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▶ Improving public addiction treatment through performance contracting: the Delaware experiment.

McLellan A.T., Kemp J., Brooks A. et al. Request reprint

Health Policy: 2008, 87, p. 296–308.

Instead of telling addiction treatment providers what to do to qualify for funding, the US state of Delaware set recruitment and engagement targets and largely left the methods up to the services. Result: more and more engaging treatment without stifling innovation.

Abstract In the USA, until 2002 Delaware's Division of Substance Abuse and Mental Health negotiated traditional contracts with addiction service providers, reimbursing them for the costs of approved treatment activities. In 2002, all outpatient programmes were switched to contracts which instead rewarded the meeting of performance standards in terms of the recruitment and engagement of patients. Certain core services commonly accepted as necessary for adequate care of public sector addiction clients were specified in advance, and providers were asked to identify at least one evidence-based practice and establish their ability to implement it. They were also required to take on any patients seeking treatment which met the criteria for their programmes. Beyond these basics, services were more or less free to meet the performance targets however they thought best. The most fundamental target was to recruit sufficient patients to run at 80% (later 90%) capacity. Payments to services were cut if they failed to meet these targets, and further incentive payments could only be earned once recruitment targets had been met. These further payments were made on the basis of the proportions of patients attending a set minimum of treatment sessions at different phases of a programme, and the number who satisfactorily completed the programme.

During a six-month run-in period, training was offered to providers, and provider-commissioner meetings established closer relationships and identified administrative barriers to meeting the targets. To meet these, all services learnt one or more of the selected evidence-based practices. Beyond this they adopted several methods to make it easier for patients to access the service and to encourage their participation, creating more 'user-friendly' services which required less effort from, and were more attractive to, the patients. Some also rewarded staff for helping the service meet its targets.

One service failed the requirements and withdrew from the contract. The remainder increased their capacity and rapidly increased the proportion of treatment slots which were filled, resulting overall in an 87% increase between 2001 to 2006 in the average number of patients in treatment. If anything, services were extended to a more severely problematic caseload. Recruitment targets were met without resort to recycling the same patients through multiple episodes of care. There was also considerable progress in encouraging patients to attend treatment sessions

The researchers concluded that properly designed, programme-based contract incentives are feasible to apply, welcomed by programmes and may help set the financial conditions necessary to implement other evidence-based clinical efforts, furthering the overall goal of improving addiction treatment.

FINDINGS Readers working in English drug treatment services will be keenly aware of the relevance of these findings to current arrangements which make funding contingent on the numbers of patients who satisfactorily complete treatment or stay for at least 12 weeks.

The main interest of the study is that it featured a payment system which (beyond certain basics) did not mandate certain activities or quality standards, but instead left it to the services to decide how to meet recruitment and engagement targets. This strategy could be applied regardless of the particular targets to which payments are linked. The authors report that it was widely appreciated as respectful of the staff's judgment, responsibility and clinical expertise. Instead of establishing uniform pre-set programmes, the result was to stimulate innovation and creativity. Services also had much to gain from sharing their ideas and experiences, so the system encouraged collaboration rather than competition. After the study ended this was extended through new contracts which rewarded services for arranging post-detoxification transfer to outpatient rehabilitation.

A key limitation is that the study was unable to test whether improved recruitment and engagement really did help resolve substance use problems more widely and more fully than would have been the case without those improvements. In general people in need of addiction treatment do better if they get it and if they participate more fully in that treatment, but the relationships are often loose. In particular, studies often find that treatment participation and retention are unrelated or only poorly related to post-treatment substance use. Initiatives which improve engagement may have no noticeable effect on outcomes. The study was also unable to eliminate the possibility that other quality improvement initiatives were at least partly responsible for the observed recruitment and engagement trends. Neither is it clear to what extent data provided by services was verified. With funding contingent on hitting targets, some truth-stretching is a possibility. However, improvements such as in opening hours, refurbishment of premises, and opening new clinics, are concrete and hard to falsify. Services which were attempting to make themselves look better mainly by manipulating the figures would be unlikely to invest in such improvements. As the authors observed, from the perspective of a potential patient, the new system has more treatment venues, better proximity to the most needy populations, more convenient hours of operation, and refurbished facilities.

Despite the gains, the study also revealed the limitations of target-driven funding. The pattern of attendance improvements at different phases of treatment suggests that

services tried to meet the targets and gain the incentive payments, but did not attempt further improvements. Improvements were most rapid in respect of recruitment targets which attracted the great bulk of funding. Together these trends suggest services responded to the financial incentives, putting in the greatest effort where the rewards were also greatest, but not necessarily seeking to excel in these or in other ways. If, as seems likely, improvements were driven by the funding, it begs the question of why services dedicated to the welfare of people with substance use problems had not already done was what needed to maximise participation in their programmes. A potential side effect of any such payment system is to reinforce a culture of doing what it takes to gain rewards for staff and service owners and managers, undermining the motivation to make life as good as possible for as many patients as possible. The post-2002 system in Delaware did much to align patient and service interests, but alignment will always be imperfect unless services place patients and potential patients at the core of their concerns.

Thanks for their comments on this entry in draft to Dr A Thomas McLellan of the Treatment Research Institute in Philadelphia, USA. Commentators bear no responsibility for the text including the interpretations and any remaining errors.

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