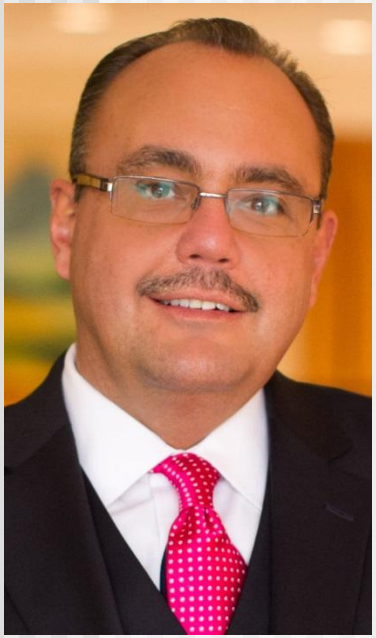
DBHDD Technical Assistance Training
Day One



Presented by:

Michael Flora, M.B.A., M.A.ED., L.P.C.C., L.S.W.

Senior Operations and Management Consultant

Phone: 815-751-0356

E-mail: Michael.Flora@mtmservices.org

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HOW CAN WE HELP YOU?

The Affordable Care Act, parity, Medicaid expansion, and new market and customer forces are ushering in an era of powerful change in how healthcare is accessed, delivered, and paid for. Mental health and addictions treatment organizations have to gear up now to meet greatly increased demand, competition, and performance standards. You need expanded capacity and high-performing prevention, early intervention, recovery, and wellness services and supports. You must work with new Medicaid systems to bill through new health insurance exchanges, adapting to demand for greater accountability, increased efficiency, better quality of care, measurable outcomes, and improved customer service.

David Lloyd, Scott Lloyd and their MTM Services team — of SPQM fame — have led 700+ behavioral health organizations across the country in adapting to changing healthcare delivery and payment systems. Today, MTM Services — in partnership with the National Council for Behavioral Health — offers a **full suite of consulting services** to prepare community behavioral health organizations, large health systems, managed care entities, and state and county behavioral health systems, for the dynamic new healthcare marketplace.

Organizations that have worked with MTM Services have seen:

- 60% reduction in consumer wait times
- 39% reduction in cost of access to treatment process
- 34% reduction in staff time needed per access to treatment event

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SCHEDULE
YOUR MEETING WITH MTM

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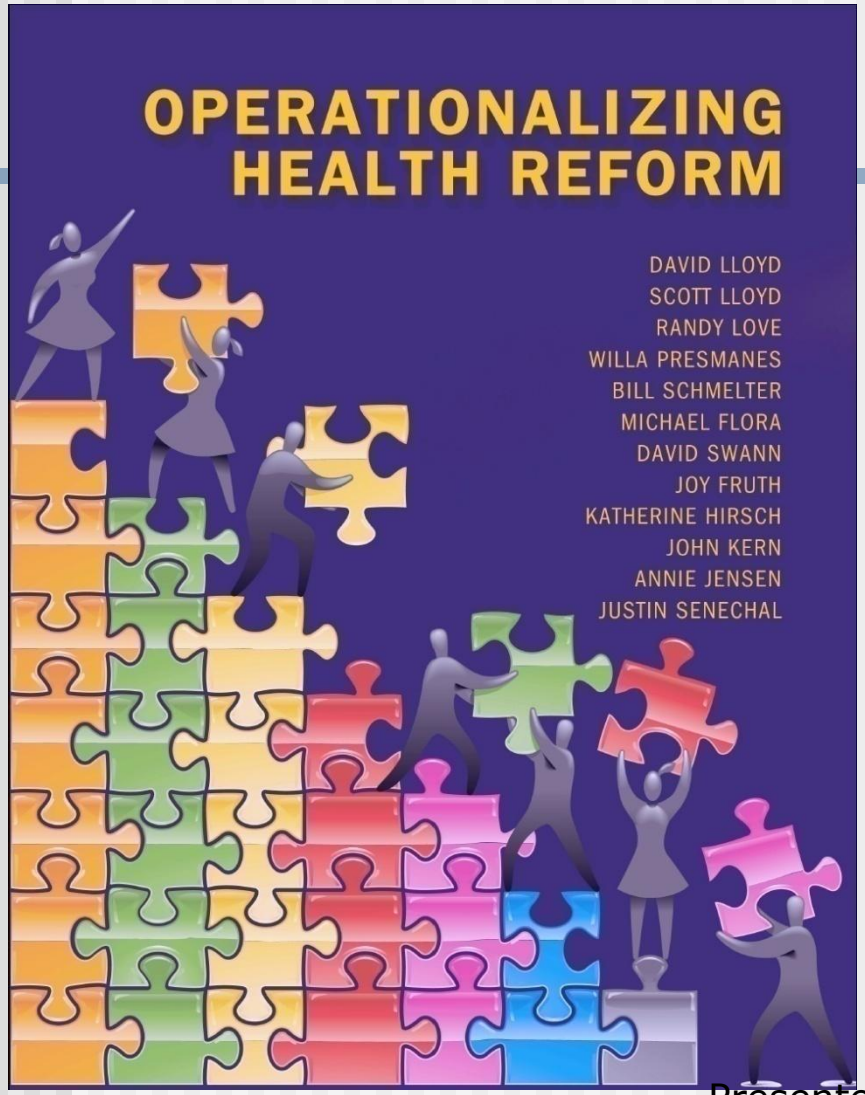

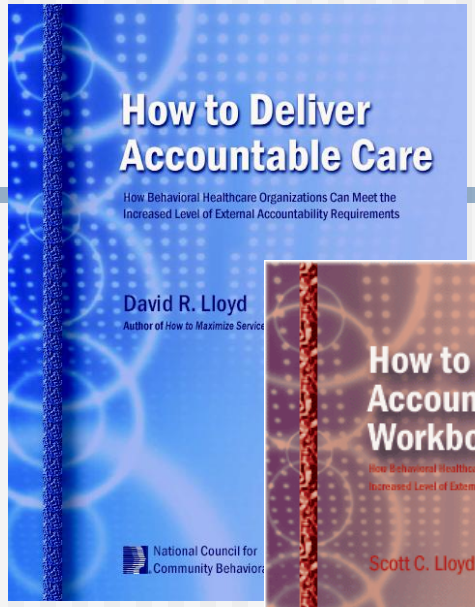

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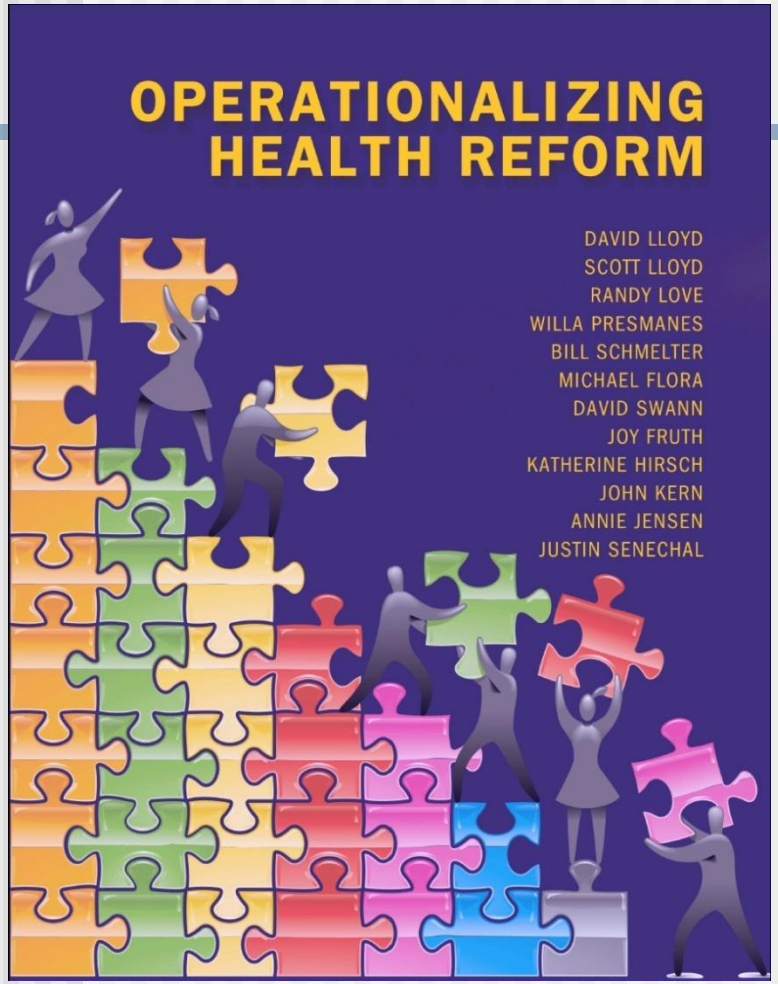
A Roadmap for Impactful Change!



Operationalizing Health Reform was written by the entire MTM Services Team to be an up to date view of what we have learned working to help hundreds of organizations across the country and abroad make the changes necessary to be successful in today's ever changing environment of health reform. Each of the book's 14 chapters deal with a specific change focus required to help vision based leaders improve their organization's quality of care, efficiency, and the compliance of their service delivery system!

To Order or for more information visit:

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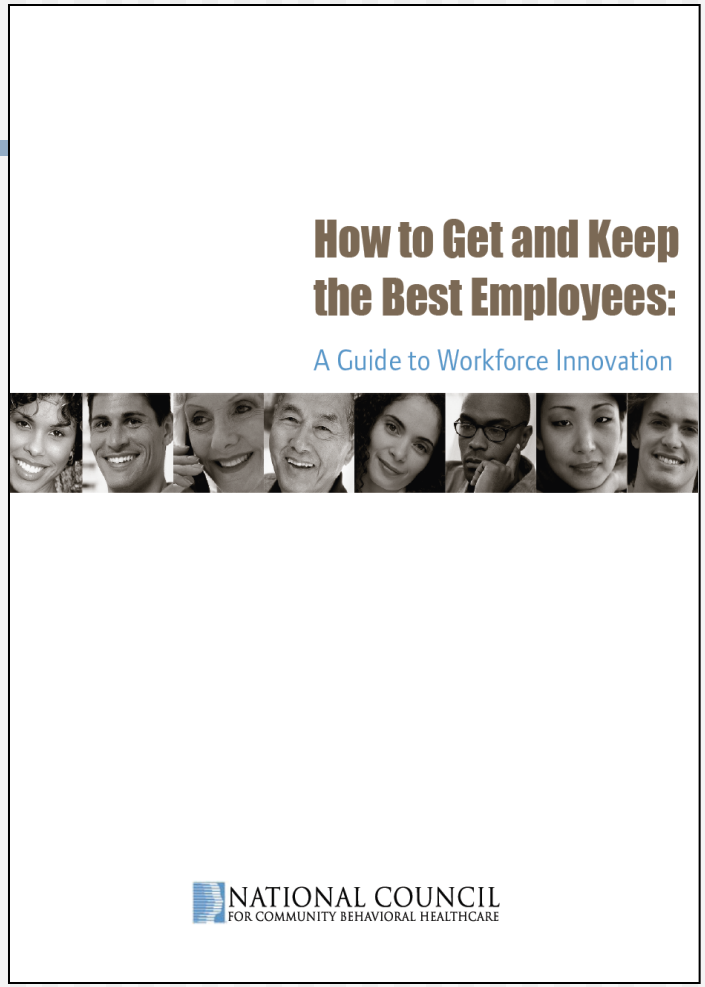
How to Get and Keep the Best Employees: A guide to workforce innovation

Michael has over 25 years experience in clinical practice and mental health administration. He has extensive experience in
•Strategic Planning,
•Performance Improvement,
•Clinical Re-Engineering,
•Marketing, Business Planning,
•Leadership Training,
•Project Management
•Mergers and Acquisitions in healthcare

He has lectured throughout the country on the national conference level on behalf of treatment and administrative issues.
His work has been highlighted in *Behavioral Healthcare Tomorrow, Behavioral Healthcare Technology, Health Care Technology*, CMHC's *One Magazine*, and *MD News* Magazine. He is a frequent contributor to the *NI Business News,* and his work has been featured in numerous publications by the National Council for Behavioral HealthCare publications.

Mr. Flora currently holds a position on the editorial board for the Joint Commission on Accreditation Healthcare Organizations (JCAHO) publication ***JCAHO Advisor for Behavioral Healthcare Providers*** and is listed in the Who's Who of Executives and Professionals. He currently serves on state and local committees to improve the behavioral health care of our children, families and adults in Illinois.



Michael Flora, MBA, M.A.Ed., LCPC

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Health Reform Implementer


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HEALTH REFORM IMPLEMENTER

ISSUE 3, 2014

5 THINGS YOUR LEADERSHIP TEAM NEEDS TO LEARN FROM THE NEW MEXICO RAC AUDITS

BILL SCHMELTER, PHD
Lead Clinical Consultant - MTM Services
Bill.Schmelter@mtmservices.org

In my 40 years in the Behavioral Health field I have benefitted from considerable experience as both an auditor and an auditee. Both as a clinician and a behavioral health organization executive I have been involved in and/or had the lead responsibility for more than 20 Joint Commission Surveys. Read More...

COACHING UP OR COACHING OUT

Maximize Service Capacity and the Bottom Line by Coaching Up Your Middle Performers

MICHAEL FLORA, MBA, M.A.ED, LCPC
Senior Operations and Management Consultant - MTM Services
Michael.Flora@mtmservices.org

Middle performers are the unsung heroes of every organization. While high and low performers get most of the attention, middle performers typically make-up 60-70% of the workforce, and are critical to your organization's success. Read More...

OPERATIONALIZING HEALTH REFORM: LEADERSHIP IN ACTION

DAVID LLOYD, FOUNDER
M.T.M. Services
David.Lloyd@mtmservices.org

In June 2013, it was my pleasure to be a part of a national panel in Washington, DC that was focused on discussing the future of behavioral healthcare in an era of healthcare reform. Read More...

BENEFITS OF TEACHING EMOTIONAL INTELLIGENCE (E.I.) IN THE HEALTHCARE WORKPLACE

MICHAEL FLORA, MBA, M.A.ED, LCPC
Senior Operations and Management Consultant - MTM Services
Michael.Flora@mtmservices.org

I have always adopted the concept of hire for attitude, train for aptitude. Most graduates and seasoned professionals have the basic clinical and non-clinical educational and work performance requirements. So what sets the top performers apart? Read More...

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- The Affordable Care Act, parity, Medicaid expansion, and new market and customer forces are ushering in rapid changes in how healthcare is accessed, delivered, and paid for. Your markets are expanding fast — behavioral health coverage will expand to 62 million Americans by 2014. And it's not going to be business as usual!
- The MTM Services team has led 700+ behavioral health organizations across the country in adapting to changing healthcare delivery and payment systems. Today, MTM Services — in partnership with the National Council for Community Behavioral Healthcare — offers the Health Reform Implementer newsletter to prepare community behavioral health organizations, large health systems, managed care entities, and state and county behavioral health systems, for the dynamic new healthcare marketplace.
- Health Reform Implementer brings you the best of the MTM team's healthcare consulting expertise and is edited by Michael Flora. The newsletter is packed with tips and tools to help you improve quality and access to mental health and addictions care; achieve operational efficiencies; streamline billing and collections; improve staff productivity; establish outcome measures; design key community collaborations; and face up to the competition in the new era defined by the Affordable Care Act.
- Purchase your subscription to Health Reform Implementer via the National Council Store.
- Breaking news and articles are posted on our website for subscribers to access at any time with a password. Subscribers receive email alerts every month, listing the latest articles available online.

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Experience –
Improving Quality in the Face of Healthcare Reform

- MTM Services' has delivered consultation to over 700 providers (MH/SA/DD/Residential) in 45 states and 2 foreign countries since 1995.

- **MTM Services' Access Redesign Experience** *(Excluding individual clients)*:
  - 5 National Council Funded Access Redesign grants with 200 organizations across 25 states
  - 6 Statewide efforts with 140 organizations
  - Over 1,500 individualized flow charts created
  - Over $16,000,000 in Annual Savings generated thus far
  - A lot of happy staff and consumers

Presented By:
Michael Flora, MTM Services
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Agenda Day One

1. Access to Care
2. Centralized Scheduling
3. Collaborative Documentation
4. No Show Management
5. Just in Time Medications
6. Treat to Target
7. Revenue Cycle Management
8. Strategic Business Planning

Agenda Day Two

1. Know your Costs
2. UM/UR
    1. CQI score Card
3. Productivity
4. Coaching your team to Peak Performance
5. Getting your Board on Board
6. Core Redesign

The National Landscape / Today's Reality

What can you do about the changes we face…Besides *Panic*?

Presented By:
Michael Flora, MTM Services

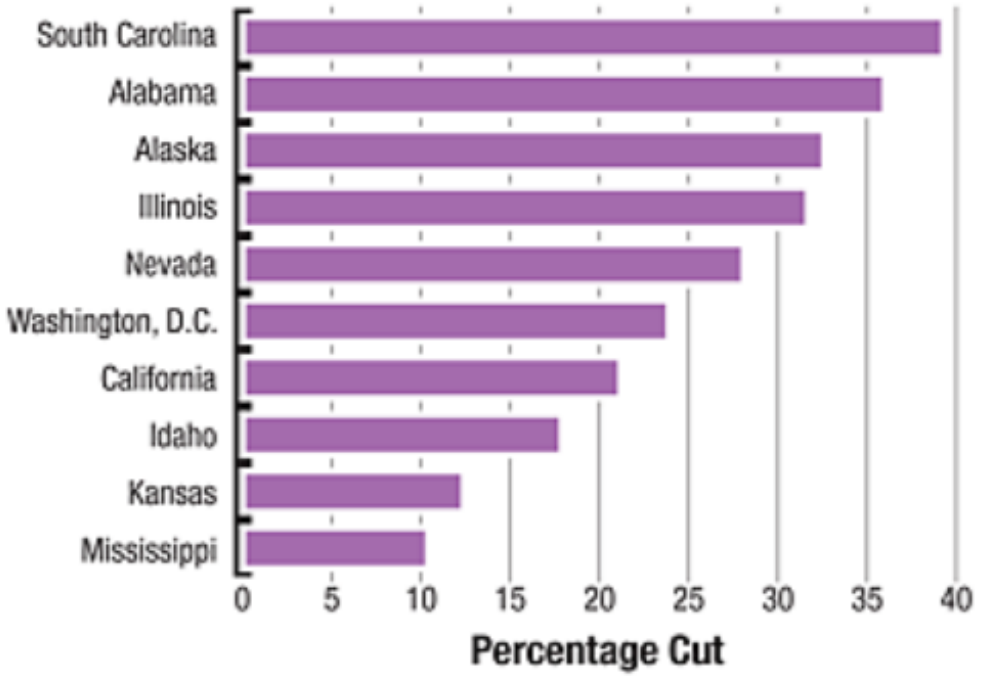
The National Landscape- Why Change at All?

- State Funding Issues
- Federal Issues: Office of Inspector General
- Integrated Care
- Healthcare Reform- Affordable Care Act
- Changing Technology
- Move to value-based care (no longer pay for volume)
- Competition - Desire to be the "Provider of Choice"
- Are future rule changes holding you hostage now?
  - Focus on what you can control
  - Agenda Item: It's so awful time -So tell me, "How bad is it?", then move on.
  - Move now, not after the challenges come about.

Shrinking Funding

State Budget Cuts Affect Many With Mental Illness

The majority of states have made significant cuts in funding for mental health services between Fiscal 2009 and Fiscal 2012. Of the 10 states with the largest proportion of cuts, four have slashed their budgets by more than 30 percent.



Source: NAMI, "State Mental Health Cuts: The Continuing Crisis," November 2011

The National Landscape

Federal O.I.G.

The Office of Inspector General

-Do you know about the Exclusions Database?

-Do you know about RAC teams?

-Medicaid RACs recovered $95.6 Million in improper payments in 2012

-Do you know why Money is being taken back?

-Increased audits with an emphasis on Medical Necessity Linkage. Approximately 60% of paybacks tied to missing or inadequate documentation

Federal OIG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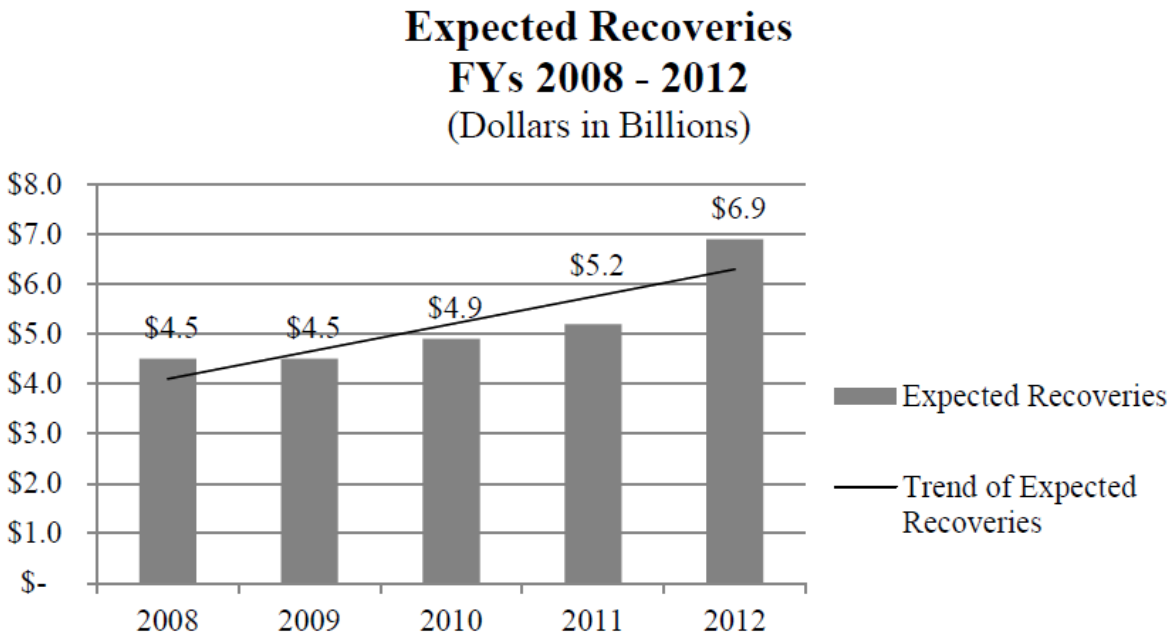
Audit Payback Realities

OIG's FY 2014 request includes an increase of +257 FTE over the FY 2012 actual level. The following graph shows that during FYs 2008 through 2012, OIG's expected recoveries increased by over 50 percent. During the same period of time, OIG's FTE levels increased by approximately 16 percent.



OIG's FY 2014 budget submission includes $388,699,000 and 2,030 FTE, an increase of +$100,852,000, which will support an additional +257 FTE above the FY 2012 actual level.

The National Landscape

New Mexico Fiasco

-OptumHealth (manager of carve-out funds) alleged fraud, PCG hired to audit providers 2/13-5/13

-15 Centers, responsible for 85% of MH care in the state – accused of $36M worth of Medicaid fraud in June 2013 (25% of all claims). "credible allegation"

- Medicaid payments stopped, Leadership ousted, 5 Arizona companies took over operations.

-6 mos later (12/13): As of December 2013, BH consumers down 23%, behavior management services down 28-59%

-1 year later (5/14): only 2 of 15 investigations complete , AG cleared both agencies of fraud, found overbilling of $34,126 and $19,000.

The National Landscape
Quantitative vs. Qualitative Audits

- Historically, State MH/DD/SA Departments have focused on quantitative review – "it is there and is it signed/dated"
- CMS has moved to a qualitative review standard – "does the documentation quality justify the intensity, duration and frequency of services?" Qualitative reviews require demonstration of the "Golden Thread".

Presented By:
Michael Flora, MTM Services

HHS Office of Inspector General

List by State

STATE NAME		STATE NAME	
Alabama	867	Montana	106
Alaska	66	Nebraska	122
Arizona	1379	Nevada	303
Arkansas	606	New Hampshire	249
California	5134	New Jersey	908
Colorado	957	New Mexico	153
Connecticut	489	New York	2715
Delaware	85	North Carolina	624
District of Columbia	70	North Dakota	71
Florida	3814	Ohio	1362
Georgia	717	Oklahoma	780
Hawaii	107	Oregon	280
Idaho	177	Pennsylvania	1664
Illinois	1292	Puerto Rico	97
Indiana	472	Rhode Island	356
Iowa	504	South Carolina	373
Kansas	264	South Dakota	96
Kentucky	736	Tennessee	809
Louisiana	841	Texas	2522
Maine	295	Utah	395
Maryland	535	Vermont	331
Massachusetts	935	Virgin Islands	3
Michigan	942	Virginia	968
Minnesota	624	Washington	666
Mississippi	965	West Virginia	180
Missouri	457	Wisconsin	379
		Wyoming	42

The National Landscape

"The Compliance Officer is accountable for the organization's compliance program, not the organization's compliance. Everyone is accountable for the latter by either their own conduct or staff or activity overseen."

Source: Adam J. Falcone
(www.feldesmantucker.com)


Quality
Customer
Efficiency
Service
Reliability

Behavioral Healthcare's Top Workforce Concerns

- Corporate Compliance
- Constant Change/ Gen Flux
- Employee Retention
- Attracting Good Employees
- Staff Shortages
- Workforce entering retirement
- Competition

BHCOE

- *"A behavioral health center of excellence is known by the entire community as a great place to get care and a great place to work. It is an organization or program within an organization that is an integral part of the health neighborhood, providing rapid access to specialty behavioral health services that include high value, comprehensive, whole person care that supports resiliency and recovery and results in excellent outcomes, and high client satisfaction." With that definition in mind,*

BHCOE 5 Key Elements

Element 1: Easy Access

Element 2: World Class Customer Service Built on a Culture of Staff and Client Engagement and Wellness

Element 3: Comprehensive Care

Element 4: Excellent Outcomes

Element 5: Excellent Value

New Leadership Challenges

1. The pace of change underway in the American healthcare system can be overwhelming as payers, employers and policy makers continue to experiment with the way that healthcare is delivered and paid for around the country.
2. States are continuing to move more and more services and populations into managed care; Accountable Care Organizations are being implemented by Medicare and Medicaid; Medical and Health Homes are spreading; and all the while all providers are being asked to quantify the value of the services that they provide while reducing the cost of care.

Distributive Justice Ethical Leadership Challenge

- **Distributive Justice Ethical Dilemma:**
  1. How do providers ensure that they are providing the greatest good to the greatest number of people based on the limited resources available?
  2. How do providers shift the primary service delivery focus from its current caseloads to an equal focus between current caseloads and persons presenting to access services?
  3. Providers need to establish key performance standards to ensure that the needs of ALL of the people in the catchment area are responded to timely and effectively

Healthcare Reform

Under Integrated care service delivery models the ***Value*** of Behavioral Health Services will depend upon our ability to:

1. Be Accessible (Fast Access to all Needed Services)
2. Be Efficient (Provide high Quality Services at Lowest Possible Cost)
3. Electronic Health Record capacity to connect with other providers
4. Focus on Episodic Care Needs/Bundled Payments
5. Produce Outcomes!
    - Engaged Clients and Natural Support Network
    - Help Clients Self Manage Their Wellness and Recovery
    - Greatly Reduce Need for Disruptive/ High Cost Services

Open Access Redesign Recommendations

- Discover Unrealized Service Capacity
- Centralized Scheduling
- Open Access
- Collaborative Documentation
- No Show Management
- Guidelines for EOC/LOC and UR/UM Procedures
- Review Productivity Standards and KPIs for Clinical and Non-Clinical Staff

Today's Change Environment requires…

Shift from "Perfect Solution" to Rapid Cycle CQI Process of Improvement

1) **Sequential Change** – complete one goal and then address the next goal, etc.
2) **Quality Improvement Process Focus (QI)** Typically Supports Processing / "What if we do this?"/Lack of Forward Movement and Goal Attainment

Vs.

3) **Transformational Change** – continuous change management model using Rapid Cycle Change Model (PDSA)

4) **Continuous Quality Improvement Solution Focus (CQI)** – Implies Continuous Movement Forward/ Does not seek 100% approval / Does not require perfection / asks "How did it work?"

BH Core Competencies

Presented By:
Michael Flora, MTM Services
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Georgia's Recovery Definition and Guiding Principles & Values Georgia's Recovery Definition

- Recovery is a deeply personal, unique, and self determined journey through which an individual strives to reach his/her full potential. Persons in recovery improve their health and wellness by taking responsibility in pursuing a fulfilling and contributing life while embracing the difficulties one has faced.
- Recovery is not a gift from any system. Recovery is nurtured by relationships and environments that provide hope, empowerment, choices and opportunities.
- Recovery belongs to the person. It is a right, and it is the responsibility of us all.

9-20-13 Version)

Georgia' Recovery Guiding Principles and Values

- Recovery ….
- Emerges from hope
- Is person-driven
- Is Strengths based
- Is Age Independent
- Recognizes the wisdom of "lived experiences"
- Occurs via many pathways
- Is holistic
- Is supported by peers, allies, advocates and families
- Is nurtured through relationships and social networks

Georgia' Recovery Guiding Principles and Values

- Is culturally based and influenced
- Is anchored in wellness- addressing a person's emotional health, environmental well being, financial satisfaction, intellectual creativity, occupational pursuits, physical activities, social engagement and spiritual health
- Addresses trauma
- Supports self- responsibility
- Empowers communities
- Is based on respect.

Today's Change Environment requires…

Asking not:

<u>HOW</u> can we do this?

Or:

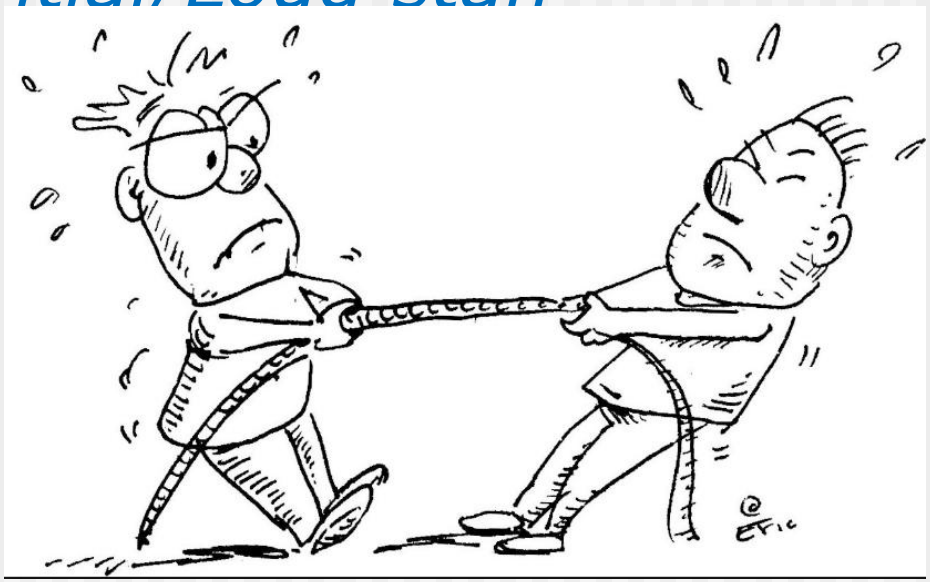
How can we <u>DO</u> this?

Ask:

How <u>CAN</u> we do this? How WILL we do this?

What are your Teams Roadblocks?

- *Team members with differing opinions*
- *Teams who setup their systems to the exceptions.*
- *Passionate /Influential/Loud staff*
- *System Noise*
- *Retreat Culture*



Getting Past Those Roadblocks…

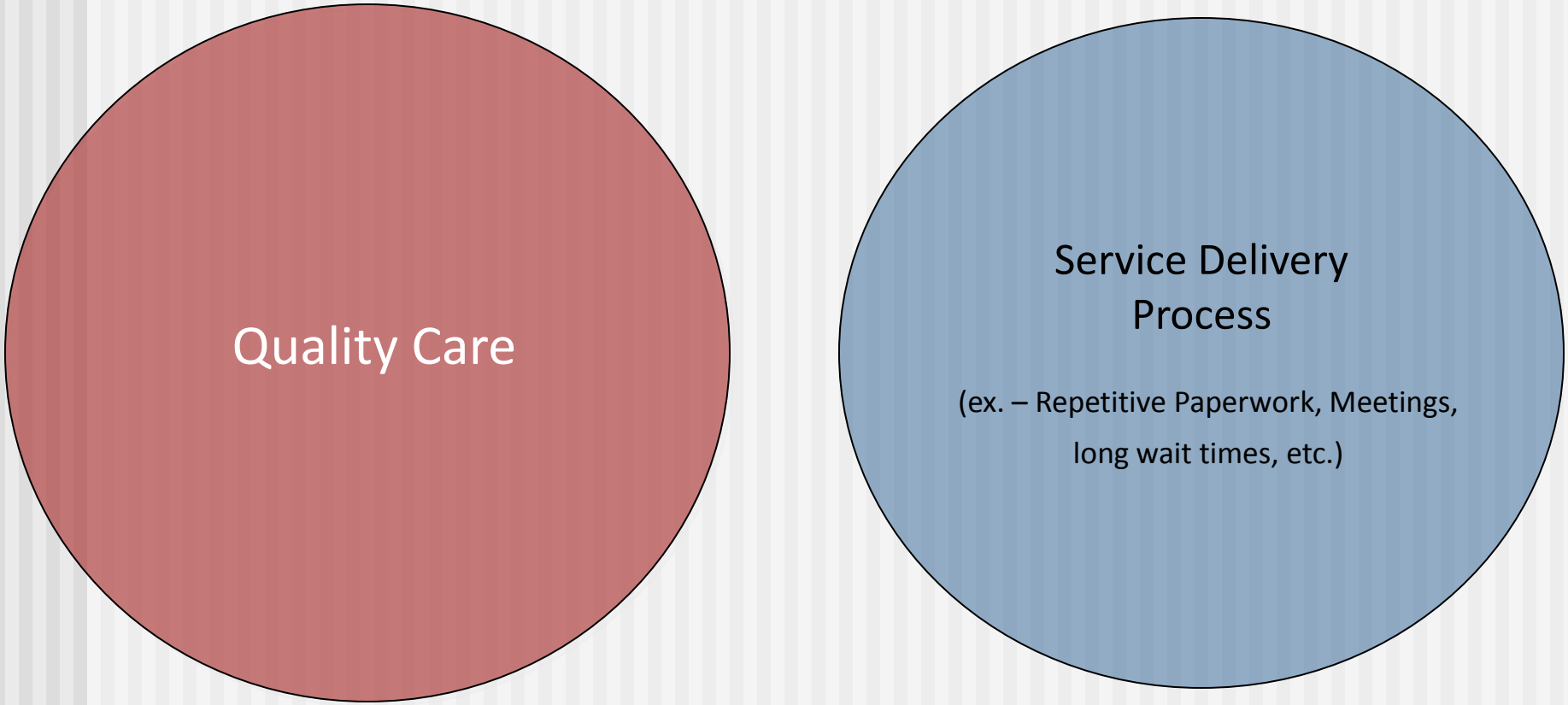
Data is the Key!

- ✓ Without data, teams set up to their exceptions.
- ✓ What data do you need and how do you get it?

How We Arrived Here…

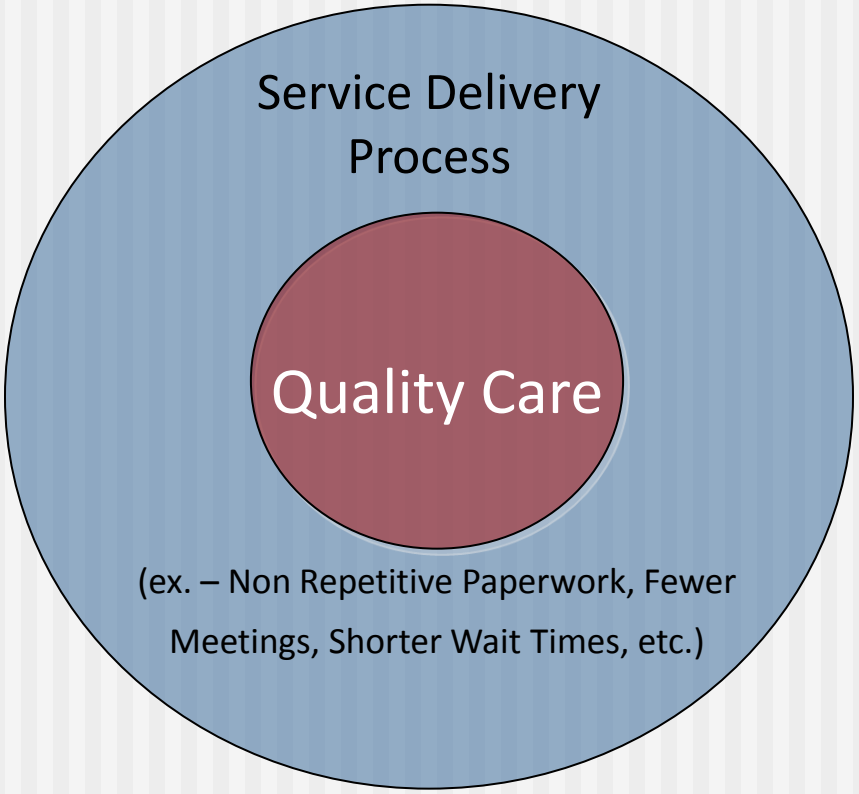
How We Arrived Here…

Delivery System Decision



How We Arrived Here...

Delivery System Setup



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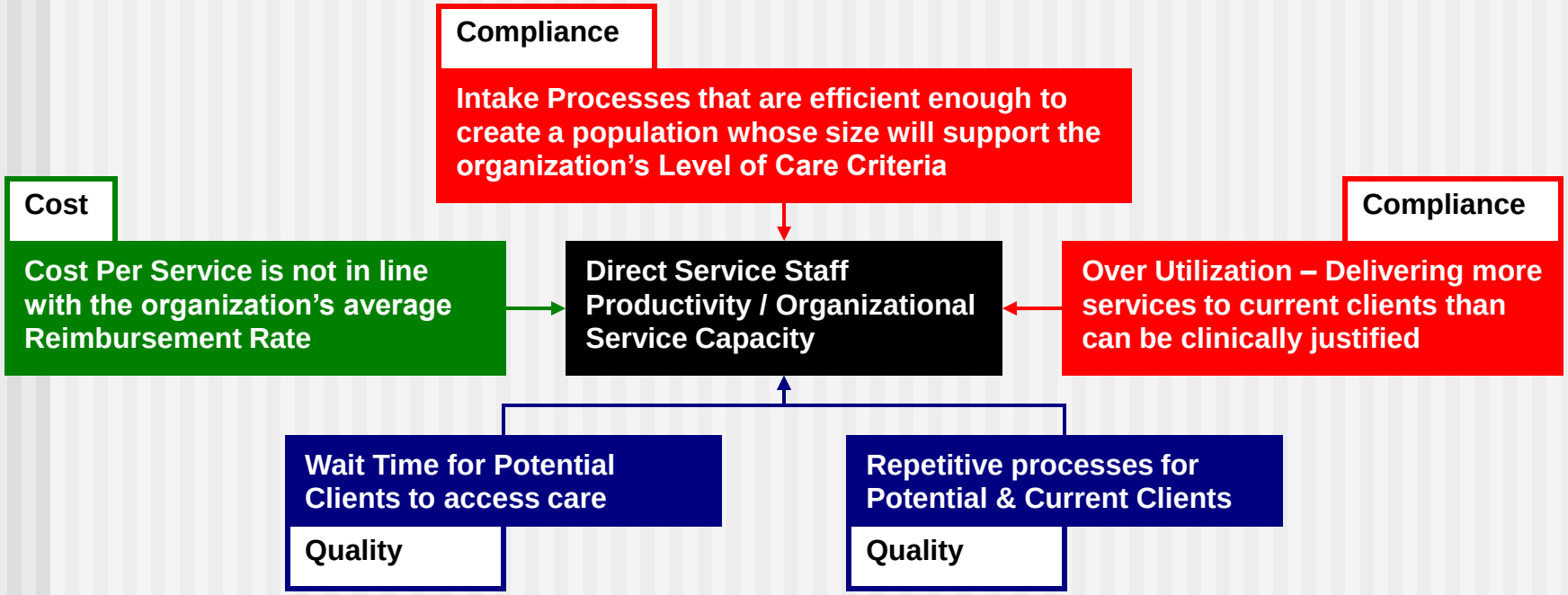
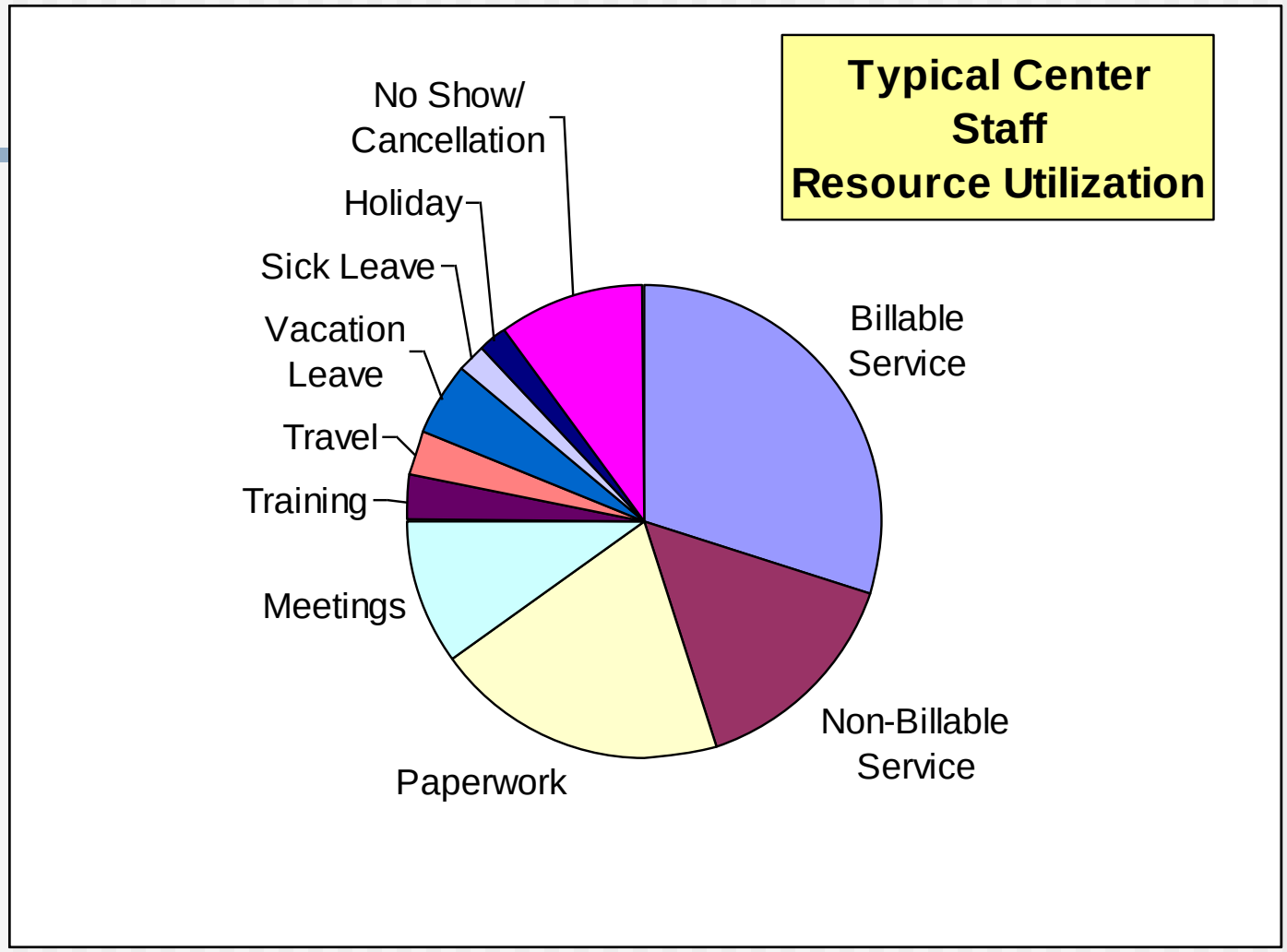
How We Arrived Here…



Cost drives your organization's productivity goals, which affects several other key areas.

For Most Organizations…

Capacity Issues create problems with access.



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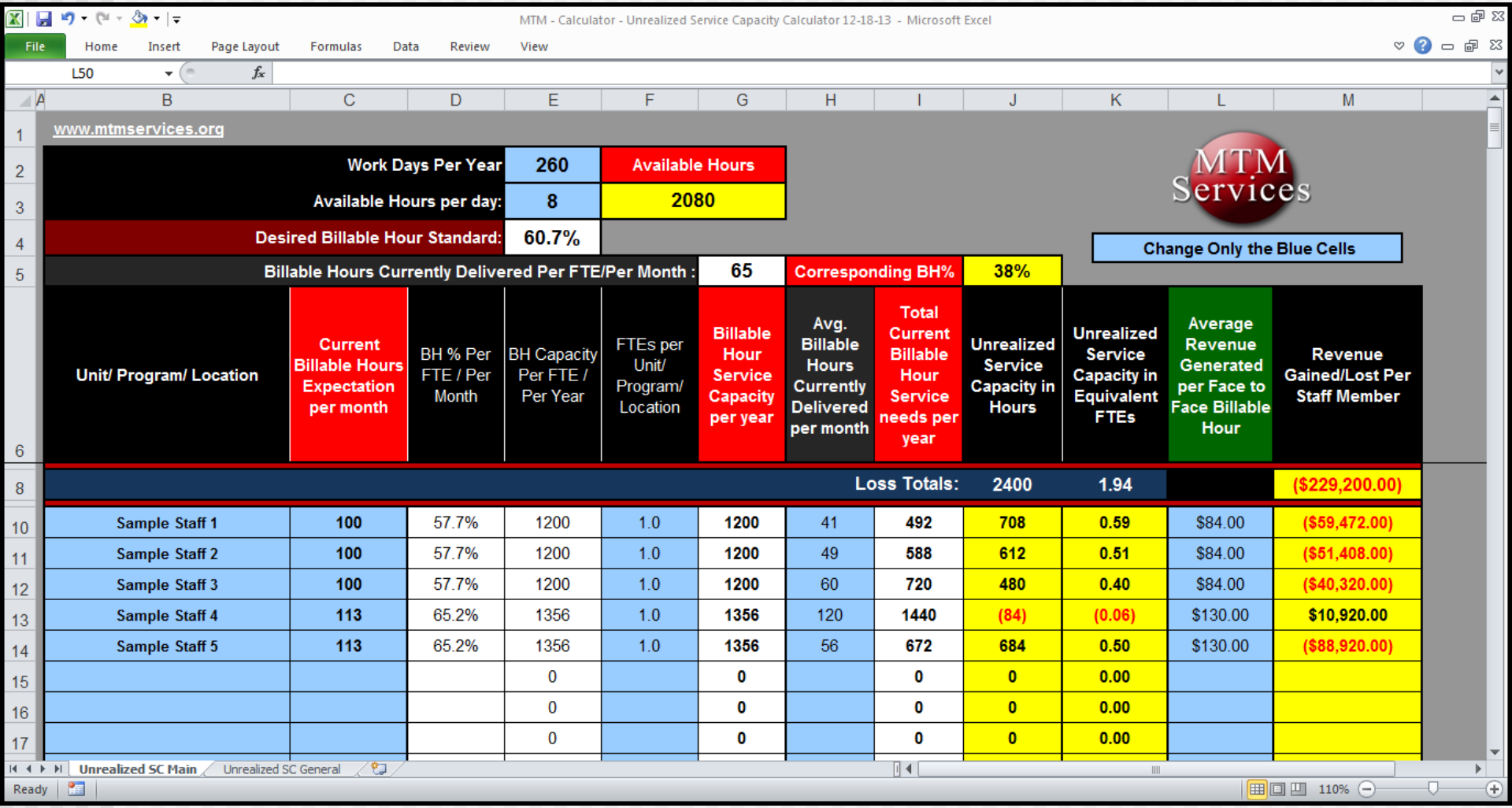
Unrealized Service Capacity?


MTM - Calculator - Unrealized Service Capacity Calculator 12-18-13 - Microsoft Excel

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Work Days Per Year	260
Available Hours per day:	8
Available Hours	2080
Desired Billable Hour Standard:	60.7%
Billable Hours Currently Delivered Per FTE/Per Month :	65
Corresponding BH%	38%

Change Only the Blue Cells

Unit/ Program/ Location	Current Billable Hours Expectation per month	BH % Per FTE / Per Month	BH Capacity Per FTE / Per Year	FTEs per Unit/ Program/ Location	Billable Hour Service Capacity per year	Avg. Billable Hours Currently Delivered per month	Total Current Billable Hour Service needs per year	Unrealized Service Capacity in Hours	Unrealized Service Capacity in Equivalent FTEs	Average Revenue Generated per Face to Face Billable Hour	Revenue Gained/Lost Per Staff Member
							Loss Totals:	2400	1.94		($229,200.00)
Sample Staff 1	100	57.7%	1200	1.0	1200	41	492	708	0.59	$84.00	($59,472.00)
Sample Staff 2	100	57.7%	1200	1.0	1200	49	588	612	0.51	$84.00	($51,408.00)
Sample Staff 3	100	57.7%	1200	1.0	1200	60	720	480	0.40	$84.00	($40,320.00)
Sample Staff 4	113	65.2%	1356	1.0	1356	120	1440	(84)	(0.06)	$130.00	$10,920.00
Sample Staff 5	113	65.2%	1356	1.0	1356	56	672	684	0.50	$130.00	($88,920.00)
			0		0		0	0	0.00		
			0		0		0	0	0.00		
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Unrealized SC Main | Unrealized SC General

Ready

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How We Arrived Here…

- **Documentation Concerns**
  - Repetitive Data Collection
  - Overly Extensive Narratives
  - Post Session Documentation Time
  - Leads to holding back time
- **Capacity Issues**
  - Caseloads "Full"
  - Staff Short on Direct Service Expectations
- **No Show Issues**
  - Leads to double booking
  - Generates Staff Anxiety

Steps to Maximize Service Capacity

1) Productivity = Service Capacity – Actual billable face to face time

2) Collaborative Documentation

3) No Show Rates- how much capacity is lost to No Shows?
   Centralized Scheduling and No Show Management

4) Level of Care Management:
   Are we cleaning caseloads appropriately?
   Do clients move on when they are stable?

If still lack capacity, then must decide: Hire staff or Turn Away Clients

What we do to fix it!

- Standardize Access to Treatment
  - Open Access
- Maximize Capacity
  - Centralized Scheduling
  - No Show Management
  - EOC/LOC Guidelines and UR/UM Processes
  - Just-in-Time Scheduling
- Streamline Documentation Processes:
  - Collaborative Documentation
  - Data Mapping

Process Redesign Review

Presented By:
Michael Flora, MTM Services

Process Redesign Results Review

	Total Number of Processes	Total Staff Time (Hrs)	Total Client Time without Wait-time (Hrs)	Cost for Process	Total Wait-time (Days)
Old Process Averages:	5.70	5.06	3.65	(331.63)	49.25
New Process Averages:	5.04	3.34	2.99	(210.20)	29.31
Savings:	0.66	1.73	0.65	$121.43	19.94
Change %:	12%	34%	18%	37%	40%

Avg. Number of Intakes Per Month	3,843
Monthly Savings:	$466,642.00
Annual Savings:	$5,599,704.00

Represented: 28 Organizations of 48 Organizations who started the Access Redesign Grant from Florida (7), Ohio (12), & Wyoming (9). The average annual savings for these 28 organizaitons if $199,989.43 per agency.

Process Redesign Results Review

	Total Number of Processes	Total Staff Time (Hrs)	Total Client Time without Wait-time (Hrs)	Cost for Process	Total Wait-time (Days)
Old Process Averages:	4.65	3.51	2.68	(249.38)	45.97
New Process Averages:	4.20	2.63	2.30	(162.19)	20.55
Savings:	0.45	0.88	0.38	$87.19	25.42
Change %:	10%	25%	14%	35%	55%

Avg. Number of Intakes Per Month	2,775
Difference Intake Volume:	530
Intake Volume Change %:	27%
Monthly Savings:	$154,419
Annual Savings:	$1,853,025.26

* Numbers are for 10 Centers from 9 states. Average Savings = $185,302.53 per agency.
* Take out the 2nd year organizations, Average Savings = $231,764.96 per agency.

Process Redesign Review

Access Comparison Worksheet				
	Total Staff Time (Hrs)	Total Client Time without Wait-time (Hrs)	Cost for Process	Total Wait-time (Days)
Old Process Averages:	4.46	3.10	($333.76)	47.43
New Process Averages:	3.50	2.69	($272.68)	23.77
Savings:	0.96	0.41	$61.08	23.66
Change %:	22%	13%	18%	50%
		Avg. Number of Intakes Per Month		8,080.87
		Intake Volume Change %:		19%
		Monthly Savings:		$493,556.41
		Annual Savings:		$5,922,676.96
		Average Savings Per Center:		$111,748.62

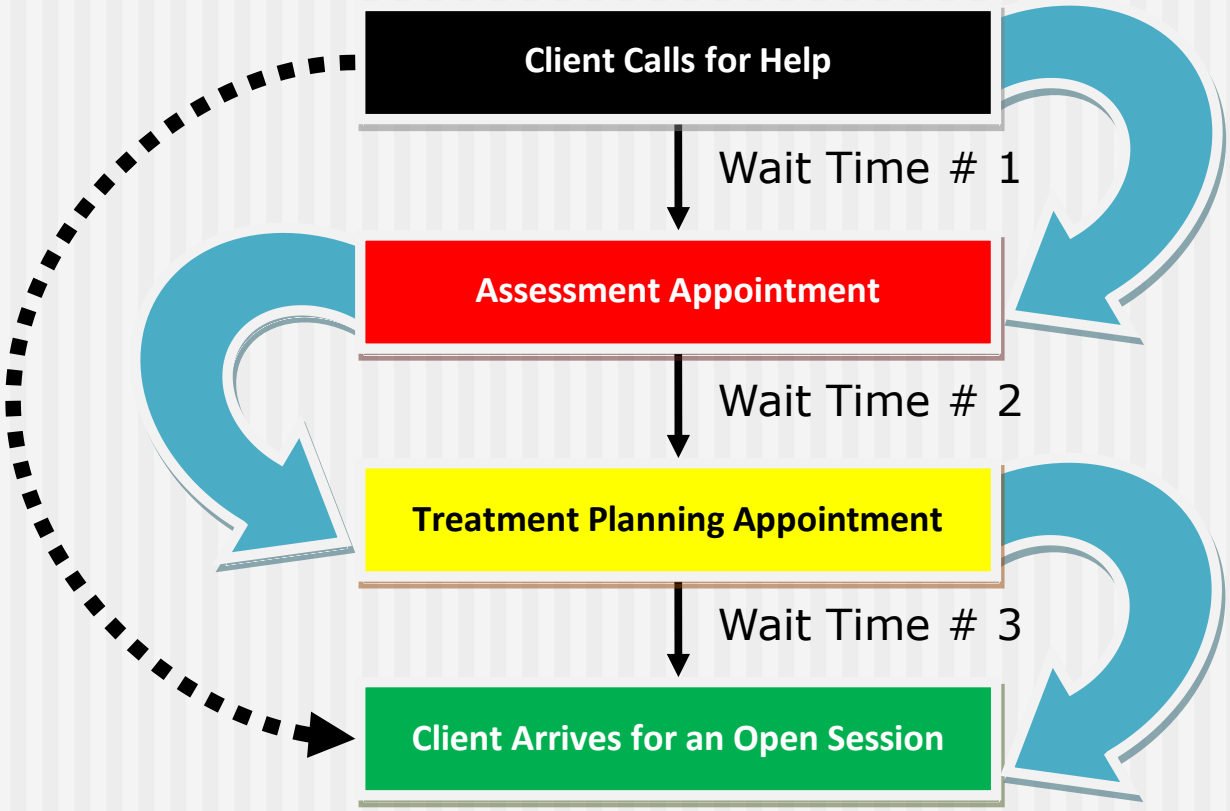
Current Same Day Access Grant in partnership with National Council for Behavioral Health. 56 teams representing 10 states

The Open Access Model; Making it Happen!

A Standardized Solution For CBHOs

Presented By:
Michael Flora, MTM Services

Client Definition of Access



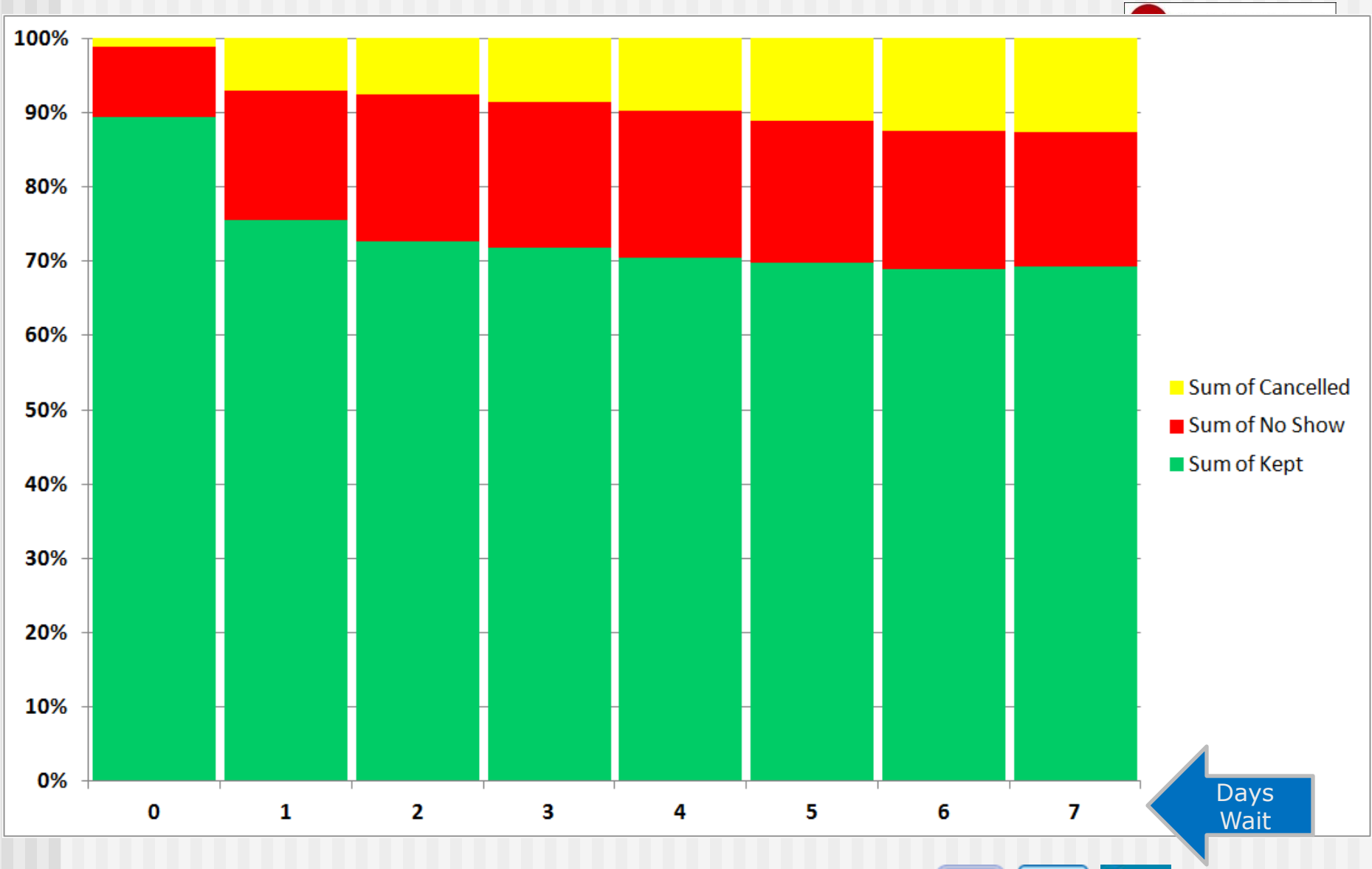
Walk In Intake/Assessments a 0% No Show Model

Why Same Day Access?

- **It makes Sense!** – When looking at Access Models, you should first ask yourself, "What do I expect when seeking medical care?"
- **Client Satisfaction/Engagement** –
  - Clients who are offered a same day appointment show up 91% of the time, those schedule one day later show up 75% of the time.
  - Teams who move to Same Day Access see a 10% increase in the kept rate of their follow up appointments on average.
- **Reduce System Waste** - In several cases, CBHOs have determined that due to the high rate of initial no shows experienced, there would be less clinician time utilized to move to a non-scheduled walk in intake process.

Presented By:
Michael Flora, MTM Services

Assessment Appointment Trends by Days of Wait for all Centers (Over 22,000 Events)



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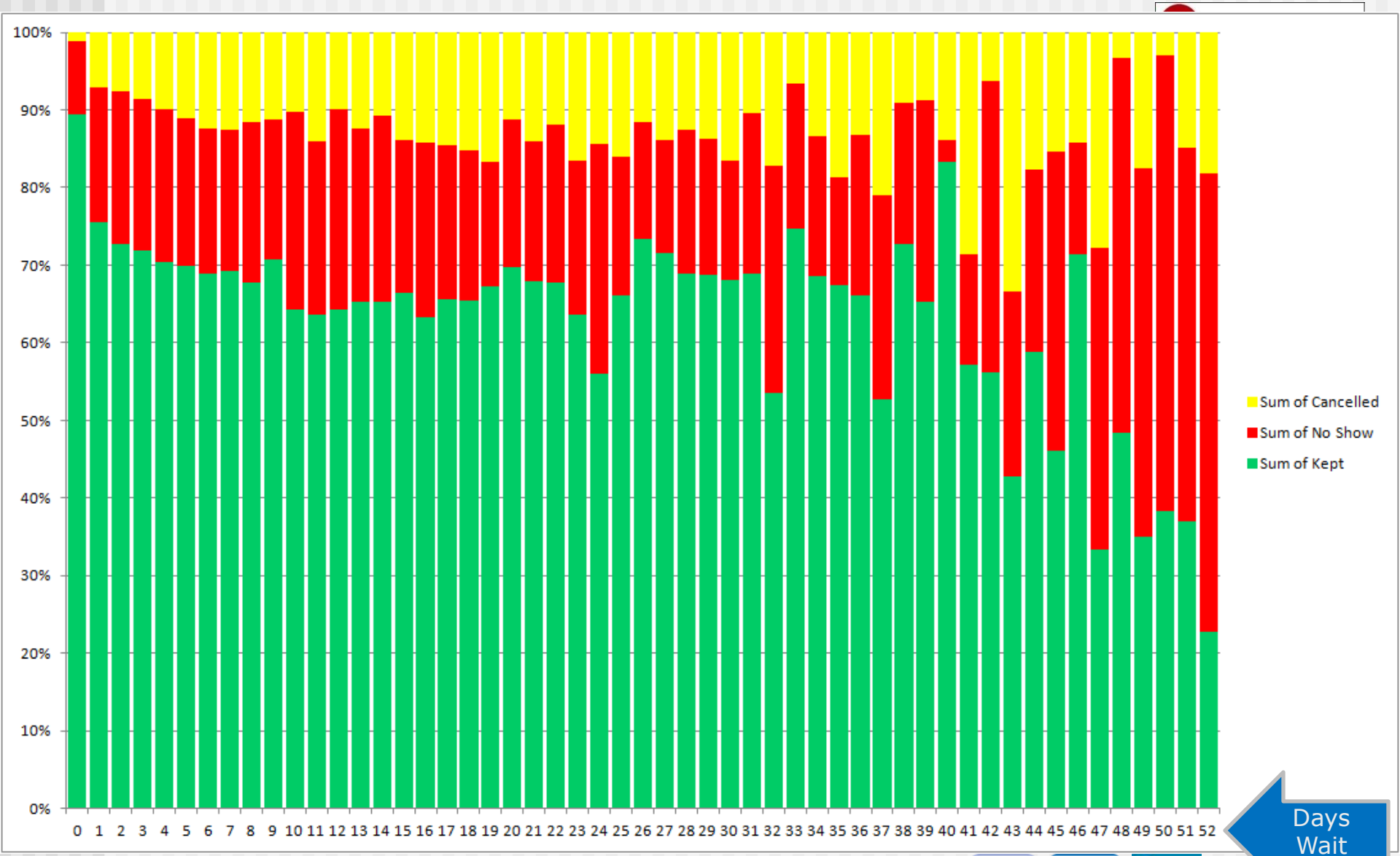


Walk In Intake/Assessments a 0% No Show Model

The *Anxiety* that can proceed this change is 10 times worse than the change itself!

Same Day Access does **NOT** look like this; as long as you plan it out correctly!

Photo Credits: Matador Records & The Simpsons

Walk In Intake/Assessments a 0% No Show Model

The Set Up Steps for Success!

1. Determine your Organization's Demand and Optimal Hours of Operation
2. Select Your Staffing / Team Model / Back-Up Contingency Staff
3. Set a Plan to handle your Existing Appointments
4. Choreograph your Wait time
5. Communicate and Go!

Presented By:
Michael Flora, MTM Services

Walk In Intake/Assessments a 0% No Show Model

Set Up Steps:

1. Determine your Organization's Demand and Optimal Hours of Operation
   - Open Access Days – (*Recommended if demand is sufficient)*
   - Full Open Access
   - Hybrid Model
   - Call Ahead Times

Presented By:
Michael Flora, MTM Services

Walk In Intake/Assessments a 0% No Show Model

Set Up Steps:

2. Select Your Staffing / Team Model / Back-Up Contingency Staff

- **Set Team** - Intake/Assessment clinicians are assigned full or part time to specifically provide all intake/assessments on a walk in basis. After assessment, consumer is referred to other clinicians for treatment. Negative to this model is that the consumer must tell their story at least two times, UNLESS, the treating clinician will trust and utilized the assessment provided at intake

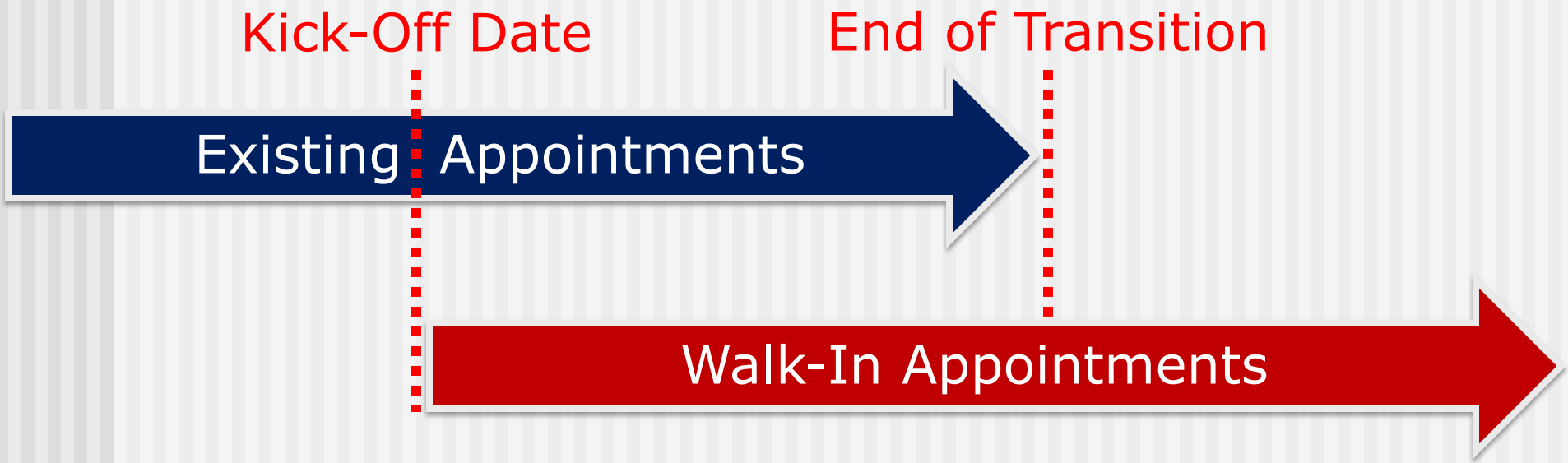
- **Rotating Team** - Regular unit clinicians are scheduled in two-hour blocks beginning each morning and throughout the day (four blocks) to provide intakes. The number of clinicians assigned to each block is based on historical intake calls received and intakes provided.

Presented By:
Michael Flora, MTM Services

Walk In Intake/Assessments a 0% No Show Model

Set Up Steps:

3. Set a Plan to handle your Existing intake / assessment Appointments – Smooth Transition



Walk In Intake/Assessments a 0% No Show Model

Set Up Steps:

4. Choreograph your Wait time
   - Pre-session: What are the pre-session activities that you will utilize?
   - Session goals:
     - Master's Level assessment provided the same day of call or walk in for help (If the consumer calls after 3:00 p.m. they will be asked to come in the next morning unless in crisis or urgent need)
     - Initial diagnosis determined
     - Level of Care and Benefit Design Identified with consumer
     - Initial treatment plan Developed based on Benefit Design Package
   - Follow Up Goals:
     - 2nd clinical appointment for TREATMENT within 8 days of Initial Intake
     - 1st medical appointment within 10 days of Initial Intake

Presented By:
Michael Flora, MTM Services

Walk In Intake/Assessments a 0% No Show Model

Set Up Steps:

5. Communicate and Go!
   - Traditional Script Elements (3-5 min) -
     - Basic Demographics (Name, Phone)
     - Confirm Crisis Status
     - Confirm what services they desire
     - Confirm their funding source - (Script B?)
     - Give them hours of operation & what to bring
     - Ask them what time they plan to come in

Presented By:
Michael Flora, MTM Services

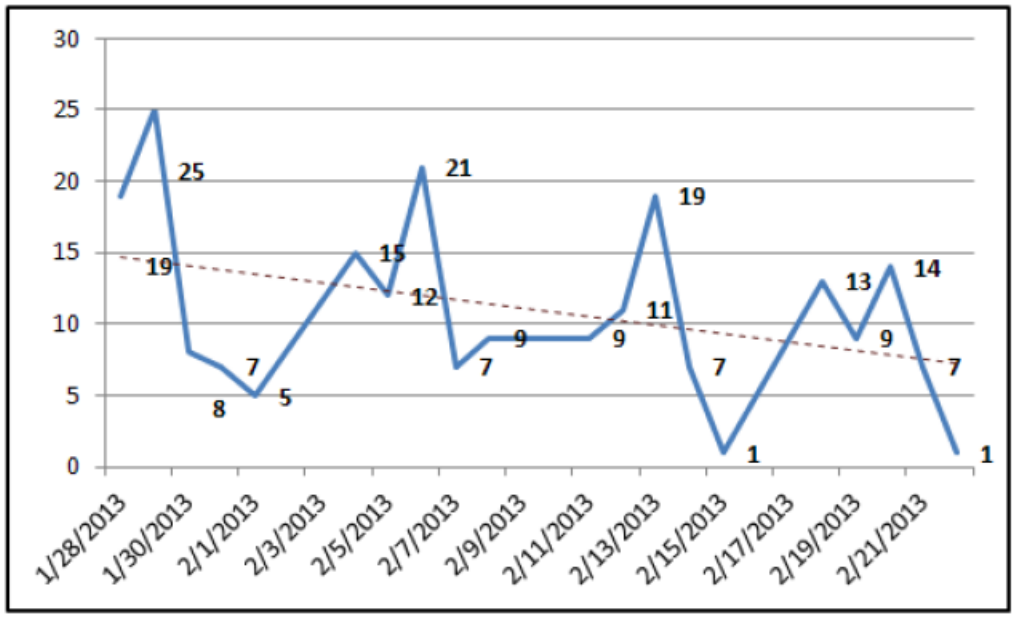
Open Scheduling Same Day Access Model – Consumer Engagement Standards

- Successfully Running - Now What?
  1. Utilize Data to Confirm Planning Assumptions.
  2. Review Capacity and Adjust accordingly
     1. No Show Management
     2. EOC / LOC Reviews

Process Redesign Review

Tracking your Transition

Number of SDA Therapy Evals / Trend



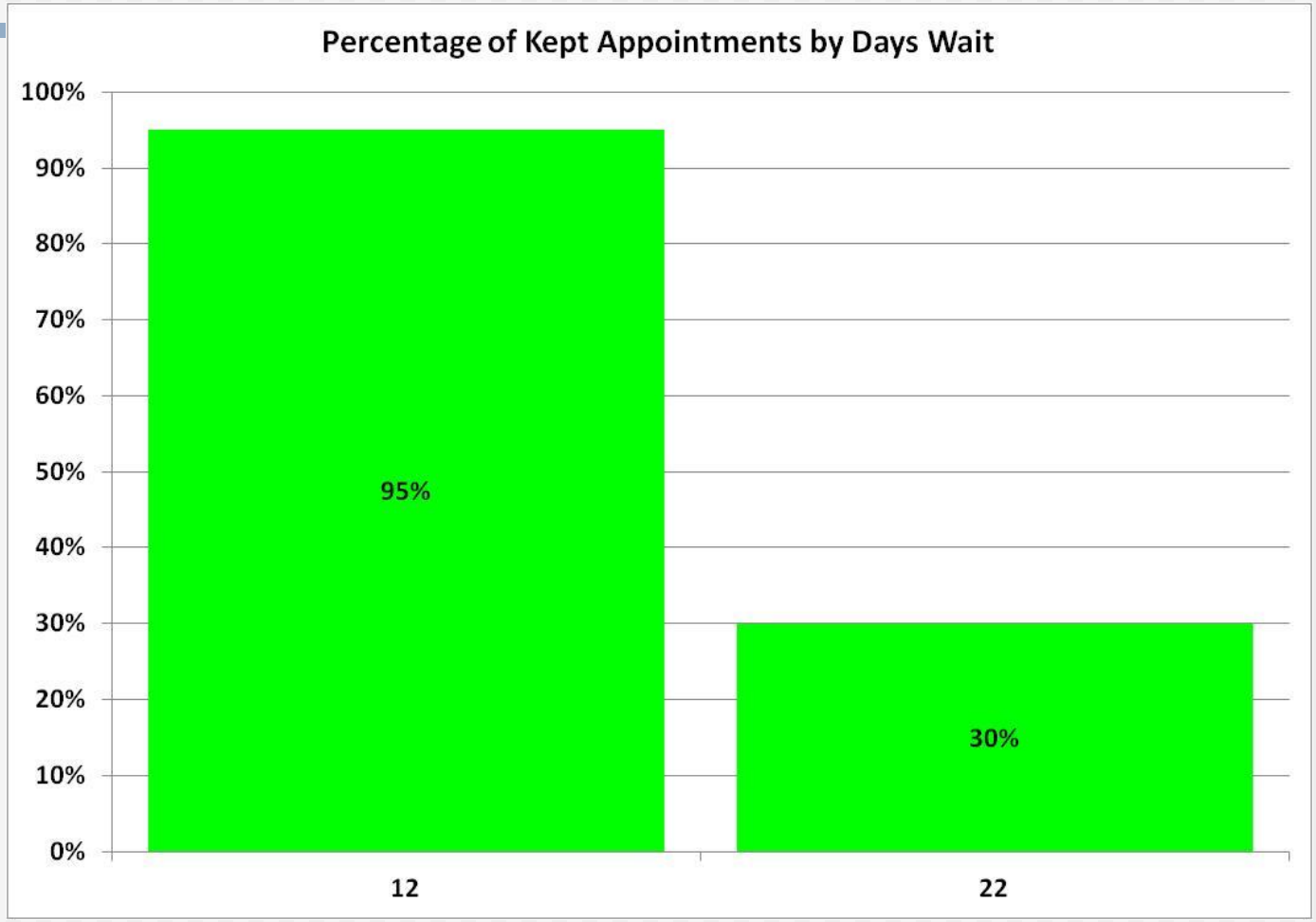
Daily Totals		
Day	Date	Total
Mon	1/28/2013	19
Tue	1/29/2013	25
Wed	1/30/2013	8
Thu	1/31/2013	7
Fri	2/1/2013	5
Mon	2/4/2013	15
Tue	2/5/2013	12
Wed	2/6/2013	21
Thu	2/7/2013	7
Fri	2/8/2013	9
Mon	2/11/2013	9
Tue	2/12/2013	11
Wed	2/13/2013	19
Thu	2/14/2013	7
Fri	2/15/2013	1
Mon	2/18/2013	13
Tue	2/19/2013	9
Wed	2/20/2013	14
Thu	2/21/2013	7
Fri	2/22/2013	1

ABBE CENTER FOR COMMUNITY MENTAL HEALTH 2/26/13

Access to Care Timeliness Case Study

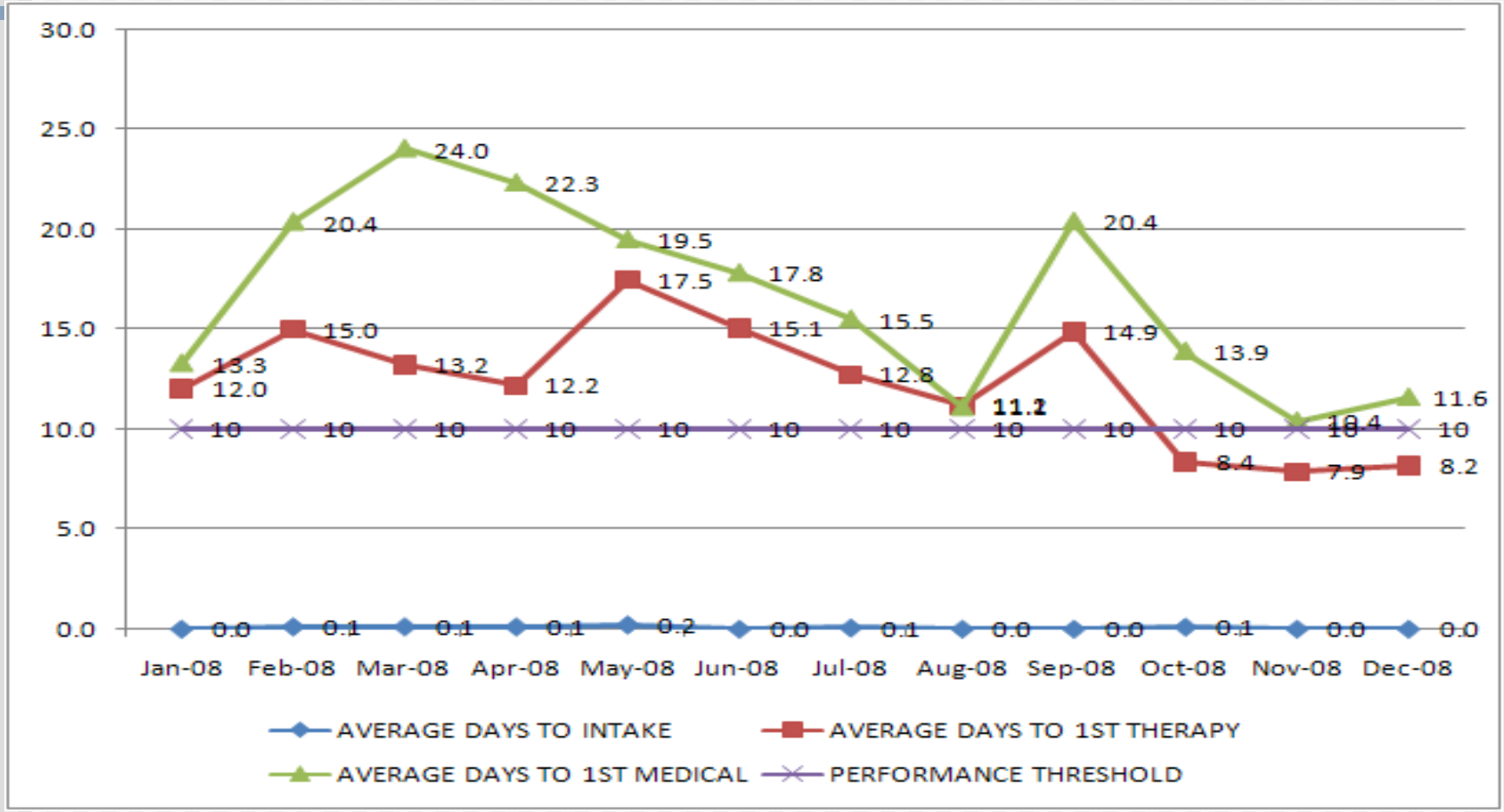
- Using data that demonstrate the following about the relationship between initial contact for help, Open access (same day assessments), second appointments and no-shows. Sample size is 561 new customers who received an intake between January 1, 2009 and May 31, 2009. The summary of outcomes identified are outlined below:
  - a. Approximately 95 percent of the customers who have their second appointment scheduled within 12.2 days of their Intake show for that appointment. Therefore the 10 day access standard that is recommended is valid for the second counseling service and medical appointment.
  - b. Approximately 70 percent of customers who have the second appointment scheduled 22 days or more after their intake did not show.
  - c. 100 percent of the customers whose second appointment was canceled by the Center – never came back.

Access to Care Timeliness Case Study



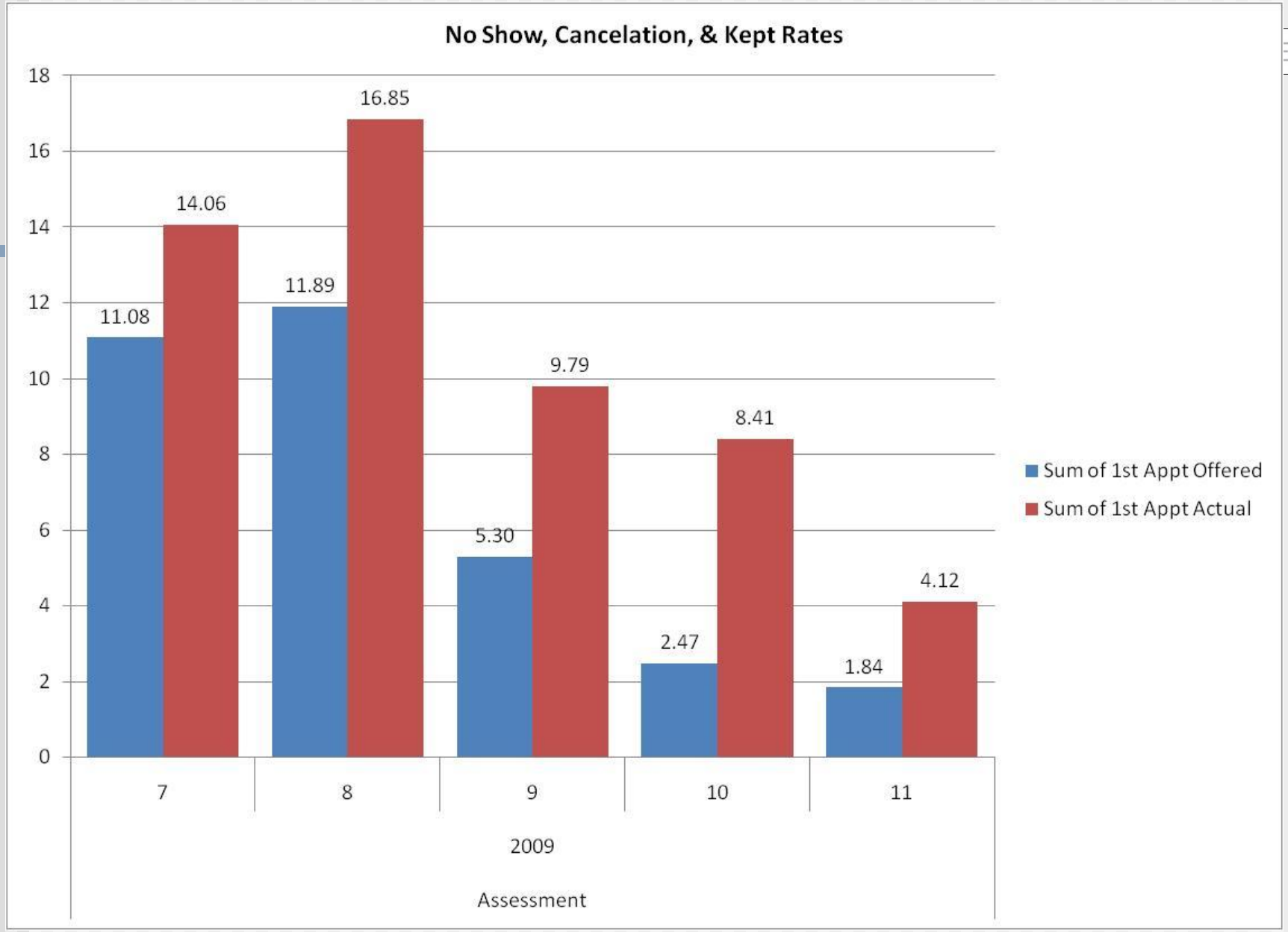
Days to Access Services

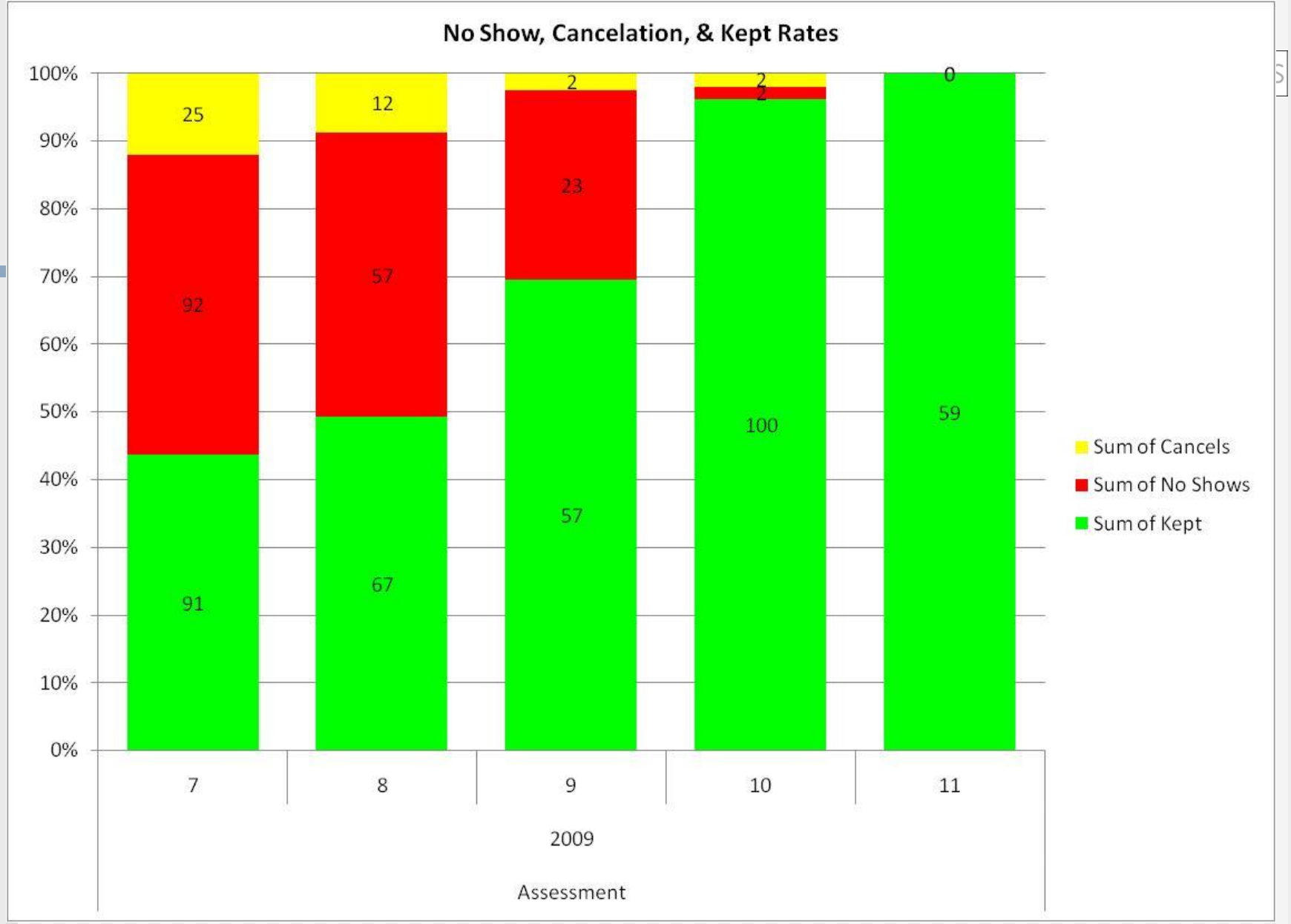
Standard: 10 days from first call/contact to Intake, 1st Therapy and 1st Medical

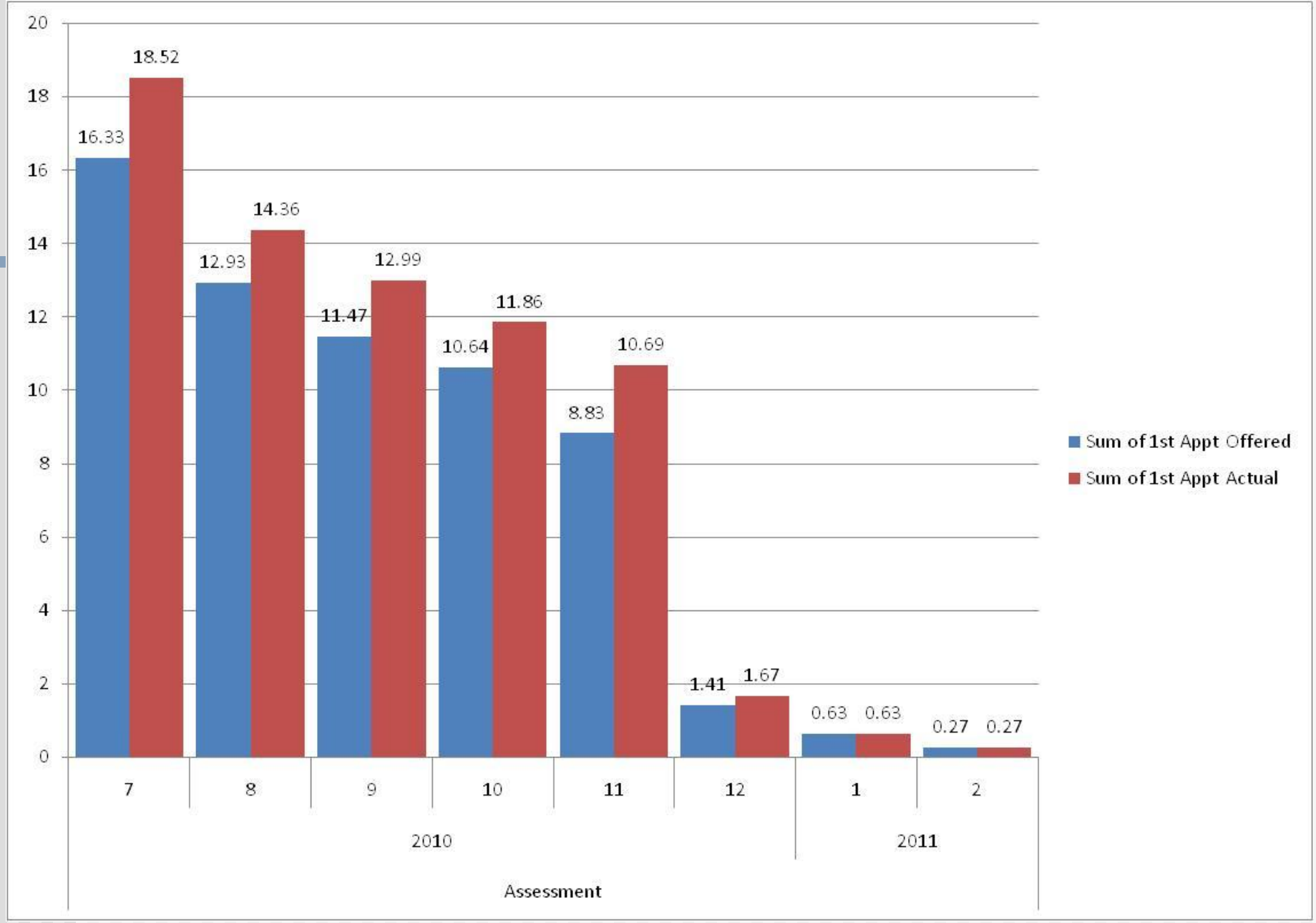


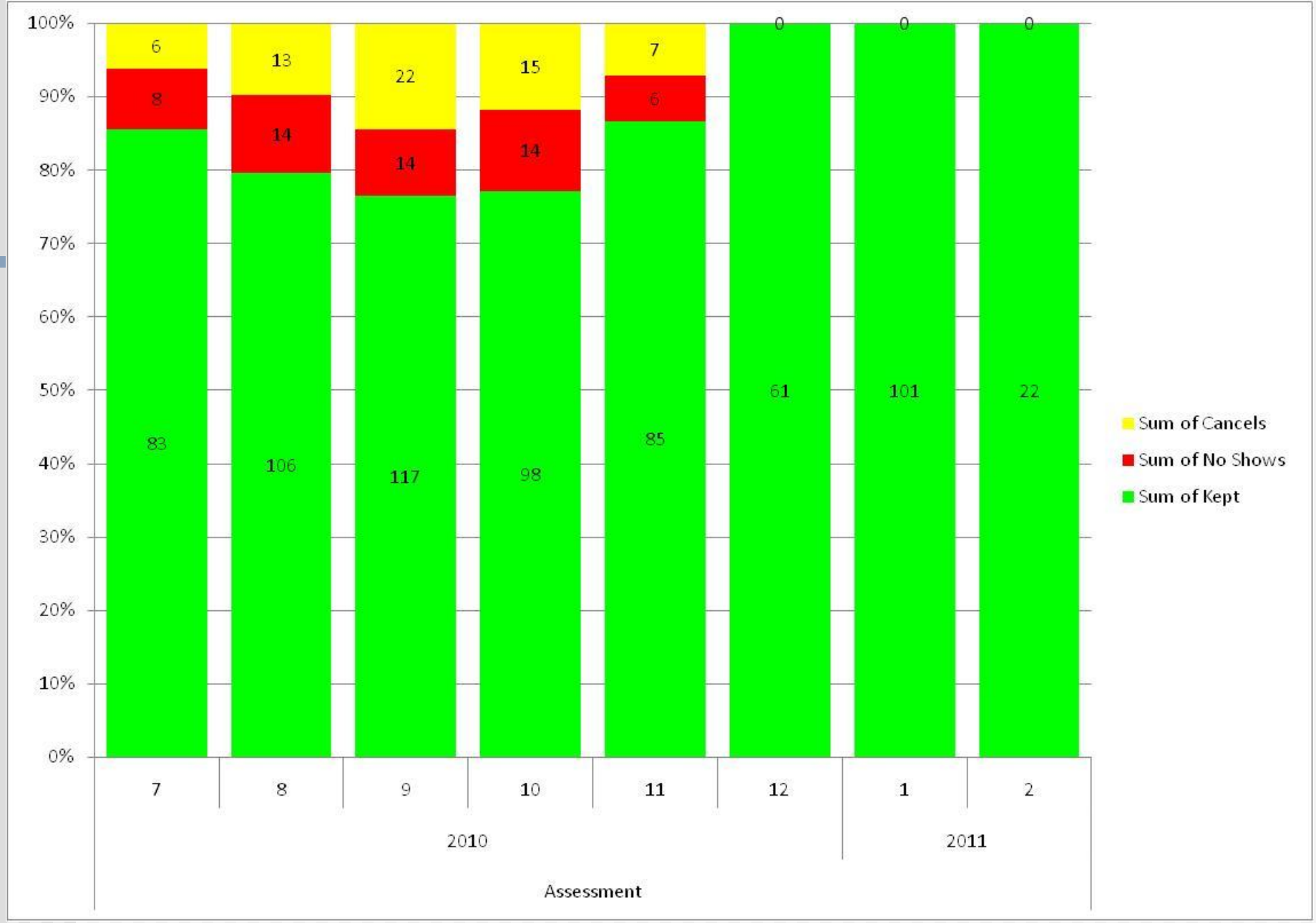
Access Redesign Grant Results

Assessment Appointment


No Show, Cancelation, & Kept Rates
18
16
14
12
10
8
6
4
2
0
16.85
14.06
11.89
11.08
9.79
8.41
5.30
4.12
2.47
1.84
7
8
9
10
11
2009
Assessment
Sum of 1st Appt Offered
Sum of 1st Appt Actual

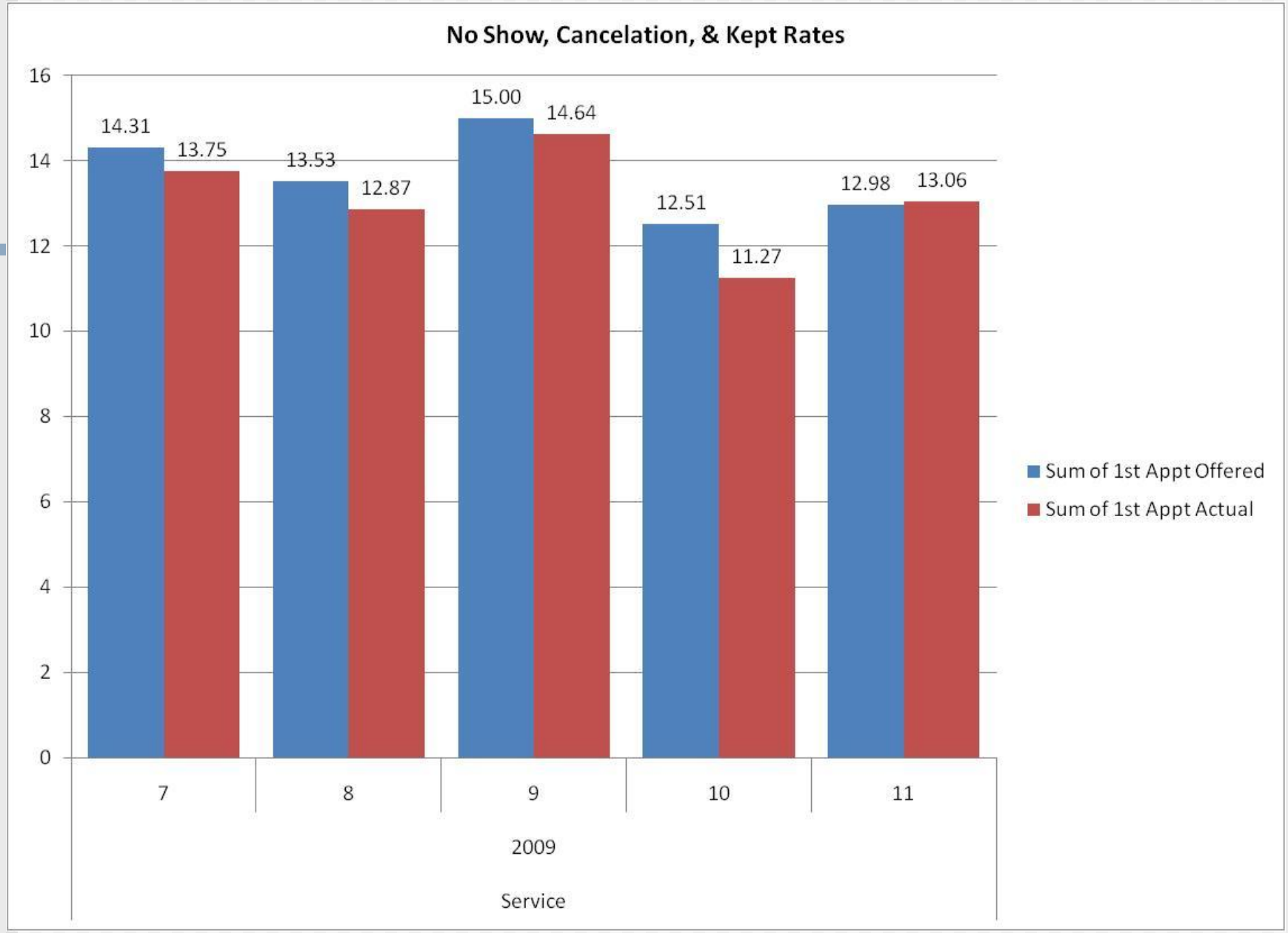

No Show, Cancelation, & Kept Rates
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
25
92
91
12
57
67
2
23
57
2
2
100
0
59
7
8
9
10
11
2009
Assessment
Sum of Cancels
Sum of No Shows
Sum of Kept

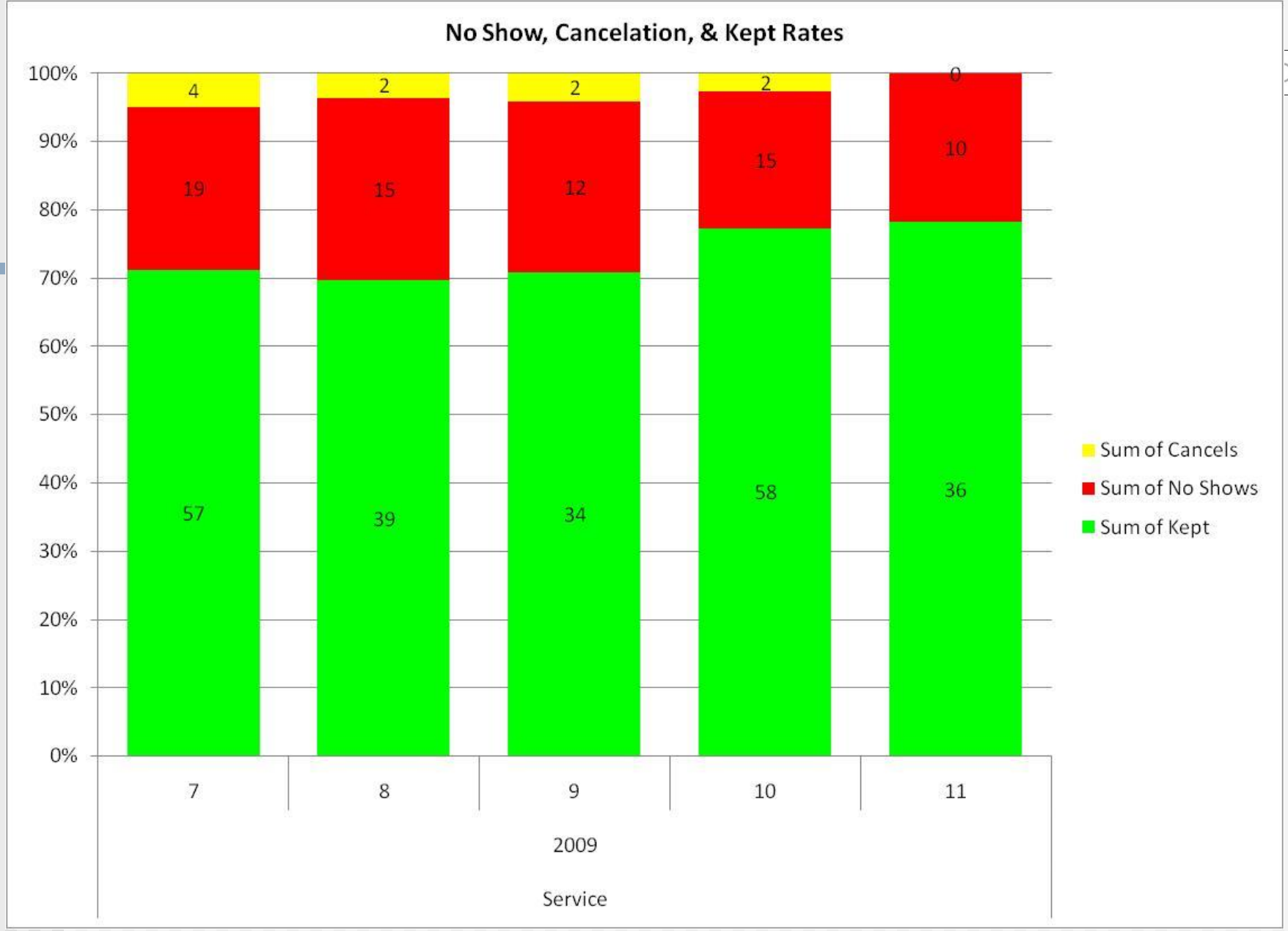

20
18
16
14
12
10
8
6
4
2
0
18.52
16.33
14.36
12.93
12.99
11.47
11.86
10.64
10.69
8.83
1.41
1.67
0.63
0.63
0.27
0.27
7
8
9
10
11
12
1
2
2010
2011
Assessment
Sum of 1st Appt Offered
Sum of 1st Appt Actual


100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
6
8
83
13
14
106
22
14
117
15
14
98
7
6
85
0
61
0
101
0
22
7
8
9
10
11
12
1
2
2010
2011
Assessment
Sum of Cancels
Sum of No Shows
Sum of Kept

Redesign Results

2nd Appointment


No Show, Cancelation, & Kept Rates
16
14
12
10
8
6
4
2
0
14.31
13.75
13.53
12.87
15.00
14.64
12.51
11.27
12.98
13.06
7
8
9
10
11
2009
Service
Sum of 1st Appt Offered
Sum of 1st Appt Actual


No Show, Cancelation, & Kept Rates
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
4
2
2
2
0
19
15
12
15
10
57
39
34
58
36
7
8
9
10
11
2009
Service
Sum of Cancels
Sum of No Shows
Sum of Kept

How to Maximize Existing Service Capacity: Centralized Scheduling

Presented By:
Michael Flora, MTM Services

Centralized Scheduling – What is it?

It is:

- A customer-focused practice that allows rapid response to changing client scheduling needs
- A practice management tool that makes efficient use of valuable human resources by reducing no shows and providing the ability to know the available service capacity at any moment.

It is not:

- Merely the ability for all to "view" the master calendar

Components of Centralized Schedule Management

1. Awareness of all available clinical time/resources in the group practice
2. Filling in available clinical time with "just in time" services
3. Schedule all in clinic and in community appointments
4. Call and confirm appointments 36 to 48 hours in advance – "You have an appointment with _____ on _____ at ____ p.m.. Do you still plan to see _____ or would it be better if I reschedule you?"
5. Back fill 90% of all cancelled appointments
6. Maintain Will Call lists from all clinicians and community support staff

Presented By:
Michael Flora, MTM Services

Centralized Scheduling – Set Up Steps

- Determine scheduling templates
- Establish policy and procedures for allowable standing appointments
- Set key performance indicators for scheduling staff – 90% backfill
- Establish procedures for maintaining backfill lists
- Restrict Authority in Schedule
- Empower scheduling staff!
- Remember not to blink

Centralized Scheduling – Standing Appointments

Have clinicians turn in their "standing appointments" at least three months in advance?

- Supervision times
- PTO
- Lunch Breaks
- Dinner Breaks
- Required Training/Meetings/Committee work

Centralized Scheduling – Field Staff

Weekly Service Planner

Staff Name:	Candy		Dates:		Weekly Units:	4
Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
4	0	0	0	0	0	0
Client:	Client:	Client:	Client:	Client:	Client:	Client:
Loc:	Loc:	Loc:	Loc:	Loc:	Loc:	Loc:
Srv: 406	Srv:	Srv:	Srv:	Srv:	Srv:	Srv:
Start:	Start:	Start:	Start:	Start:	Start:	Start:
Stop:	Stop:	Stop:	Stop:	Stop:	Stop:	Stop:
Units: 1.25	Units:	Units:	Units:	Units:	Units:	Units:
Client:	Client:	Client:	Client:	Client:	Client:	Client:
Loc:	Loc:	Loc:	Loc:	Loc:	Loc:	Loc:
Srv:	Srv:	Srv:	Srv:	Srv:	Srv:	Srv:
Start:	Start:	Start:	Start:	Start:	Start:	Start:
Stop:	Stop:	Stop:	Stop:	Stop:	Stop:	Stop:
Units:	Units:	Units:	Units:	Units:	Units:	Units:
Client:	Client:	Client:	Client:	Client:	Client:	Client:
Loc:	Loc:	Loc:	Loc:	Loc:	Loc:	Loc:
Srv:	Srv:	Srv:	Srv:	Srv:	Srv:	Srv:
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Loc:	Loc:	Loc:	Loc:	Loc:	Loc:	Loc:
Srv:	Srv:	Srv:	Srv:	Srv:	Srv:	Srv:
Start:	Start:	Start:	Start:	Start:	Start:	Start:
Stop:	Stop:	Stop:	Stop:	Stop:	Stop:	Stop:
Units: 1	Units:	Units:	Units:	Units:	Units:	Units:
Client:	Client:	Client:	Client:	Client:	Client:	Client:
Loc:	Loc:	Loc:	Loc:	Loc:	Loc:	Loc:
Srv:	Srv:	Srv:	Srv:	Srv:	Srv:	Srv:
Start:	Start:	Start:	Start:	Start:	Start:	Start:
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Units: 1.75	Units:	Units:	Units:	Units:	Units:	Units:
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Loc:	Loc:	Loc:	Loc:	Loc:	Loc:	Loc:
Srv:	Srv:	Srv:	Srv:	Srv:	Srv:	Srv:
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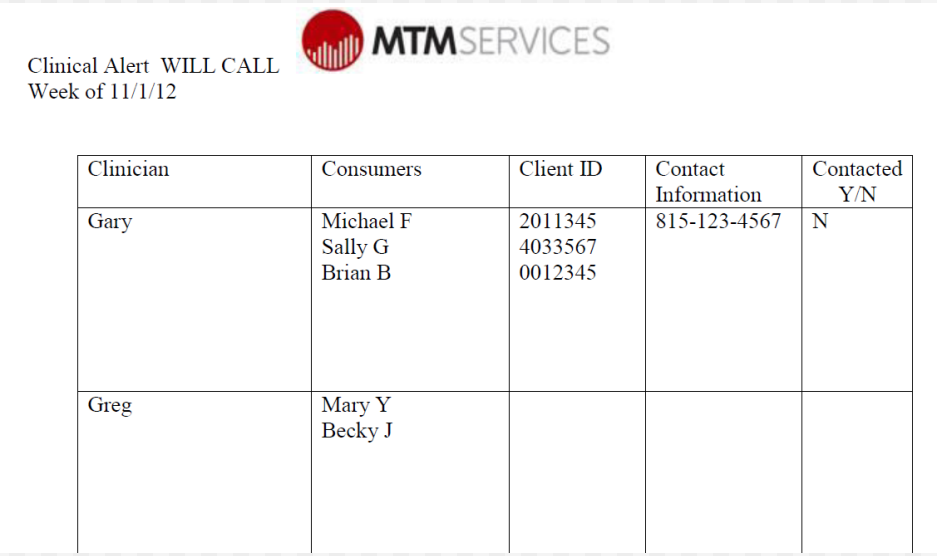
Stop:	Stop:	Stop:	Stop:	Stop:	Stop:	Stop:
Units:	Units:	Units:	Units:	Units:	Units:	Units:

Appointment Back-Fill Protocol

1. Whenever an appointment is cancelled by consumer, the CSR or his/her designee shall be responsible for offering the appointment time to new consumers or existing consumers needing an earlier appointment.
2. All new consumers with regular intake appointments scheduled beyond the 7-calendar day criterion specified by Agency policy and funder requirements shall automatically be placed on a " Will Call List" for earliest availability.
3. To ensure optimal productivity, each Clinician shall provide, for Area Business Manager's use, a " Will Call List" of consumers who should be given priority consideration for earlier appointment based on ISP and level of care needed.
4. This list should be reviewed and updated by the Clinician as needed and at least weekly.

Will Call List to Support BACK FILL Strategies

- On a specific day of the week each clinician will submit their will call list
- Schedule Manager staffs call clients on the list to back fill client cancels



Clinical Alert WILL CALL
Week of 11/1/12

Clinician	Consumers	Client ID	Contact Information	Contacted Y/N
Gary	Michael F Sally G Brian B	2011345 4033567 0012345	815-123-4567	N
Greg	Mary Y Becky J			

Backfill Calculator

Back_Fill_Scheduling_Calculator_2-8-10(1) [Compatibility Mode] - Microsoft Excel

Back Fill Calculator

Outcomes Achieved:	Percentage
1. Client Connection %:	100%
2. Client Cancelled %:	67%
3. Client Rescheduled %:	67%
4. Back Fill %:	33%

Staff Name:	Brad G.
Date:	5.1.11

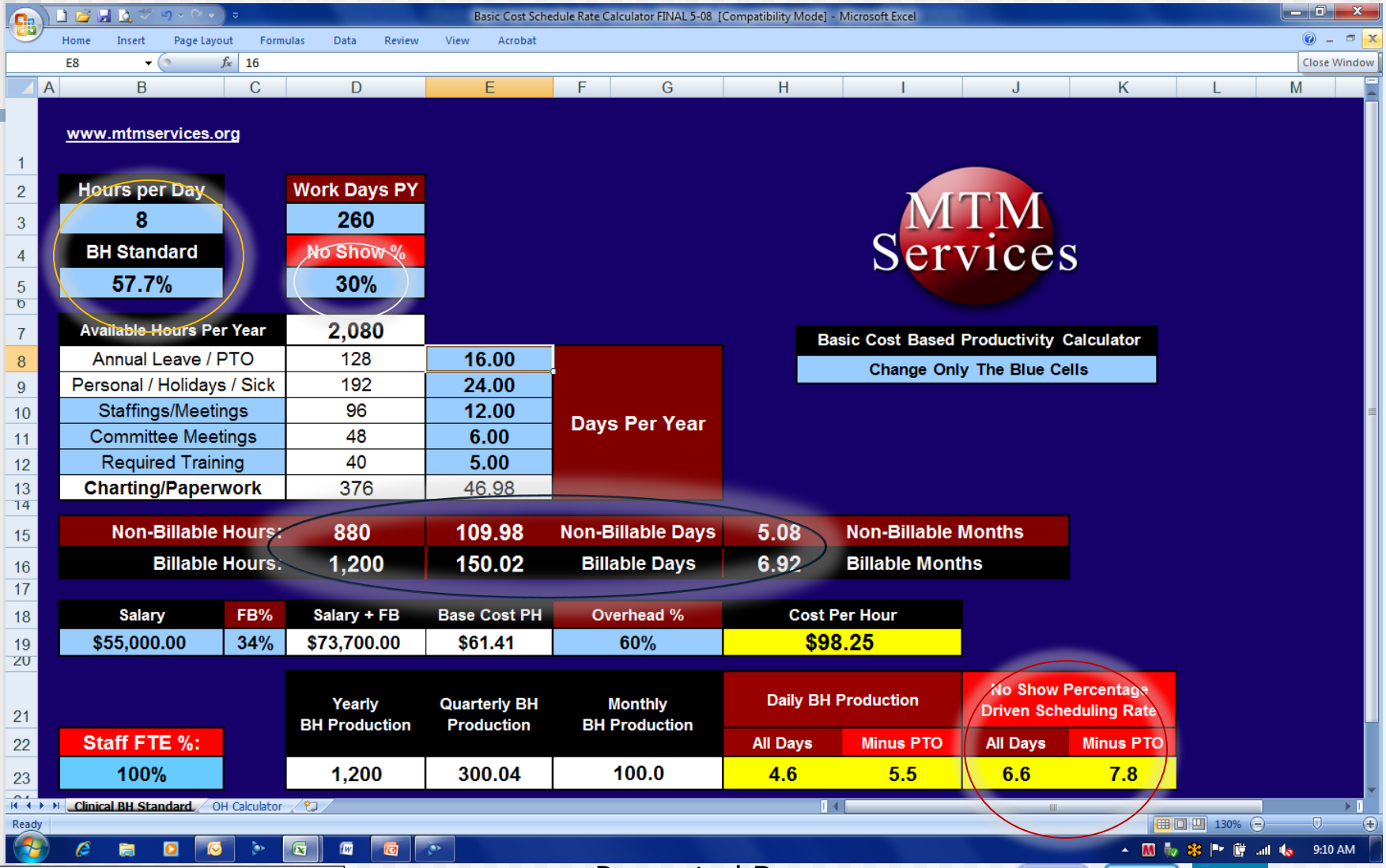
Measurement Indicators to Use in Columns C - G Below: Yes = Y and No = N

	First Call Connection		Second Call Connection If Needed		Did Client Cancel Appt.?		Did you Reschedule Client?		Did You Back Fill Form Appt. Slot?		
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	
Totals	1	0	2	0	2	1	2	2	1	3	
Client ID											Other Information As Needed:
12345	Y		Y		Y		Y		Y		only after 3 pm
12346	N		Y			y		y		y	medicad
12347	n		N			y		y		y	BC/BS
12348	n		N			y		N		N	Unfunded
123459			N			N		N		N	
	n				Y		Y			N	

Sample Centralized Scheduling Guidelines

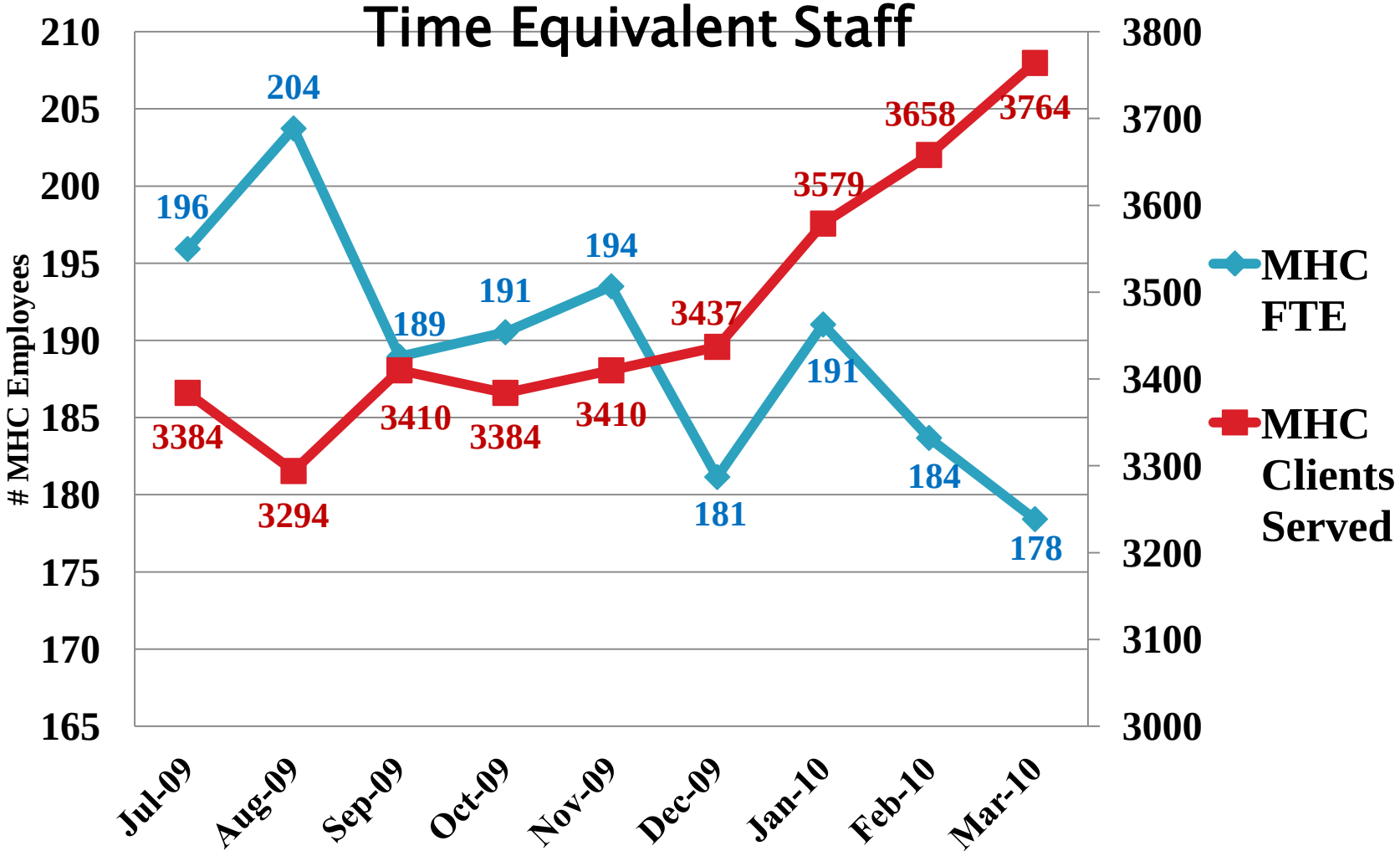
1. Commitment to move to centralized scheduling.
2. Schedule is 100% agency availability, except for items listed below.
3. Allow up to two sessions to be scheduled in advance.
4. Staff leave must be requested (90 days in advance?).
5. Point of Service staff responsible for all scheduling activity. No one else will schedule clinic-based clinical staff.
6. At a minimum community-based staff will enter planned schedule every Thursday for the following week.
7. Implementation Date is (Set and publish implementation date)
8. Permissible reserve times are vacation, approved training, clinical supervision, administrative supervision, planned sick leave (Doctor, dentist appointments), approved meetings, work group sessions, and agency holidays.

Individual Scheduling Template and Productivity Calculator



RESULTS

Colorado West Persons Served per Full Time Equivalent Staff



Cost-Benefit of Centralized Scheduling

Cost benefit of the use of Centralized Scheduling

Office Staff FTEs	Hours lost (weekly) to scheduling functions	Total agency hours lost (weekly)
24	2.5	60

Agency-Wide

Billable hours lost to scheduling (weekly)	Average Reimbursement per billable hour	Potential Revenue Lost due to unbillable scheduling (daily)
60	$75.06	$4,504

Potential Revenue Lost due to unbillable scheduling (Monthly)
$18,014

Potential Revenue Lost due to unbillable scheduling (Annually)
$216,173

Streamlining Documentation Processes: Data Mapping and Collaborative Documentation

Presented By:
Michael Flora, MTM Services

What are the biggest challenges with documentation?

- Systematic redundancies
- Compliance requirements
  - How much is actually required?
  - How much of this are we "doing to ourselves"
  - How much is attributable to our own anxiety?
  - Legacy questions
  - Compliance may dictate what, but not *how* we gather information
  - Compliance is everyone's responsibility, not just the compliance officer.

Data Mapping to Enhance Customer Service (and reduce redundancy)

Case Study of Exhaustive Data Collection Model: M.T.M. Services provides project management and consultation services for the Access and Retention Grant. In their work with CBHOs they provide data mapping of the number of data elements each center collects from the first call for services through the completion of the diagnostic assessment/intake.

A recent data mapping effort for a community provider produced the following outcomes:

1. Total number of data elements collected in the process = **1,854**
2. Total number of redundant data elements collected in the process = **564**
3. Total number of data elements really required for access to treatment planning processes = **957**
4. Total staff time required to administer the original flow process = **Four hours ten minutes**
5. Total staff time required to administer the revised flow process **= One hours twenty minutes**

Presented By:
Michael Flora, MTM Services

MTM SERVICES
www.mtmservices.org

CBHO Consortium EMR Case Study

1. Six Georgia Community Service Boards (now up to 8 members)
2. Reduced 29 separate process flows to one standardized service flow process
3. Reduced over 2,700 data elements being recorded to 975 data elements through data mapping process to reduce staff costs and wait times by over 50%
4. Standardized documentation data elements for all clinical forms processes
5. Co-Location of one IT – electronic record solution
6. Consortium based cost savings over $**1,000,000** over the next first four years

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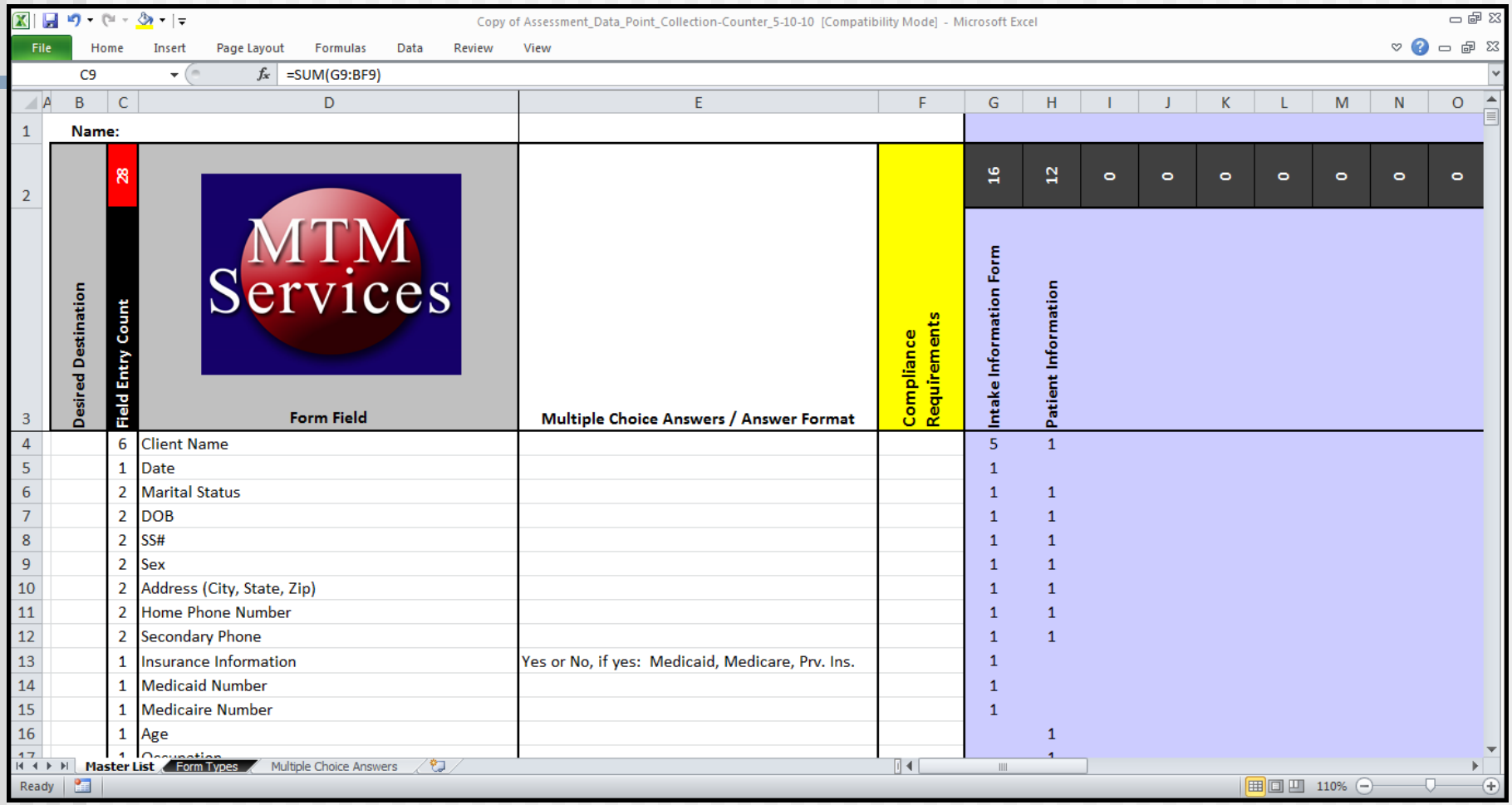
Data Mapping Tool

Measure, Review, Reduce!



Copy of Assessment_Data_Point_Collection-Counter_5-10-10 [Compatibility Mode] - Microsoft Excel

File | Home | Insert | Page Layout | Formulas | Data | Review | View

C9 =SUM(G9:BF9)

	B	C	D	E	F	G	H	I	J	K	L	M	N	O
1	Name:													
2		28				16	12	0	0	0	0	0	0	0
3	Desired Destination	Field Entry Count	Form Field	Multiple Choice Answers / Answer Format	Compliance Requirements	Intake Information Form	Patient Information							
4		6	Client Name			5	1							
5		1	Date			1								
6		2	Marital Status			1	1							
7		2	DOB			1	1							
8		2	SS#			1	1							
9		2	Sex			1	1							
10		2	Address (City, State, Zip)			1	1							
11		2	Home Phone Number			1	1							
12		2	Secondary Phone			1	1							
13		1	Insurance Information	Yes or No, if yes: Medicaid, Medicare, Prv. Ins.		1								
14		1	Medicaid Number			1								
15		1	Medicaire Number			1								
16		1	Age				1							

Master List | Form Types | Multiple Choice Answers

Ready 110%

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What is Collaborative Documentation?

- **Collaborative Documentation is an effective tool for Group & Individual Sessions**
  - Assessments, Treatment Plans are completed Real Time
  - Progress Notes are completed during the last 10 min. Groups & Individual
- **Collaborative Documentation is <u>NOT</u> typing during the entire treatment session.**

Why do Collaborative Documentation?

Reasons for Collaborative Documentation

- Improved Quality of Care
  - Better Engagement with the Client
  - Better Outcome Achievement
- Higher Quality Documentation
- Improved Quality of life for the Provider.
- Lower cost, Increased productivity

Billable Hours Per Year	1200
PN Time in Minutes	Total:
	Mins	Hours
5	6,000	100
7.5	9,000	150
10	12,000	200
12.5	15,000	250
15	18,000	300

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Collaborative Documentation Setup

How to Make it Happen:

- **Scripts –** Know how you are going to explain the process to your clients before your session.
- **Technology Needed -** What technology is needed/available?
- **Office Setup –** Do you need to move computers, screens, office furniture?
- **HIPAA Compliance -** Carrying information into the field offers specific risks.
- **Do as much as you can -** Completing a portion of the note in session as you are starting out is okay; simply move to do more each time.
- **Clinical Judgment -** Collaborative documentation will not work with every client in every situation.

Collaborative Documentation Scripts

- **Script Elements –**
  - This is your note/chart
  - This is your care
  - Writing the note now will help us assure a higher quality note
  - Your opinions are/feedback is very important to help us meeting your treatment goals
  - We want to make each service the best for you that we can
  - We will only take notes during the last few minutes of your session

Collaborative Documentation Scripts

- **Treatment Planning/Individual Session Sample Script –**

After introductions:

"Today we will be doing something new. I'm going to take notes during the session, and then during the last five to ten minutes we will review those notes. Do you have any questions?"

Collaborative Documentation Scripts

- **Treatment Planning/Individual Session Sample Script –**

After introductions:

"We will have open communication during our session today, which means that I will be taking notes along the way, and we will review the information at the end of the service today. This will ensure that we are providing you with the appropriate services to address your needs."

Collaborative Documentation Scripts

- **Sample Script –** After introductions on both sides:

  "We are going to utilize a new note taking strategy during our session today. Instead of taking notes after the session, we will take notes during the session which will allow us to better focus on and help us to be in agreement on what is being expressed. In doing so I will allow you to read the notes I take to actively participate in the reflection process."

Collaborative Documentation Scripts

- **Nurses' Sample Script –** After introductions on both sides:

  "What concerns do you have today? I am going to write them down during this session so that we can review them, address the concerns you feel are most important, and current treatment issues."

Consumer Satisfaction with Concurrent Documentation Model

Concurrent Documentation Consumer Satisfaction Outcomes:

A critically important component of the concurrent documentation model at MHCGM was to solicit and use the feedback from consumers/ families. Below is a brief summary of the Concurrent Documentation Satisfaction Survey evaluation outcomes for the period September 1, 2003 through August 31, 2004 which included:

A. Of 927 respondents whose clinician used the concurrent documentation practice:

1. 83.9% felt the practice was helpful.
2. 13.7% found the practice neutral
3. 2.3% disagree with the practice

B. Of the 284 respondents whose clinician did not use the concurrent documentation practice:

1. 31.5% felt the practice would be helpful
2. 36.9% felt the practice would be neutral
3. 31.3% disagree that it would be helpful

Concurrent Documentation Setup

- **Scripts –** Know how you are going to explain the process to your clients before your session.
- **Technology Needed -** What technology is needed/available?
- **Office Setup –** Do you need to move computers, screens, office furniture?
- **Group & Individual Sessions**
  - **Progress Notes - Last 10 min. Groups & Individual**
  - **Assessments, Treatment Plans – Real Time**
- **HIPAA Compliance -** Carrying information into the field offers specific risks.
- **Clinical Judgment -** Concurrent documentation will not work with every client in every situation.

Concurrent Documentation Setup

- **Treatment Planning/Individual Session Sample Script –**

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MHC of Greater Manchester

Concurrent Documentation Case Study

- "Introducing this to clients was not very difficult. I began by asking if they would like to summarize what we discussed and in particular address what was useful for them during the session and what might have been not so helpful. I found that most were very willing to participate in the process."

MHC of Greater Manchester
Concurrent Documentation Case Study

- "This worked well for the progress notes, as for other forms of documentation such as treatment plans, three month reviews, and annual clinical updates: I found introducing them at the start to their treatment made for a smoother transition and became something they would be expecting to complete as treatment progressed."

MHC of Greater Manchester
Concurrent Documentation Case Study

- "The advantages to doing much of the clinical notes and forms in session were immediately apparent. I noticed that following a therapeutic hour, I felt different. I was not burdened to quickly write a note before the next hour began."

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MHC of Greater Manchester
Concurrent Documentation Case Study

- "They like my interest. They like that I jot down every detail stating, "That's important". I'm very much in connection with my clients… How could we possibly remember without writing it down? So, the leap to writing other notes in session was not so far. Last month there was a huge reduction in my DNA rating (13%) and, to me, that's an indication that my clients like my attention and my approach."

Consumer Satisfaction with Concurrent Documentation Model

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Presented By:
Michael Flora, MTM Services

Collaborative Documentation Results

Presented By:
Michael Flora, MTM Services

Consumer Satisfaction with Collaborative Documentation Model

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Michael Flora, MTM Services

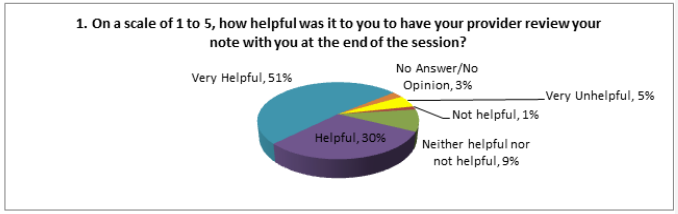
Consumer Satisfaction with Collaborative Documentation Model

Responses for All Participating Centers

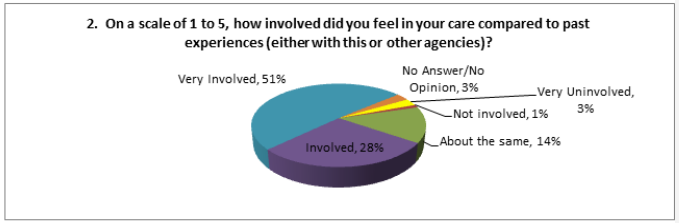
Collaborative Documentation Survey

*Thank you for taking a minute to answer a few questions about your session today. We're working on making the services you receive more open to you, giving you the chance to play a bigger part in the process of tracking the work we do, making sure our notes are accurate, and making sure that we're focused on your treatment goals . **We value your opinion!***

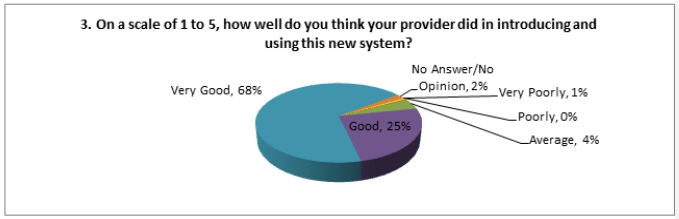
1. On a scale of 1 to 5, how helpful was it to you to have your provider review your note with you at the end of the session?	Percentages Total	Total %
1 Very Unhelpful	895	5%
2 Not helpful	244	1%
3 Neither helpful nor not helpful	1662	9%
4 Helpful	5458	30%
5 Very Helpful	9251	51%
NA No Answer/No Opinion	466	3%
Total/Approval %:	17,976	93%



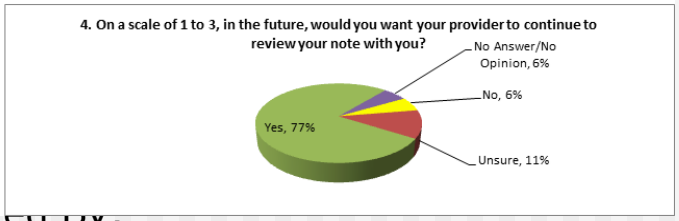
2. On a scale of 1 to 5, how involved did you feel in your care compared to past experiences (either with this or other agencies)?	Total	Total %
1 Very Uninvolved	471	3%
2 Not involved	181	1%
3 About the same	2378	14%
4 Involved	4851	28%
5 Very Involved	8673	51%
NA No Answer/No Opinion	482	3%
Total/Approval %:	17,036	96%



3. On a scale of 1 to 5, how well do you think your provider did in introducing and using this new system?	Total	Total %
1 Very Poorly	85	1%
2 Poorly	44	0%
3 Average	746	4%
4 Good	4150	25%
5 Very Good	11558	68%
NA No Answer/No Opinion	347	2%
Total/Approval %:	16,930	99%



4. On a scale of 1 to 3, in the future, would you want your provider to continue to review your note with you?	Total	Total %
1 No	939	6%
2 Unsure	1867	11%
3 Yes	12571	77%
NA No Answer/No Opinion	904	6%
	0	0%
	0	0%
Total/Approval %:	16,280	94%



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Strategies for No Show Management

Presented By:
Michael Flora, MTM Services

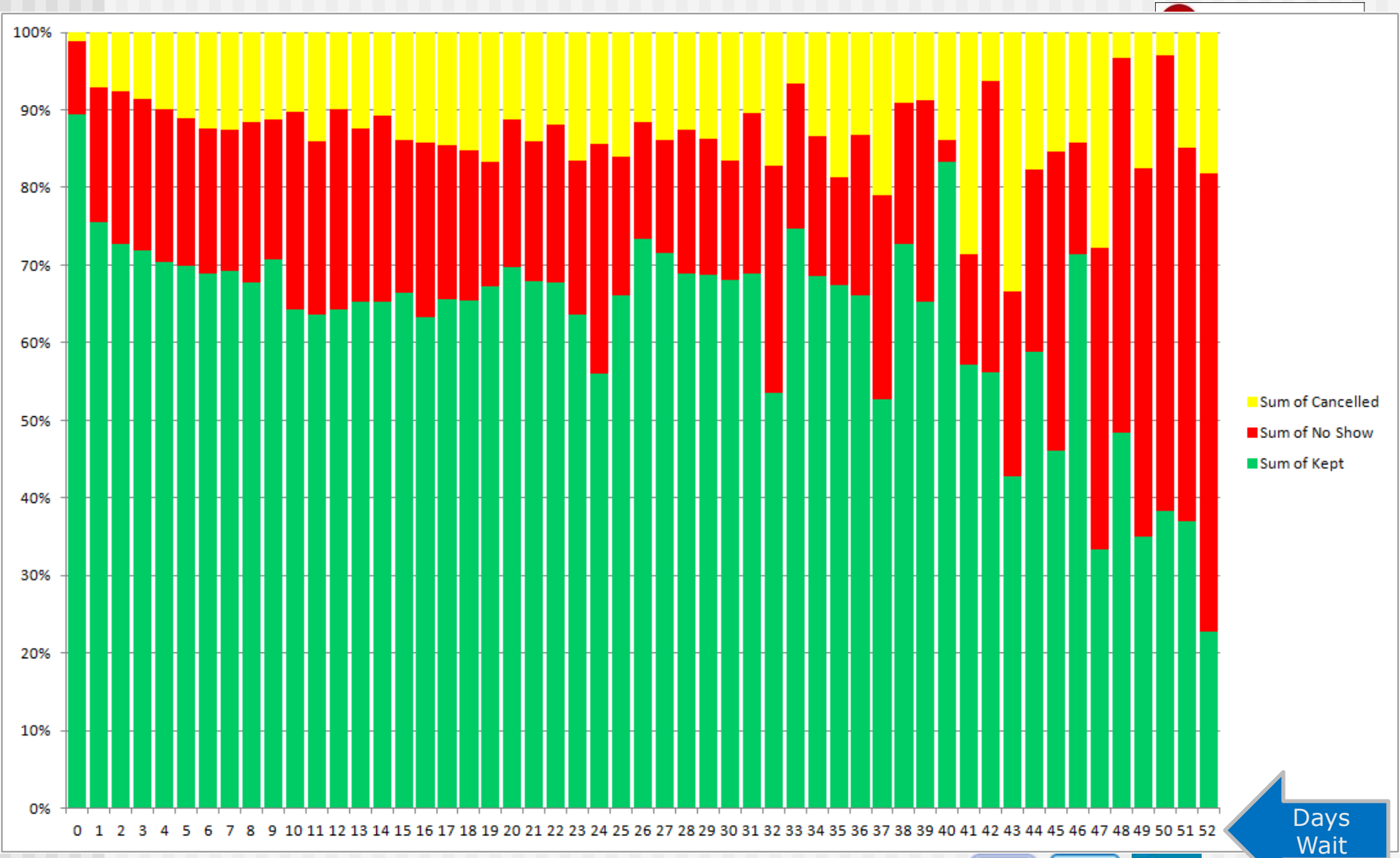
Measurement

- *Goal-* reduce client no shows

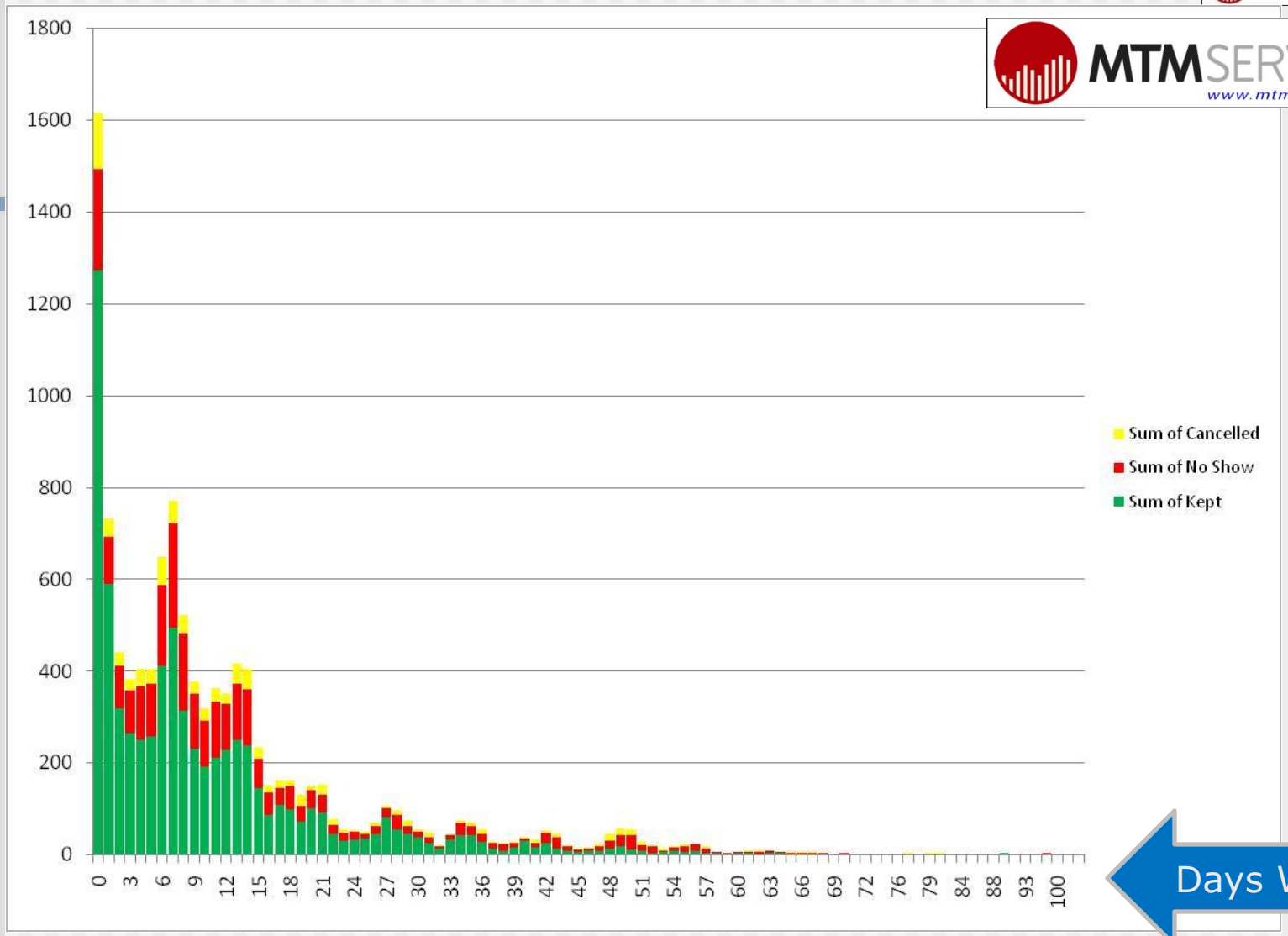
- *Measure:*
  - No Show rates for established clients
  - Unrealized Service Capacity

- *Decide*

Assessment Appointment Trends by Days of Wait for all Centers (Over 22,000 Events)



Assessment Appointment Trends by Days of Wait for all Centers (Over 11,000 Events)



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Steps to Managing No Shows

- Accept: Cannot depend on consumers' changing their no show behavior – staff members must change
- Develop Policy with No Show, Cancel definitions and threshold
- Develop protocols to measure no shows and cancellations as defined per policy
- Develop and implement no show performance standards for staff as Key Performance Indicator
- Prevent NS by implementing Centralized Scheduling
- Use an Engagement Specialist to implement No Show Management Policy
- Consider Just-in-Time/Easy Access for med services

Recommended No Show Definitions

- **"No Show"** – Consumer did not call and did not cancel scheduled appointment for services.
- **"Late Cancellation"** - Consumer called and cancelled appointment for service less than 24 hours before appointment.
- **"Cancellation"** - Consumer called and cancelled appointment for service more than 24 hours before appointment.
- **"Provider Cancelled"** – Clinician cancelled appointment.

No Show Performance Standards – Scheduled Intake

Client Initial No Show Rate:

- **Definition- Percentage of all client appointments that the client did not attend the initial assessment.**
- **Standard-Initial No Show rate will average less than 20% during the last 3 months.**
- **Source- Staff Activity Log**
- **Compliance Rating- Initial No Show Rate less than 20%= Full Compliance**
- **Initial No Show Rate more than 20%= Non-Compliance**
- **Solution Plan- Provider and supervisor will meet within 7 days of report to develop plan to decrease client initial no show rate.**

No Show Performance Standards – Ongoing Services

Client Ongoing No Show Rate

- **Definition- Percentage of all client appointments that the client did not attend after the initial assessment.**
- **Standard- Ongoing No Show Rate will average less than 10% during the last 3 months.**
- **Source- Staff Activity Log**
- **Compliance Rating- Initial No Show Rate less than 10%= Full Compliance**
- **Initial No Show Rate more than 10%= Non-Compliance**
- **Solution Plan- Provider and supervisor will meet within 7 days of report to develop plan to decrease client ongoing no show rate.**

Standards – Kept Appointments

Provider Kept Appointment Rate:

- **Definition - Percentage of all appointment that the provider did not cancel.**
- **Standard - Provider kept appointment rate will average 90% during the last 3 months.**
- **Source - Staff Activity Logs**
- **Compliance Rating - Provider kept appointment rate 90% or above = Full Compliance**
  Provider appointment rate less than 90% = Non-Compliance
- **Solution Plan- Provider and supervisor will meet within 7 days of report to develop plan to increase provider's kept appointment rate.**

Data Collection Protocols

- **No Shows:** Clinicians OR (if agency has centralized scheduling) Front Desk Staff code no shows on Event Ticket or service activity logs
- **Cancellations:** Clinicians OR (if agency has centralized scheduling) Front Desk Staff code as a non billable service code(s).
- **Clinician Cancelled:** Front desk staff maintains record.

Don’t Just Have a Schedule – Manage it!

Having a Schedule Model:

- **Schedule Out:** Experience indicates that many clinicians schedule out appointments for several months when the consumer comes into services. The assumption is that the symptom level of individual consumers will maintain a sufficiently high level to be able to predict that the consumer will need services on the first and third Tuesdays three months from now. In this model it is only when the consumer does not show that we know. A manager can identify this model by reviewing the next two months’ schedule for each clinician to determine if it is “Fully Booked”.

Managing a Schedule Model:

- **Negotiate the Next Appointment: At the end of each appointment, the clinician discusses the need for a next appointment, the interval of time and a commitment to come. This model does not assume that the consumer will need services weeks/months in advance. Further, by completing the Progress Note at the end of each session, the clinician and consumer can discuss outcomes in light of a continued need to maintain the same frequency and intensity of services.**

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Don’t Just Have a Schedule – Manage it!

Having a Schedule Model:

- **Assume Attendance:** In the scheduled out model the general assumption seems to be that the consumer will show. This assumption can be verified by asking, “How many consumers are called before each appointment to remind them?” A response such as, ”We have been talking about doing that” provides a strong suggestion that staff are utilizing the “have a schedule” model.

Managing a Schedule:

- **Call to Ask for Commitment:** A call is made to each consumer (who has phone service and who consents to the reminder calls at intake) approximately 36 to 48 hours prior to each appointment. The call can be made by support staff or by clinical staff if there are therapeutic reasons. The caller asks a very important question, “We would like to remind you of your appointment with Dr. Jones on Friday at 3:00 p.m., will you be able to attend, or would it be more convenient if I rescheduled you?” This commitment question seems to be an important aspect of calling.

Don’t Just Have a Schedule – Manage it!

Having A Schedule:

- **Let No Show Occur:** The traditional model of clinicians keeping their own appointment books prohibits to a large degree support staff managing the schedule to back file any openings due to no shows or late cancellations.

Managing A Schedule:

- **Back Fill Appointments:** If the consumer indicates during the call that he/she will not be able to make the scheduled appointment, then a new appointment date and time is established and the support staff then calls a waiting list for each clinician to back fill the now open appointment slot.

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Don’t Just Have a Schedule – Manage it!

Having A Schedule:

- **Keep Scheduling Consumer:** In many cases clinicians will schedule consumers at the next “regularly scheduled time and day” even though they know the consumer will probably not show.

Managing A Schedule:

- **Move Consumer to Group Modality:** In most CBHOs, that proactively work on managing no shows, the standard protocol is that when a consumer does not show for two consecutive appointments after calling to confirm, they are moved to and alternative scheduling plan or group modality within each clinicians case load. This protocol is openly discussed with consumers at service planning. Regarding groups, it is explained that group modality can provide dynamic and inter-reactive peer support as well as therapy.

Don't Just Have a Schedule – Manage it!

Having A Schedule:

- **Carry No Show Consumers in Case Loads:** At one CBHO, our work focused on a service utilization assessment for each caseload member in increments of 30 days (i.e., 30 days, 60 days, 90 days, etc.). The outcome was somewhat typical, **37% of the active caseloads within the CBHO had not been seen face-to-face for over 120 days.** Clinicians continued to schedule these consumers as if they would show. Additionally, these clinicians expend immense amounts of energy carrying the paperwork requirements of maintaining an active chart.

Managing A Schedule:

- **Appropriately Transfer/ Discharge Consumers:** If consumers will not show for individual (using the alternative scheduling plan) or group modality after phone confirmation, then the consumer is appropriately discharged. Clinicians are not going to spend time nor expose the organization to the risk of carrying caseload members for periods of time when they are not receiving services.

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Don’t Just Have a Schedule – Manage it!

- The “Having a Schedule” model is very inefficient for the consumer, the clinician and the organization. Continuing to schedule consumers after they have given clear indication their symptom levels do not require additional services creates further dependence on the system rather than independence, self-monitoring, etc. Obviously, consumers with SPMI needs will continue to need med monitoring and prescription services. Perhaps therapy and other non-medical services could really benefit from the Managing a Schedule Model.

Process Redesign Review

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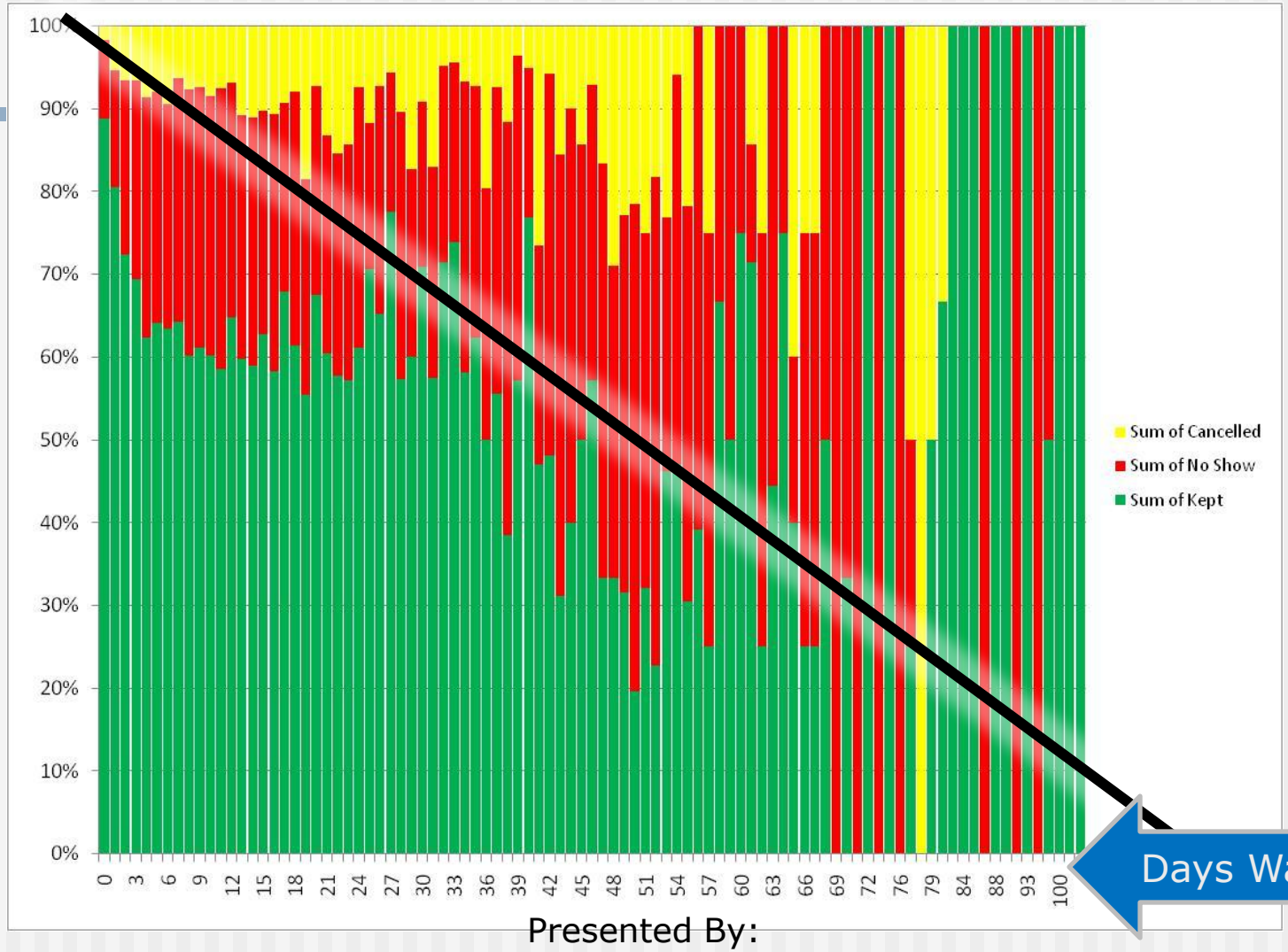
Michael Flora, MTM Services

Access and Engagement and Access Redesign Initiatives
First Call to Assessment Kept vs. No Show/Cancelled
Trend by Days Wait from First Call to Appointment



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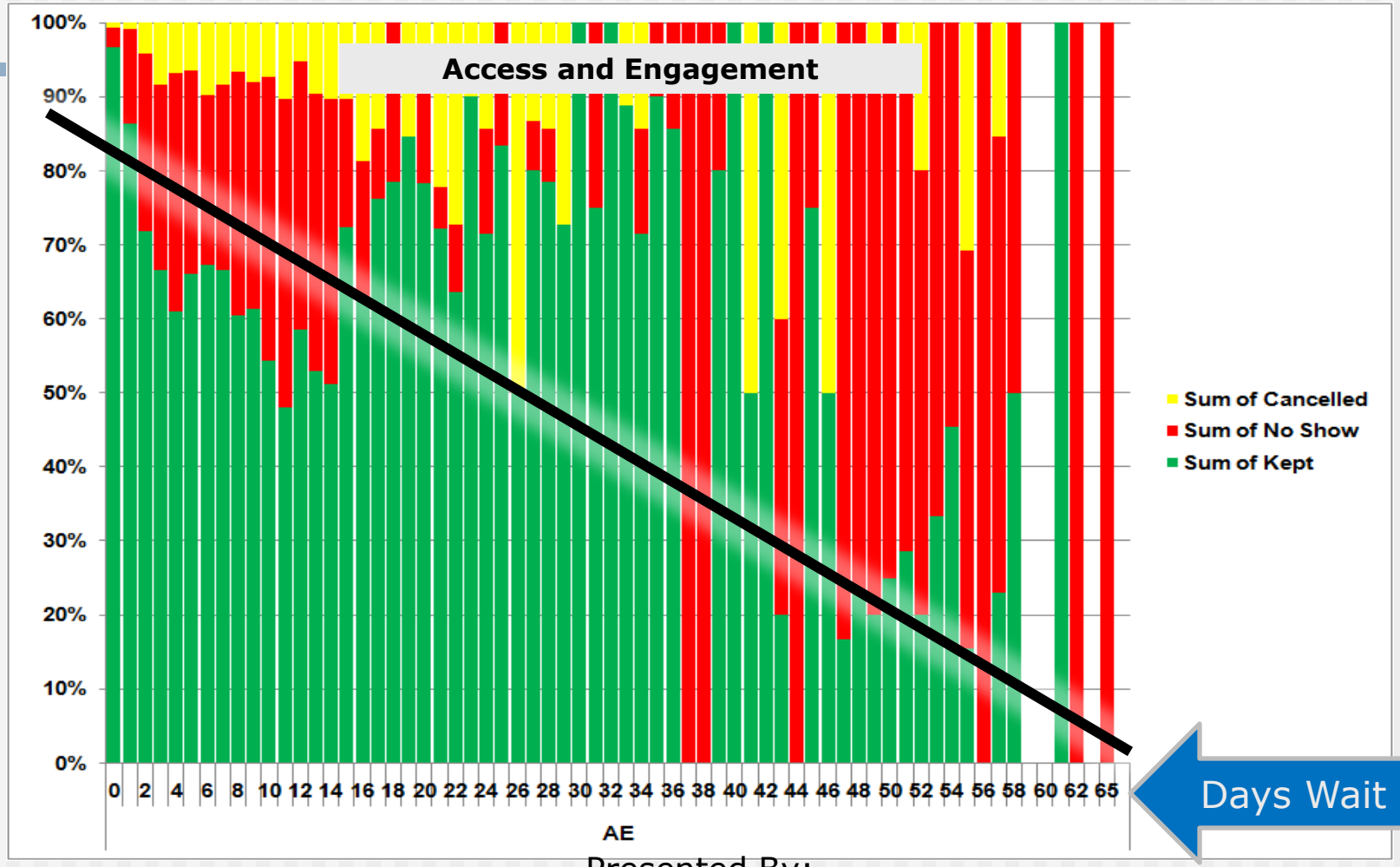
Michael Flora, MTM Services

Access and Engagement Initiative **First Call to Assessment** Kept vs. No Show/Cancelled Trend by Days Wait from First Call to Appointment



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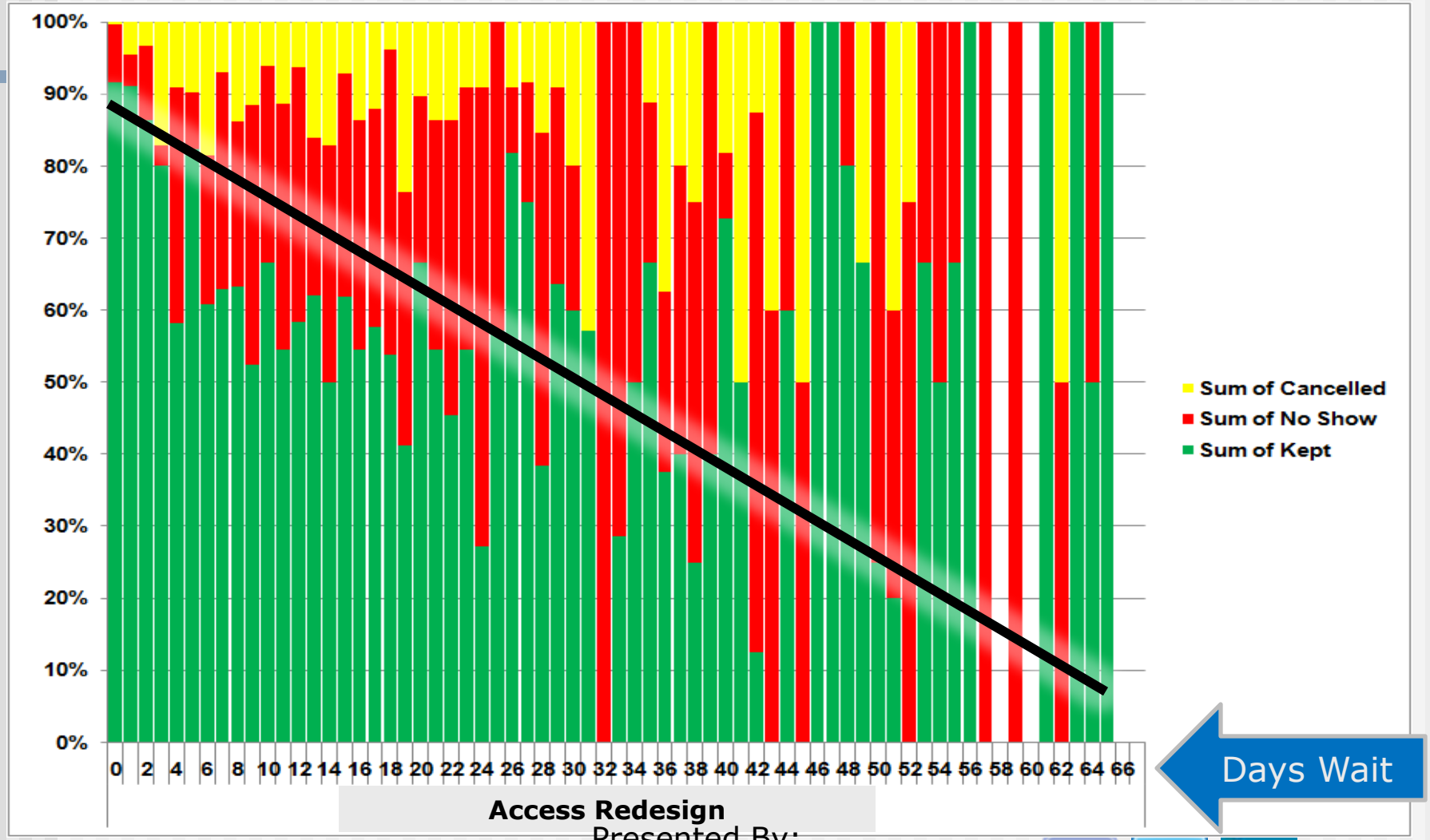
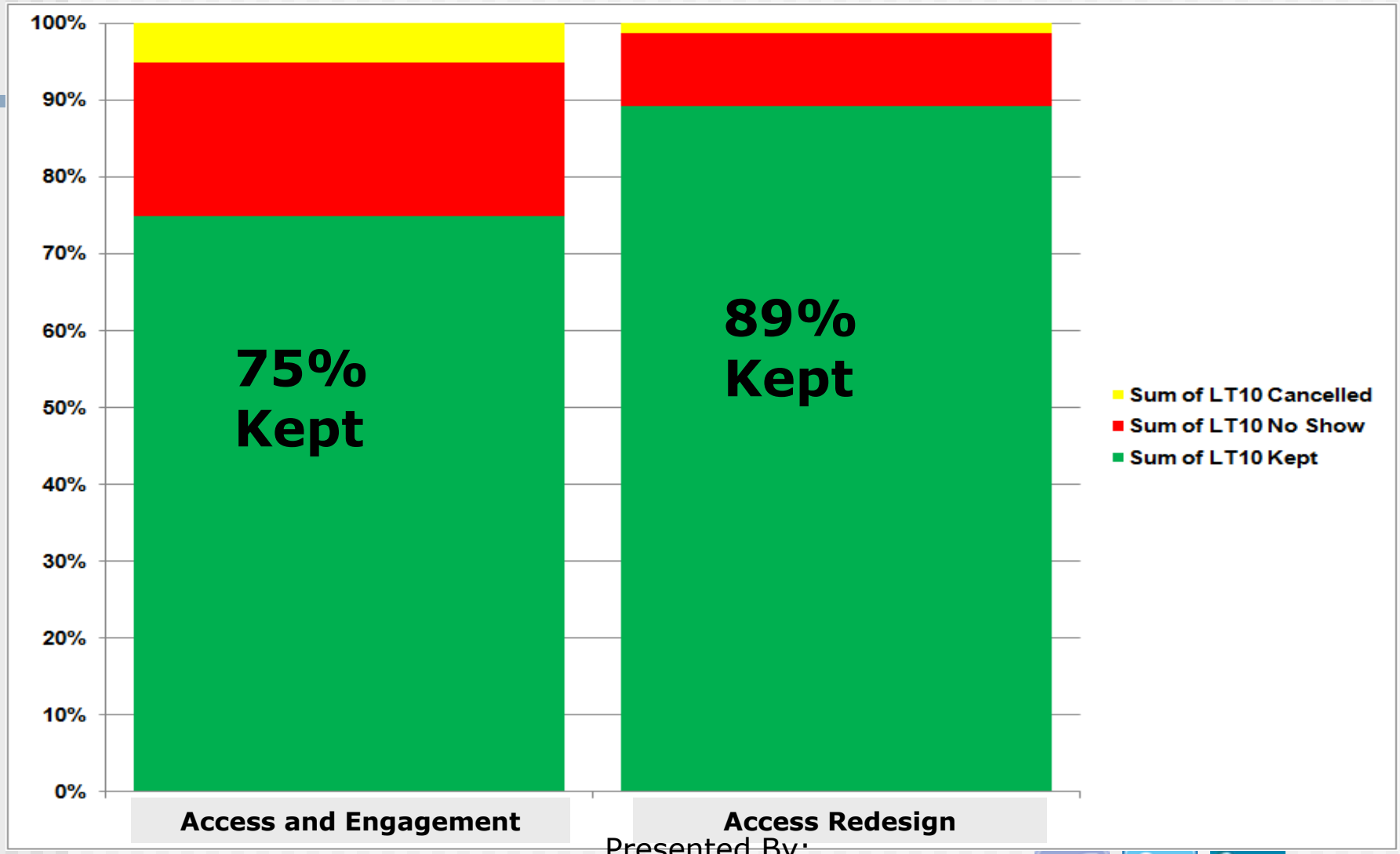
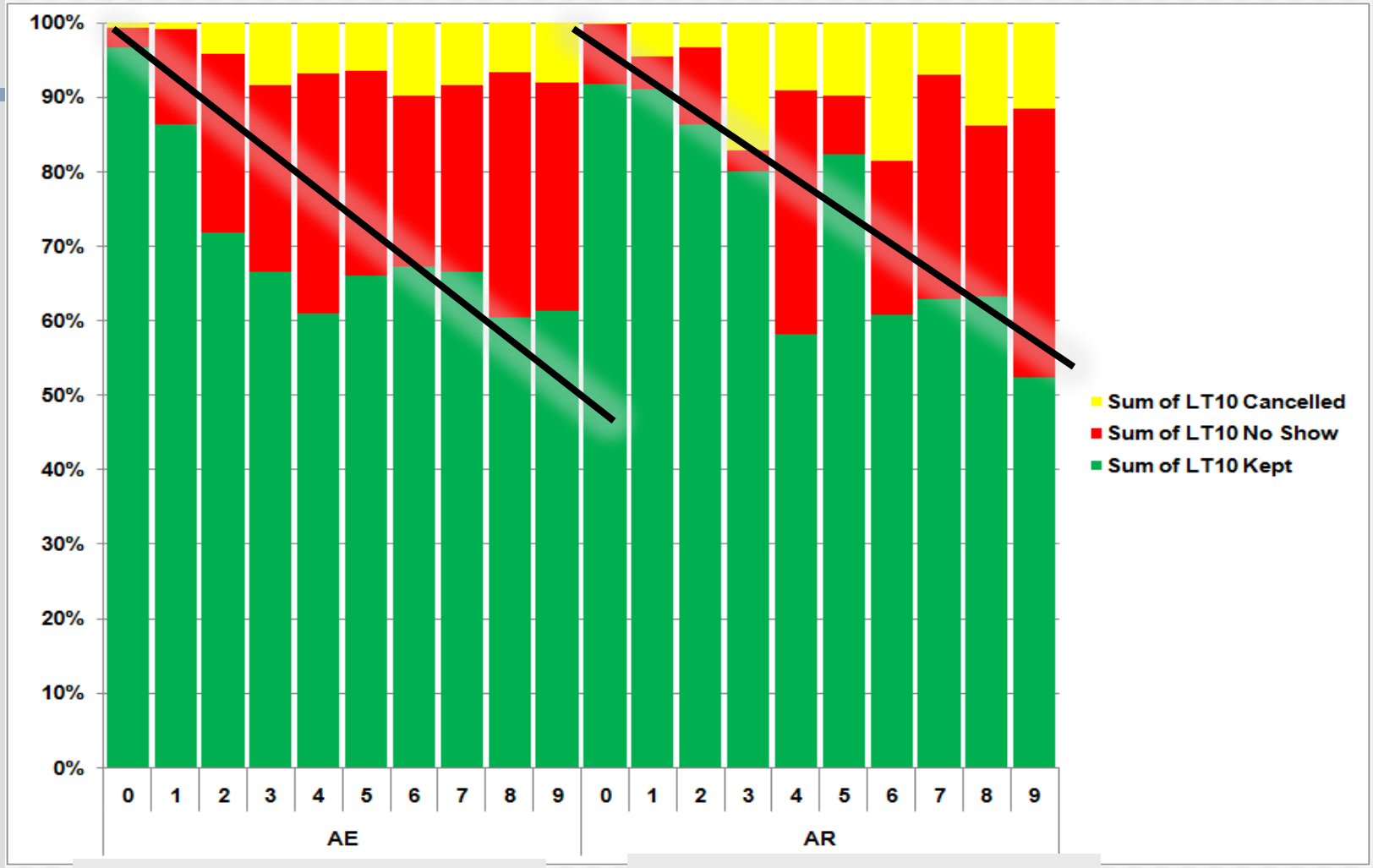
Access Redesign Initiative **First Call to Assessment Kept** vs. No Show/Cancelled Trend by Days Wait from First Call to Appointment



Total Assessment Appointments "Kept" Trend for Persons Scheduled in ***Less than Ten Days from First Call***



Assessment Appointments "Kept" Trend by Number of Days from First Contact to Appointment Day for Persons Scheduled in *Less than Ten Days from First Call*



Access and Engagement **Access Redesign**

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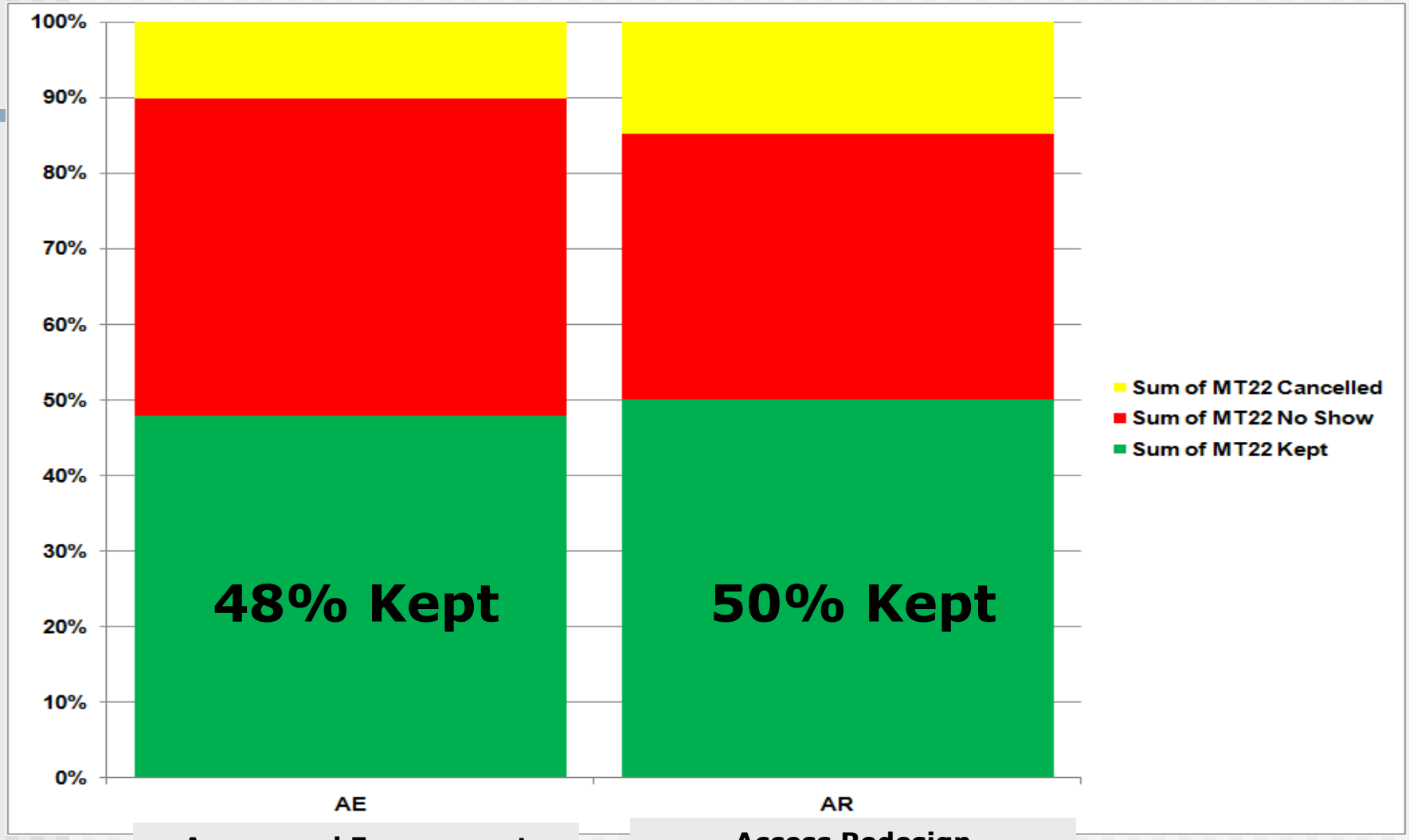
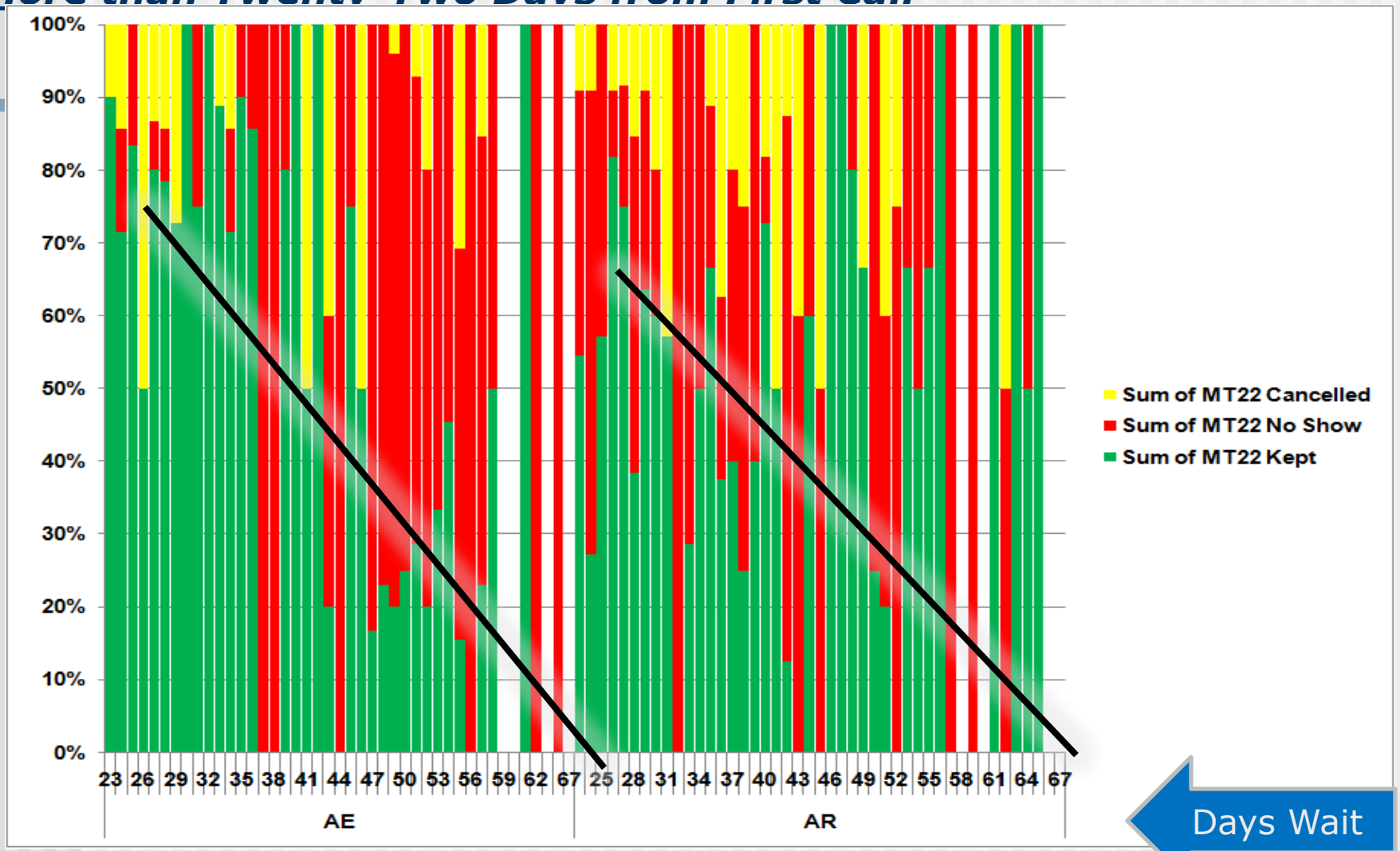
Total **Assessment Appointments** "Kept" Trend for Persons Scheduled in ***More than 22 Days from First Call***



Assessment Appointments "Kept" Trend by Number of Days from First Contact to Appointment Day for Persons Scheduled in ***More than Twenty-Two Days from First Call***



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Just-In-Time Scheduling for Med Services

Presented By:
Michael Flora, MTM Services

Access to Medical Services

1. The primary challenge facing almost every healthcare provider is having adequate service delivery capacity to support timely and effective access to treatment.
2. In an era of integrated healthcare reform, access to treatment is even more critical.
3. The historical three levels of access to care challenge have been:

a. Primary Access – Time to provide client face to face initial intake/assessment after call for help

b. Secondary Access – Time to provide client face to face service with his/her treating clinician following intake/assessment date

c. Tertiary Access – Time to first face to face service with Psychiatrist/APRN following the intake/assessment data

The Business Case of Health Reform

Under Integrated care service delivery models the ***Value*** of Behavioral Health Services will depend upon our

ability to:

1. Be Accessible (Fast Access to all Needed Services)

2. Be Efficient (Provide high Quality Services at Lowest Possible Cost)

3. Electronic Health Record capacity to connect with other providers

4. Focus on Episodic Care Needs/Bundled Payments

5. Produce Outcomes!

- Engaged Clients and Natural Support Network
- Help Clients Self Manage Their Wellness and Recovery
- Greatly Reduce Need for Disruptive/ High Cost Services

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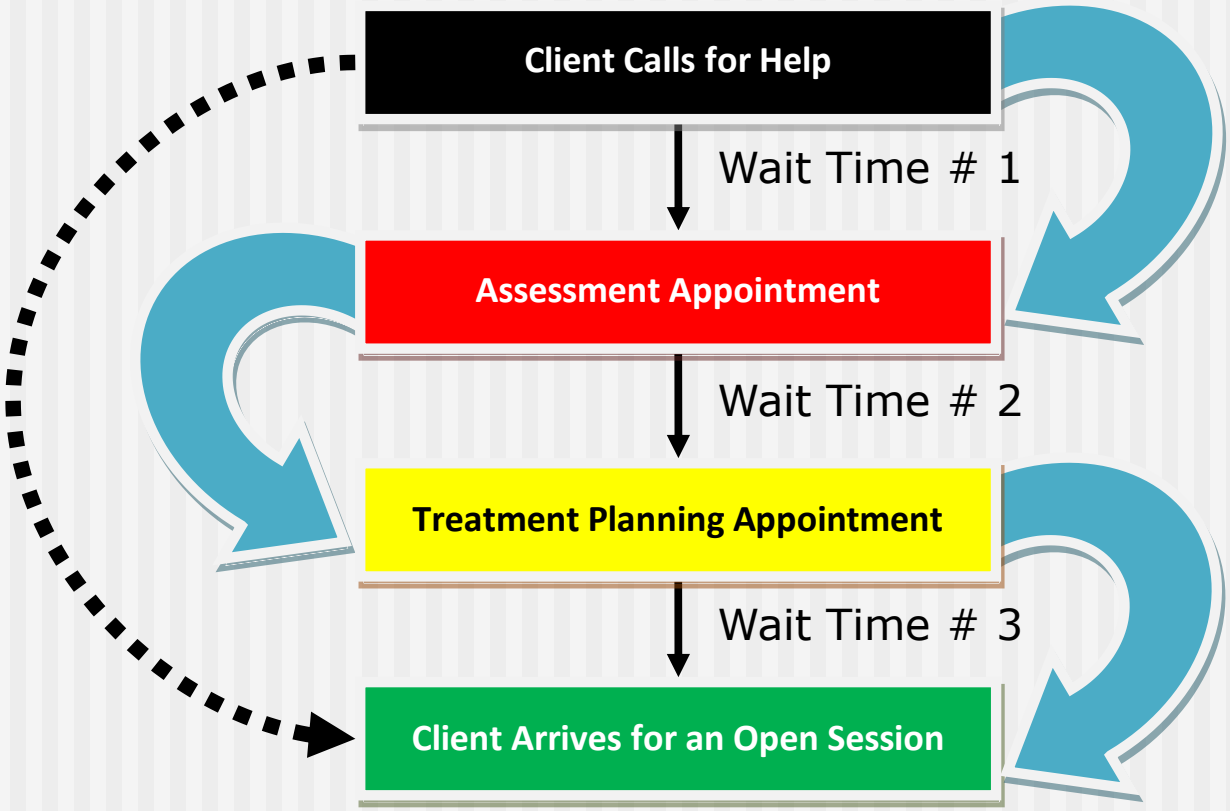
Why Just-In-Time Scheduling?

- Reduce Wait Time For New Evaluations
- Reduce Wait Time For Follow-up Appointments
- Eliminate "Lost Time" Created By No-Shows and Last-Minute Cancellations
- Stop Providing Medication Refills and Start Providing Care
- Reduce Cost

JIT – To a Prescriber in 3 Days

Client Definition of Access



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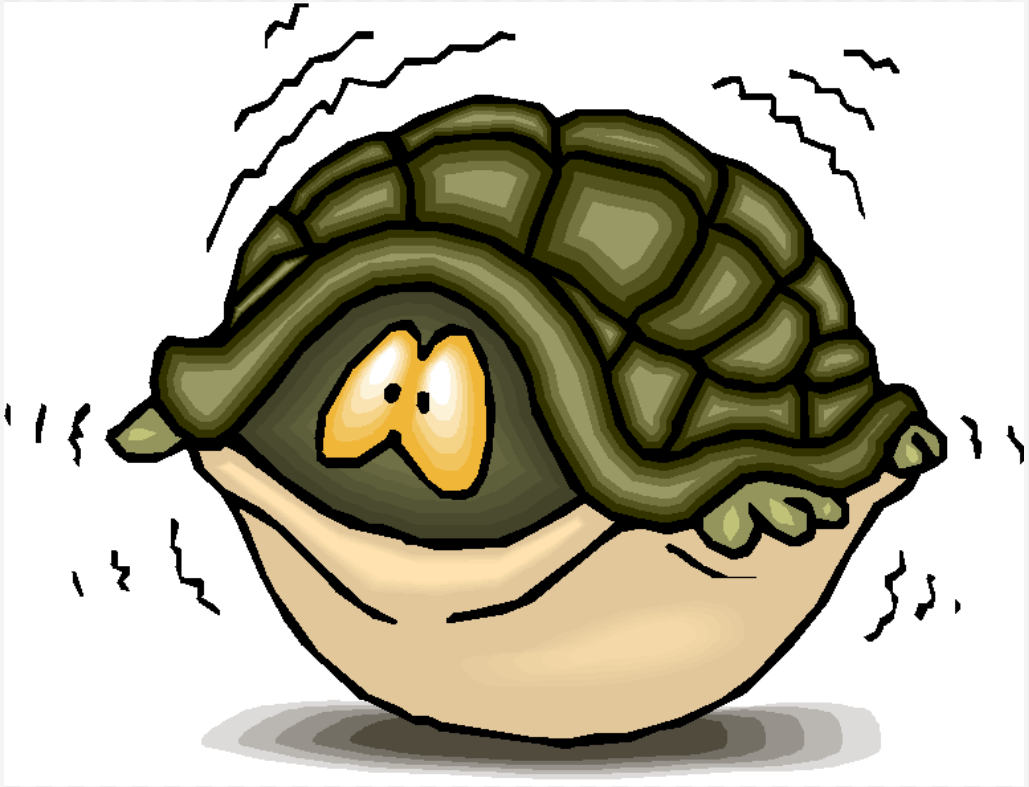
Why Not Just-In-Time Scheduling?



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Rosecrance Berry Campus
Rockford, IL
Open Access Case Study

Richard Jaconette M.D.
Child/Adolescent Psychiatrist

rosecrance

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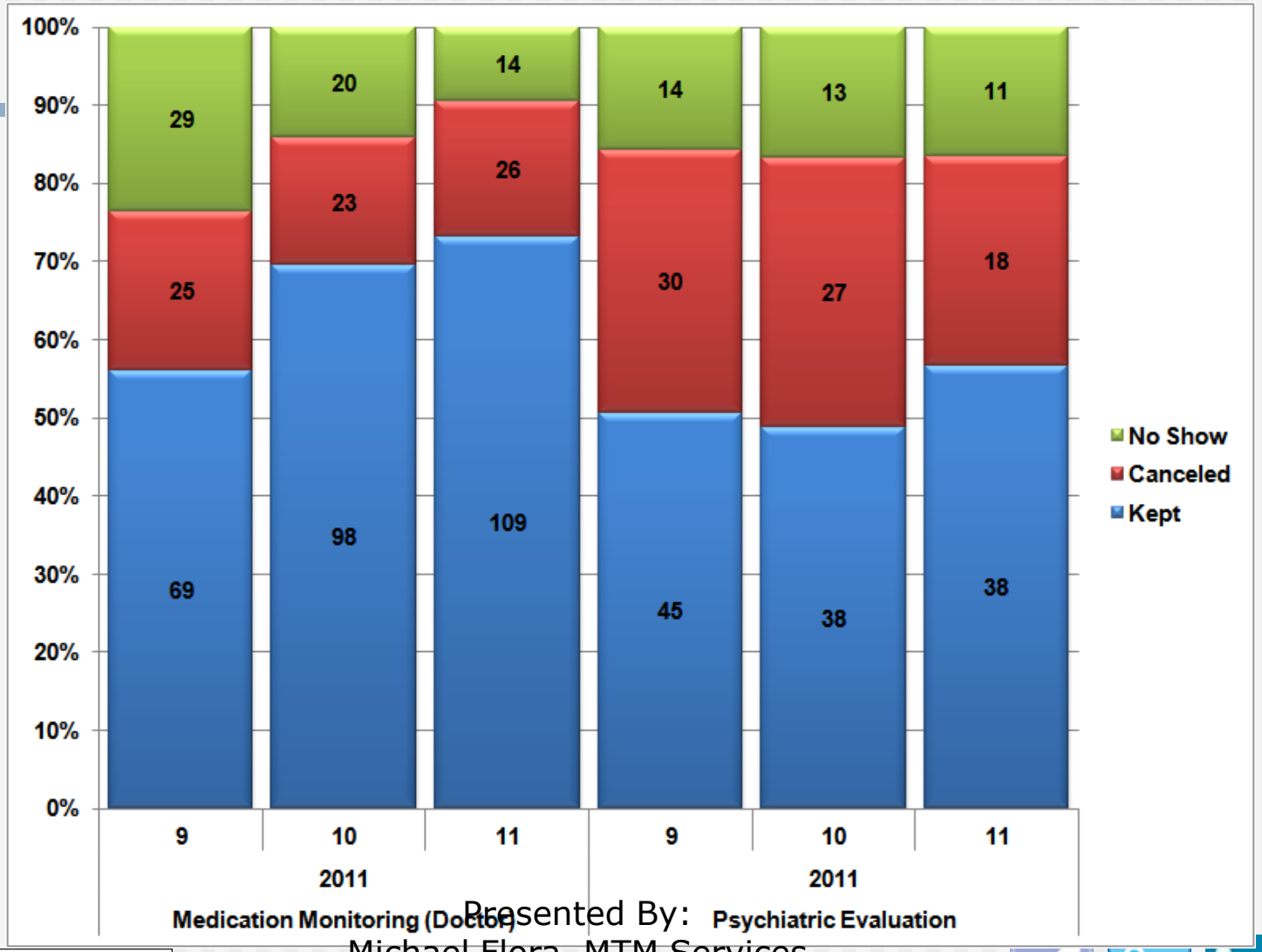
JIT – To a Prescriber in 3 Days

The False Reality of Full!



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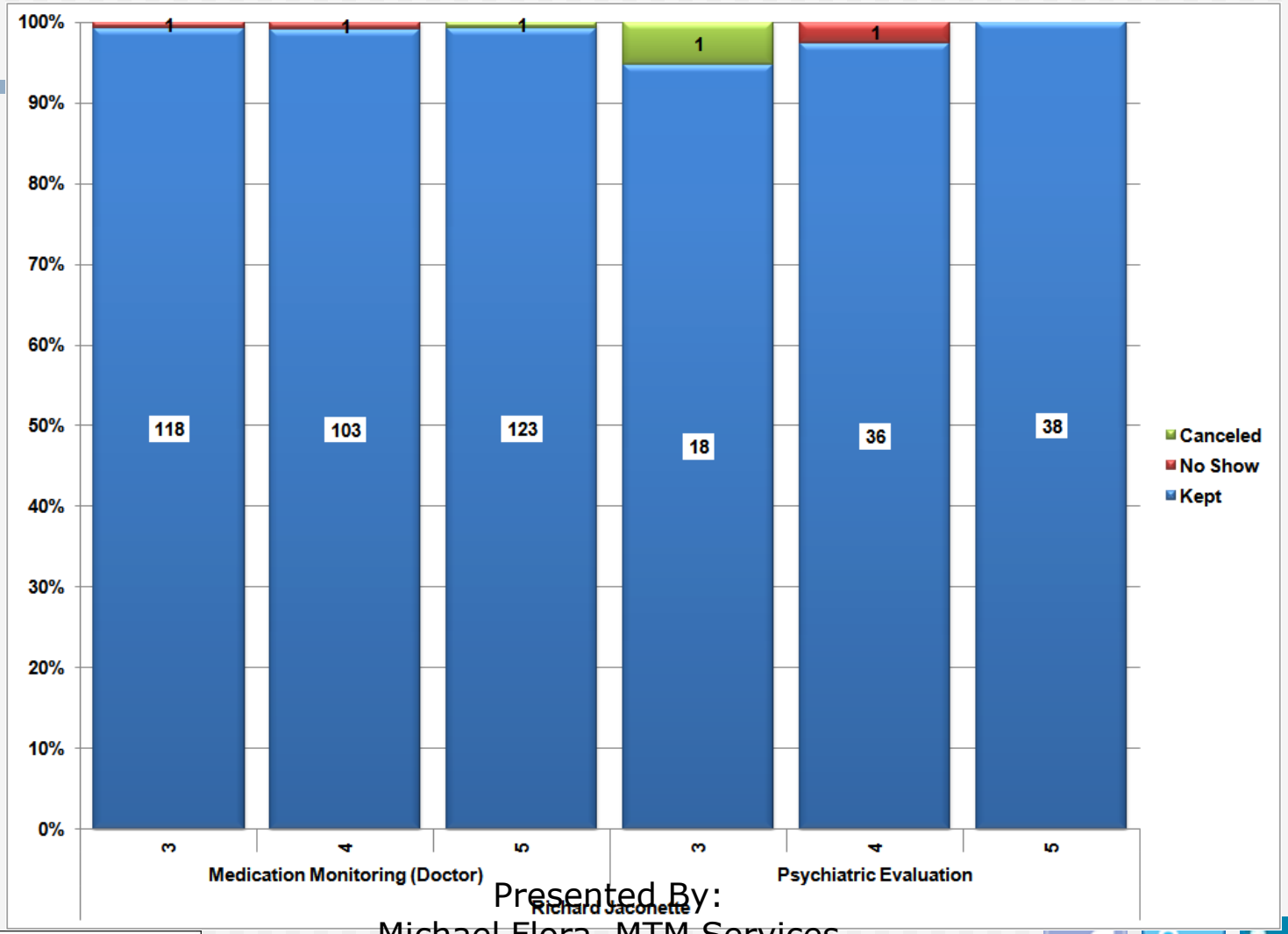
The False Reality of Full!



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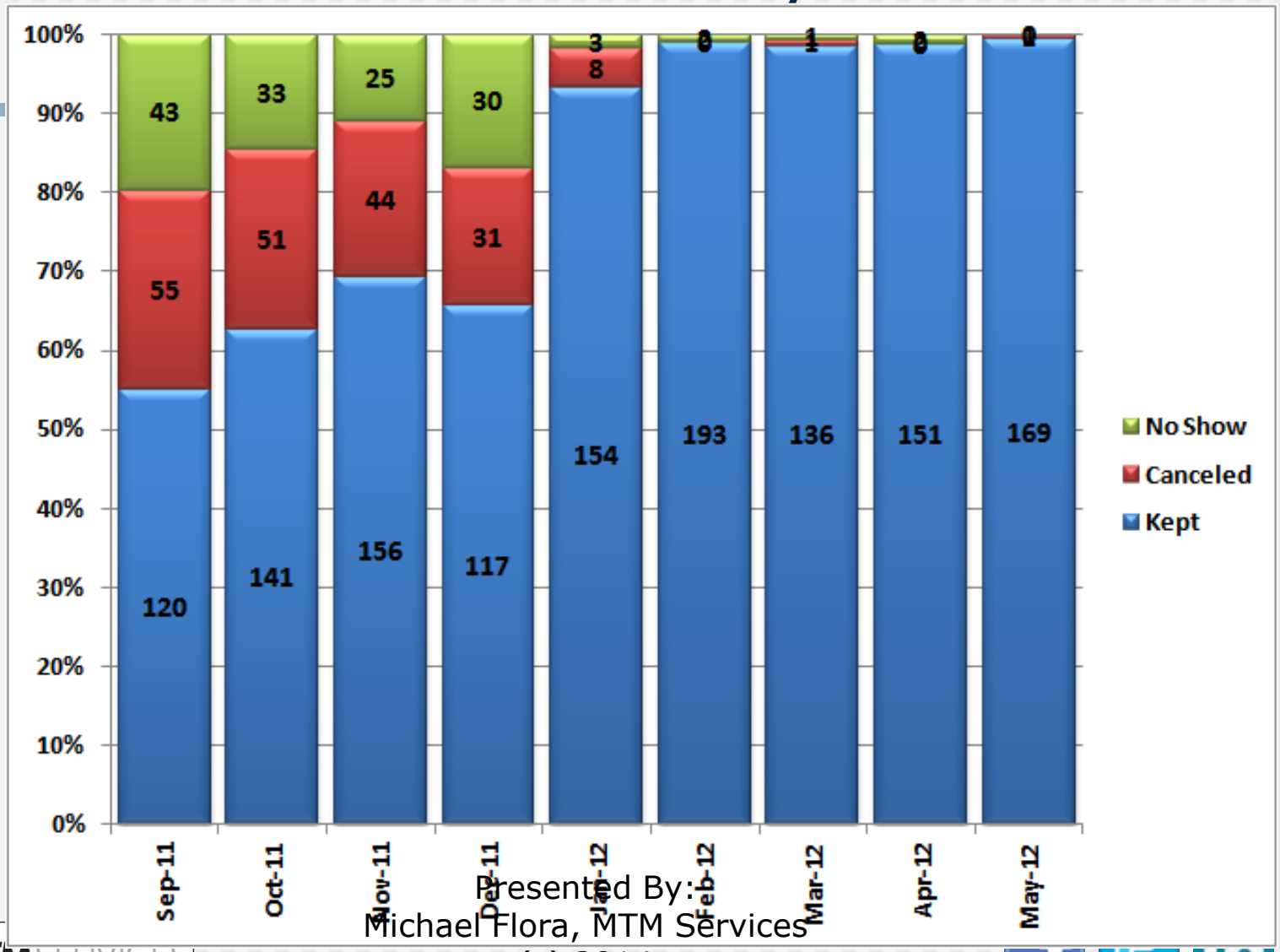
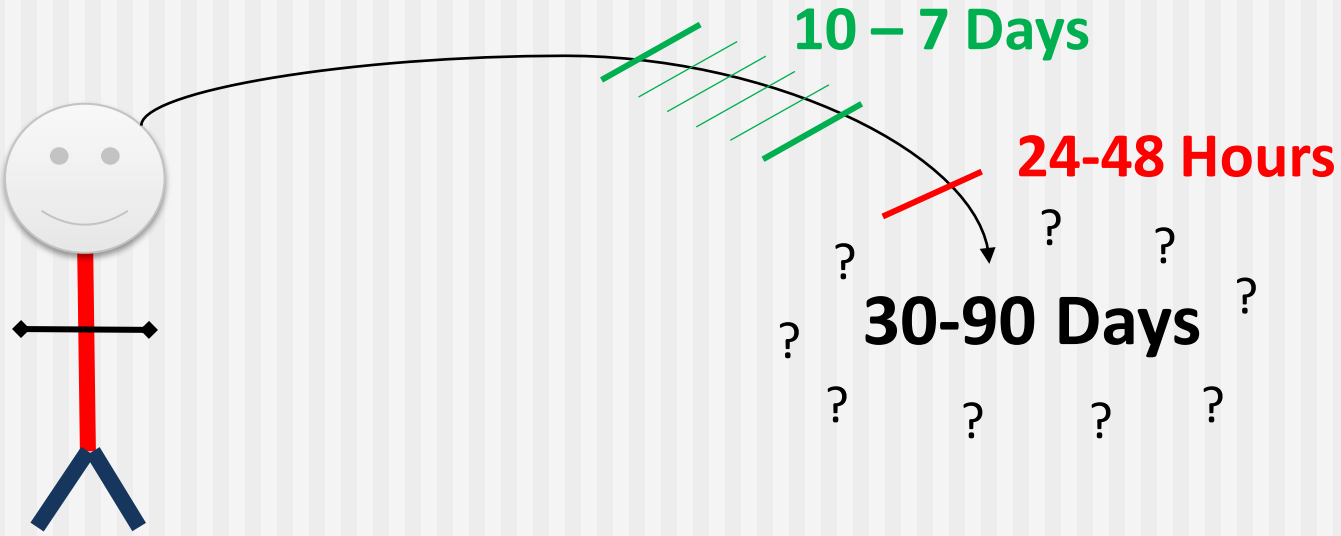
The False Reality of Full!



JIT – To a Prescriber in 3 Days

The Crux of the Problem – We make Consumers Guess!



Where will you be in 30-90 Days at 2:15!?

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Biggest Obstacle To Implementation

- **Anxiety--Within the:**
  - Doctor
  - Families
  - Front Office Staff
  - Other Clinicians
  - Administration

Key Factors for Success!

1. **No Prescriber Appointments are Scheduled more than 3 to 5 days out.**

2. **No More Calling in Med Requests, the consumer must be seen face to face for a script.**

What About the Current Schedule?

Source/Photo Credit - Wile E. Coyote and Road Runner are Trademarked Characters of Warner Brothers

"Blow it Up"/Hit the reset button!

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Timeline

- Sent clients letters 1 month in advance
- Gave scripts to front desk, supervisors and clinicians
- Recorded Open Access line
- Held meetings for staff, including Family Resource Developers to explain process
- Roll out January 3, 2012!

VIEW POINT Health

OPEN ACCESS

New Procedures for Appointments with Psychiatrists

WHO: Clients at View Point Health

WHAT: A new procedure for you to schedule doctor appointments - Open Access for doctor appointments. Open Access means we will schedule doctor appointments within 72 hours to 1 week of the time when you call for an appointment.

WHEN: Starting July 1, 2013

WHERE: Newton Center

HOW: The front office staff will give you a reminder card when you leave your doctor's appointment. Instead of scheduling a follow-up appointment, the reminder card will let you know when to call View Point Health to schedule your next appointment. When you call, your appointment will be scheduled in 3 - 5 business days.

WHY: Currently, 40% of our doctor's appointments are not kept while we have other clients waiting to see the doctor. We have found it necessary to change our schedule to one that is more open, flexible and client friendly.

For example, if you have an appointment with your psychiatrist on July 1, and the doctor wants you to come back in 8 weeks, the front office staff will give you a reminder card that says: "Call during the week of August 26th to schedule your appointment". When you call on August 26th, the Access staff will schedule your appointment with your doctor between August 29 and September 2, 2013 (3 – 5 business days).

Another important change is that you will not be able to call in and request medication refills if you miss an appointment. Instead, you can walk-in between 8:00 am – 2:00 pm on Monday – Thursday and 8:00 am – 1:00 pm on Friday. You may have to wait and you may not be able to see your regular doctor. Additionally, if the doctor is unavailable, you may be asked to return the next morning.

If you miss 2 consecutive appointments without notification, you will have to see the doctor on a walk-in basis. Thank you for your patience as we implement this new system.

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View Point Lawrenceville, GA

Client Letter

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Michael Flora, MTM Services

JIT – To a Prescriber in 3 Days

Sample Appointment Reminder Card

JIT – To a Prescriber in 3 Days

This is just a Scheduling Change, and Gives you better control of your caseload and lowers liability!

Client Med Refill/Scheduling Tracker

Outcomes Achieved:	Percent
1. % of Clients That have Self Scheduled:	17%
2. % of Clients to Call:	17%
3. % of Clients Called:	0%
4. % of Clients Successfully Scheduled:	0%

MTM SERVICES www.mtmservices.org

Margin: 7

Staff Na

Date

Measurement Indicators to Use in Columns K - M Below: Yes = Y and No = N

	Has The Client Scheduled?		Does The Client Need to be Called?		Have they been Called?		Has the Client been Scheduled?	
	Yes	No	Yes	No	Yes	No	Yes	No
Totals	1	5	1	5	0	0	0	0

Days Left to Refill	Margin Eclipsed?	Does The Client Need to be Called?	Client Name	Case Number	Refill Date	Phone #	Secondary Phone #	Provider Name	Has The Client Scheduled Themselves? (Must be Y or N)	Have they been Called due to an eclipsed margin?	Has the C been Sche by our s
			** To Sort the information below, please select only cells E15 to N15 down to the final row with data present and then do a custom sort by								
3	Y	Y	Scott		5/9/2014				N		
5	Y	N	Mark		5/11/2014				Y		
23	N	N	Marya		5/29/2014				N		
26	N	N	David S		6/1/2014				N		
40	N	N	David		6/15/2014				N		
8	N	N	Marya	2423423432	5/14/2014	919919919			n		

Macro1 | JIT Worksheet - P1 | JIT Worksheet - P2

Support Staff Impacts

Current –

1. Schedule the Client day of the Appointment
2. Do Reminder Calls
3. Chasing down/Rescheduling No Shows
4. Handling Multiple Refill Calls

JIT –

1. Update the Tracking Sheet
2. Field or Make One Call to Schedule the Consumer

Results

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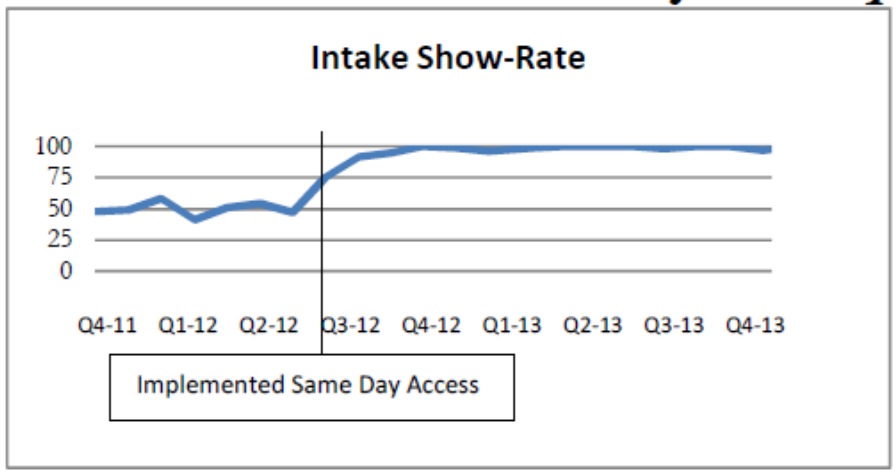
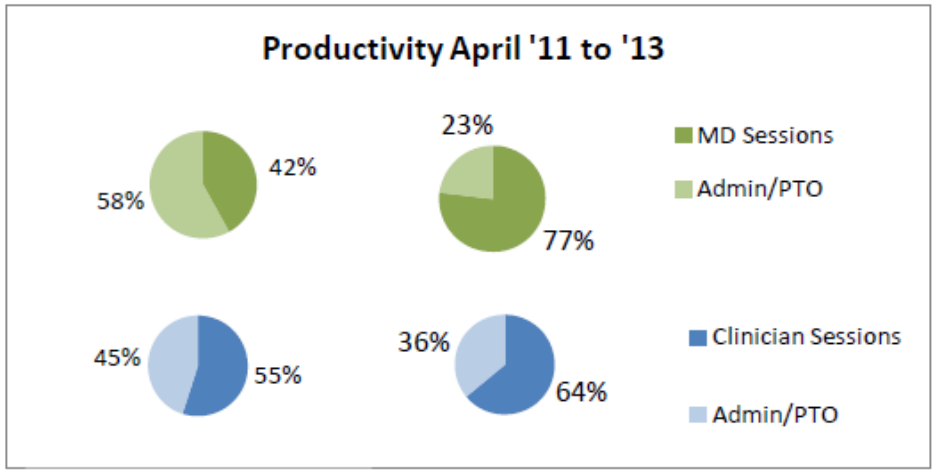
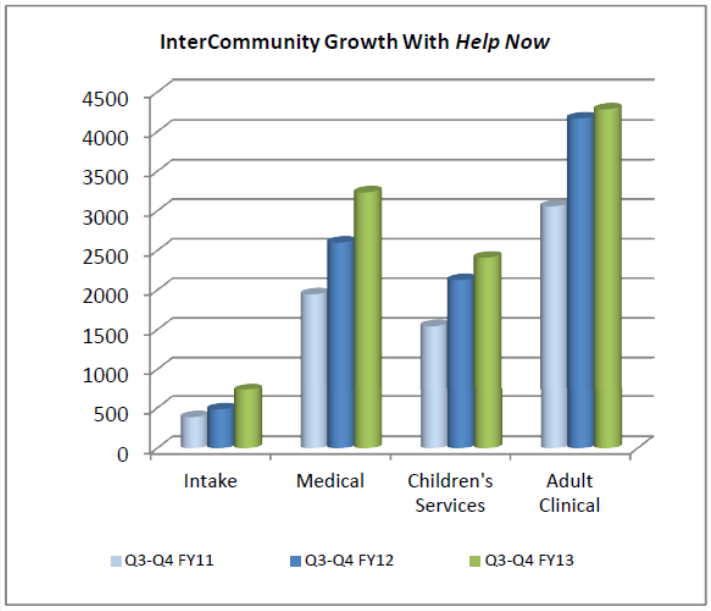
JIT – To a Prescriber in 3 Days

InterCommunity's *Help Now* Outcomes FY 2013







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JIT – To a Prescriber in 3 Days

- Hub concept
  - Purpose
  - staffing
- Use of Telemedicine
  - Connectivity
  - Hardware
- Open access across our outpatient programs
  - 19 outpatient sites

Monarch
Helping Dreams Take Flight

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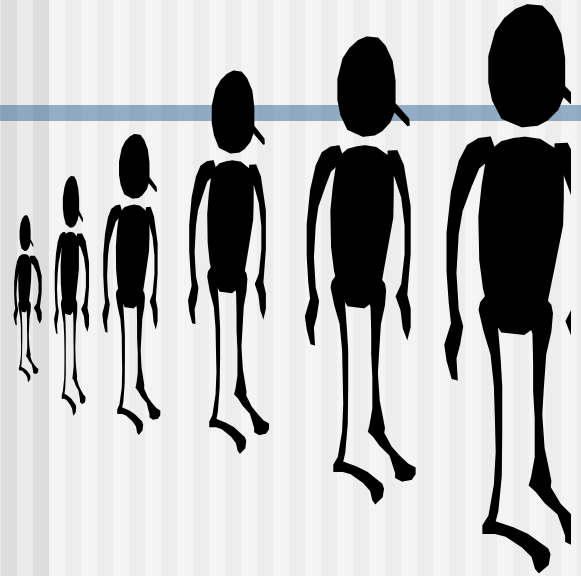
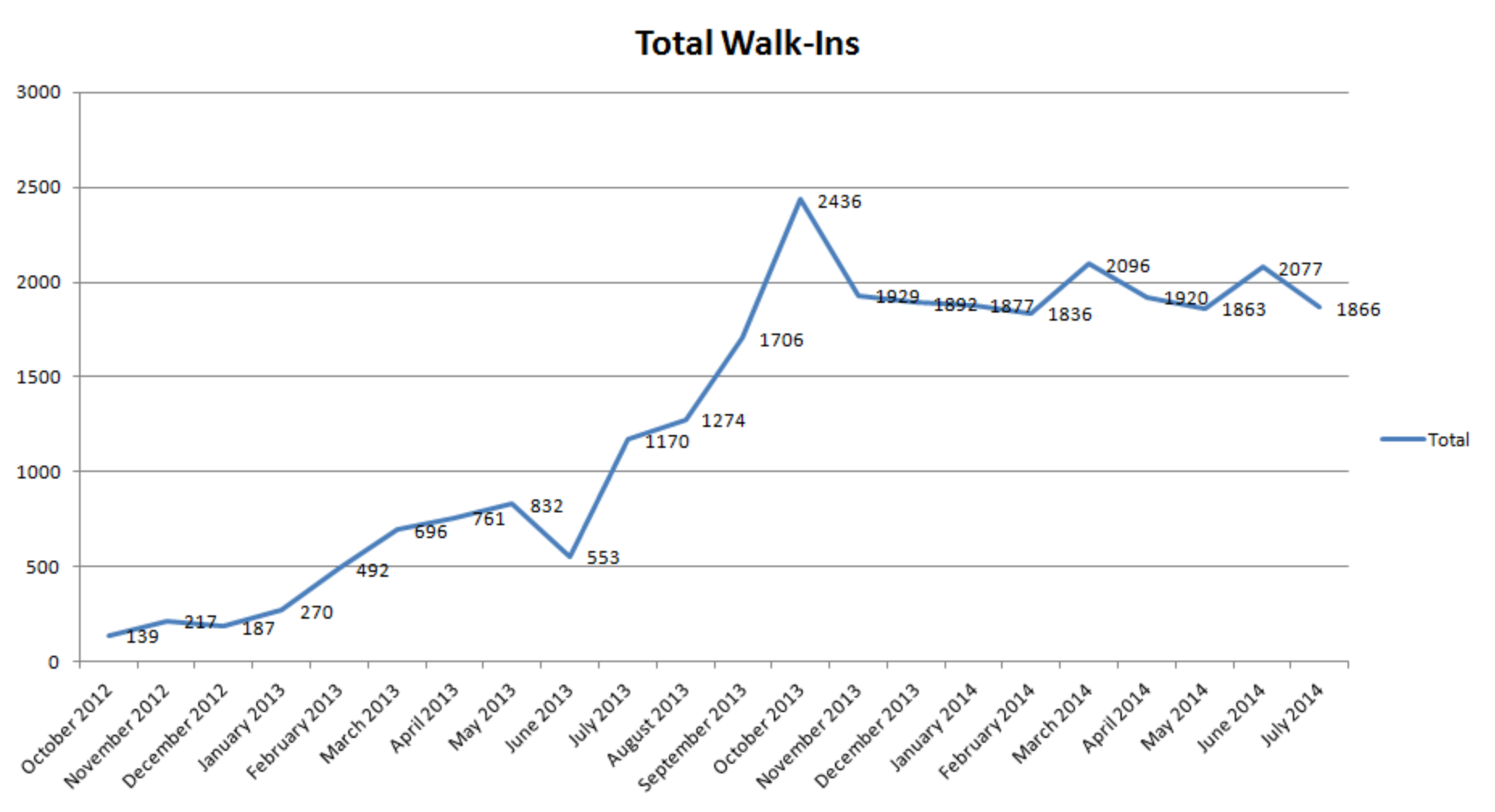
JIT – To a Prescriber in 3 Days



- Growth!!!
  - April 2012—took over services for an MCO (beginning of our move toward open access)
  - June 2013—took over services from another MCO—specifically to bring open access
  - July 2013—Awarded more capacity from an MCO to increase services
  - Oct 2013—Awarded services in a new 3 county area to bring open access to the area
  - Aug 2014—asked to enter an MCO network to add open access concept

JIT – To a Prescriber in 3 Days



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JIT – To a Prescriber in 3 Days

If Monarch did not have a walk in open access center, I would have received my services from:

	Gone to an urgent care center	Gone to another agency to get services today	Gone to my primary care physician	Gone to the hospital emergency department	Not gotten services anywhere	Waited weeks/months to get services from another company
July	5%	13%	9%	27%	25%	21%
August	5%	6%	11%	27%	33%	18%
September	3%	14%	12%	26%	30%	15%
October	4%	14%	10%	25%	31%	16%

Monarch
Helping Dreams Take Flight

InterCommunity Case Study – E. Hartford, CT

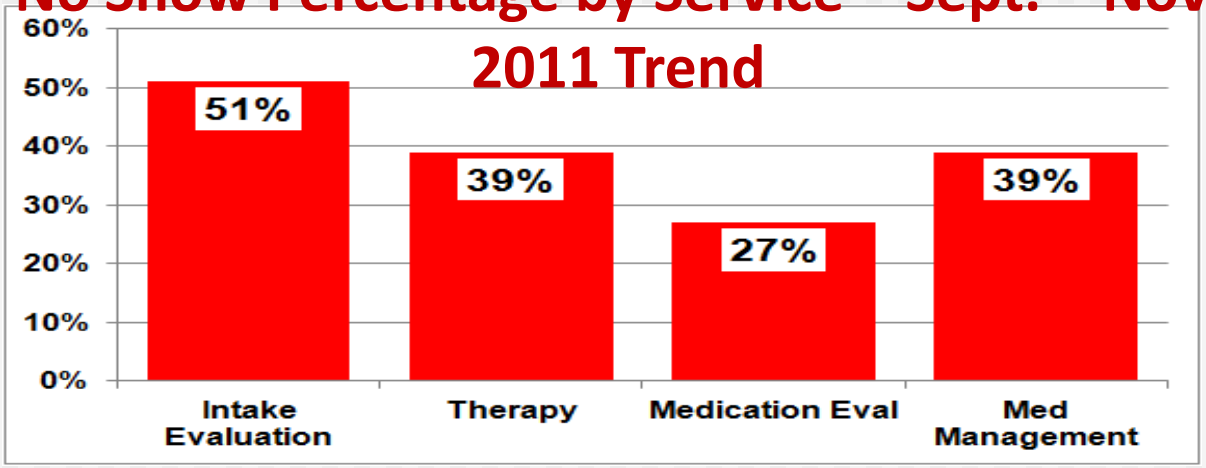
Identifying The Problem

Recognizing that what we were doing wasn't working, and that although it seemed to be the norm for most agencies it wasn't really good care, we began looking at data and meeting in Project Change Teams to identify where we were working harder rather than smarter.

Perhaps the most significant issue we discovered was how No-Shows:

- Prevented clients in need from getting in to see their "booked" provider
- Caused providers to manage case loads rather than provide services
- Financially were ruining the agency as staff were paid to be busy but were not generating revenue.

No Show Percentage by Service – Sept. – Nov. 2011 Trend



InterCommunity Case Study – E. Hartford, CT

Medication Mismanagement

No Shows were having an even more devastating impact on quality of care and agency fiscal viability:

- Productivity for prescribers was 42%
- Due to lack of openings in the prescribers' schedules Medication Evaluation's were being booked out two months even after a client demonstrated engagement by attending other services for months
- Clients seeking non-scheduled visits with their prescriber were being booked out two to four weeks
- **A full-time staff was being used exclusively to call and reschedule medication appointments due to no shows or time off as requested by the prescribers**
- **No-shows and bridging medication became the unintended standard of care**
- Rather than treating clients, prescribers were busy bridging medications.

Just In Time Access to Services Solution Outcomes InterCommunity Case Study – E. Hartford, CT

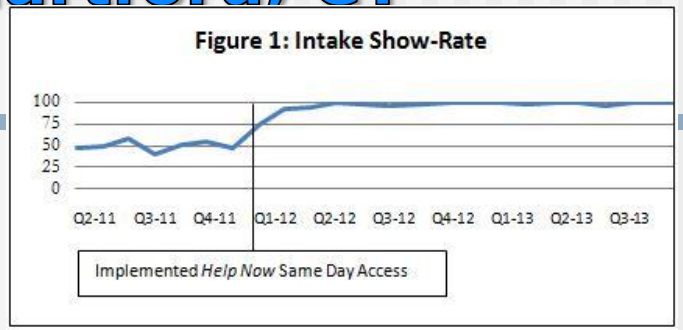
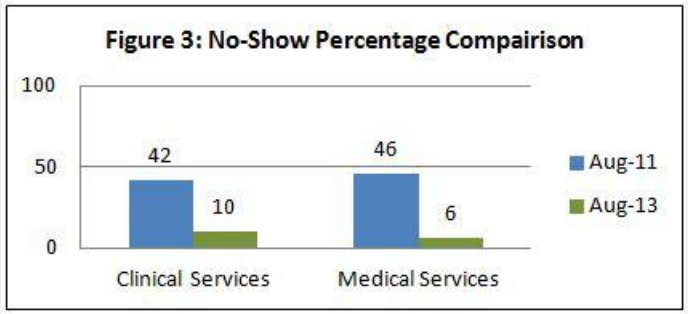
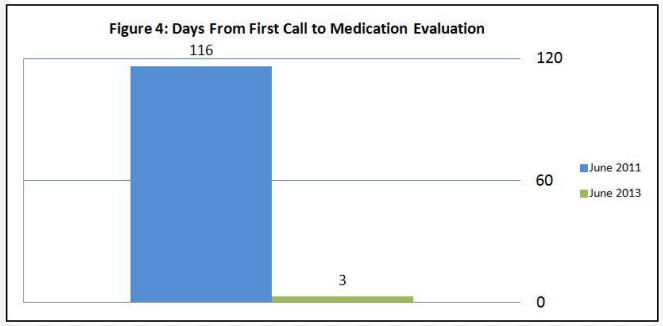
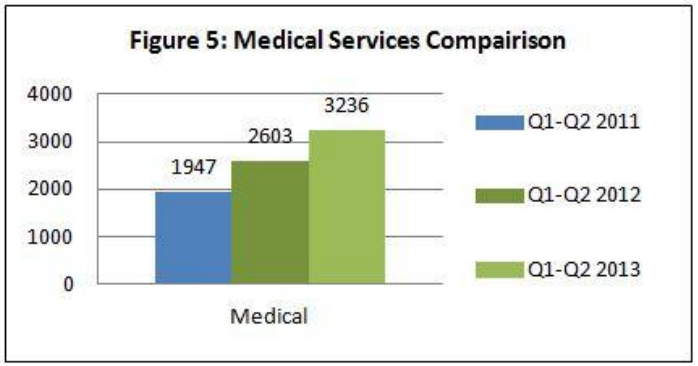


Figure 2: Completed Intake Assessments

	Jan	Feb	Mar	Apr	May	Jun	% increase
2011	42	52	81	76	66	70	
2013	116	113	136	112	138	119	90%







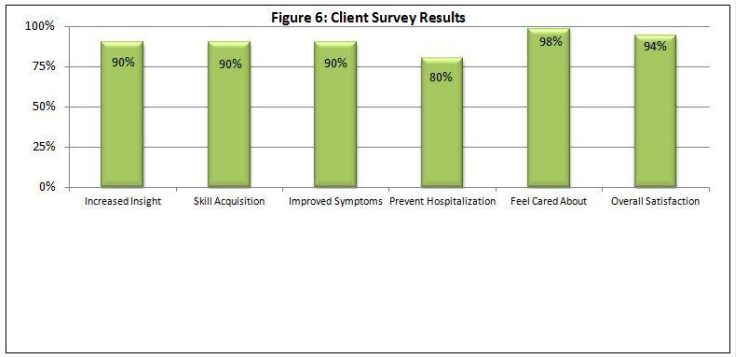


Figure 7: Services Delivered and Staffing Q1 and Q2 For Each Fiscal Year Below

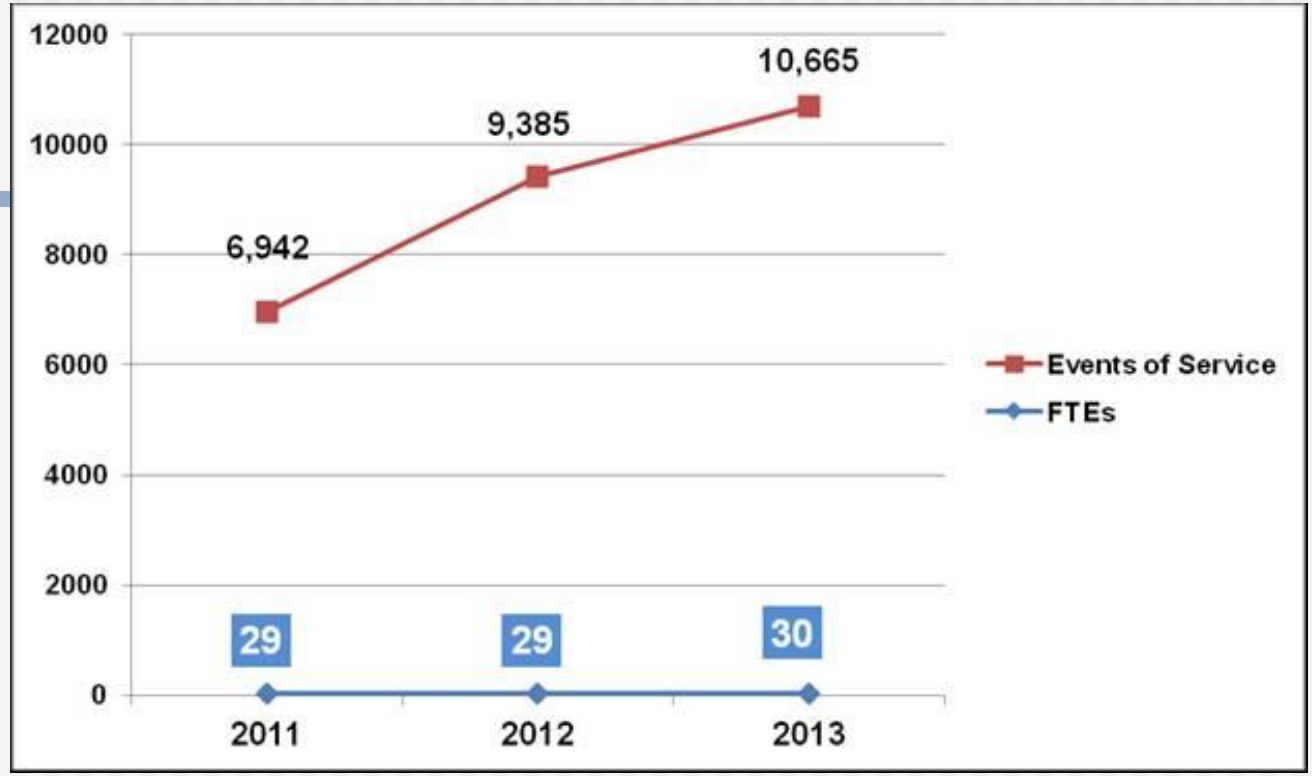


Figure 8: Staffing Levels for Same Fiscal Years:

Year	Assessment FTEs	Adult Clinician FTEs	Medical Team FTEs	Administrative Support FTEs	Total FTEs (Rounded)
2011	4.5	5.875	3	15.5	29
2012	5	5.875	3.62*	14.62	29
2013	5	6.875	4.77*	13.62	30

"Help Now" Outcomes Summary
InterCommunity Case Study – E. Hartford, CT

- In addition to improved engagement, client surveys indicate a 94% client satisfaction rating with **98% of clients reporting feeling cared for**, 90% reporting benefits from therapy, and 80% asserting that InterCommunity's timely services have prevented a need to seek inpatient psychiatric care. Figure 6 provides the client satisfaction outcomes achieved in 2013 after Help Now was implemented.
- The **risk management benefits** of the Help Now model of care have had a significant risk reduction and "bending the cost curve" effect on care. InterCommunity's improved capacity to provide access to treatment has led to a decrease in ER visits/ hospitalizations at a savings of over $3.7 million.
- The **financial benefit** (revenue over expenses) is also impressive. **Staffing has been able to stay flat despite a 90% increase in intakes, 66% increase in medical services delivered, and 45% increase in clinical services delivered** with *Help Now* (comparing Q3-Q4 of '11 to '13).The significant increase in delivered billable services, again without increased staffing, has led to a **48% increase in third party revenue**.
- The **staff feels so positively** about *Help Now* and their experience at the behavioral health center that they voted InterCommunity a Top Work Place in the state for the past three years.

Georgia Pines CSB

Summer No Show Rates

	All Clinics (%)	Thomas County (%)
MAY	**31**	**33.1**
JUNE	**34.1**	**37**
JULY	**28.6**	**24.4**
AUG	**24.3**	**5.7**

JIT Fully Implemented

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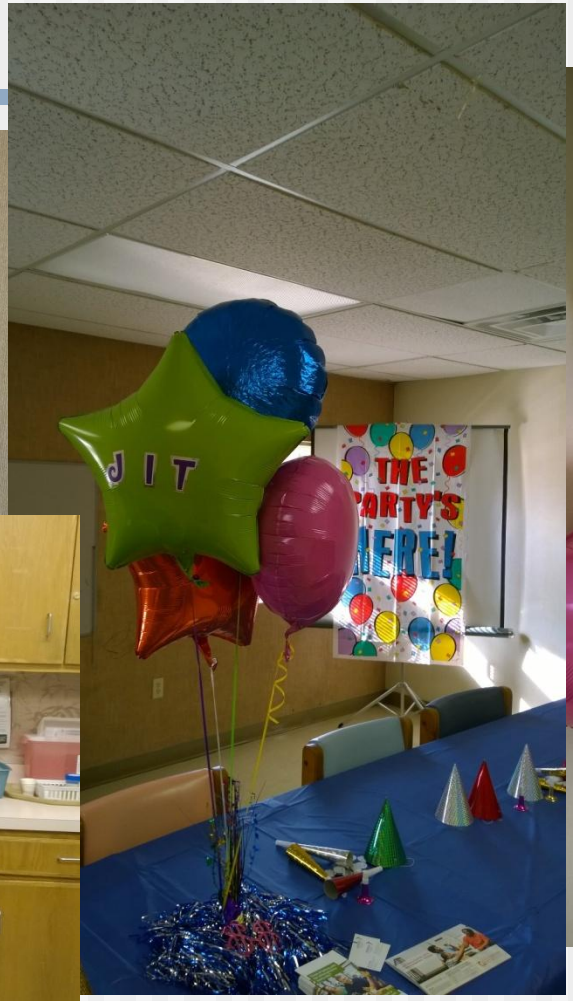
Serenity Behavioral Health Systems



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How to Transition…

- Select a start date
- Create a Communication Plan for Staff
- Create a Communication Plan for Clients – letter, signage, reminder cards
- Set up your tracking system- how will you know when a client's "due date" has passed– MTM has a calculator for that!
- Go!

Episodic Care – Treat to Target

Presented By:
Michael Flora, MTM Services

Distributive Justice Ethical Leadership Challenge

- **Distributive Justice Ethical Dilemma:**
  1. How do providers ensure that it is providing the greatest good to the greatest number of people based on the limited resources available
  2. How do providers shift the primary service delivery focus from its current caseloads to an equal focus between current caseloads and persons presenting to access services?
  3. Providers will need to establish key performance standards to ensure that the needs of ALL of the people in the catchment area are responded to timely and effectively

Change starts with Measurement

- *Goal-* Caseload management through Episodic Care Model, review staff productivity, etc.
- *Measure:*
  - Current Average Length of Stay
  - No Show rates for established clients
  - Unrealized Service Capacity
  - Individual Caseload Review
- *Decide*

What's the Big Deal?

- Typically 40% of a clinician's caseload consists of clients who are stable, not needing services now.
- This dependence results in access lags, in part due to increased client no shows.
- No shows impair a clinician's ability to meet his/her productivity
- Lack of productivity drives up agency cost, lack of raises, etc.
- Ethical problem: limited agency services should be provided to the clients who need it the most, *when* they need it.
- Clients hang on, doing the minimum necessary because they fear "losing their spot"– Same Day Access solves this

- What do we do about it?

What's the Big Deal?

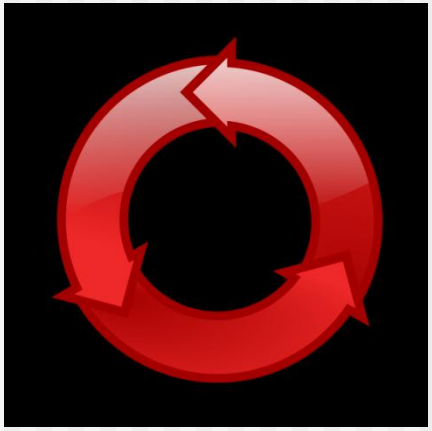
Typically 40% of a clinician's caseload consists of clients who are stable, not needing services now.

⇒ Clients hang on, doing the minimum necessary because they fear "losing their spot", but they no show/cancel because they don't really need the service. This dependence results in access lags, in part due to increased client no shows. Access lags lead to more no shows. No shows impair a clinician's ability to meet his/her productivity.

⇒ Lack of productivity drives up agency cost, lack of raises, etc.

What's the Big Deal?

- What do we do about it?



- Uncover and break the dependence Cycle with NS Management and Episodic Care

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Episodes of Care

- Episodic Care – uses treat to target approach
- Steps to Implement:
  - Select functional measure (DLA-20, GAF, LOCUS, etc.)
  - Design levels of care
  - Set treatment LOS guidelines
  - Measure outcomes regularly during EOC
  - Review cases at prescribed intervals
  - Discharge, or transition when outcomes are achieved
  - Examples

Revenue Cycle Management

Presented By:
Michael Flora, MTM Services

Revenue Cycle Management

Admission Eligibility
Authorization
Verification
Open to Schedule

Treatment
Co-Pay Collections
Post Session Scheduling

Post Discharge
Account Receivable Management
Billing
Cash Posting
Consumer Follow-Up

Presented By:
Michael Flora, MTM Services

Many CBHOs Face Substantial Barriers in Revenue Cycle Management :

- Challenge with timely access to treatment to support Commercial and Public Payers referral requirements
- Inconsistent Revenue Cycle Management procedures that enhance timely collections
- Collection of Co-Pays
- Documentation errors and incomplete documentation that “bogs” down the system
- Understanding of the target markets in our communities

Revenue Cycle Management

- A greater understanding of cash flows and management of billing practices will be needed in the new environment
  - How long is your billing process?
    - Are you billing weekly?
    - Can you process third party claims daily?
  - What is your percent of denials?
  - What is your performance standard on reconciliation of billing errors?
  - What percent of co-pays and self pay amounts are you collecting daily
    - Do you establish a daily collection figure for your front desk?

Visit

- Collection of Co-Pays
- Clinical Care Documentation
- Charge capture
- Coding
- Utilization Management

Step 1
Improving Access Management

- Assess the workflow processes and eliminate redundancies in collection and rework.
- The new behavioral healthcare organization will need to accurately
  - authorize services,
  - determine, validate coverage for payment,
  - assess payment risk
  - schedule resources prior to the patient's arrival.

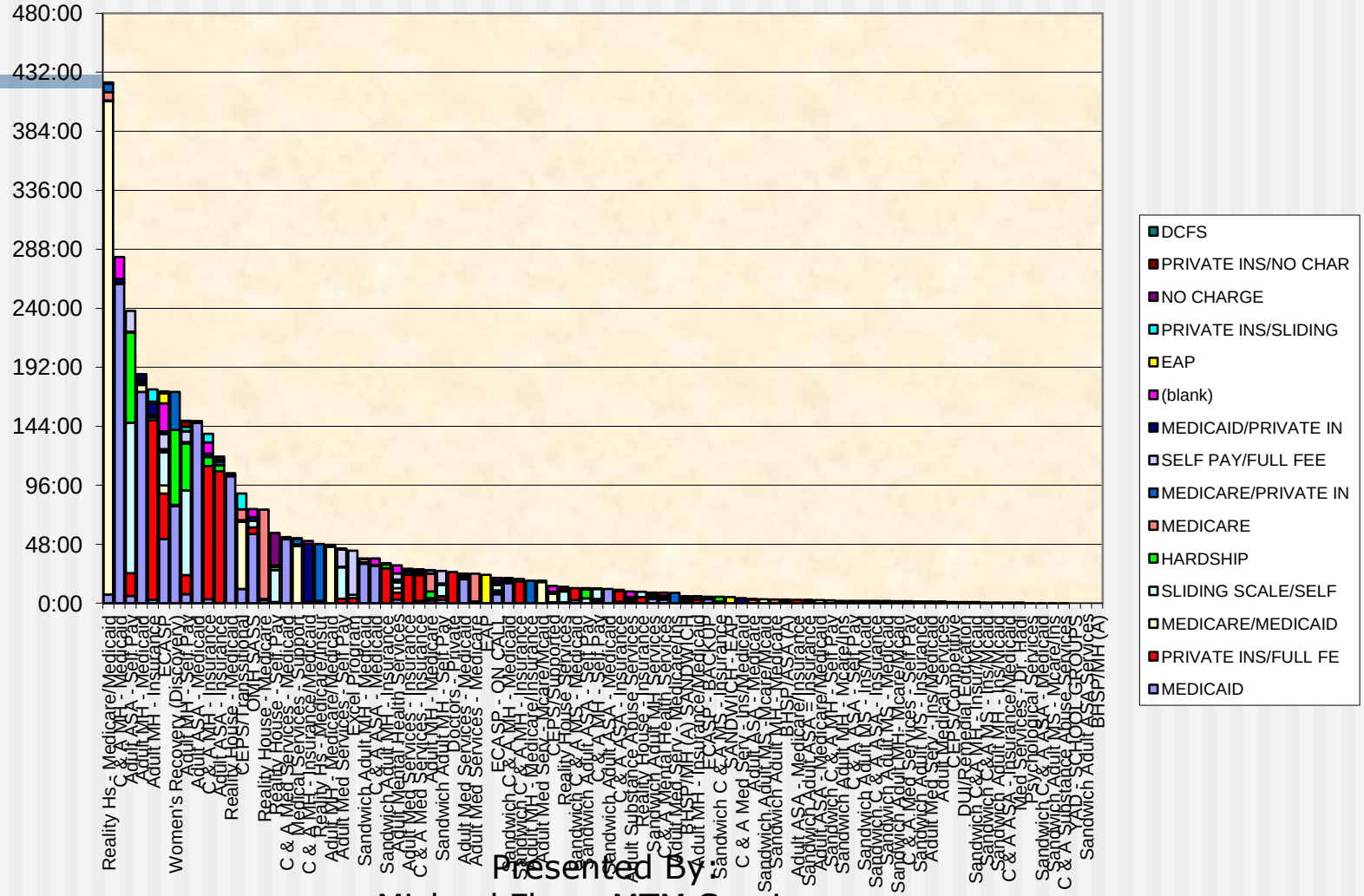
Roles of Support Staff In Revenue Cycle

1. Centralized Scheduling is needed to ensure referral is made to clinician on the appropriate insurance panel
   - Ability to know at all times the availability of clinical staff that are credential on third party panels will be critical to timely acceptance of new referrals
2. Re-think Front Desk functions/needs
   - Collection of Co-Pays prior to Service
   - Confirmation of Insurance via copy of Insurance cards prior to service

Roles of Clinical and Financial Staff In Revenue Cycle

1. Completion and submission of all required clinical documentation by direct care staff will be needed to support authorizations after Intake (if required) and re-authorizations
2. Filing timely and accurate claims will be critical
3. Monitoring level of unreimbursed third party care – determine reasons for non payment and correct issues

Payor Volumes Chart



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Information Capture at the Front Desk

SIGN IN FORM

Client Name:_____

Address:_____

City:_____

State:_____Zip code:_____

Phone:_____

Client Birthdate:_____

Name of Insurance:_____

Name of Policy Holder:_____

SS# of Policy Holder:_____

Birthdate of Policy Holder:_____

Any Changes in your Medical Condition since your last visit YES/NO

Appointment With:

Are you Public Aid?.....YES/NO
Have you Applied for Public Aid YES/NO

Presented By:
Michael Flora, MTM Services

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Revenue Enhancement Work Sheet

Third Party Payer Assessment Sheet

3rd Party Revenue Evaluation Form						
Payor	**Credentialing Requirements** *(I.e., Rule 12 for Organization or Individual Providers)*	**Licensure/Experience Requirements**	**Check all that apply:** *(Click on box with your curser to check)*	**Rate Structure**	**Status/Notes:**	**Recommend Pursuing?**
			☑ Pre-Certification Required ☐ Authorization/Re Authorization Required ☑ Custom Clinical Forms Required ☐ Provider Panel is Open If not open, when will it open again: ____ / ____ / ____			
			☐ Pre-Certification Required ☐ Authorization/Re Authorization Required ☑ Custom Clinical Forms Required ☐ Provider Panel is Open If not open, when will it open again: ____ / ____ / ____			
			☑ Pre-Certification Required ☐ Authorization/Re Authorization Required ☑ Custom Clinical Forms Required ☐ Provider Panel is Open If not open, when will it open again: ____ / ____ / ____			
			☑ Pre-Certification Required ☐ Authorization/Re Authorization Required ☑ Custom Clinical Forms Required ☐ Provider Panel is Open If not open, when will it open again: ____ / ____ / ____			

Non-Clinical Performance indicators

FINANCE:

Goals:

- Accurate billing statements will be generated and issued to consumers no longer than 20 business days after month end 100% of the time
- Based on the number of consumers billed, substantiated customer complaints will not exceed 2%
- Third party fees will be billed 100% of the time
- 100% of complete and accurate invoices will be paid within 30 days of receipt
- Financial reports will be generated and distributed to management staff within 15 business days of month end 90% of the time
- Consumer satisfaction survey rating for financial matters/charges will not fall below a score of 90%.

Gather financial intake data

- a. Definition: A financial intake package (annual, updates, as status changes, or as required by program) will be completed on all individuals requesting services with the center.
- b. Standard: Financial intake paperwork will be entered by support staff into CMHC/CIS prior to or on the date of clinical intake.
- c. Source: Monthly audit of financial assessments.
- d. Compliance Rating: 100% of these entries made prior to clinical intake =compliant. Less than 100% = non-compliant.
- e. Solution Plan: Development note and retraining for first non-compliant rating. A Written Warning and retraining will be offered following the second consecutive non-compliant period and Separation from employment upon the third consecutive non-compliant period.

Step 2: Pre-Service confirmation/reminder calls

- During the confirmation call the Customer Service Representative (CSR) not only confirms the appointment but also confirms outstanding balance and co-pay as needed.

Point of Service Contact

Collection of Co-Pay/Reimbursement for services

- a. Definition: collection for all billable service co-pays provided by the center staff will be executed at each customer visit.
- b. Standard: CSR staff will accurately collect bill for services at the point of service
- c. Source: Review of financial reports.
- d. Compliance Rating: 98% or greater of these entries made at the POS =compliant. Less than 98% = non-compliant.
- e. Solution Plan: Development note and retraining for first non-compliant rating. A Written Warning and retraining will be offered following the second consecutive non-compliant period and Separation from employment upon the third consecutive non-compliant period.

Step 3: Accelerating Cash Collection

- What are your days of sales outstanding?
- After services are delivered behavioral healthcare organizations revenue cycle needs to assess and maximize revenue capture and streamline the billing and collection process.
  - electronic claim processing,
  - direct entry of Medicare/Medicaid claims,
  - automatic secondary/Waterfall billing,
  - remittance posting,
  - contract and denial management,

Non-Clinical Performance Indicators

Billing statements

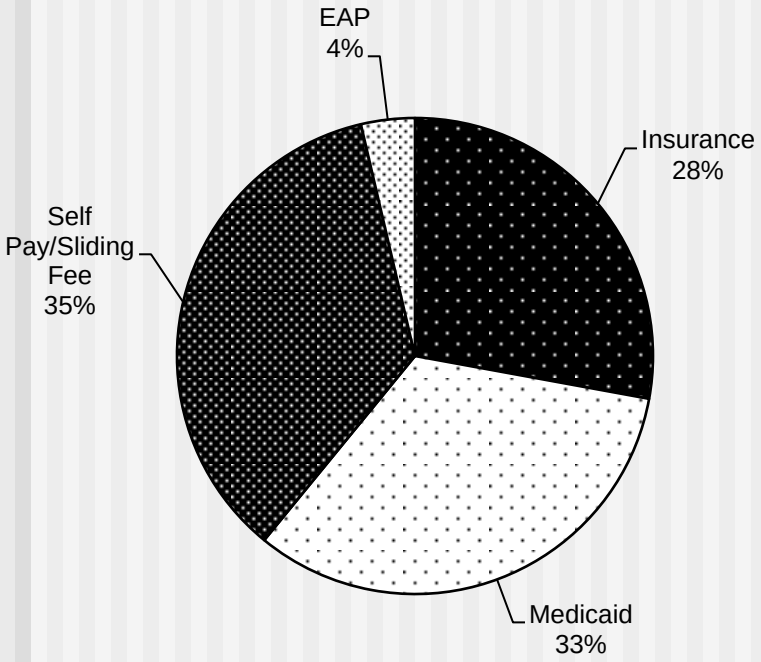
- a. Definition: Client statements will be accurate and issued to each individual via mail each month.
- b. Standard: Client statements will be reviewed for accuracy and mailed out no later than the 20th day of each month.
- c. Source: Client statement spreadsheet
- d. Compliance Rating: 98% or higher of the statements are accurate and mailed = compliant. Less than 98% accuracy and distribution = non-compliant
- e. Solution Plan: Development note and retraining for first non-compliant rating. A Written Warning and retraining will be offered following the second consecutive non-compliant period and separation from employment upon the third consecutive non-compliant period.

What about the payors?

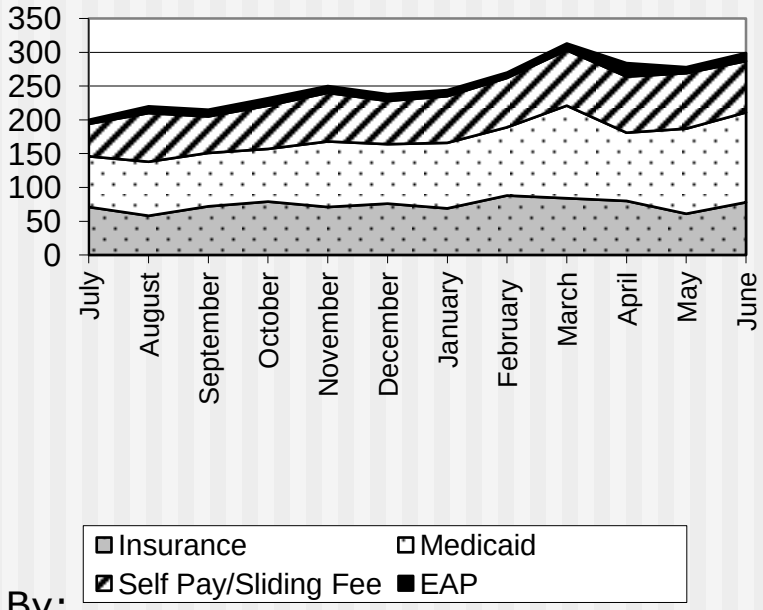
- **Improving Payor Performance**
  - **Knowing Payor expectations**
  - **What payors are in your market**
  - **What is the % of Medicaid ?**
  - **What is the % of uninsured?**
  - **What is the % of Insured?**

How does your payor mix compare to your market?

Intakes by Payor Source



Requests for Service Monthly Trend by Payor Source



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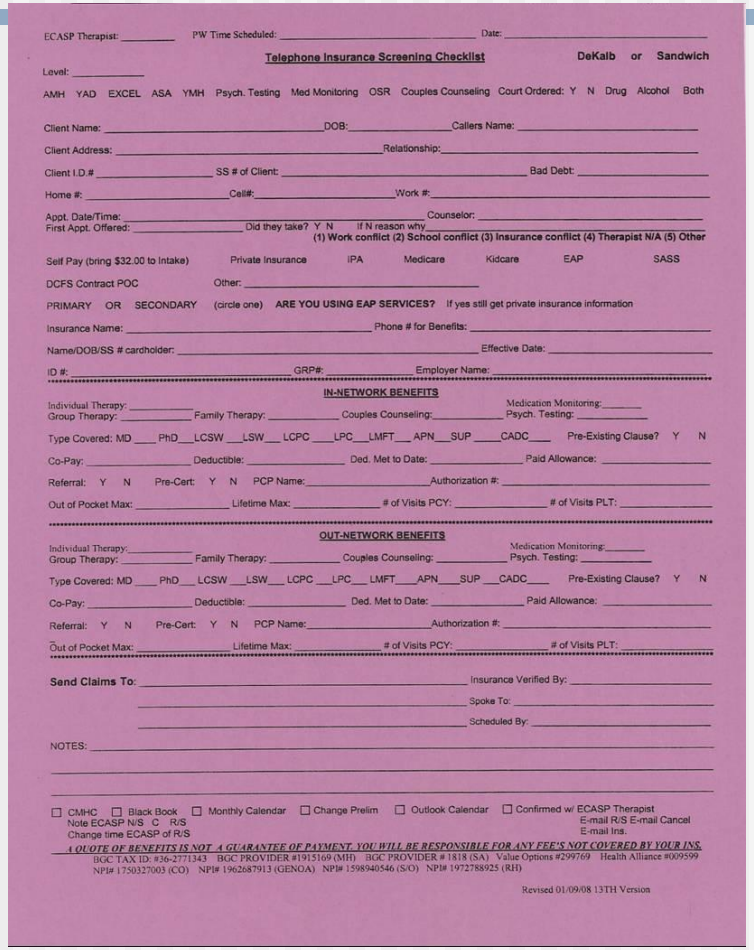
Pre-Visit

- Contract management
- Patient Scheduling
- Medical Necessity
- Eligibility/Benefits Management
- Registration
- Point of Service

Verification of Payer



ECASP Therapist: _____ PW Time Scheduled: _____ Date: _____

Telephone Insurance Screening Checklist **DeKalb or Sandwich**

Level: _____

AMH YAD EXCEL ASA YMH Psych. Testing Med Monitoring OSR Couples Counseling Court Ordered: Y N Drug Alcohol Both

Client Name: _____ DOB: _____ Callers Name: _____

Client Address: _____ Relationship: _____

Client I.D.# _____ SS # of Client: _____ Bad Debt: _____

Home #: _____ Cell#: _____ Work #: _____

Appt. Date/Time: _____ Counselor: _____

First Appt. Offered: _____ Did they take? Y N If N reason why _____

(1) Work conflict (2) School conflict (3) Insurance conflict (4) Therapist N/A (5) Other

Self Pay (bring $32.00 to Intake) Private Insurance IPA Medicare Kidcare EAP SASS

DCFS Contract POC Other: _____

PRIMARY OR SECONDARY (circle one) **ARE YOU USING EAP SERVICES?** If yes still get private insurance information

Insurance Name: _____ Phone # for Benefits: _____

Name/DOB/SS # cardholder: _____ Effective Date: _____

ID #: _____ GRP#: _____ Employer Name: _____

IN-NETWORK BENEFITS

Individual Therapy: _____ Medication Monitoring: _____

Group Therapy: _____ Family Therapy: _____ Couples Counseling: _____ Psych. Testing: _____

Type Covered: MD ___ PhD ___ LCSW ___ LSW ___ LCPC ___ LPC ___ LMFT ___ APN ___ SUP ___ CADC ___ Pre-Existing Clause? Y N

Co-Pay: _____ Deductible: _____ Ded. Met to Date: _____ Paid Allowance: _____

Referral: Y N Pre-Cert: Y N PCP Name: _____ Authorization #: _____

Out of Pocket Max: _____ Lifetime Max: _____ # of Visits PCY: _____ # of Visits PLT: _____

OUT-NETWORK BENEFITS

Individual Therapy: _____ Medication Monitoring: _____

Group Therapy: _____ Family Therapy: _____ Couples Counseling: _____ Psych. Testing: _____

Type Covered: MD ___ PhD ___ LCSW ___ LSW ___ LCPC ___ LPC ___ LMFT ___ APN ___ SUP ___ CADC ___ Pre-Existing Clause? Y N

Co-Pay: _____ Deductible: _____ Ded. Met to Date: _____ Paid Allowance: _____

Referral: Y N Pre-Cert: Y N PCP Name: _____ Authorization #: _____

Out of Pocket Max: _____ Lifetime Max: _____ # of Visits PCY: _____ # of Visits PLT: _____

Send Claims To: _____ Insurance Verified By: _____

_____ Spoke To: _____

_____ Scheduled By: _____

NOTES: _____

☐ CMHC ☐ Black Book ☐ Monthly Calendar ☐ Change Prelim ☐ Outlook Calendar ☐ Confirmed w/ ECASP Therapist
Note ECASP N/S C R/S E-mail R/S E-mail Cancel
Change time ECASP of R/S E-mail Ins.

A QUOTE OF BENEFITS IS NOT A GUARANTEE OF PAYMENT. YOU WILL BE RESPONSIBLE FOR ANY FEE'S NOT COVERED BY YOUR INS.

BGC TAX ID: #36-2771343 BGC PROVIDER #1915169 (MH) BGC PROVIDER # 1818 (SA) Value Options #299769 Health Alliance #009599
NPI# 1750327003 (CO) NPI# 1962687913 (GENOA) NPI# 1598940546 (S/O) NPI# 1972788925 (RH)

Revised 01/09/08 13TH Version

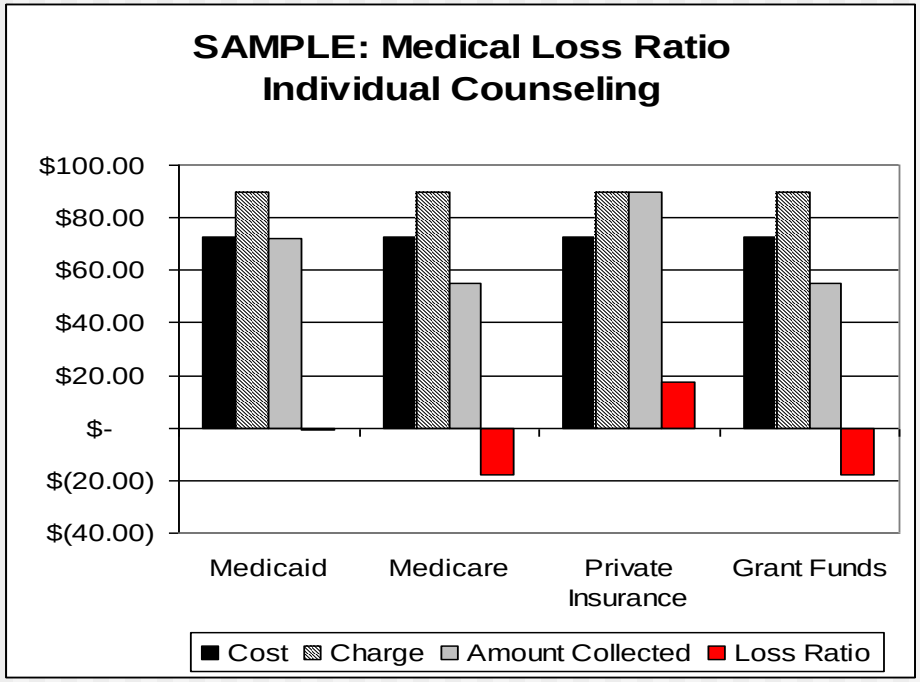
- Verify Insurance and Payer information
- In Network Benefits
- Out of Network Benefits
- Authorizations
- Credentials of providers
- Claims management

Post visit

- Billing
- Collections Management
- Denial Management
- Data Warehouse Analytics

Medical Loss Ratio

This report provides a summary of the actual cost of service vs. the reimbursement for those services



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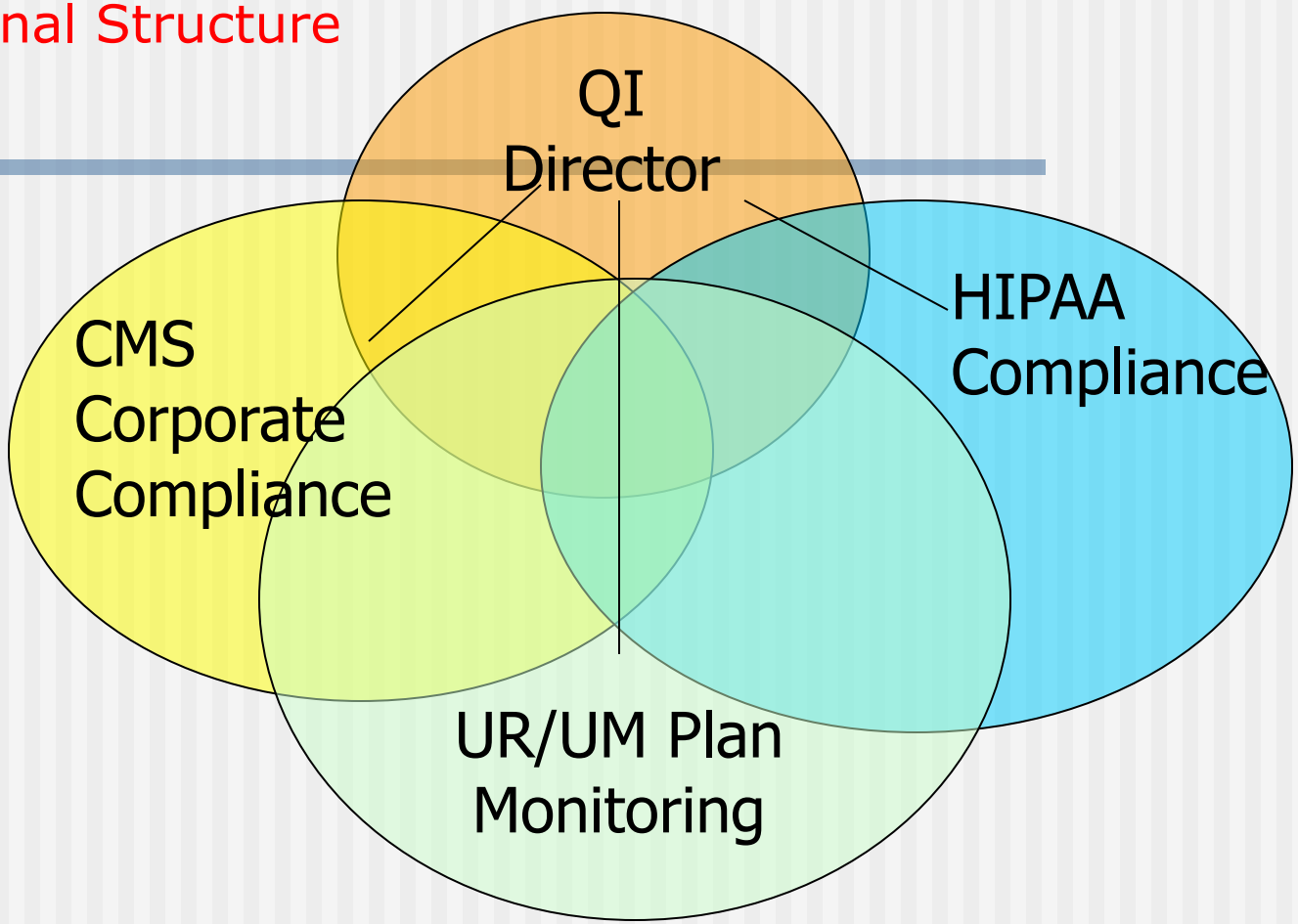
Utilization Review Vs. Utilization Management

- **Utilization Review** is primarily focused on retrospective review of what has or has not happened in services
- **Utilization Management** is focused on retrospective, concurrent and prospective management of service delivery capacity from intake to discharge and every thing in between

Integrated Quality Improvement/ Organizational Structure



Clinical and Support/Admin staff assigned based on size of organization and active caseload

Access & Quality Improvement Department

Access to Care:
- Screening/Triage
- Emergency Services
- Eligibility (Includes Part C)
- Provider Profiling
- Customer Service
- Education
- Referral
- Follow-up

Utilization Management:
- Internal Utilization Review/ Corporate Compliance
- External Authorization/ Re-Authorizations
- Appeals
- Contract Compliance
- Qualitative and Quantitative Auditing

Quality Improvement:
- Quality Management Council
- Office of Consumer Services
- Consumer Satisfaction Surveys
- Clinical Outcomes
- Health Information System

Community Relations:
- Grant Writing
- Public Information and Marketing
- Prev. Community Education

Contract Negotiations:
- Satisfaction
- Clinical Provider Supports
  - Insurance Provider Enrollment
  - Licensure Preparation Support
  - Performance Based Contracting

Support Staff

Child/Family Department

Assessment:
- Intake
- Crisis Stabilization

Outpatient Therapy:
- IOP
- Individual/ Family/ Group
  - VOCA
  - Detention-based Services
  - Sexual Offender
  - Restoration

Early Intervention:
- Project Daniel
- Transition School

School/Community Based Services:
- Day Treatment
- In-School Outpatient Indiv/ Groups
- SA Prevention Programs
- Behavior Support Services

Home-Based Services:
- In-home Training/Supports
- Individual/ Family/ Group
- Behavior Support Services

Family Supports:
- Parent Support Services
- Early Intervention

Service Coordination:
- Case Management

Residential Services:
- Therapeutic Foster Care
- Respite
- Independent Living

Psychiatric/Medical Services:
- Psychiatry/Medical Doctor
- Nursing

Support Staff

Adult/Family Department

Assessment:
- Intake
- Crisis Stabilization

Outpatient Therapy:
- IOP
- Individual/ Family/ Group
- Pegasus
- Family Support
  - MESA
  - SA Family Support

Service Coordination:
- Case Management

Community Support:
- Day Program (LRC)
- Supported Living
- Psychosocial Rehab
- Wrap-Around Services
- PACT
- Census Reduction

Residential:
- Group Homes/ ICF
- Respite

Residential Treatment:
- Residential
- Detox
- Halfway House

Psychiatric/Medical Services:
- Psychiatry/ Medical Doctor
- Nursing

Support Staff

Finance & Support Services Department

Finance:
- Accounts Payable
- Purchasing
- General Ledger

Reimbursement:
- Billing
- Collecting and Posting Payments
- Reporting

Information Technology:
- Tech Support
- CMHC Operating System
- Hardware and Software for Network
- E-mail Communications
- Internet Access
- Information and Management Reports
- Installation and Maintenance of PCs
- Computer Training

Human Resources:
- Center Focused Staff Training
- Payroll
- Recruitment
- Personnel Policies and Files
- Receptionists

Performance Contracting with State

Building/Maintenance:
- Vehicle Fleet Management and Maintenance
- Building and Grounds

Support Staff:
- Agency Program Support
- Operational Policy & Procedure
- Training

UR/UM Plan Support Tools Needed

Entry Into Care

1. What are the Access to Care standards for consumers per level of acuity that are required by the third party payers (**Emergent = within one hour, Urgent = within 24 hours and Routine = within 7 to 10 days**)?
2. Who will:
   - Determine the type of Third Party Insurance a client has
   - Obtain initial authorization prior to service delivery and
   - Refer the client to a clinician that is credentialed on the right insurance company panel?
   - Confirm if an additional authorization is needed to continue services after the initial intake/assessment
   - Ensure appropriate front desk co-pay collections are done
   - Submit timely/accurate claim submission to support payment for services provided
3. What clinical tool(s)/Reports will they use to make the assignment (i.e., Access data base of all third party payers and the clinicians credentialed on each panel, etc.)?

UM Plan Support Tools Needed

UM Information Sources and Documentation Requirements

1. What data elements/fields or information will be used to monitor/measure outlier management process?
2. What forms/written process will be used to document utilization reviews and inform staff and clinical managers of findings?
3. How will information regarding findings be conveyed to appropriate staff?
4. Need procedures in Plan for following up on case review recommendations.

Relationship Between Clinical Services (Front Office) and Back Office Accountability

- The Dynamics of Balancing the needs of the Front Office and Back Office Accountability requires a clearly defined skill set.
- Many organizations struggle with the NEW skill set required to efficiently and effectively manage the operations of the organization

Relationship Between Clinical Services (Front Office) and Back Office Accountability

- **Customer Service**
- **Business/Service Management**
- **Systems Management**
- **Workflow Processes**
- **Authorizations/Re-Authorizations**
- **Human Resource Management**
- **Financial Management**
- **Claims management, Collections, Billings**
- **Information technology and systems**
- **Facilities and equipment management**

Record Review and Authorization

- NEW CLINICAL STAFF
-
- For the first six weeks of active clinical work, UM/UR will review each chart weekly. UM/UR will then provide a personal review to the staff member regarding their paperwork timeliness and accuracy. At the end of this four week period, UM/UR will either sign off that the clinician is competent or that the clinician requires another two weeks of review.
-
- Once the clinician has been signed off on, UM/UR will review one week of charts once per month for the next nine months. UM/UR will provide a written assessment of their performance to their supervisor, which will be reviewed during supervision, signed off on by both supervisor and employee, and placed in the employee's personnel file.

Record Review and Authorization

- **EXISTING STAFF**

- All staff will have 20% of their charts audited the month before their annual review. UM/UR will provide a written evaluation to assist the manager with the review process. If their compliance is above 95%, they will be placed in the "A" category. If less than 95% compliance is noted on this annual review, the clinician will be put into the "B" category. If less than 85% compliance is noted, the clinician will be placed in the "C" category.

UM/UR

Category A:

- Clinicians in this category will receive semi-annual spot audits in addition to their annual review audit.

Category B:

- Clinicians in this category will be required to adjust any incorrect documentation in the audited charts. They will also be subjected to once-per-month spot audits that will be documented and reviewed in supervision. They will have to make any necessary adjustments to the documentation and will need to have their supervisor sign-off on their spot-audit sheet verifying that this is done. This will continue monthly until compliance meets 95% or until 6 months have passed. If 95% compliance is not reached within 6 months, the clinician will be put into category C.

UM/UR

Category C:

- Clinicians in this category will be required to submit all documentation daily to UM/UR. UM/UR will evaluate it for completeness and accuracy and will provide the supervisor with a daily report. UM/UR will be available to provide additional training to the clinician if required to ensure compliance. This will continue for 30 days, at which time compliance should reach 95%. The clinician will then be placed in Category B, although they will have expanded evaluation of treatment plan compliance for the first three months. If compliance does not reach 95% within 30 days, further disciplinary action will need to be taken at the discretion of the supervisor.

UR/UM Plan Clinical Tools Needed

Re-Authorizations During Service

1. Who will:
   - Confirm the number of sessions that have been delivered against the current authorization from payer
   - Obtain re-authorization prior to the end of the current authorization if additional services are clinically needed, and
   - Engage in appeals process with payer if re-authorization is denied?
2. What clinical tool(s)/Reports will they need/use to monitor current authorization levels and confirm need for re-authorizations (i.e., Number of remaining session in current authorization are recorded in centralized scheduler, etc.)?

Sample Assessment Review

Clerical Support/ Back Office

COMPREHENSIVE ASSESSMENT			
1. Was the CA formulated/signed by the QMHP?			
2. Was the need for psychiatric/psychological evaluation determined?			
3. Does the summary adequately reflect the data?			
4. Are treatment recommendations prescriptive and based on the information in the CA?			
5. Was the CA competed prior to the initiation of non-assessment services (crisis excluded)?			
6. Was Medical History complete, including date of last physical exam?			
7. Were all areas of the CA complete?			

Sample Treatment Plans Review

Clerical Support/ Back Office

INDIVIDUAL TREATMENT PLAN			
1. Was the ITP completed within 45 days of the CA being signed by the QMHP?			
2. If not, do progress notes indicate the reasons for the deficiency?			
3. Was the ITP signed by the client and/or parent/guardian?			
4. Has the client been given a copy or refused a copy of the signed ITP?			
5. Was the ITP signed by the QMHP?			
6. Was the ITP signed by the LPHA?			
7. Was the ITP signed by the physician if part of service?			
8. Is the Treatment Issue related to the goal and objectives?			
9. Are the services related to the treatment goals?			
10. Was a master ITP developed for multiple services, if applicable?			
11. Is the target date filled out for 6 months from date initiated?			
12. Has the ITP been updated and signed as required?			
INDIVIDUAL TREATMENT PLAN: QUALITATIVE			
1. Does the goal address the client's condition as described in the CA?			
2. Will the goal diminish impairment or prevent significant deterioration in an important area of life functioning as identified in the CA?			
3. Do the goals focus on specific behaviors to be changed?			
4. Are objectives measurable?			

Presented By:
Michael Flora, MTM Services

Referral, Intake, & Billing Process

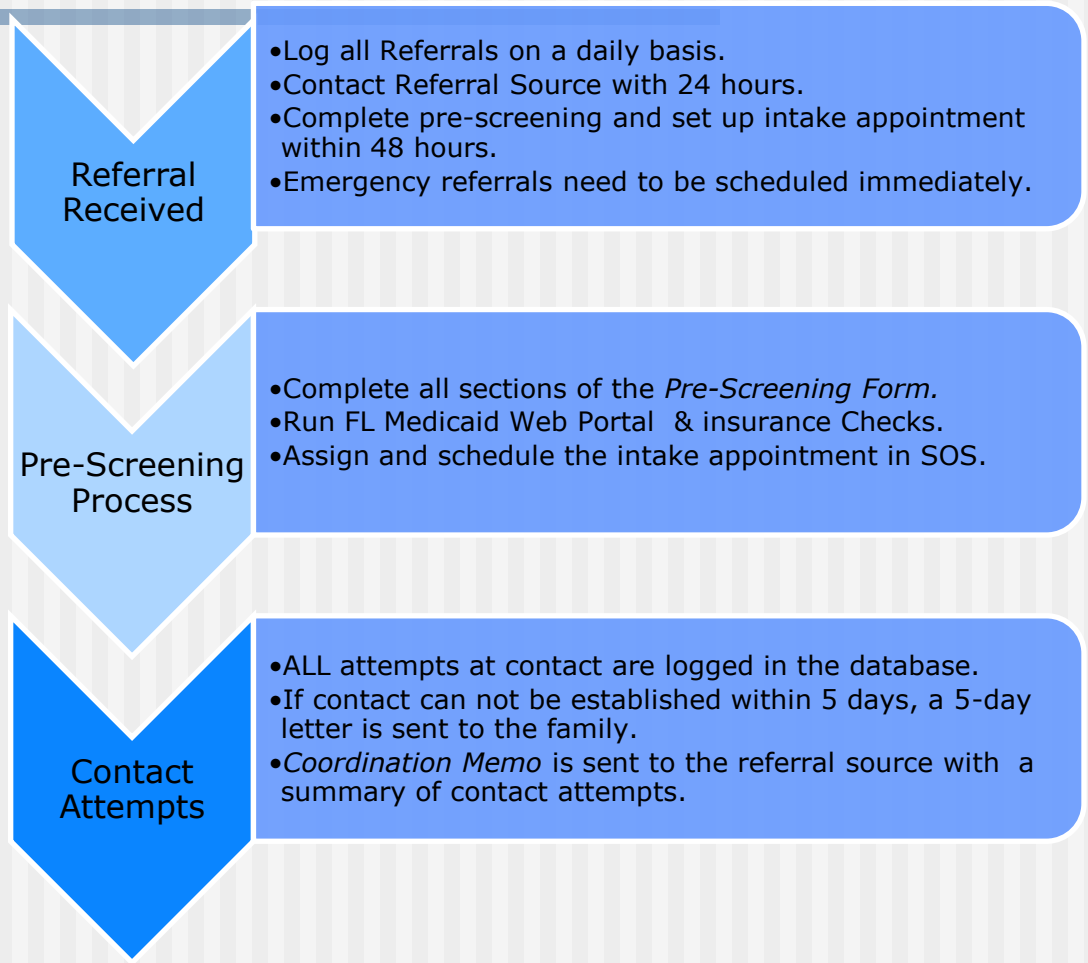
Presented By:
Michael Flora, MTM Services

External Referrals

Referrals are received via e-mail, fax, phone, FoCiS, web portal, call from the insurance company, other providers, or walk-in.

The Intake Coordinator is responsible for logging all referrals and contacting the referral source to acknowledge receipt of referral.

The Intake Coordinator, Intake Therapist, or designee are responsible for completing all pre-screening procedures. This includes: The Pre-admit Screening Form, insurance and web portal Medicaid check, Fee Policy Form, and the Financial Worksheet & Sliding Scale Fee Table. All applicable authorizations will be completed at this time, prior to the initial appointment.



Client Eligibility

Eligibility Checks

- At the beginning of the month, clients with intake appointments scheduled during the prior month need to be rechecked.
- Eligibility check will be completed by the Intake Coordinator ***before*** the telephone call is made to confirm the intake appointment.

Tracking Referrals

- ALL referrals and intakes need to be logged in the database.
- All unsuccessful referrals are maintained in files by the Intake Coordinator, with corresponding notes and letters showing attempts at contact.

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Referrals

Referrals for Specific Therapists

- Intake Coordinator is given the referral and completes the prescreening procedures.
- The Intake Packet is given to the therapist to schedule the intake appointment.
- Therapist e-mails status and contact attempts to the Intake Coordinator.
- If attempts at contact are unsuccessful, therapist gives referral with copy of 5-day letter to Intake Coordinator.

Timeliness

- All referrals will be logged on a daily basis.
- Referral sources need to be contacted within 24 hours.
- Ongoing communication needs to occur through use of the *Coordination Memo*. This can be done by fax, e-mail, or telephone. Does not apply for FoCiS and web portal referrals .
- Non-Emergency intakes are scheduled within 48 hours.

Customer Service

- PCC's services will be defined by a strong focus on customer service, with consistent communication and follow-up .
- Continual feedback from staff and stakeholders will be used to improve our processes.
- Staff will work as a team to achieve optimal efficiency in service delivery and customer satisfaction.

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Intake Process

Informed Consent

Client/Family is given Intake Packet, in preferred language, to complete.

Intake Therapist completes informed consent procedures, including explanation of privacy practices and grievance process.

Intake Paperwork

Internal Recommendation & Referral Form is immediately placed in the waitlist folder so a therapist can be assigned.

All intake paperwork, applicable authorizations, and billing must be submitted within a 24-48 hour period.

Internal Referrals

The Senior Therapist will monitor and follow-up with all referrals. This includes contacting families on status and facilitating assignment with therapists.

During weekly group and individual supervision, referrals will be discussed and assigned.

Expectations

- All original *Internal Recommendation & Referral Forms* will be placed in the Access folder on the day the intake is completed.
- Clients will be assigned after completing the intake to the most appropriate therapist, based on specialties and clients' needs.
- Referrals will be made to external programs as needed to meet the clients' needs.
- Program Directors are responsible for monitoring caseloads and facilitating assignment of clients, based on priority, as needed.
- High priority clients will be assigned within 7 business days, medium priority within 14 business days, and low priority with 21 business days. If assignment is not possible, there must be clear documentation indicating barriers or issues. Indicate date assigned on the original referral form.
- Senior Therapists send intake letters, monitor referral binder, make calls regarding assignment status and document contact, send out 5-day letters, and complete administrative discharges.

Internal Referral and Assignment Process

On referral form, indicate:

- Date referral was submitted.
- Date contact was made with client.
- Date entered into EHR.
- Date of therapist assignment.
- Date referrals were scanned and e-mailed.
- Date assigned therapist reports difficulty contacting family or barriers to treatment.
- Date original copies were submitted to QI Director.

Billing Process

Within 24-48 hours of intake, all documentation and billing is submitted to the program Senior Therapist. A compliance review of documentation is completed. Therapist is informed of any needed corrections. When documentation is in compliance, the Daily Billing Sheet is stamped.

The documentation is submitted to the Health Information Department and the billing is submitted to the Billing Department. The Billing Department stamps the billing sheet.

The Health Information Department enters all client data into SOS and creates the client chart. The Billing Department inputs service codes/descriptions provided on the Daily Billing Sheet into SOS.

Eligibility Checks

The Billing Department verifies all carriers and funding agency eligibility during the first week of each month. MCD will be completed first and an e-mail will be sent to the Program Directors, showing a list of the non-eligible clients. HMOs and other funding agencies will follow. Even if the client is not set-up in EHR, a print-out of eligibility information will be provided.

Each day, the Program Directors will get a summary of the insurance changes this period.

During the rest of the month, Program Directors will make eligibility checks, as needed, for clients.

The Clinical Services Manager will oversee and coordinate all authorizations. Program Directors and staff will follow-up, as needed. **Unauthorized services do not count toward staff or program productivity**.

A list of all unauthorized services will be submitted by the Billing Department and reviewed by the Division Director on a monthly basis.

Beginning of Month

- Complete all eligibility checks, including Magellan, CSC, SAMH, etc during the 1st week of each month.
- At the end of each day, a summary is sent to the Program Directors.
- The Clinical Services Manager informs staff of insurance changes and facilitates completion of authorizations.

'Pending" Carrier

- All inactive/ineligible clients will be moved to the 'pending' carrier in EHR by billing.
- Program Directors will inform therapists who will review funding status with client and develop a plan for services.
- Program Director will submit a *Change of Information* Form to billing for every client on the pending/ineligible list. Pro Bono MUST be approved in writing by Division Director.

Change of Information

- When therapist or TCM becomes aware of a change in client insurance, a *Change of Information Form* needs to be submitted to the Billing Department.
- The Billing Department will enter all changes in SOS. Clinical Services Manager will monitor authorizations.

WORKFORCE READINESS

Presented By:
Michael Flora, MTM Services

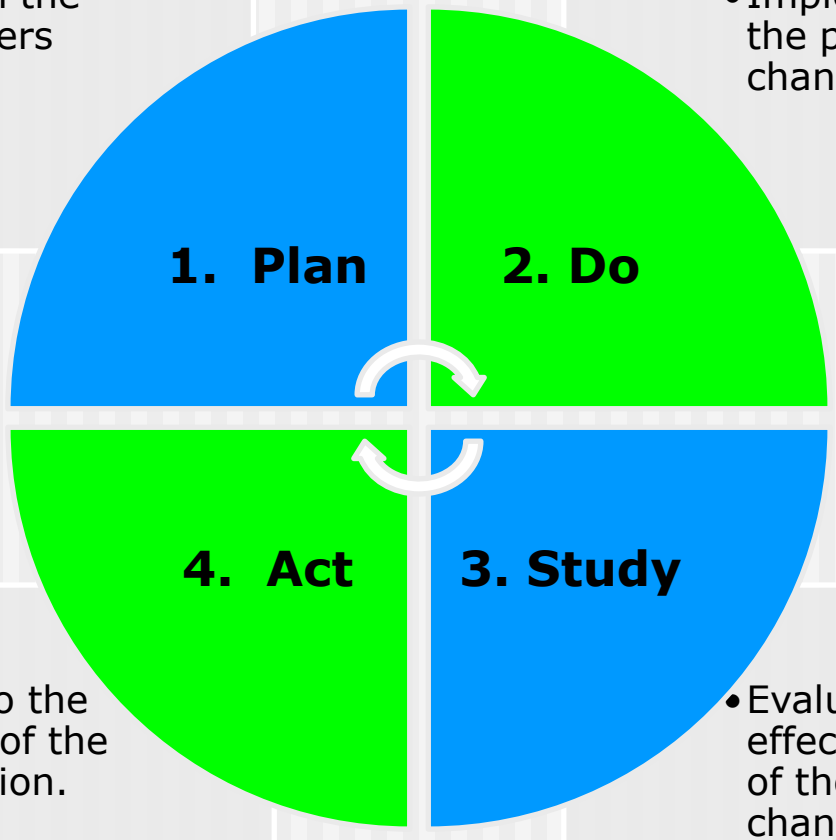
RAPID CYCLE CHANGE SUPPORT AND COACHING

Presented By:
Michael Flora, MTM Services

Rapid Cycle Change Planning

- Establish the Parameters for the change.

- Implement the planned changes.



- React to the results of the evaluation.

- Evaluate the effectiveness of the change.

The Deming Cycle, Deming's wheel, or the PDSA cycle is a long time utilized continuous quality improvement change philosophy created as part of W. Edwards Deming's Total Quality Management process (TQM) in the 1950's. Deming's work was based off of the Plan, Do and See cycle created by Mr. Walter A. Shewart in the 1920's, and has created successful change initiatives across multiple industries.

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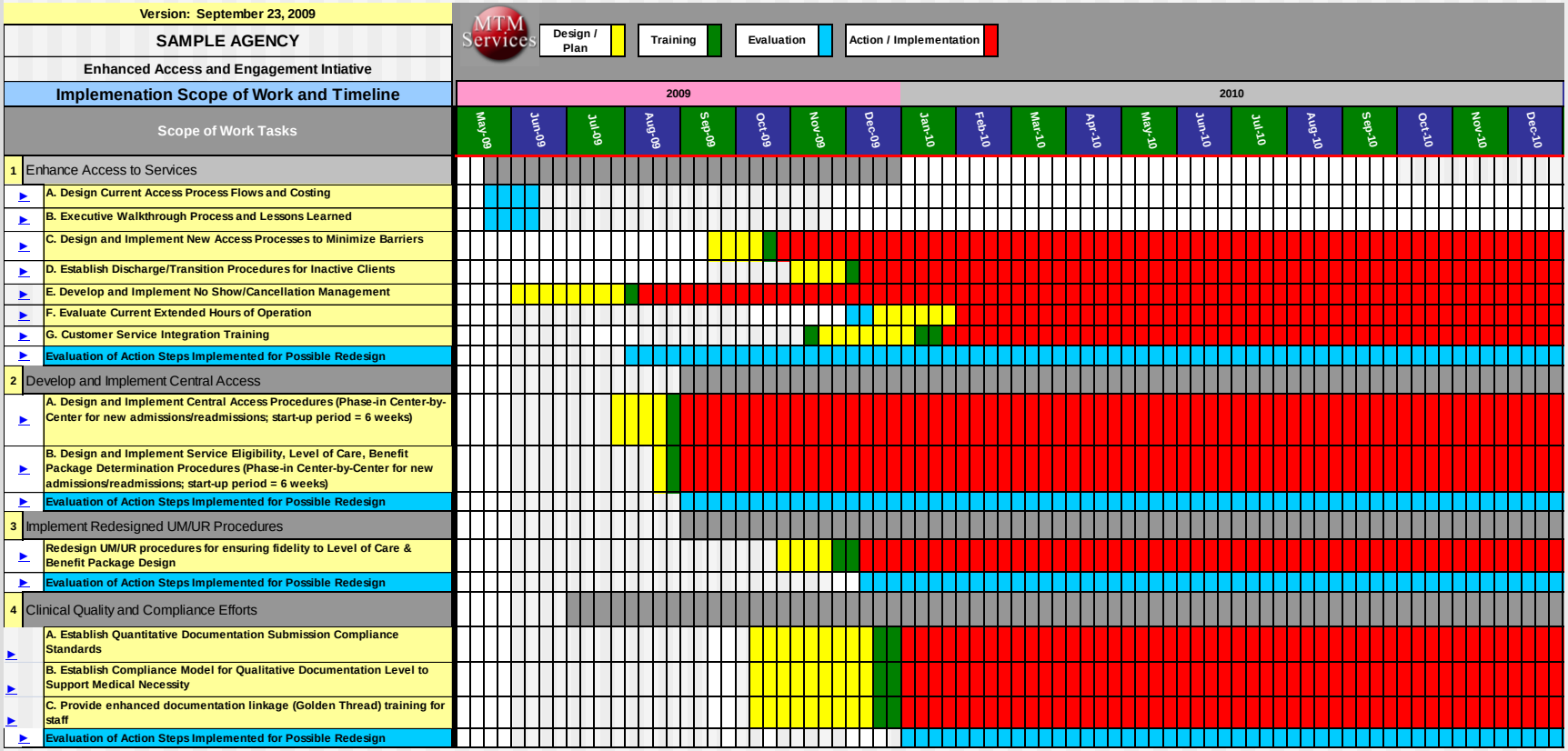
SAMPLE RCCP



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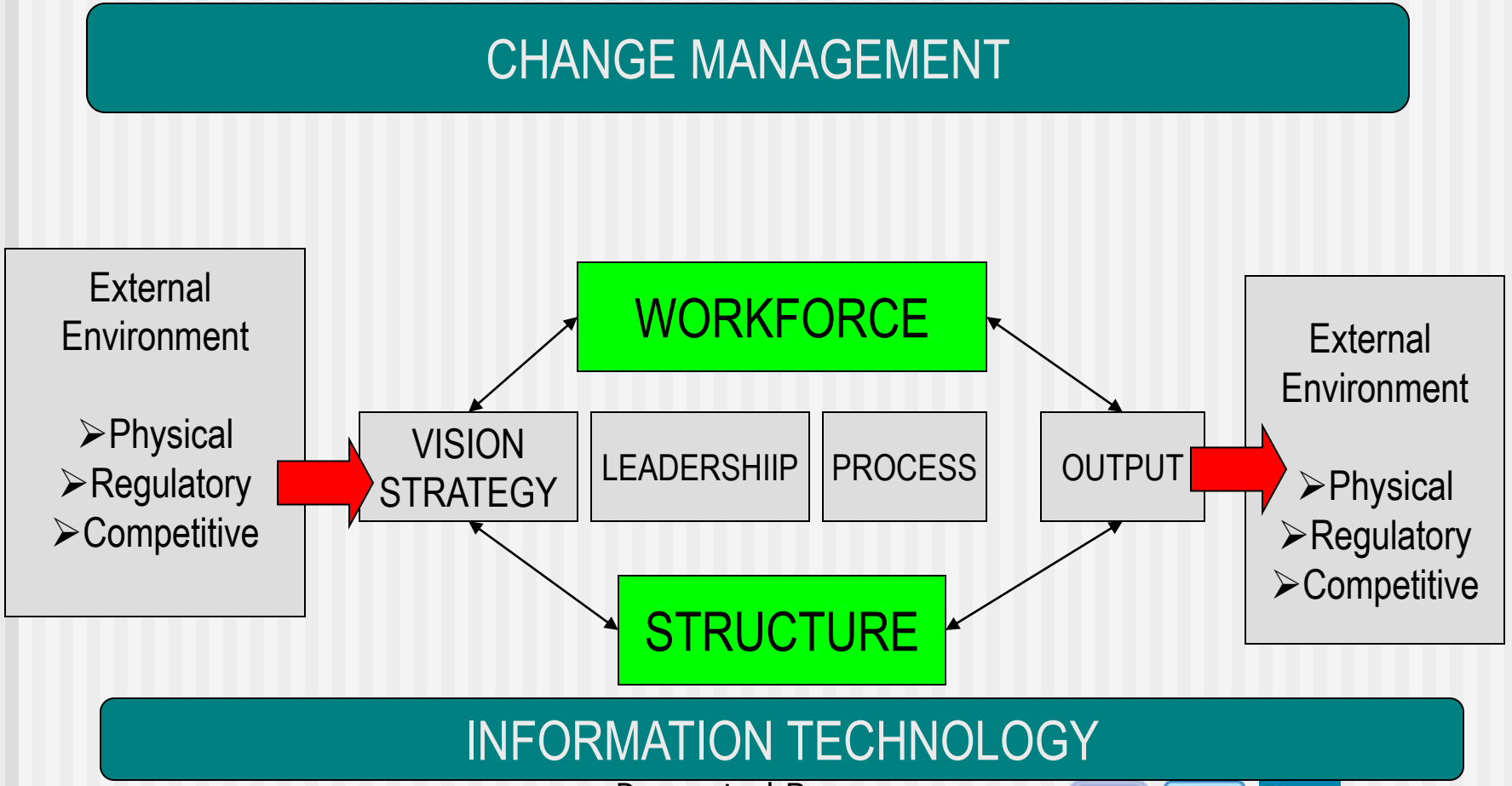
Sample UM/UR RCCP Deliverables

- **Recommendation 1:** Establish KPI and monthly monitoring dashboards for management review.
- **Recommendation 2:** Develop standard operating procedures for UM/UR process, credentialing and authorization of services across the newly organized service delivery structure

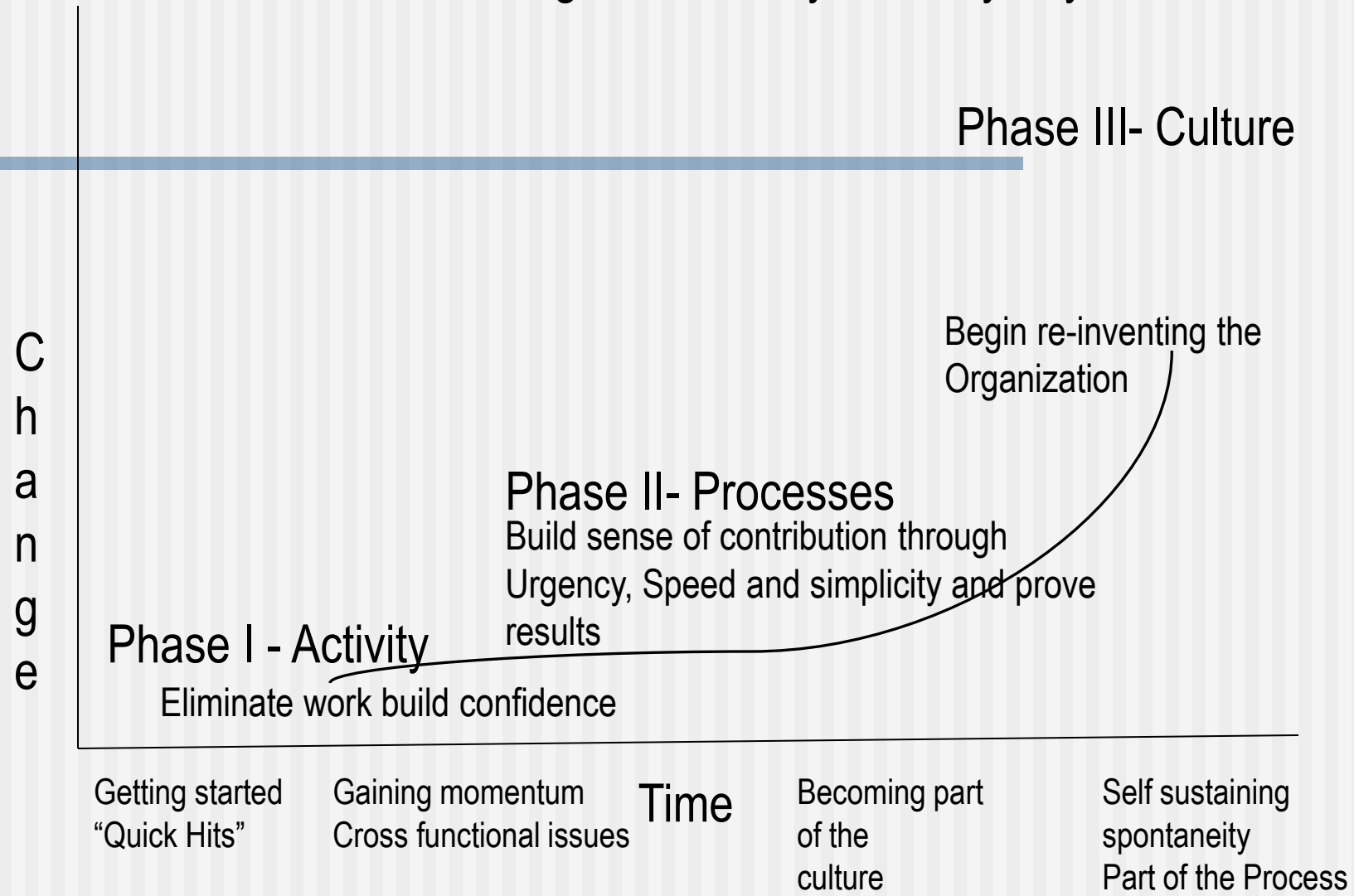
Sample RCM RCCP Deliverables

- **Recommendation 1**: Develop monitoring protocols for monitoring all payors in the service market to establish staff credentialing protocols and availability to add clinical team members on the panel.
- **Recommendation 2**: Develop front desk protocol to confirm insurance and payor information and changes in consumer information.
- **Recommendation 3**: Develop performance standards around billing error rates.
- **Recommendation 4**: Develop standard operating procedures to collect service encounter data as not to lose billing for services.

Change Management



Finding a better way…..every day



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Michael Flora, MTM Services

Strategic Planning in Chaotic Times

Presented By:
Michael Flora, MTM Services

The Nature of our Business

"It is not the strongest of the species that survives; nor the most intelligent that survives. It is the one that is most adaptable to change".

-Charles Darwin

Change in the healthcare industry has always happened.

The GE Six Rules of Strategic Planning

- Control your destiny, or someone else will.
- Face reality as it is, not as you wish it were.
- Be candid with everyone.
- Don’t manage, lead.
- Change before you have to.
- If you don’t have a competitive advantage, don’t compete.

Source: Jack Welch former CEO of General Electric.

- Like the healthcare industry in general, the behavioral healthcare industry is changing rapidly.
- From industry-wide changes due to healthcare reform, regulations, and technology to internal changes related to mergers and acquisition, turnover, upgrades, or even marketing campaigns, change is inevitable, constant, and, at times, unnerving.
- At the same time, change brings with it an opportunity to better serve patients, staff, and stakeholders. Uncertainty and risk accompany change, making it necessary to take charge and lead your team through the process.

W ration Flux

- Generation Flux is less a demographic designation than a psychographic one
- Gen Flux is not age specific. We all can be part of Gen Flux.
- We have not necessarily been trained for a new environment that the most important skill are adaptability, agility and to be able to respond to and operationalize chaos quickly.

Source: This Is Generation Flux: Meet The Pioneers Of The New (And Chaotic) Frontier Of Business, Fast Company January 2013

- Our organizations, and for the most part our funding environment, have not been built for this new environment of constant change and chaos.
- So how do we create order, Standard Operating procedures, Strategic plans if we are responding to the pitching machine set on “high”?

- As leaders and team members we must begin to break the mold.
- From our universities, governments and to our board rooms we have been trained to expect an orderly life.
- Our systems will have to change, or they will feel even more out of date than they do now.

- Today's healthcare leaders must be able to take unprecedented risks, expand and branch out of our comfort zones into a very ambiguous and frenzied environment but at the same time make it appear that all is well.

Change management is a process that requires:

- An understanding of why change is needed – You need to understand the reason and so do your healthcare providers and other stakeholders
- An understanding of the human response to change – Expect resistance, confusion, and excitement
- Ideas, strategies, and skills to plan, implement, and support change – Vision, leadership skills, and an action plan are all essential for managing any type of change

Leading Change

- Guiding your team through these stages requires leadership skills and foresight. Whether your change initiative involves adding a second or third shift to handle a surge of new patients, switching to electronic health records, merging with another facility, or complying with a new regulation, you'll need to manage your healthcare providers, get their buy-in, and prepare the workforce for change.
- An effective transition requires sharing information with your healthcare providers, who will then be tasked with doing the same with their teams.

Why the change is necessary

- Your providers and stakeholders need to know the reason for the change before they can buy into it.

  Why is the change necessary?
  - To stay competitive?
  - To incorporate Recovery Principles into our organizational culture?
  - To serve more consumers ?
  - To support caregivers?
  - To expand?
  - To stay financially solvent?
  - To prevent bad outcomes ?
  - To limit liability?
  - Dig deep to find a compelling reason that goes beyond compliance.
- Anchor your changes in your mission, values and guiding principles.

What the expected results are

- While explaining the reason for the change is a good starting point, your healthcare providers will want to know what results are expected.
- How many new consumers will be served?
- How will the change enhance recovery?
- How many clinical outcomes improved?
- How many individuals will be helped?
- Stress the benefits that can be expected as a result of the change such as less paperwork, more time with patients, fewer audits, and so on.

Why the change is necessary

- Your providers need to know the reason for the change before they can buy into it. Why is the change necessary? To stay competitive? To serve needy patients? To support caregivers? To expand? To stay financially solvent? To prevent bad outcomes ? To limit liability? Dig deep to find a compelling reason that goes beyond compliance.
- Anchor your changes in your mission, values and guiding principles.

How the changes will be implemented

- Explain how and when the change will be rolled out. Discuss the project's path, milestones, and planned training so that your healthcare providers can visualize how it will work.

How the changes will affect them

- How will the change impact each individual? What role will each person be asked to play? What's in it for them? Everyone affected by the change, from the top down, should understand their role – and the potential benefits they can expect.

Overcoming Obstacles

- When dealing with change in a group setting, individuals will likely move through the different stages of change at varying paces. Some will recognize the need for change quickly while others will resist it until there's no other choice left but to adapt. Learn to recognize which where your team is in adjusting to change and tailor your approach to match.

- Healthcare reform and technology are two driving factors affecting change in the behavioral healthcare industry. Whether you're in your own room of contentment, denial, confusion, or renewal, use your leadership and change management skills to move through these rooms and help your entire team do the same.

In the Age of Flux

- We have to be agile as no one plan leads to success
- We must be able to be flexible and in some cases thrive and excel with very ambiguous in formation
- We may not always be able to forecast as we once did or are comfortable with in the past. Tolerating, accepting, and, yes, reveling in paradox is the approach demanded by our chaotic economy.

What will the BIG game changers be in 2014-2015?

Integrated Healthcare "Values": Leadership Needed

Under an Accountable Care Organization Model the ***Value*** of Behavioral Health Services will depend upon our ability to:

1. Be Accessible (Fast Access to all Needed Services)
2. Be Efficient (Provide High quality Services at Lowest Possible Cost)
3. Electronic Health Record capacity to connect with other providers
4. Focus on Episodic Care Needs and Treat to Target Models
5. Ability/Willingness to participate in Bundled/Case Rate Shared Risk Payment Models
6. Produce Outcomes!
   - Engaged Clients using Natural Support Networks
   - Help Clients Self Manage Their Health, Wellness and Recovery
   - Reduce Need for Emergent/ High Cost Services

Essential Health Benefits

The Act defines certain categories of benefits as "Essential Health Benefits." The categories of essential health benefits are:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- **Mental health and substance use disorder services, including behavioral health treatment**
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

Strategic Planning

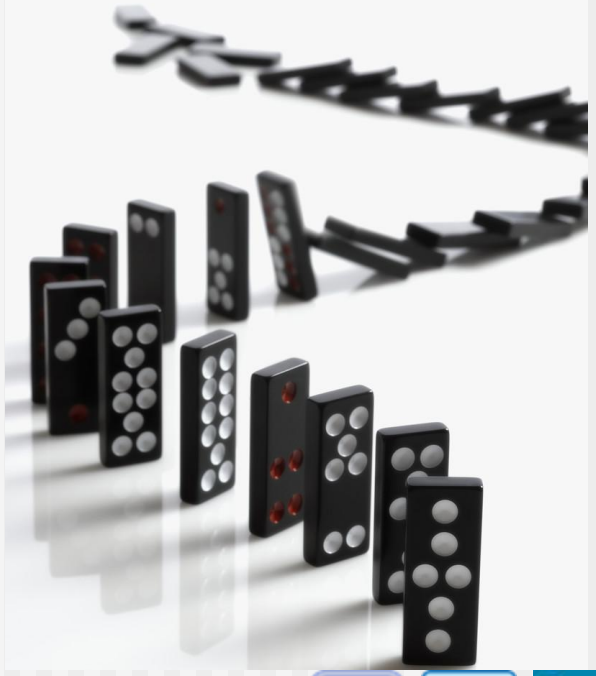
- Step One – Long Range Goals - 2 years
- Step Two- Intermediate Action Objectives to meet the Long Range Goal- 1 Year
- Step Three-45-90 Planning Cycles to meet step two and one.

SAMPLE STRATEGIC BUSINESS PLAN FY-011 – FY-13
GOALS, OBJECTIVES AND STRATEGIES

GOAL #1					
Objective #1					***Priority: 1***
Priority	Strategy	Committee or Individual Responsible	Start Date	Completion Date	Status
1					
2					
3					
4					
5					
6					
7					
Objective #2:					*Priority: 2*
Priority	Strategy	Committee or Individual Responsible	Start Date	Completion Date	Status FY10 Q2
1					
2					
3					
4					
5					
6					
Objective #3:					***Priority: 3***
Priority	Strategy	Committee or Individual Responsible	Start Date	Completion Date	Status FY10 Q2
1					

Break down the larger goals into 45-90 day planning cycles

Be agile and adaptable



Sample 45 day Planning Cycle

MTM SERVICES

MTM Services

45 Day Plan

Issue	Resp	ANNUAL GOAL	5 - DAY BENCHMARK	15 - DAY BENCHMARK	ACTION STEPS	RESULTS
Centralized Scheduling		Have 100% of all clinical schedules active in the system 100% of the time 75% of all cancelled apt within 48 hours must be back filled.	Communicate to staff the directive that all schedules will need to be in the system by October 24, 2012. Confirm Mobile staff schedules to be centrally scheduled. 100% of Mobile staff will have the next three months in the schedule by 10/31/12 had the next three weeks in the system. Office based staff will have 100% of their schedules full 100% of the time Document process/flow for 48 hour confirmation calls and develop information linkage of action and scheduling Revise back fill policy Develop reporting structure for all no	Develop back fill will call policy and procedures Review clients that have not been seen in 30, 60, 90 days. Attain goal. Review barriers and bottlenecks in CQI. Reengineer as needed.	1) Review case loads individually and defines those clients who have not been seen, are due for TX plan updates, etc. 2) Review back fill policy and assure for compliance 3) Clinicians complete back fill list weekly and give to CS. 4) Review logistics of CS	Lack of Clarity for Operational Procedures and protocols Without clarity we are not accountable

Questions and Feedback

- Questions?
- Feedback?
- Next Steps?

Thank you for your time

Contact Information

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