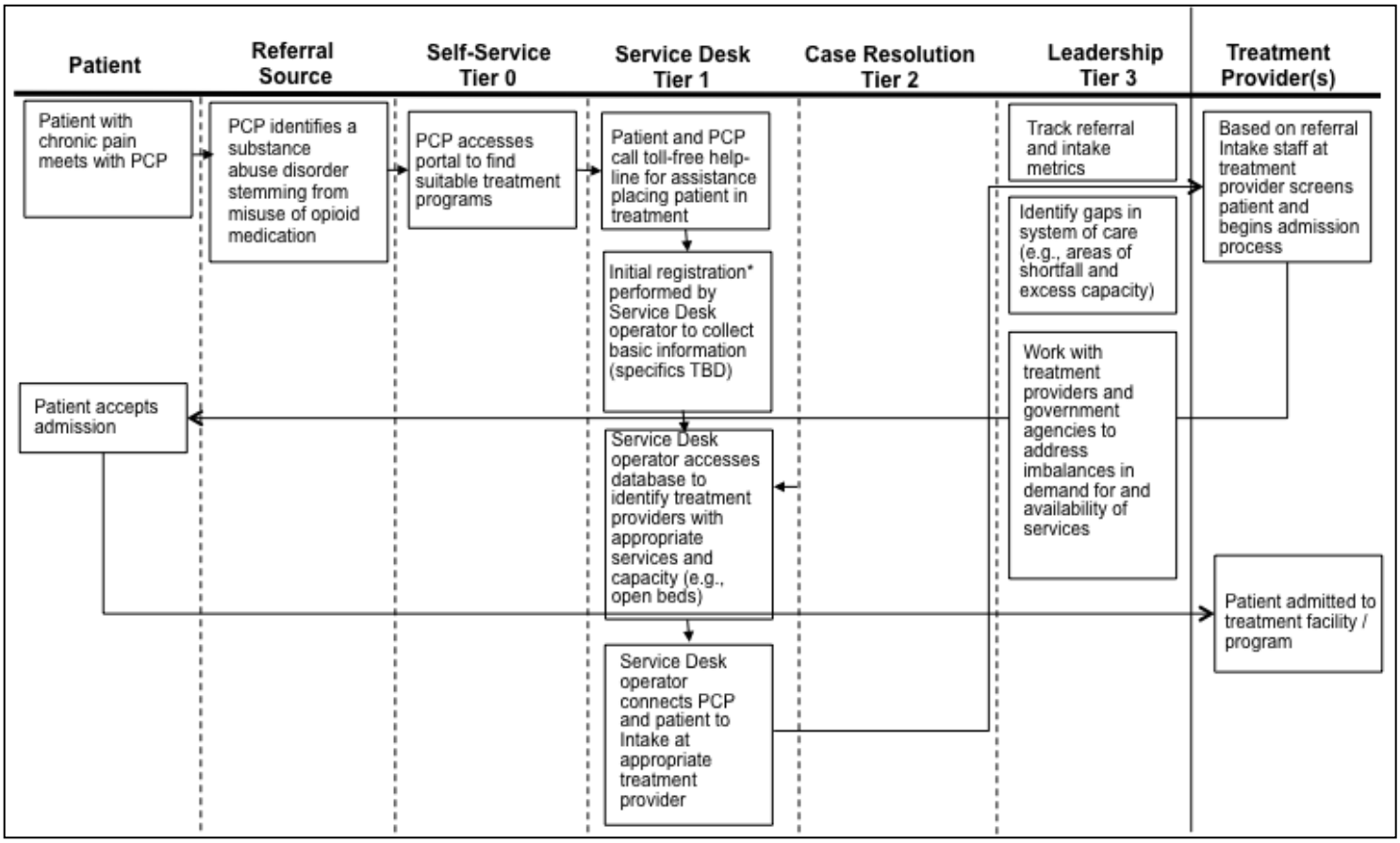
Appendix B: Sample Future System of Care Escalation Rates

The purpose of the shared services center is to meet the needs of users of the system of care in a fast and cost-effective manner. The majority of inquiries and transactions (e.g., 66%) will be carried out via self-service, with the vast remainder (e.g., 28%) handled by the dedicated "help desk". This will enable end-users to be self-sufficient in meeting their own needs, while still having access to "high touch" services when needed. Typically, a small number of inquiries and transactions (e.g., 5%) will require escalation to experts (at Tier 2) or the Leadership Team (at Tier 3) for resolution. These usually involve exceptions to established processes and/or policies. An example of this type of situation is provided in Appendix D. The typically escalation rate is illustrated below:



Appendix C: Illustrative Scenario – Typical Service Request

The following illustrates how the shared services center would handle a typical request for information about, and admission to, treatment. Depending on the design of the self-service components of the model it is possible that end-users (e.g., the PCP and patient) could complete basic information themselves (e.g., filling out a basic information form on-line) without requiring the assistance of a service desk representative.



*NOTE: In this context "registration" refers to a basic collection of information to assess the patient's treatment needs and their eligibility for treatment (e.g., insurance coverage). It does not include the clinical intake which will be carried out by the admitting treatment facility.

Appendix D: Illustrative Scenario – Service Request Requiring an Exception

The following illustrates how the shared services center could handle a request for admission to treatment that requires an exception to the normal process. In this case the patient requires immediate admission but there are no appropriate treatment programs with availability. As a result the request for admission is escalated to the leadership team for resolution.