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Results of a State-Wide Evaluation of “Paperwork Burden” in Addiction Treatment

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Abstract

This article chronicles three steps taken by research, clinical and state staff towards assessing, evaluating and streamlining clinical and administrative paperwork at all public outpatient addiction treatment programs in 1 state. The first step was an accounting of all paperwork requirements at each program. Step two included the development of time estimates for the paperwork requirements, synthesis of information across sites, providing written evaluation of the need, utility and redundancy of all forms (paperwork) collected, and suggestions for eliminating unused or unnecessary data collection and streamlining the remaining data collection. Thirdly, the state agency hosted a meeting with the state staff, researchers and staff from all programs and agencies with state-funded contracts and took action. Paperwork reductions over the course of a 6-month outpatient treatment episode were estimated at 4 – 6 hours, with most of the time burden being eliminated from the intake process.

Keywords

addiction treatment; clinical information systems; electronic records; evaluation; paperwork

1. Introduction

Substance abuse treatment providers are inundated with reporting requirements (McLellan, Kleber, & Carise, 2003). The burden of excessive paperwork in the healthcare field is well-documented and many studies have demonstrated its negative impact on the well-being of healthcare professionals. For example, a study of professional psychologists found that increased administrative and paperwork hours were associated with greater emotional exhaustion and burnout (Rupert & Morgan, 2005). Other studies have found that paperwork

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was among the greatest stressors (Rupert & Baird, 2004) and challenges (Kantorowski, 1992) reported among professionals in the mental health field.

Many studies have also documented the degree to which paperwork is associated with job dissatisfaction. In a study of mental health professionals, 50% of those surveyed reported dissatisfaction with the amount of time they spent on paperwork. When asked to choose from a list of job responsibilities, mental health nurses identified paperwork as being the one item with which they were most dissatisfied (Robinson, Murrells, & Smith, 2005). Cypres and colleagues also surveyed mental health professionals and found that paperwork was one of the greatest job complaints as counselors reporting it compromised the amount of time they were able to spend with their clients (Cypres, Landsberg, & Spellmann, 1997).

Paperwork burden problems are not unique to the nursing or mental health fields. Counselors in the substance abuse treatment field frequently report being inundated by documentation requirements. The burden of these requirements was a pervasive complaint reported by a sample of 175 substance abuse treatment programs in a telephone survey on information collected in the course of their day to day work. Numerous programs cited paperwork burdens of 4 hours or more at patient admission simply to collect data required by state agencies and multiple managed care organizations (McLellan, Kleber, & Carise, 2003).

In other studies, 38% of substance abuse treatment case managers reported spending over 20% of their work week completing paperwork (Brindis & Theidon, 1997), and McDaniel and colleagues also documented the dissatisfaction substance abuse treatment providers reported with the increased paperwork requirements resulting from managed care (McDaniel, Spiegelman, & Beattie, 2006).

Substance abuse treatment programs collect data for accreditation, managed care, research and outcomes reporting purposes. State offices, accrediting agencies, managed care organizations and other regulatory agencies (including but not limited to drug courts, parole, welfare, and child welfare) each demand collection of specific information or data. Perhaps most important in this regard is that much of this data collection is considered nothing more than "paperwork" by the counselors and other personnel within the programs that collect it since the information collected in most of these forms is not inherently useful for clinical care decisions. Adding to the burden and the resentment caused by these multiple reporting requirements is the frustrating and often substantial overlap in the nature of the information requested by the various agencies and organizations.

The focus of our original work with the Delaware Division of Substance Abuse and Mental Health (DSAMH) was to assist with the design and evaluation of a new statewide, performance-based contracting (PBC) system. All outpatient abstinence-oriented adult substance abuse treatment programs were required to provide treatment services at a minimum of 90% capacity. Additionally, they were required to collect standard admission data on all clients and to rapidly report client attendance data during treatment as well as type and date of discharge. The data reported were audited for accuracy and capacity and rates of attendance became central determinants of reimbursement for the programs. As a result of this project, those programs that were able to retain clients in active participation longer, received performance incentives, while programs that were not able to retain clients did not receive these incentives (McLellan, Kemp, Brooks, & Carise, 2008). This contracting effort, though purposely quite simple, led to significant increases in client census and in lengths of stay in the participating programs - as well as increased income.

In addition to the measures associated with Performance Based Contracting, DSAMH was interested in initiating a pilot project with the assistance of TRI to introduce the collection of key clinical data items by counselors in face to face treatment sessions during the course of

outpatient treatment. The collection of these additional client status measures on all clients at multiple times over the course of treatment (called Concurrent Recovery Monitoring (CRM) (McLellan, McKay, Forman, Cacciola, & Kemp, 2005) threatened to impose still more data collection on the already burdened clinical staff at these treatment programs. While clinical staff were not conceptually against CRM – and indeed, even endorsed it – there was understandable frustration regarding how this additional data collection of client-level behavioral measures at each individual session, would actually be accommodated.

Acknowledging that these clinically meaningful activities would also result in additional data collection and reporting, TRI conducted a “Paperwork Burden” assessment, to determine the nature, volume, and extent of overlap among the multiple data collection demands currently affecting all state-funded outpatient substance abuse treatment programs. If it were not possible to eliminate at least the same amount of data collection, time and effort required for the proposed CRM procedure, it seemed unfair to ask the programs to participate in the CRM study.

Therefore, this article describes this systematic evaluation of the data collection and reporting requirements at these treatment programs; and reports the administrative changes (to decrease paperwork) resulting from this evaluation.

2. Methods

The director of the research team had several years of prior experience working with the State Director and indirectly with the treatment programs. The investigator of this project met with the State Director and asked if he would be interested in piloting the Paperwork Burden study and if he felt this would be of interest to the state-funded outpatient, substance abuse treatment programs. With interest and approval from the State Director, during a regularly scheduled quarterly meeting with the providers and state director, the investigator described the Paperwork Burden evaluation (and the larger study) to the providers (primarily program directors and supervisors). The providers were enthusiastic and agreed to participate. To implement the paperwork reduction assessment, 2 senior TRI research staff traveled to each of the 11 state-funded, adult outpatient substance abuse treatment programs for a ½-day meeting (approximately 5 hours) with various staff members. The purpose of this in-person site meeting was to assemble a complete inventory of all data collection instruments and forms. This paperwork assessment was not confined to the paperwork required by the state drug and alcohol agency as each of these 11 programs had client referral arrangements with other state agencies (e.g., Probation/Parole, Child Protective Services, etc.), managed care organizations and private insurance carriers. In addition, programs received referrals from managed care organizations that also required various information and reports. Finally, the documentation also included data collection requirements of non-governmental organizations such as Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

The study was approved by the Institutional Review Boards at both Treatment Research Institute and the Delaware Health and Social Services. Since participating in the Paperwork burden review was completely voluntary for staff, did not involve patients and collected no identifying information from staff, informed consent was not required. The paperwork burden assessment was conceptually very simple but procedurally quite demanding. It required 6 months to complete and initially consisted of the 5-hour in-person visits to each site by 2 senior TRI research staff who met with the program directors, administrative and clinical staffs to compile every form and piece of information required by any of the agencies described above. The evaluation included all forms required by any of the above agencies or organizations, on clients at admission, during the course of treatment, at discharge/transfer and at follow-up. This part of the evaluation resulted in a spreadsheet identifying all forms collected by program.

These spreadsheets were sent via email to each site where they were inspected by participating site staff followed by several additional interactions generally by phone but occasionally in person with staff to assure the accuracy and completeness of our reports. In this regard, staff at the programs often had mixed opinions about which data collection activities were required, by whom and for which clients. It was regularly the case that clinical staff at a program (who actually collect the data) would say that “we use the “XYZ” Form, its required”, however, their supervisor would say “we don’t use the “XYZ” form, it hasn’t been required for several years” or vice-versa. In these cases we entered into our spreadsheets all those forms that were actually used in data collection by at least one staff member but recorded all the comments from both supervisors and direct care staff. We believe this method provided the most realistic appraisal of the *actual* paperwork collected. We provided these final reports to the State Substance Abuse Director, other DSAMH staff, and to all treatment programs. The State Director, treatment providers and research staff met as a group once more when the Director dedicated 3 hours of their regularly scheduled quarterly meeting to reviewing the results of these findings deciding on a course of action.

2.1 - Description of Treatment Programs

All outpatient substance abuse treatment programs that had contracts with DSAMH (N=11) participated in the paperwork reduction assessment project. We used the Addiction Treatment Inventory (ATI) to measure program characteristics. The ATI is a semi-structured interview completed with treatment program directors. It is designed to provide standard information on the staffing profile, treatment orientation, organizational structure, financing, and services delivered in all modalities of addiction treatment programs (Carise, McLellan, & Gifford, 2000).

2.2. - Program Organization

The 11 outpatient programs in this review were actually run by 4 “parent” agencies. Nonetheless, results reported here refer to the 11 treatment programs since even those programs within parent agencies routinely differ in their characteristics.

2.3. - Frequency of group and individual counseling

In 8 of the 11 sites (73%), clients attended group treatment twice a week and had individual counseling sessions about once a month. At the remaining 3 sites (27%), clients attended group once per week and saw a counselor on an individual basis twice a month.

2.4. - Intake Scheduling

Six of the sites (55%) accepted only scheduled clients for admissions, while 2 sites (18%) had no scheduled appointments - all admissions completed via “walk-in” procedures. The remaining 3 sites (27%) accepted both walk-in and scheduled clients.

2.5. - Accreditation

Six of the 11 sites (55%), were accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and 2 sites (18%) were in the process of obtaining JCAHO accreditation. Five sites (45%) reported being accredited by CARF – the Commission on Accreditation of Rehabilitation Facilities. Four sites (36%) were accredited by both CARF and JCAHO.

3. Results

3.1. Organizing forms

All sites used the following 3 Organizing Forms – though it later emerged that only one form, the Client Service Record, was required by the state.

3.1.1. Intake Log/Schedule Book—All sites had a log or sign-in book to document who entered care and at what date. Time required: 1–2 minutes per client.

3.1.2. Client Service Record—Documentation of services provided to all clients was required by DSAMH's licensing standards. This form documented the dates and duration of services provided such as pre-admission/evaluation meetings, individual/family, mental health/psychiatric, group sessions and case management session for an individual client through their course of treatment. All sites used this state-required form. Time required: 3–5 minutes per contact/session.

3.1.3. Checklist of Required Forms—All sites had 1 or more forms to assure inclusion of all required forms in each client chart. According to state authorities, these forms were intended to assist staff as a reminder of items that needed clinical review or updating. However, some sites reported completing this form at discharge suggesting that they may be utilizing it simply as an administrative checklist. Time required: 10–20 minutes total when done throughout treatment), however, some sites reported the form took 60 minutes when completed at or after discharge.

Organizing Forms Suggestions: The intake log/schedule book carries only a minimal burden of 1–2 minutes per client and the Client Services Record (the only required document in this category) takes only 3–5 minutes per contact or session) – no changes are suggested. The problematic form was the Checklist of Required Forms. Although it is often useful for agencies to have a checklist to make certain all required forms have been completed, filling out the Checklist after the patient has left treatment diminishes its usefulness and presents a significant time burden to the counselor. As a result, we strongly recommended that if sites wanted to continue using the checklist of required forms for their own assurance purposes, that they collect this information during the course of treatment, not at discharge. With that provision, the average amount of time taken for Organizing Forms could go from an average of 14–67 minutes down to 14–27 minutes, decreasing the paperwork burden between 0 – 40 minutes depending upon the current practice at the site (See also Table 1).

3.2. Client Administrative Forms at Intake

The great majority of client data collection for all programs surveyed was completed at intake/admission. Six of the 11 sites reported that intake data collection requirements could be completed in 1 session (approximately 2–3 hours) whereas 5 of 11 sites reported that intake requirements could take 2–3 separate sessions and up to 7 hours.

The administrative portion of the intake paperwork requirements included 1) client protection & rights forms (including confidentiality and protection of information procedures), 2) consent for treatment and release of information forms, and 3) documents describing the program, its rules, fee agreement and grievance policy.

3.2.1. Client Protection & Rights, Statement of Confidentiality and HIPAA—These forms are required by DSAMH licensing standards and all sites had forms related to these issues however, there was significant variability across sites in the application of these forms. Each site was missing some of the components of HIPAA requirements, including specific

information on expiration dates of consents, a statement of the individual's right to revoke his/her Authorization and how to do so, whether treatment, payment, enrollment, or eligibility of benefits could be conditioned on authorization, or a statement of the potential risk that PHI may be re-disclosed by the recipient. Time required: 10–20 minutes.

3.2.2. Consent and release of information forms

All sites had consent forms. All but 1 site had Emergency contact releases, 6 combined this information with other forms and 4 had separate forms. All sites had forms for the DSAMH requirements of (1) for DSAMH to let the treatment program know if a client is covered by state funding and (2) for treatment programs to bill DSAMH for covered services provided by the treatment program. Six of the 11 sites had 2 separate forms for this purpose whereas the other 5 sites combined the forms into a single consent. Combined release forms and to/from releases are accepted as long as the consent is completed correctly according to Federal Law requirements (SAMHSA, 2004). Time required: 5–10 minutes

3.2.3. Documents on Program Descriptions & Rules

Nine of the 11 sites (82%) had program descriptions, rules and schedules on separate forms – each of which required patient signatures. These were local forms not required by State licensing, but they did inform clients about relevant aspects of the programs' operations. Seven of the 11 sites (64%) had a Client Handbook that included all client-relevant forms and schedules. Nine of the 11 sites (81%) had formal grievance policies; with 4 sites (36%) having included this information in their HIPAA forms. There was some confusion regarding a "Client Choice" document designed to ensure notification to the client of alternate treatment options. Six sites (55%) thought it was required and included it while 5 others did not. We confirmed for sites that this form was not required and several immediately stopped using it. There were 2 sites (18%) that continued to use this form as they felt that it was important for clients to be aware of other treatment options. All sites had multiple fee agreement forms including a Fee Collection Sheet, Sliding Scale Fee Guideline form, Fee Schedule. Time required: 5 minutes.

Client Administrative Forms Suggestions—We developed a HIPAA form that could be used by all sites that fully covered all requirements for HIPAA authorization. We also recommended that all programs combine their Consent and Information Release forms into a single form that would service all state agencies and that could accommodate sending of information in **both** directions between the state agencies and the programs. So, for example, whereas most sites currently had 1 form to allow the treating agency to send intake information to DSAMH as required and an additional form for clients to allow DSAMH to send information to the treating agency to identify if the client was covered by the state for the treatment services provided, they now use a single form.

We also recommended that the 4 sites that did not provide a Client Handbook begin doing so, as this is a way to provide relevant information in 1 document. Finally, we recommended the consolidation of the Fee Collection Sheet, Sliding Scale Fee Guideline form and the Fee Schedule form into 1 form thereby reducing the number of forms to review with the client. Program staff estimated that completion of Client Administrative Intake Forms averaged 20–35 minutes per client. By following our recommendations, the time to complete this category of paperwork would be reduced to 15–30 minutes per client, decreasing paperwork burden by 5 minutes.

3.3. Intake Assessment Forms

Perhaps the most time consuming forms collected were those for client assessment. All sites were required to collect data on the State's Consumer Reporting Form (CRF). Additionally;

at admission and again at various times during the client's treatment, administration of the Addiction Severity Index and the American Society of Addiction Medicine (ASAM) client placement criteria were required. In addition to these, sites also collected various other assessments or biopsychosocial instruments either of local interest or required by various managed care organizations. Some of these included the Michigan Alcoholism Screening Test (MAST), the South Oaks Gambling Screen (SOGS), and several non-standardized forms.

3.3.1. Delaware's Consumer Reporting Form (CRF)

The CRF was the core instrument required by DSAMH to begin the process of registering the client as having entered the treatment system and to collect basic client level data, much of which is required by the Substance Abuse Prevention and Treatment (SAPT) Block Grant. Time required: 10–15 minutes.

3.3.2. The Addiction Severity Index (ASI)

The State required the ASI (McLellan et al., 1992) be completed upon intake for all clients. The majority of these sites (10 of 11) used the DENS computer assisted form of the ASI. The DENS version of the ASI requires appreciably less time than the standard paper and pencil interview and also produces a narrative summary of the information and the beginnings of a basic treatment plan (Carise, Gurel, Kendig, & McLellan, 2002). Time required: 45–60 minutes.

3.3.3. The American Society of Addiction Medicine (ASAM) Patient Placement Criteria

(ASAM PPC-2R). The ASAM PPC is a set of guidelines used for placement, continued stay and discharge of clients with alcohol and other drug problems into 5 broad levels of care from Early Intervention to Medically Managed Inpatient Treatment to aftercare (ASAM, 06/17/2006, <http://www.asam.org/ppc/ppc2.htm>). Time required: 30 minutes if client is not transferring to a higher level of care.

3.3.4. Additional forms

South Oaks Gambling Screen (SOGS)—The SOGS is a brief self-report questionnaire designed to detect gambling problems (Lesieur & Blume, 1987; Stinchfield, 2002) that was used by all treatment programs as it had been required by DSAMH several years earlier. Time required: 10 minutes.

The Michigan Alcohol Screening Test (MAST)—This is a brief self-report questionnaire designed to detect alcoholism (Selzer, 1971). It is widely used in clinical and research settings. The 24 scored items assess symptoms and consequences of alcohol abuse. Four of the 11 sites reported using the MAST to fulfill requirements by the state or its licensing board. Time required: 7–10 minutes to administer and score.

The Interpretive Summary—Five sites wrote a specific “interpretive summary,” essentially a clinical impression of the data collected at admission assessment. Time required: 30–45 minutes.

The Assessment Summary—Ten of the 11 sites were also doing an assessment summary of the ASI and ASAM data. Time required: 30–45 minutes.

Miscellaneous Forms—There were also items collected on the following topics: Spirituality, Leisure time activities, HIV/Risk Assessment, Nutritional Screening, and Quality of Life information. Much of this appeared to be clinically important as well as necessary for JCAHO requirements. Time required: 15 – 30 minutes total.

Intake Assessment Suggestions

CRF and ASI—We recommended no changes to Delaware’s State Intake form (CRF), recognizing that a change in this form would necessitate a complete overhaul of the state administered computerized data collection system. Additionally, we recommended no overall changes to the ASI form as this too would leave 10 of the 11 sites without computerized capability for collecting this data.

ASAM—Since the programs in this evaluation were outpatient programs, and there is almost never a challenge on treatment need for this level of service, the ASAM criteria may not be essential, particularly if traditional outpatient care was determined to be the level of care needed. However, it was acknowledged that the ASAM criteria might be necessary for those patients seeking transfer to a higher level of care. DSAMH agreed to the use of ASAM criteria only for higher levels of care and this saved approximately 30 minutes on intake paperwork.

SOGS—The requirement to complete the SOGS was clinically sensible but not necessary for all clients. A 2-question screener (taking no more than 1–2 minutes to administer) was designed to identify patients who had never gambled. Only a positive screen to these 2 questions led to administration of the full SOGS. Therefore, if the client had never gambled (and a significant proportion had not), the SOGS was not administered. This decision rule led to a time savings of approximately 8 minutes.

MAST—Although the MAST is a useful clinical tool, the evaluation uncovered that it was not required by DSAMH (as programs had thought) and that it did not collect substantially different information than was already being collected at intake. As a result, treatment programs decided to eliminate it from the standard data collection, resulting in a savings of 7–10 minutes. Assessment and Interpretive Summaries: Most sites were completing an Assessment Summary and an “Interpretive Summary”. We checked to see if DSAMH preferred a particular style or content for client admission interview and summary (other than requiring the ASI and CRF) and found that these 2 documents were not required and that all methods of other assessment and intake summaries were acceptable. Since more than half of the sites were interested in JCAHO accreditation; and since JCAHO required a *narrative* intake summary, we suggested that sites use the automated DENS-ASI summary which contains all relevant information in a computer generated, narrative report and has been used successfully in many JCAHO accredited sites (10 of the 11 sites were using the DENS ASI software). DSAMH agreed to accept the DENS-ASI narrative relieving the programs of the “Interpretive Summary” and the “Assessment Summary”, and resulted in a total time savings of 60–90 minutes (30–45 minutes were typically needed to write each summary).

Miscellaneous Forms—As noted above, many programs were using their own forms for additional questions about leisure time activities, quality of life, pain assessments, family, nutritional and HIV assessment. Since the forms were utilized randomly by different sites, and counselors reported that they served a specific purpose, we did not recommend deletions here. Instead we recommended that programs retain those forms they found useful but produce a common battery of these forms in standard formats so that they were all collecting the information in the same way and consolidate these questions into 1 form. These procedures resulted in a 5–10 minute decrease in paperwork.

In summary, prior to the implementation of our suggestions, completing the Intake Assessment Forms took from just under 3 hours to just over 4 hours (177 – 245 minutes) to complete (depending upon site procedures and inclusions). Per our suggestions, the elimination of the ASAM for those entering traditional outpatient care, the MAST and the Interpretative & Assessment summaries; the adoption of a SOGS screener, and the consolidation of

miscellaneous forms, resulted in a reduction of 1.8 – 2.3 hours (110–140 minutes) in paperwork. Intake assessment now takes on average 1.1 to 1 ¾ hours (67–105 minutes) to complete. See Table 1 for a tabular representation of the findings.

3.4. During Treatment Documentation

Treatment planning and treatment documentation paperwork was much more variable across the 11 programs and there were fewer requirements by the state and less standardization. Most treatment programs reported that an administration of the ASI was required every 3 months throughout the course of treatment. This was actually not the case but it was essentially a widespread misunderstanding causing most programs to spend 30 – 45 minutes per client, every 3 months completing an updated ASI. Similarly, programs believed the ASAM client placement summaries were also required for all clients every 3 months although DSAMH reported that this requirement had been eliminated some time prior to this evaluation. ASAM summaries continued to be required only if the client was moving to a different level of care. Time required for repeated ASAM placement criteria was approximately 10 – 15 minutes per client - repeated every 3 months.

During Treatment Documentation Suggestions—Re-administering the complete ASI every 90 days for clinical purposes during the course of treatment is not necessary. Also, as indicated previously, re-evaluating the ASAM placement criteria may only be desirable in the case of client transfers to more intensive levels of care. Thus, we recommend that DSAMH clarify that they had indeed previously eliminated both the ASI and ASAM administration requirements for **during treatment** reporting and that a more streamlined client “check-up” form be pilot tested to achieve the same purposes. Based upon this recommendation, DSAMH reiterated that ASI and ASAM updates were not required during treatment with 1 exception - ASAM summaries continue to be required to refer a client in outpatient treatment to a DSAMH funded residential program. This resulted in a net time savings of 40–60 minutes every 3 months, or 1 ¼ to 2 hours over the course of a 6-month treatment episode.

3.5. Discharge Paperwork

3.5.1. Delaware’s Consumer Reporting Form (CRF) at Discharge—A second CRF form is required to be completed and sent to DSAMH to document the date and nature of the client’s discharge from the treatment system. Time required: 5–10 minutes.

3.5.2. ASI—All programs were required to collect a final ASI at the time of discharge on all clients. Time required: 30–40 minutes per client.

3.5.3. ASAM PPC—All programs were required to collect a final ASAM PPC form at the time of discharge. Time required: 10–20 minutes per client.

Discharge Paperwork Suggestions: Based on the reasoning noted in section 3.4 (above) regarding the use of the ASI and ASAM PPC-2R during treatment, DSAMH eliminated the collection of the ASI and ASAM-PPC at discharge as well. This led to a reduction of an additional 40–60 minutes of paperwork at discharge while still obtaining all of the information that they were actually using from the state CRF form that is re-administered at discharge

3.6. Follow-Up Meeting/Action Plan

As noted above in Methods, after providing the final reports to all participants, the State Director, treatment providers and research staff met as a group once more when the Director dedicated 3 hours of their regularly scheduled quarterly meeting to reviewing the results of these findings deciding on a course of action. Representatives of all treatment programs, the

researchers involved, the State Substance Abuse Director and other DSAMH staff, including representatives from the licensing unit, were in attendance.

This meeting began with a presentation of the findings from the paperwork assessment that highlighted each form, the amount of time taken to complete the form, the number of sites completing the form and whether or not they believed the form was required. For each form, the group entered into discussion regarding the use of the data, the State Director discussed reasons for requiring the form (if applicable), the research staff presented reasons for and against the collection of the data (i.e. we were against the collection of the ASI and ASAM every 90 days and provided both a scientific and practical basis for our reasoning), the provider staff discussed their experience with collecting the information and the group, led by the State Director, came to a decision regarding whether or not the form/data collection was valuable clinically or administratively.

Interestingly, one of the most compelling findings was the extent of misunderstanding regarding what was required by the various funding and regulatory agencies (e.g., DSAMH, criminal justice and child protective agencies, JCAHO and CARF) and the rationale for why information was collected. In general, many forms that programs believed to be required were no longer used nor required. Moreover, some of the forms that were required did not actually result in administrative action or decision support and thus were not really useful to those who were requesting them. Based upon the findings gathered in the evaluation, the majority of the recommendations for elimination and consolidation of reporting were accepted and put into place immediately.

In summary, data collection time was reduced by approximately 2 – 3 hours per patient at intake/admission, approximately 1 – 2 hours per patient during the course of an average 6 month outpatient treatment episode; and approximately 40–60 minutes at treatment discharge. A reasonable estimate of total time saved per patient over the course of a 6-month treatment episode is 4 – 6 hours.

4. Discussion

We believe the Paperwork Burden Assessment led to a more streamlined and efficient data collection process that importantly, has not eliminated any useful information. Moreover, this effort was seen as a good faith effort to acknowledge and address the legitimate time constraints on these programs – paving the way for a collaborative effort to improve clinically and administratively relevant data collection for improved accountability. We believe the implications are significant for other administrators and public authorities, to give them a tangible estimate of the data collection burden that affects so many programs as well as one reasonable way to add the collection of new, important variables. That is, if new measures or data collection items are to be added, the value and necessity of collection of older items or measures should be reviewed. Whenever possible, don't add to data collection without taking away something that is already being collected. Equally important, don't collect data that is not being used and show providers that the utility and value of the data by providing results back to those you are asking to collect the data. Once clinical staff see the use of the data and maybe even begin to use it clinically, their investment in collecting accurate and timely data will increase.

It is likely that the history of this group (providers, researchers and the State Director) working together was an important factor in the success of this meeting, however, the importance of the willingness and openness of the State Director in discussing the data collection and making changes to the current requirements cannot be underestimated. This activity simply could not have been successful without the State Director's willingness to make changes, to hear the

treatment providers concerns and suggestions and to trust the research group's scientific opinions. The level of interest in program improvement can also be seen by the participation of 2 treatment programs involved in the Network for the Improvement of Addiction Treatment (NIATx) projects as well as the State's participation in the Robert Wood Johnson Foundation's Advancing Recovery initiative. Both of these programs have goals of improving systems of care that are consistent with this project.

The Paperwork Burden assessment was an important and valuable activity for the state, its substance abuse treatment providers and the participating researchers. It was rewarding to see such a significant impact from such a basic endeavor. These activities positively affected the relationship between the state agency and the treatment providers, the treatment providers and the researchers and led to a number of basic gains for all involved.

First, it created a stronger collaborative atmosphere for all concerned - the state agency, the state-funded treatment providers and the researchers working within the state. Providers saw that both research and state agency staffs were listening to them and were responding to their concerns. In addition to increasing collaboration and good will between the parties, these activities generated a new way of thinking about "paperwork" and data collection within the state. It became clear that that data should only be collected if it could produce meaningful information. The process has re-oriented thinking on the part of programs and DSAMH leading to a better understanding of the need to have a specific reason for collecting each form and each piece of data. The state is more cognizant of only requiring those items that they believe are essential for client care or those they will actually use for some specific purpose in the future. Likewise, treatment programs report feeling more accepting of the data collection required, knowing that there is a purpose to each requirement. Finally, they are more likely to view data collection as part of good clinical management - not just paperwork. Put simply, there is no longer a feeling of administering forms simply for the purpose of collecting data.

Directors of several other states have expressed interested in replicating this work in their state systems and although these states are much larger than the pilot state, it is incumbent upon us to find a way to assist states, agencies, providers and programs of every size to easily collect the information they need, to have the ability to use that information for decision making at the program, agency and state level and not to be side-tracked by collection of extraneous data that serves neither the state policy makers, the program directors, nor the patient.

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Table 1

Time Reductions by Type of Paperwork

Intake/Admission Forms (3 Components)	Paperwork Burden Prior to Study	Recommend Change	Paperwork Burden After Study	Burden Reduction
	Range/Minutes		Range/Minutes	Range/Minutes
1. Organizing Forms				
Intake Log/Schedule Book	1-2	No	1-2	0
Client Service Record	3-5	No	3-5	0
Checklist of Required Forms	10-60	Do During	10-20	0-40
Total Organizing Forms Total	14-67		14-27	0-40
2. Client Administrative Forms				
Client Rights, Confidentiality, HIPAA	10-20	No	8-18	2-2
Consent & Release of Info	5-10	Combine	4-7	1-3
Program Description & Rules	5	Combine	3-5	2-0
Total Client Administrative Forms	20-35		15-30	5-5
3. Intake Assessment Forms				
CRF	10-15	No	10-15	0
ASI	45-60	No	45-60	0
ASAM-PPC-2R	30	Yes	0	30
SOGS	10	Screener	2-10	8-0
MAST	7-10	Yes	0	7-10
Interpretive Summary	30-45	Yes	0	30-45
Assessment Summary	30-45	Yes	0	30-45
Other info for JCAHO	15-30	No	10-20	5-10
Total Intake Assessment Forms	177-245		67-105	110-140
Intake Paperwork Tally/Reduction	211-347		96-162	115-185
DURING TREATMENT & Treatment Planning Forms				
	Paperwork Burden Prior to Study	Recommend Change	Paperwork Burden After Study	Burden Reduction
	Range/Minutes		Range/Minutes	Range/Minutes
ASI Update every 3 months	30-45	Yes	0	30-45

Intake/Admission Forms (3 Components)	Paperwork Burden Prior to Study	Recommend Change	Paperwork Burden After Study	Burden Reduction
ASAM Update every 3 months	10–15	Yes	0	10–15
Subtotal	40–60		0	40–60
Treatment Paperwork Tally/Reduction (6-Month Treatment Episode)	80–120		0	80–120
DISCHARGE Forms				
	Paperwork Burden Prior to Study	Recommend Change	Paperwork Burden After Study	Burden Reduction
	Range/Minutes		Range/Minutes	Range/Minutes
CRF	5–10	No	5–10	0
ASI at Discharge	30–45	Yes	0	30–45
ASAM at Discharge	10–20	Yes	0	10–20
Discharge Paperwork Tally/Reduction	45–75		5–10	40–65
Overall Paperwork Reductions				
Total Paperwork Reduction (in Minutes)	336–542		101–172	235–370
Total Paperwork Reduction (in Hours)	5.6–9.0		1.7–2.9	3.9–6.2