Open Access and Other Top Six Things to Do Now to Prepare for Healthcare Reform

Presented by:

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Healthcare Reform Context:

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/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

Our Value Enhancing Change Management Focus Areas for This Workshop

1. Open/Same Day Access to Treatment Capacity
2. Assessing Current Caseloads and Implementing Internal Levels of Care/Benefit Package Design Models
3. Centralized Scheduling Implementation including Integrating Scheduling Rate Templates and Cancellation Back Fill Protocols including Implementing No Show/Cancellation Management Principles including an Engagement Specialist to Provide Qualitative Support
4. Cost Based Key Performance Indicators for all Staff
5. Implementing Collaborative Concurrent Documentation Model
6. Designing and Implementing Internal Utilization Management Processes.

Key Qualitative Based No Show Management Question

- Are we treating the illness we have professionally diagnosed that each client has?
- OR
- Are we carrying inactive active caseload members?… (i.e., Clinical Protocols that require Therapist to Carry Chart for Physicians)

Sample Definition of Treatment

- Define a definition of “treatment” and therefore what is not treatment:

  Sample Definition:

  “***Behavioral health therapeutic interventions provided by licensed or trained/certified staff either face to face or by payer recognized telephonic/ Telepsychiatry processes that address assessed needs in the areas of symptoms, behaviors, functional deficits, and other deficits/ barriers directly related to or resulting from the diagnosed behavioral health disorder.***”

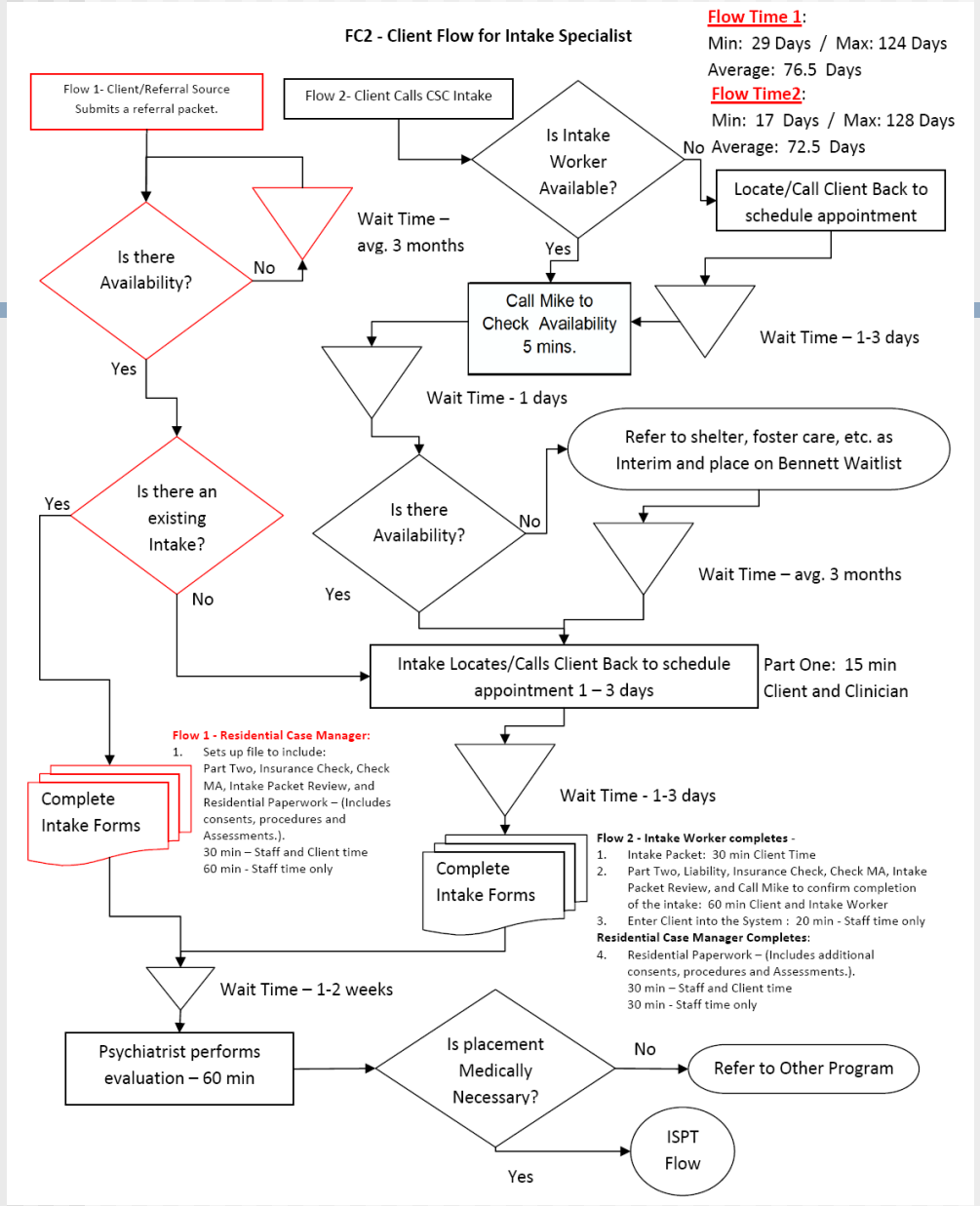
What Treatment is Not…

Carrying cases in order to:

- Provide treatment planning and other documentation support to "medication only" clients
- Providing pseudo services to unengaged clients to support maintenance of benefits or legal conditions
- Avoid closing cases

Accessibility to TREATMENT – A CORE Issue

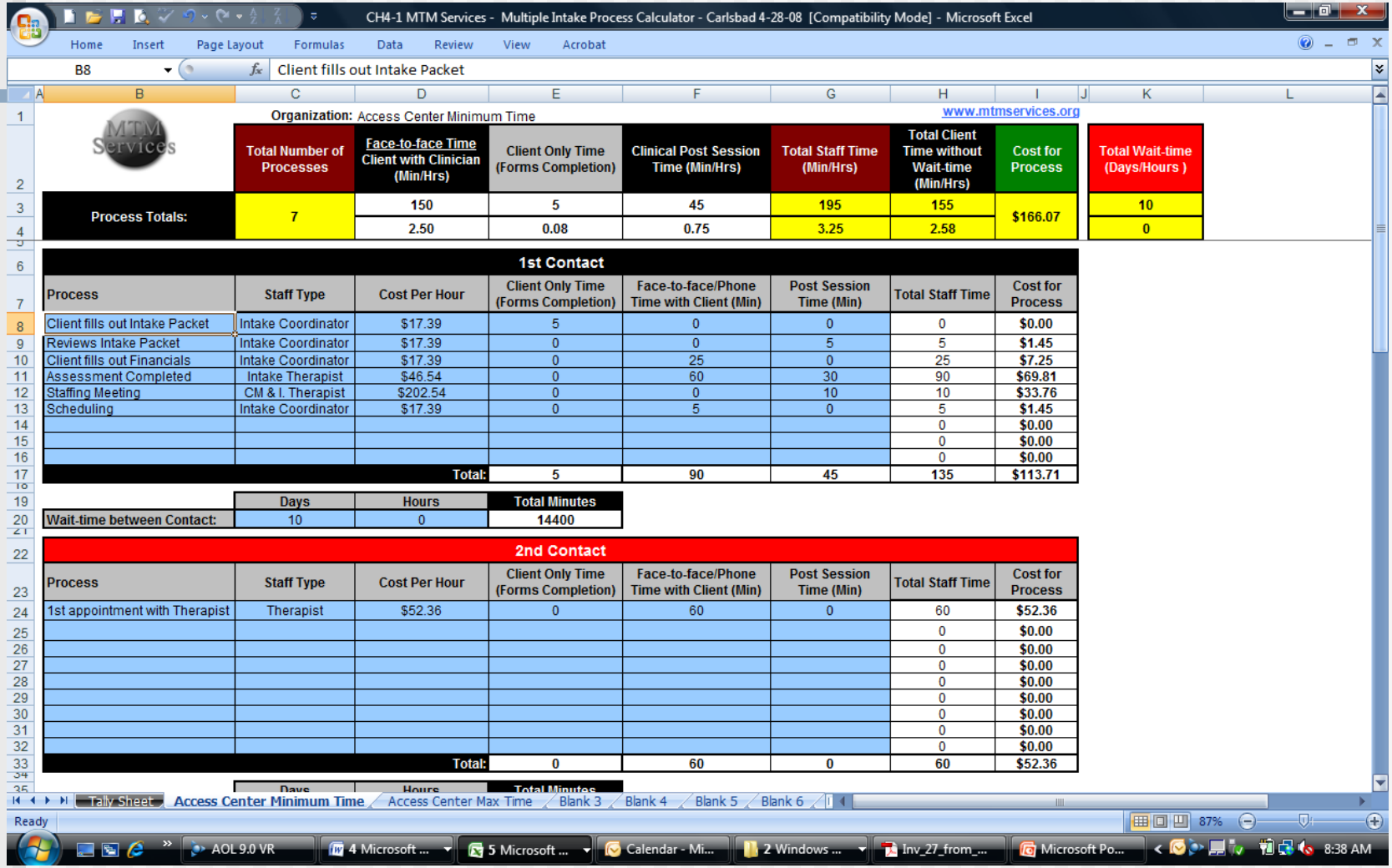
- Three Levels of Challenge:
  1. Primary: Time required from the initial Call/Walk In for Routine Help to the face to face Diagnostic Assessment/Intake
  2. Secondary: Time required from the initial Face to Face Diagnostic Assessment to the appointment with Therapist to complete treatment planning
  3. Tertiary: Time required from the treatment planning appointment to initial appointment with MD/APRN



Measurement Tools/ Processes

First Contact to Treatment Plan Completion Process Flows Created To Identify Redundancy and Wait Times

Measurement Tools/Processes



CH4-1 MTM Services - Multiple Intake Process Calculator - Carlsbad 4-28-08 [Compatibility Mode] - Microsoft Excel

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

B8: Client fills out Intake Packet

Organization: Access Center Minimum Time — www.mtmservices.org

	Total Number of Processes	Face-to-face Time Client with Clinician (Min/Hrs)	Client Only Time (Forms Completion)	Clinical Post Session Time (Min/Hrs)	Total Staff Time (Min/Hrs)	Total Client Time without Wait-time (Min/Hrs)	Cost for Process	Total Wait-time (Days/Hours)
Process Totals:	7	150	5	45	195	155	$166.07	10
		2.50	0.08	0.75	3.25	2.58		0

1st Contact

Process	Staff Type	Cost Per Hour	Client Only Time (Forms Completion)	Face-to-face/Phone Time with Client (Min)	Post Session Time (Min)	Total Staff Time	Cost for Process
Client fills out Intake Packet	Intake Coordinator	$17.39	5	0	0	0	$0.00
Reviews Intake Packet	Intake Coordinator	$17.39	0	0	5	5	$1.45
Client fills out Financials	Intake Coordinator	$17.39	0	25	0	25	$7.25
Assessment Completed	Intake Therapist	$46.54	0	60	30	90	$69.81
Staffing Meeting	CM & I. Therapist	$202.54	0	0	10	10	$33.76
Scheduling	Intake Coordinator	$17.39	0	5	0	5	$1.45
						0	$0.00
						0	$0.00
						0	$0.00
		Total:	5	90	45	135	$113.71

	Days	Hours	Total Minutes
Wait-time between Contact:	10	0	14400

2nd Contact

Process	Staff Type	Cost Per Hour	Client Only Time (Forms Completion)	Face-to-face/Phone Time with Client (Min)	Post Session Time (Min)	Total Staff Time	Cost for Process
1st appointment with Therapist	Therapist	$52.36	0	60	0	60	$52.36
						0	$0.00
						0	$0.00
						0	$0.00
						0	$0.00
						0	$0.00
						0	$0.00
						0	$0.00
						0	$0.00
		Total:	0	60	0	60	$52.36

Days | Hours | Total Minutes

Tally Sheet | Access Center Minimum Time | Access Center Max Time | Blank 3 | Blank 4 | Blank 5 | Blank 6

Ready — 87% — 8:38 AM

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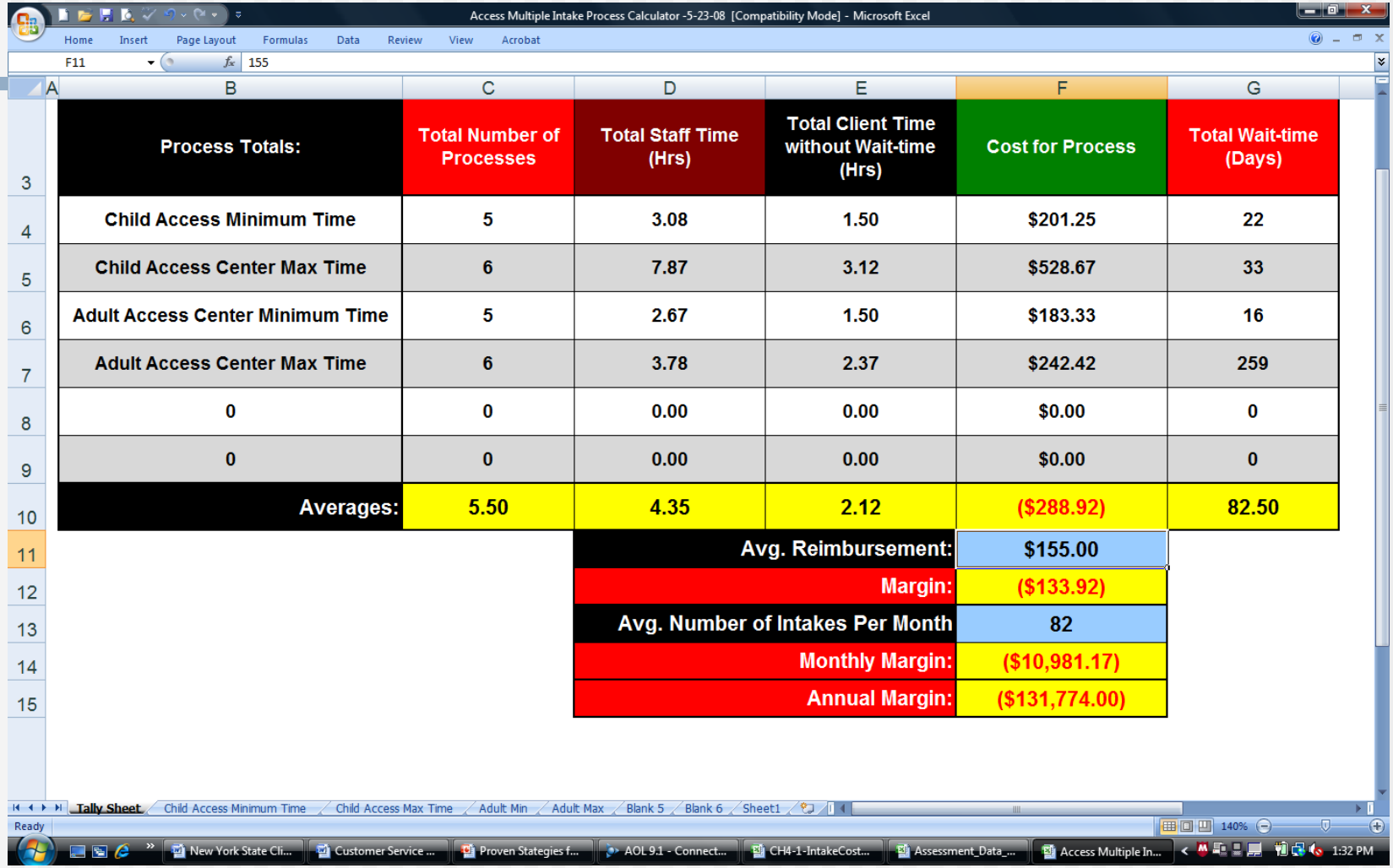
Measurement Tools/Processes



Process Totals:	Total Number of Processes	Total Staff Time (Hrs)	Total Client Time without Wait-time (Hrs)	Cost for Process	Total Wait-time (Days)
Child Access Minimum Time	5	3.08	1.50	$201.25	22
Child Access Center Max Time	6	7.87	3.12	$528.67	33
Adult Access Center Minimum Time	5	2.67	1.50	$183.33	16
Adult Access Center Max Time	6	3.78	2.37	$242.42	259
0	0	0.00	0.00	$0.00	0
0	0	0.00	0.00	$0.00	0
Averages:	5.50	4.35	2.12	($288.92)	82.50

Avg. Reimbursement:	$155.00
Margin:	($133.92)
Avg. Number of Intakes Per Month	82
Monthly Margin:	($10,981.17)
Annual Margin:	($131,774.00)

Data Mapping Sample

Desired Destination	Form Field	Compliance Requirements	Adult OP/PEC	Child OP	Methadone	WORD I&II	Drug Free (SW-UCC)	Family Preservation	Child FFT	Adult TCM	Child TCM	Family Based	YSC	Ct Evals	Mobile
DEL	3rd Party Relationship		REF												
CA	Abuse (Physical/Verbal/Sexual)			CIA, CIA											
CA	Abuse (victim, witness, perpetrator)		CBE	CIA											
CA	Academic Performance			CIA											
CA	Accepts Referral (appt. date/time, unit, w/whom, location)			IRF											
TP	Action Steps		TP												
CA	Acts of Violence (experienced/witnessed)			CIA											
CA	Adaptive Strengths		CBE, CBR												
BO	Address change		AFS	CFS											
PI	Address, City State Zip		AIC, AFS, AUD, NBI, B, GC	CIC,CIS,CFS, CIF, NBI, B, GC, PER, CHR, CCM	NBI, B	NBI, B	NBI, B	NBI, B	NBI, B, GC	NBI, B, GC	NBI, B, GC	NBI, B, GC	NBI, B, GC	NBI, B, GC	NBI, B, FE
DS	Aftercare Plan for Medications		AP												
DS	Aftercare Recommendations		DS												
PI	Age		AIC	CIC, CIS, FSS, PER, CBCL, CYSR											
PI	Agency (Referral)		AIC	CIC											
BO	Agency Name			CST, CST											
CA	Aggression hx/ER/explain			CIF											
CA	Aggression to Animals			CIA											
CA	Aggression to Others			CIA											
CA	Aggression to Self			CIA											
TP	Agree/Do not agree		TP												
PI	Alias Name		NBI	NBI	NBI	NBI	NBI	NBI	NBI	NBI	NBI	NBI	NBI	NBI	NBI

Data Mapping to Reduce Access Time

- **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**

Data Mapping Results – Victor Treatment Centers Operating in 17 Counties in California

	Elements	Percentages
Total Starting Data Elements:	1331	
Auto Populating Elements:	59	4.43%
Duplicated Data Elements:	482	36.21%
Deleted Data Elements:	92	6.91%
Removed By John:	69	5.18%
Total:	702	52.74%
Remaining Unique Items:	629	47.26%

Standardize Service Flow Processes

- GAIT Consortium Case Study:
  1. Six Georgia Community Service Boards
  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

National Access Redesign Grant Outcomes

	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	

Total Annual Savings:

- Produced an average annual savings of **$199,989.43** per CBHO
- **34%** reduction in staff time
- **18%** reduction in the client time
- Based on 28 grant CBHOs from Florida (7), Ohio (12), & Wyoming (9) - total annual savings equals **$5,599,703.99**.

National Access and Engagement Grant Outcomes

	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:	4.56	3.75	2.74	(276.84)	51.96
New Process Averages:	4.00	2.65	2.28	(167.77)	20.82
Savings:	0.56	1.10	0.46	$109.07	31.15
Change %:	12%	29%	17%	39%	60%

Avg. Number of Intakes Per Month	2,430
Difference Intake Volume:	460
Intake Volume Change %:	26%
Monthly Savings:	$154,510
Annual Savings:	$1,854,119.72

<u>Total Annual Savings</u>:

- Produced an average annual savings of **$231,764** per CBHO – 39% Reduction in costs
- **29% reduction** in staff time
- **17% reduction** in the client time
- **60% reduction** in wait time
- **26% increase** in Intake Volume Provided
- Based on eight first year A&E Centers from seven states - total annual savings equals **$1,854,119**.

Intake/Diagnostic Assessment Model Can Contribute to No Shows/Cancellation Rates

- Wait time from initial contact and Intake/Diagnostic Assessment date has impact which is usually exacerbated by long intake processes and high no show/ cancellation rates for intakes
- Multiple face-to-face Intakes/ Diagnostic Assessment sessions exacerbate No Show/Cancellation Levels
- When we ask questions, the clients indicated they are helping US, when we listen, they indicate we are helping THEM

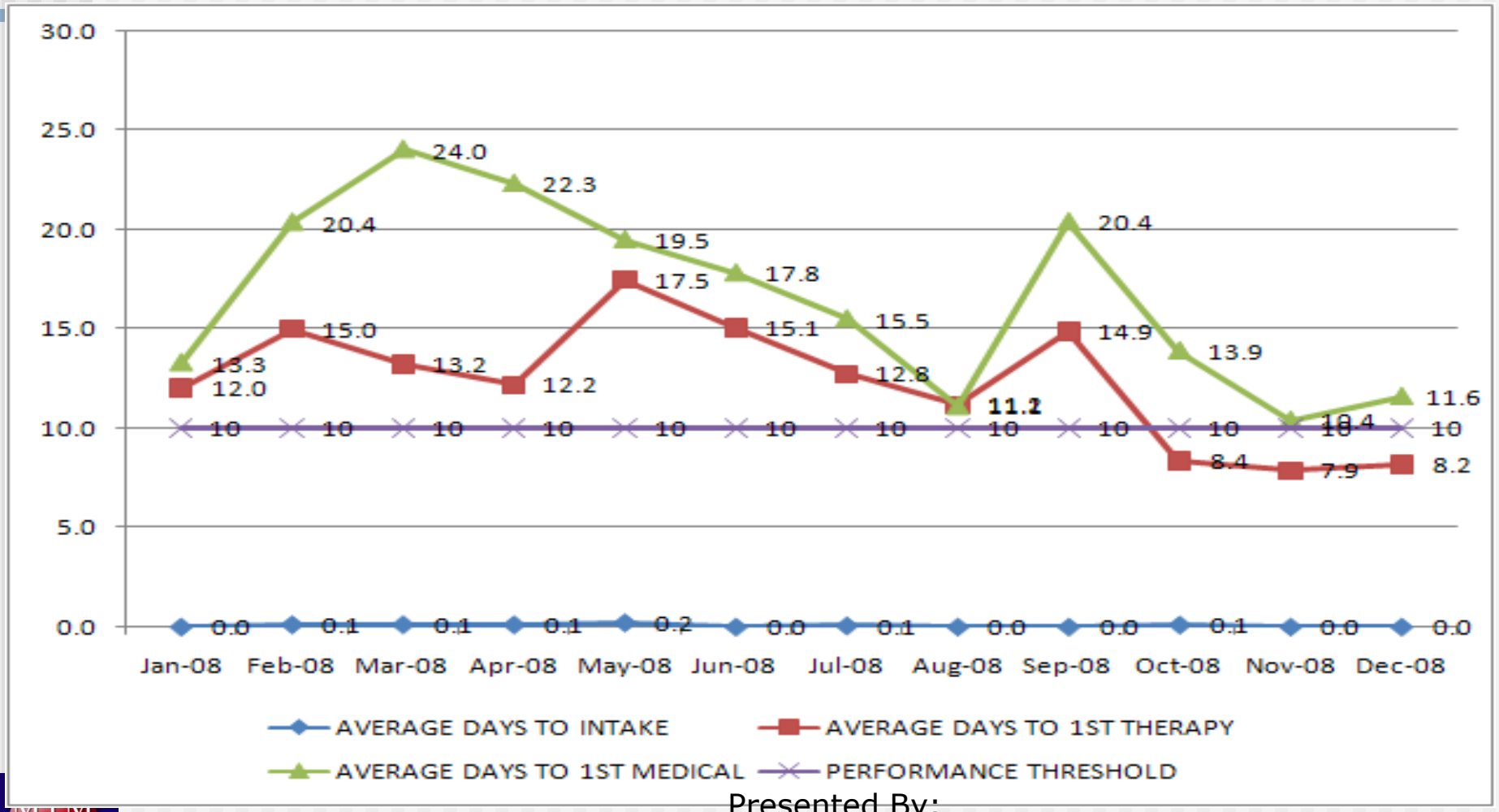
Access and Engagement and Access Redesign Initiatives **First Call to Assessment** Kept vs. No Show/Cancelled Trend by Days Wait from First Call to Appointment

Open Access

- Client/consumer centered
- Accountability management
- Focused on case completion
- Increases capacity
- Diversifies funding streams
- Lays foundation for Episodes of Care
- Relieves the symptoms of a lethargic practice
  - High No Shows
  - Low Productivity

Carlsbad Mental Health Center: Days to Access Services

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



Open Scheduling Same Day Access Model – Consumer Engagement Standards based on Carlsbad MHC

1. Open Scheduling Same Day Access - 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)
2. Initial diagnosis determined
3. Level of Care and Benefit Design Identified with consumer
4. Initial treatment plan Developed based on Benefit Design Package
   - 2nd clinical appointment for TREATMENT within 8 days of Initial Intake
   - 1st medical appointment within 10 days of Initial Intake

Access to Care Timeliness Case Study – Carlsbad Mental Health Center, Carlsbad, NM

- Carlsbad MHC produced data that demonstrate the following about the relationship between initial contact for help, Open access, 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**.

Refocusing on Treatment

- Develop internal level of care expectations based on assessed needs and client choice (benefit packages)
- Review caseloads to determine if beneficial treatment levels are being provided
- Employ person centered/driven engagement strategies to engage/re-engage individuals with legitimate needs
- Address caseloads accordingly to ensure that your resources are maximized to provide treatment!

Internal Benefit Design to Support Engagement and Create A Capacity for New Clients to Receive Treatment

- Purpose is to establish Group Practice Clinical Guidelines to Facilitate Integration of all services into one service plan
- Provide an awareness to consumers at entry to services the types of services and duration of services the practice has found most helpful to meet their treatment needs so that the consumer will know and the staff will know what services are needed to complete that level of care
- Moves consumers to a more recovery/ resiliency based service planning and service delivery approach
- Facilitates being able to use centralized scheduling using the actual service plan of each consumer

Engagement Based Same Day Access/Treatment Plan Model Using Benefit Design/Level of Care Criteria

Level of Functioning 3:	Service	Amount	Add-Ons
Indicators of Level: GAF 41 – 50 **and** Moderate Levels in at least 5 of the 10 Client/Family/Guardian Expression of Needs/Preferences Recovery Indicators **Recommended Length of Services:** • **6 to 18 Months** **(Descriptors)** ▪ Prior history of hospitalizations within past 2 years ▪ No imminent dangerousness to self or others ▪ Moderate structure and supports in his/her life ▪ Everyday functioning is impaired ▪ Potential for compliance fair to good ▪ However, the person is tenuous and feels unstable because of situational loss or an occurrence ▪ No crisis management needed **Discharge Criteria:** ▪ Stable on meds ▪ Self administers meds ▪ Means of obtaining meds when discharged ▪ Community integration ▪ Community support ▪ No substance abuse ▪ Medical needs addressed ▪ Minimal symptoms ▪ Client is goal directed ▪ Employed or otherwise consistently engaged (volunteer, etc.) ▪ Client has a good understanding of illness ▪ Family or significant other understand the illness	**1. Diagnosis/Assessment** **2. Crisis Interventions** **3. Partial Hospitalization** **4. Counseling/Psychotherapy**: **5. Community Support Program (CSP)** ▪ Ongoing assessment of needs ▪ Assistance in achieving personal independence in managing basic needs as identified by the individual and/or parent ▪ Facilitation of further development of daily living skills, if identified by the individual and/or parent or guardian ▪ Coordination of the ISP, Including: a. Services identified in the ISP; b. assistance with accessing natural support systems in the community; and c. Linkages to formal community services/systems ▪ Symptom monitoring ▪ Coordination and/or assistance in crisis management and stabilization as needed ▪ Advocacy and outreach ▪ As appropriate to the care provided to individuals, and when, appropriate, to the family, education and training specific to the individual's assessed needs, abilities and readiness to learn ▪ Mental health interventions that address symptoms, behaviors, thought processes, etc., that assist in an individual in eliminating barriers to seeking or maintaining education and employment ▪ Activities that increase the individual's capacity to positively impact his/her own environment **6. Medication/Somatic Services**	1. Maximum of 2 contacts per episode of need 2. As needed, no maximum 3. Up to 20 days per episode of need 4. Up to 15 sessions per episode of need 5. Up to a maximum of 4 hr/wk per episode of need 6. Psychiatric Evaluation completed at first contact within 4 weeks of admission. Minimum of 1 contact a month with MD, RN and/or other qualified provider if medications are required	▪ Supported Employment - at least 1 visit per month • Consumer operated services • Peer support • Social and recreational support • Hotline Services • Mental Health Education and Referral

KPIs Are Key Tools for Managers/Leaders:

Use and measure key performance indicators (KPI) for all staff to ensure the movement to a true group practice model

Sample Key Performance Indicators

1. Performance Standards for all staff – clinical, support and admin
2. Access to Treatment Measurement per day, week and month
3. Outpatient Admissions per day – month
4. Number of client's Served vs. active caseloads
5. **Share Sample Performance Standards**

Community Behavioral Healthcare Cost-Efficiency Performance Indicators

Report Month: July 1999

Please utilize this form to calculate the cost efficiency performance indicators for Day/Night Programs, Residential Services and Detox/Crisis Stabilization Services.

Crisis Stabilization/Detox Services

Efficiency Rating*: _____

Staff to Client Ratio Standard	Actual Staff to Client Ratio	Net Diff Client to Staff	Total Beds	Total Bed Days Avail.	Actual Bed Days Utilized	Percent Beds Utilized	Target Bed Utilization Rate	Over (Under) Target	Mnth Drug Costs	Over/ Under Drug Budget	Mnth Repair Costs	Over/ Under Repair Budget	Mnth Food Costs	Over/ Under Food Budget	YTD Total Salary and Fringes	YTD Total Admin/ Overhead
1:7	1:6	+1	24	720	600	83%	90%	(7%)								

Total Month Revenues	Total Month Expenses	Net Month R/E	Mnth R/E %	Total YTD Revenues	Total YTD Expenses	Net YTD R/E	YTD R/E %

Residential Programs

Efficiency Rating*: _____

Staff to Client Ratio Standard	Actual Staff to Client Ratio	Net Diff Client to Staff	Total Beds	Total Bed Days Avail	Actual Bed Days Utilized	Percent Beds Utilized	Target Bed Utilization Rate	Over (Under) Target	Mnth Rent/ Mort. Costs	Over/ Under Budget	Mnth Repair Costs	Over/ Under Repair Budget	Mnth Food Costs	Over/ Under Food Budget	YTD Total Salary and Fringes	YTD Total Admin/ Overhead
1:6	1:4	+2	6	180	120	68%	90%	(22%)								

Total Month Revenues	Total Month Expenses	Net Month R/E	Mnth R/E %	Total YTD Revenues	Total YTD Expenses	Net YTD R/E	YTD R/E %

Day/Night Programs

Efficiency Rating*: _____

Staff to Client Ratio Standard	Actual Staff to Client Ratio	Net Diff Client to Staff	Total Per Day Cap.	Total Client Capac. Avail.	Actual Client Capac. Utilized	Percent Capac. Utilized	Target Capacity Utilization Rate	Over (Under) Target	Mnth Trans. Costs	Over/Under Budget	Mnth Repair Costs	Over/ Under Repair Budget	Total # FTEs	YTD Total Salary and Fringes	YTD Total Admin/ Overhead
1:4	1:3	+1	25	537.5	400	73%	90%	(17%)							

Total Month Revenues	Total Month Expenses	Net Month R/E	Mnth R/E %	Total YTD Revenues	Total YTD Expenses	Net YTD R/E	YTD R/E %

* Efficiency Scale: **"A" Rating** = Met or exceeded 95% of all indicators; **"B" Rating** = Met of Exceeded 85% of all indicators; **"C" Rating** = Met or Exceeded 75% of all indicators; and **"D" Rating** = Met or exceeded 70% of all indicators

Title	**REVENUE STANDARD**
Standard	Employees will maintain weekly, monthly, quarterly and annual productivity requirements as published under the productivity policy.
Source	Productivity Policy. Fiscal Reports.
Compliance Rating	90% - 100% with emphasis on demonstrated efforts to obtain 100% of the goal
Solution Plan	Failure to comply with productivity requirements at the end of the month will require a meeting with the direct supervisor to develop a correction plan to be implemented immediately.

Title	**TIMELY PAPERWORK STANDARD**
Standard	In addition to the regulatory practice which already exists in submission of all documentation relating to clients counseling, effective Monday, June 16, 2003 all staff will provide progress notes no later than 5:00 p.m. on the day following the date of service.
Source	
Compliance Rating	100% Compliance
Solution Plan	Meet with supervisor within 24 hours of lack of compliance to develop a correction plan that will take effect immediately.

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Hours per Day	Work Days PY
8	260
BH Standard	**No Show %**
60.0%	30%

MTM Services

Basic Cost Based Productivity Calculator

Change Only The Blue Cells

Available Hours Per Year	2,080		
Annual Leave / PTO	256	32.00	Days Per Year
Personal / Holidays / Sick	0	0.00	
Charting/Paperwork	248	31.00	
Training/Staffings	120	15.00	
Travel Time	40	5.00	
Other Non-Billable Activity	168	21.00	

Non-Billable Hours:	832	104.00	Non-Billable Days	4.80	Non-Billable Months
Billable Hours:	1,248	156.00	Billable Days	7.20	Billable Months

Salary	FB%	Salary + FB	Base Cost PH	Overhead %	Cost Per Hour	Avg. Revenue	Margin
$40,842.00	30%	$53,094.60	$42.54	43%	$60.62	$62.00	$1.38

Staff FTE %:	Yearly BH Production	Quarterly BH Production	Monthly BH Production	Daily BH Production		No Show Percentage Driven Scheduling Rate	
				All Days	Minus PTO	All Days	Minus PTO
100.0%	1,248	312	104.0	4.8	5.5	6.9	7.8
			Hours Weekly	24.0	27.4	34.3	39.1

Clinical BH Standard - Lovegove | Clinical BH Standard - Zavala | Overhead Calculator | Hourly Rev Calculator

Hours per Day			Staff Type		
8			Therapist		
BH Standard					
60.0%					

MTM Services

Case Load Calculator - Detail

Change Only The Blue Cells

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Available Hours Per Year	2,080		
Annual Leave/PTO	96	12.00	Days Per Year
Personal/Holidays	88	11.00	
Sick Leave	96	12.00	
Training/Staffings	0	0.00	
Travel	160	20.00	
Charting/Paperwork	392	49.00	

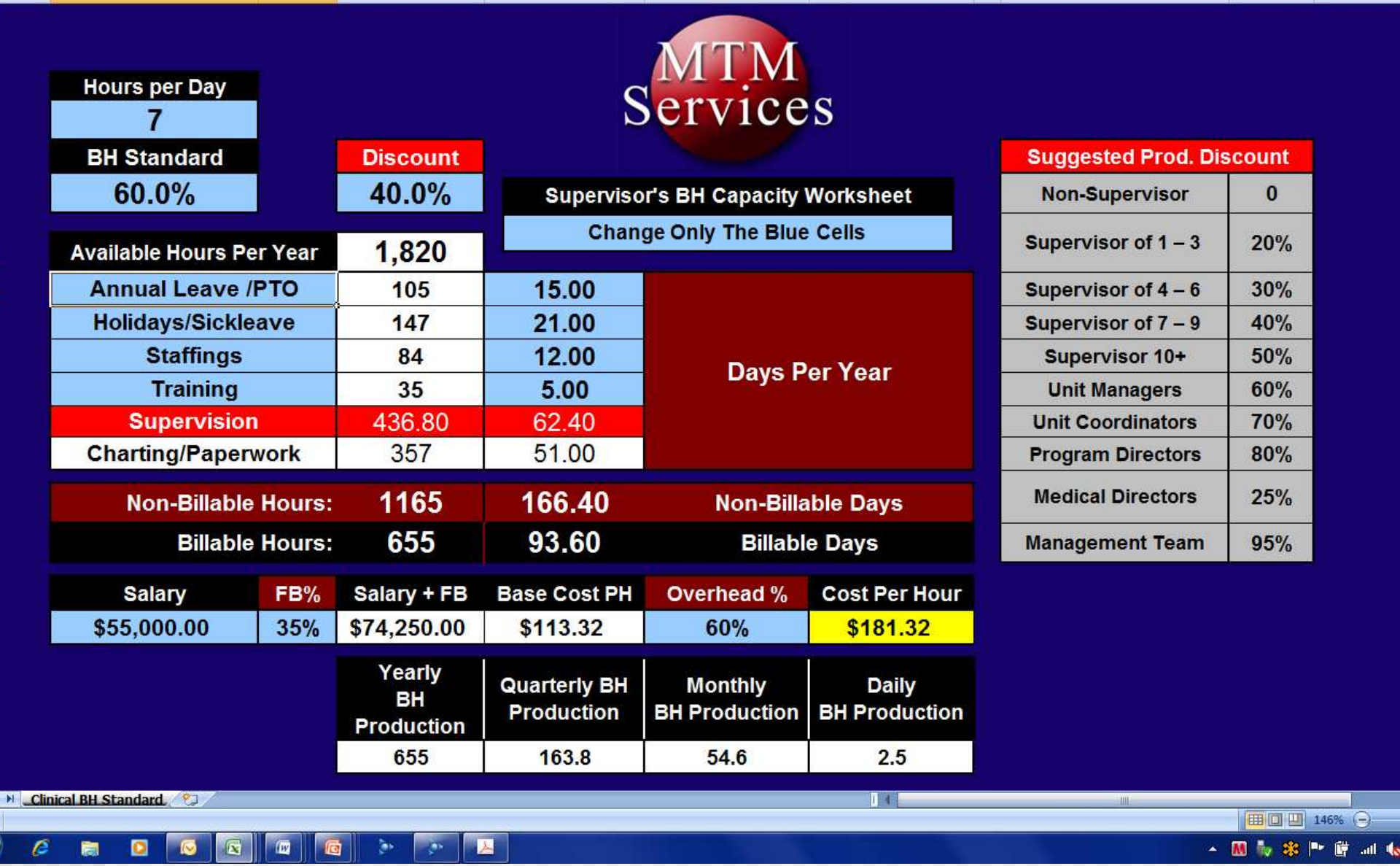
Non-Billable Hours:	832	104.00	Non-Billable Days	4.80	Non-Billable Months
Billable Hours:	1,248	156.00	Billable Days	7.20	Billable Months

% of BH Standard/FTE %	Billable Hour Standard Per Month	Minus Other Billable Time	Net Billable Hours Per Month for Direct Services	Total Hours Required	Available Hours vs. Hours Needed
100%	104	0	104	104	0

Salary	Fringe Benefit %	Salary + Fringe	Overhead %	Salary + FB + OH	Cost Per Billable Hour
$45,000.00	29%	$58,050.00	50%	$87,075.00	$69.77

#	Leve of Care (LOCUS/CAFAS SCORE)	# of Clients in Each Level	Time Parameters per Month (Hours) Per Client	# of Contacts Per Month	% of Caseload	Total Hours Required Per Month	Average Contacts Per Client
1	Level One	28	0.5	1	41%	14	1.88
2	Level Two	20	1.5	2	29%	30	Average Hours Per Case Per Month
3	Level Three	20	3	3	29%	60	
4	Level Four	0	4	4		0	1.53
5						0	Cost Per Case Per Month
6						0	$106.71
	Total Cases:	68		Must Equal 100%	100%	104	

Caseload Detail



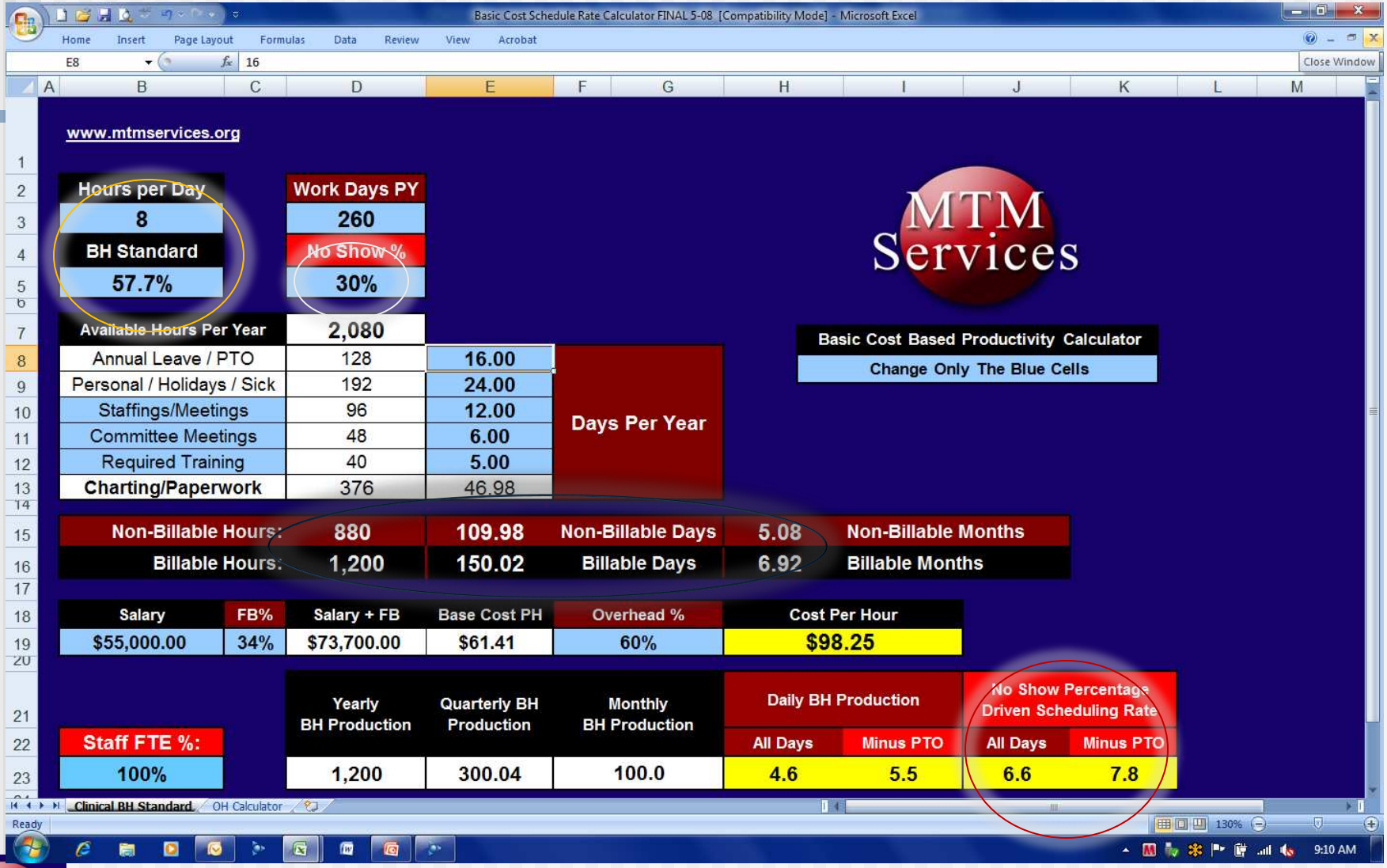
Supervisors' Performance Standards

National No Show/ Cancel Measures

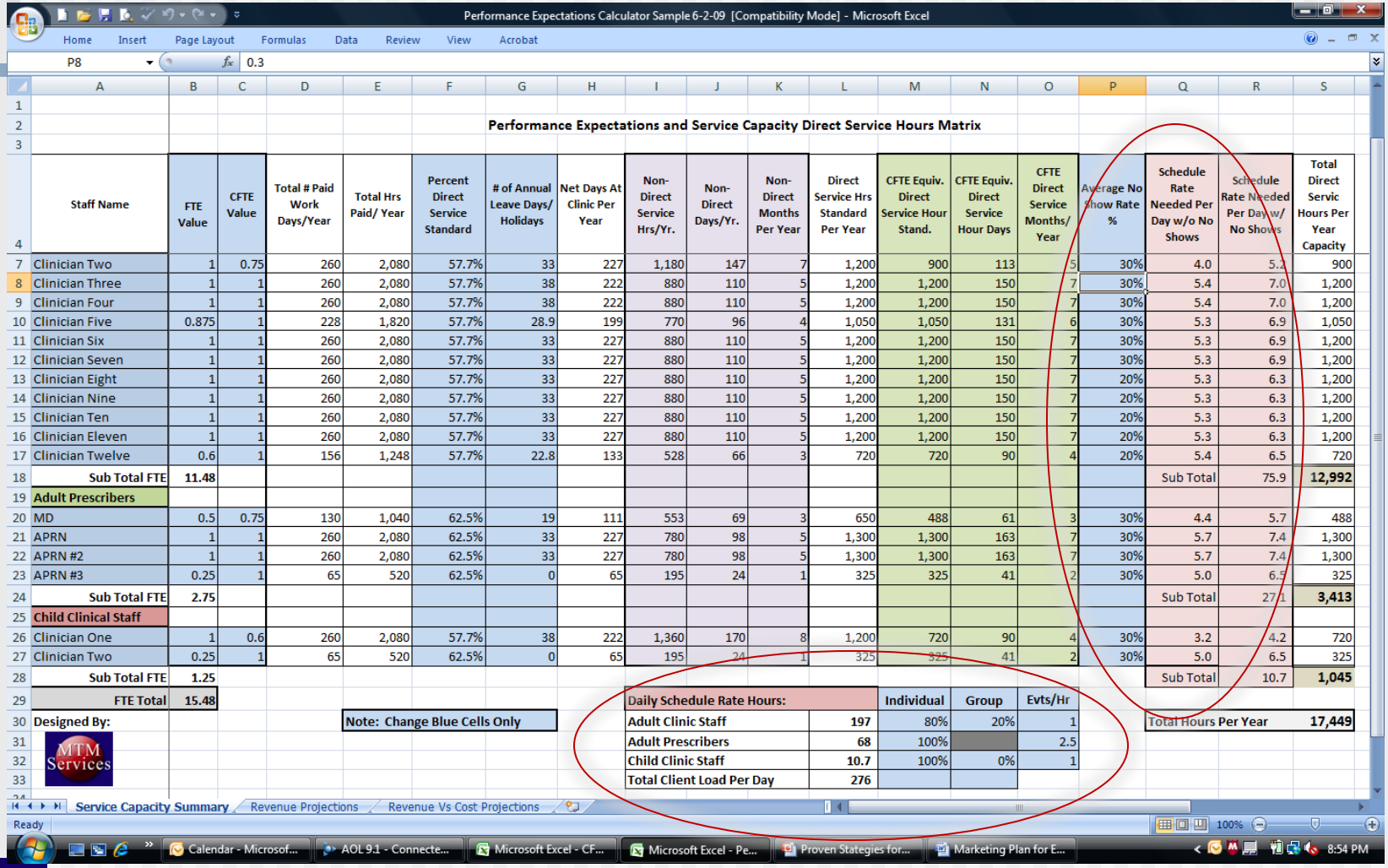
National Standard for Appointment Types:

- Appointment Kept
- No Show (less than 24 - 48 hrs Notice)
- Appointment Canceled by Client (48 - 24 hrs or more notice)
- Appointment Canceled by Staff

Individual Scheduling Template and Productivity Calculator



Clinic Level Scheduling Template and Productivity Calculator



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Available Annual Hours	2,080		
Annual Leave Hours	264	33.00	Days Per Year
Holidays Hours	48	6.00	
Sick Leave Hours	0	0.00	
Training/Staffings	24	3.00	
Travel Hours	0	0.00	
Non-Direct Activity	184	23.00	
Non-Direct Hours:	520	65.00	Non-Direct Days
Direct Service Hours:	1,560	195.00	Direct Srvc Days

Staff Type	
Cent. Scheduler	
Hours per Day	Direct Standard
8	75.0%

MTM Services

Case Load Calculator - Detail

Change Only The Blue Cells

% of BH Standard	Hours Available	Yearly Call Load	Monthly Call Load	Daily Call Load	Hourly Call Load
100%	1560	26743	2229	103	17

Salary	Fringe Benefit %	Salary + Fringe	Overhead %	Salary + FB + OH	Cost Per Activity
$34,000.00	25%	$42,500.00	40%	$59,500.00	$2.22

Staff Responsibilities	Call Length (Min.)	% of Calls	Average Call Length
Schedule Maintenance	1	10%	3.5
Rescheduling Calls	3	30%	
Reminder Calls	4	50%	
Faxing	5	5%	
Filing	5	5%	
Level 6			
Level 7			

Caseload Basic | Caseload Detail

ct destination and press ENTER or choose Paste

Community Based Staff Scheduling

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:
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:
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:
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Loc:	Loc:	Loc:	Loc:	Loc:	Loc:	Loc:
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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:
Start:	Start:	Start:	Start:	Start:	Start:	Start:
Stop:	Stop:	Stop:	Stop:	Stop:	Stop:	Stop:
Units:	Units:	Units:	Units:	Units:	Units:	Units:

Centralized Scheduling Standing Appointment Standards

- 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

STANDING APPOINTMENT SCHEDULE

NAME _____ PROGRAM _____ MONTH _____

TIME	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
8-8:30 am					
8:30-9 am					
9-9:30 am					
9:30-10 am					
10-10:30 am					
10:30-11 am					
11-11:30 am					
11:30-noon					
12-12:30 pm					
12:30-1 pm					
1-1:30 pm					
1:30-2 pm					
2-2:30 pm					
2:30-3 pm					
3-3:30 pm					
3:30-4 pm					
4-4:30 pm					
4:30-5 pm					
5-5:30 pm					
5:30-6 pm					
6-6:30 pm					
6:30-7 pm					
7-7:30 pm					
7:30-8 pm					
8-8:30 pm					
8:30-9 pm					

SPECIAL NOTATIONS:

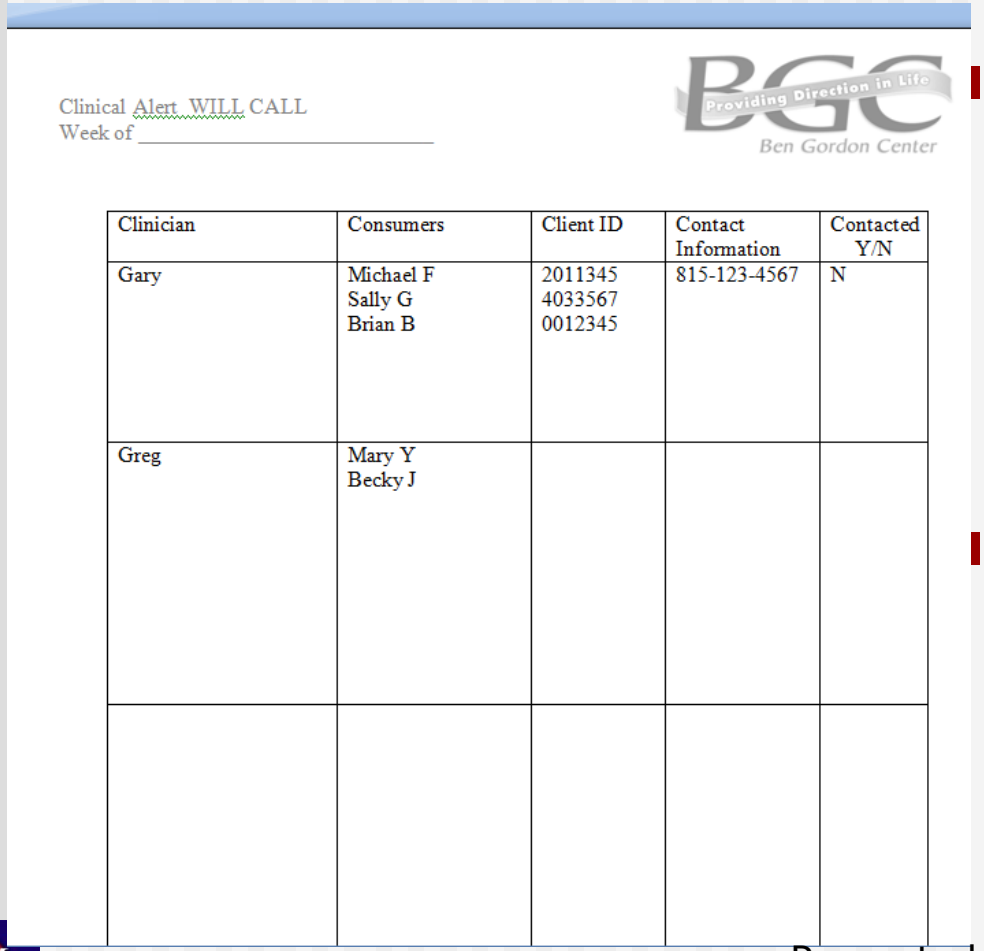
Components of Centralized Schedule Management

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

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



Clinical Alert WILL CALL
Week of _____

Providing Direction in Life
Ben Gordon Center

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			

- 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

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%

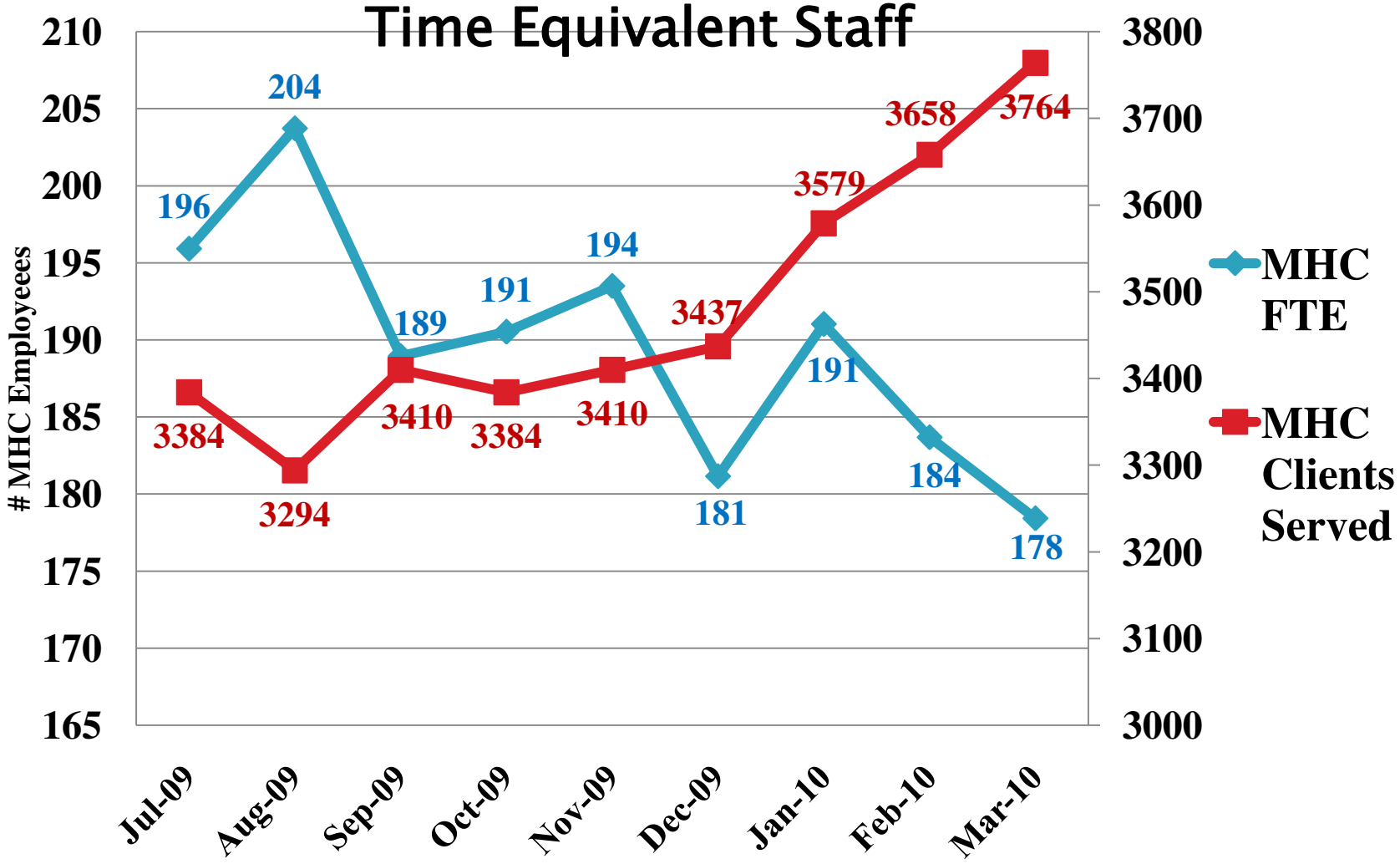
Staff Name: Brad G.

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	

Colorado West Persons Served per Full Time Equivalent Staff



Qualitative Dilemma With Quantitative Based No Show Policies

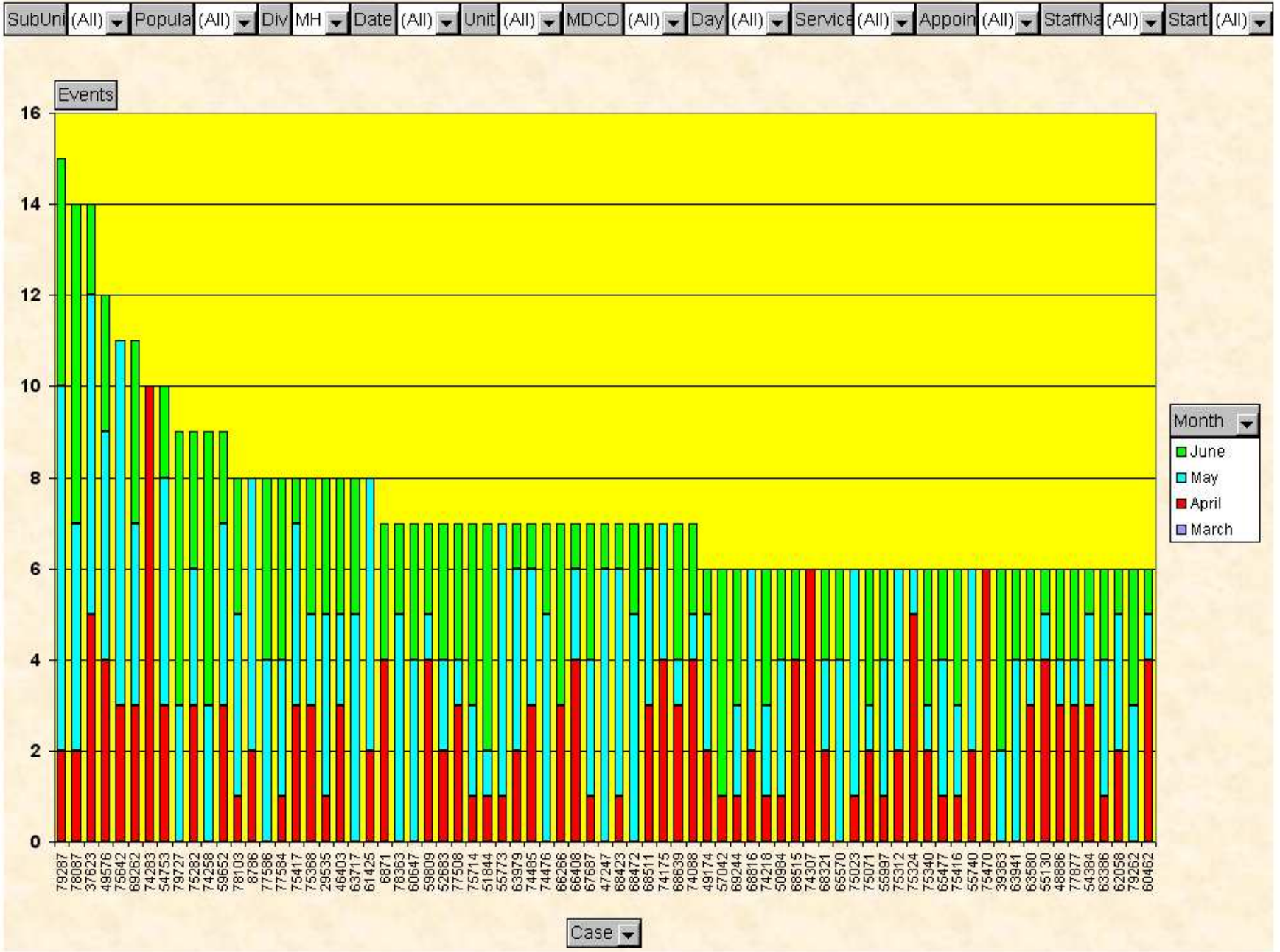
- Typical No Show Policies (i.e., Miss two appointments in three months and center will not reschedule client, etc.) are quantitative based which creates risk management concerns by clinical staff
- **SOLUTION**: Use Engagement Specialist Model

Qualitative Dilemma With Quantitative Based No Show Policies

- Engagement Specialist Model:
  1. When client misses two appointments, the centralized scheduler turns the client over to the engagement specialists (LPN, Case Manager)
  2. Engagement Specialist contacts the client to confirm if they want services
     - Identifies barriers to client attending and addressing them (i.e., different day, time, etc.)
     - Drops clients into med clinics, group therapy, etc. to re-engage client
     - Begins Discharge/Transfer Planning if the client cannot be re-engaged in treatment

Measurement of Case Loads – The Answer

- Measurement of specific caseload members no showing/canceling is critical part of the ability to reduce rates
- Need information in clinical staffings and supervision in order to change our behavior
- Need agency protocol when staff are to begin action on no show/cancellation challenge that is case level specific


SubUni (All)
Popula (All)
Div MH
Date (All)
Unit (All)
MDCD (All)
Day (All)
Service (All)
Appoin (All)
StaffNa (All)
Start (All)
Events
16
14
12
10
8
6
4
2
0
79287 78087 37623 49576 75642 69262 74283 54753 79727 75282 74258 59652 78103 8786 77586 77584 75417 75368 29535 46403 63717 61425 6871 78363 60647 59809 52683 77508 75714 51844 55773 63979 74485 74476 66266 66408 67687 47247 68423 68472 68511 74175 68639 74088 49174 57042 69244 68816 74218 50984 68515 74307 68321 65570 75023 75071 55997 75312 75324 75340 65477 75416 55740 75470 39363 63941 63580 55130 48886 77877 54384 63386 62058 79262 60462
Case
Month
June
May
April
March

Types of Service Modality Shifts

- Refill Clinics
- Clinic Model (Think Primary Care)
- No Show Clinics
- Specialized Population Services
  - ADHD
  - DUI
  - Court Ordered Services
- Drop in Services
- Open Access
- No-Show Cancel Management
- Clinical Alert Protocols for Appointment Back Fill
- Customer Service/ Performance Culture
- Level of Care Scheduling
- Centralized Access
- Geographic Caseloads
- Single Clinician Intake and Follow-u

Engagement Strategies to Reduce No Show Rates

- Developed 'Engagement Strategy' Recommendations Document:
  - Person Centered Processes
  - Use of Collaborative Concurrent Documentation
  - Implement No Show/ Cancel Policies and Protocols and Support Policies with an Engagement Specialist Model
  - Addressing Specific Attendance/ Engagement Barriers
  - Alternative Service Schedule Options (e.g. Medication Clinics)
  - Customer Service Awareness

National Access and Engagement Grant - Subset A and Subset B Teams

Subset A
(experimental):

- Carlsbad
- Colorado West
- CSEA
- The H Group
- Ozark Guidance Center

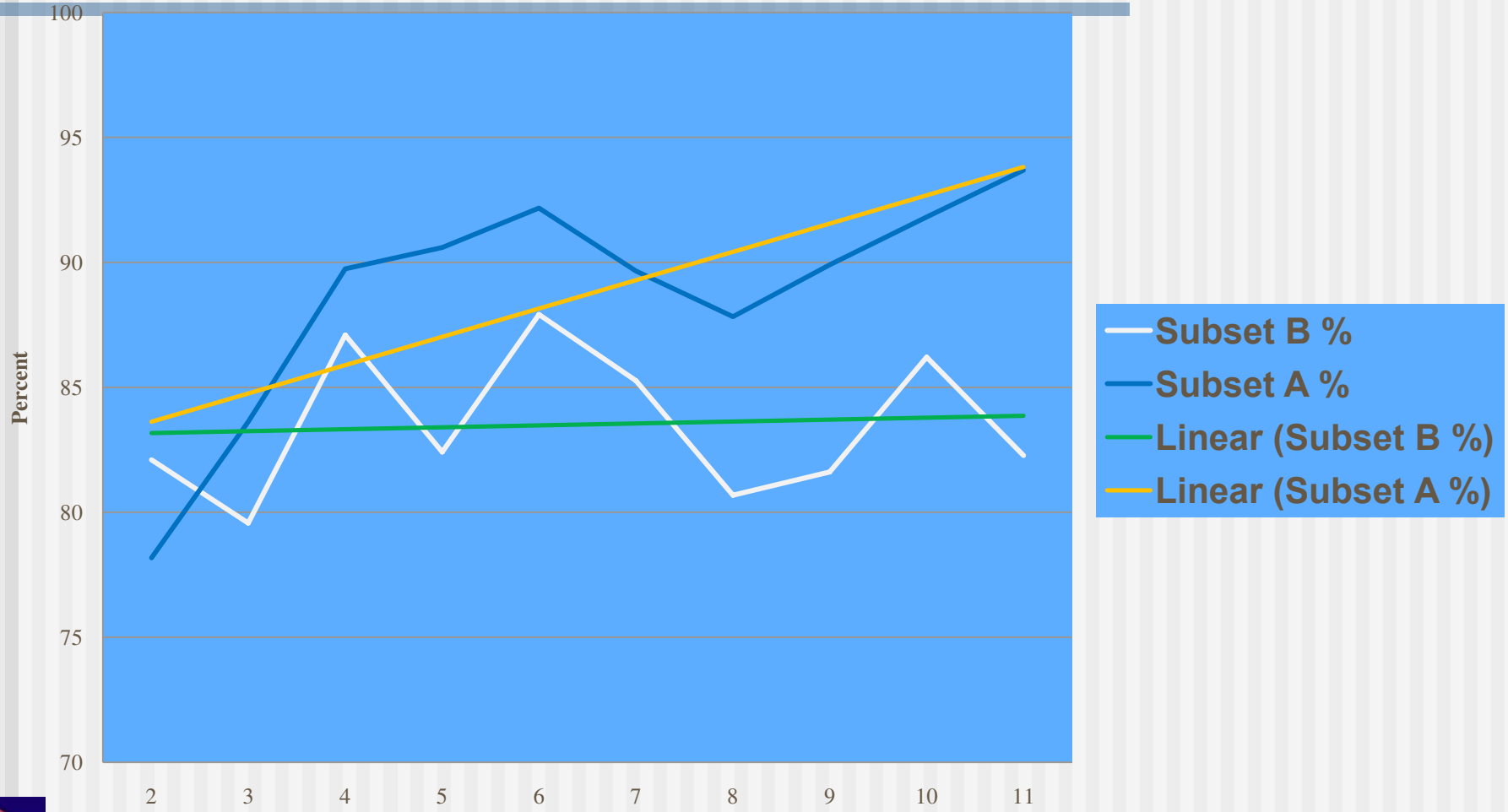
Subset B
(Control):

- AtlantiCare
- Avita Partners
- Cascadia
- The Consortium
- North Side

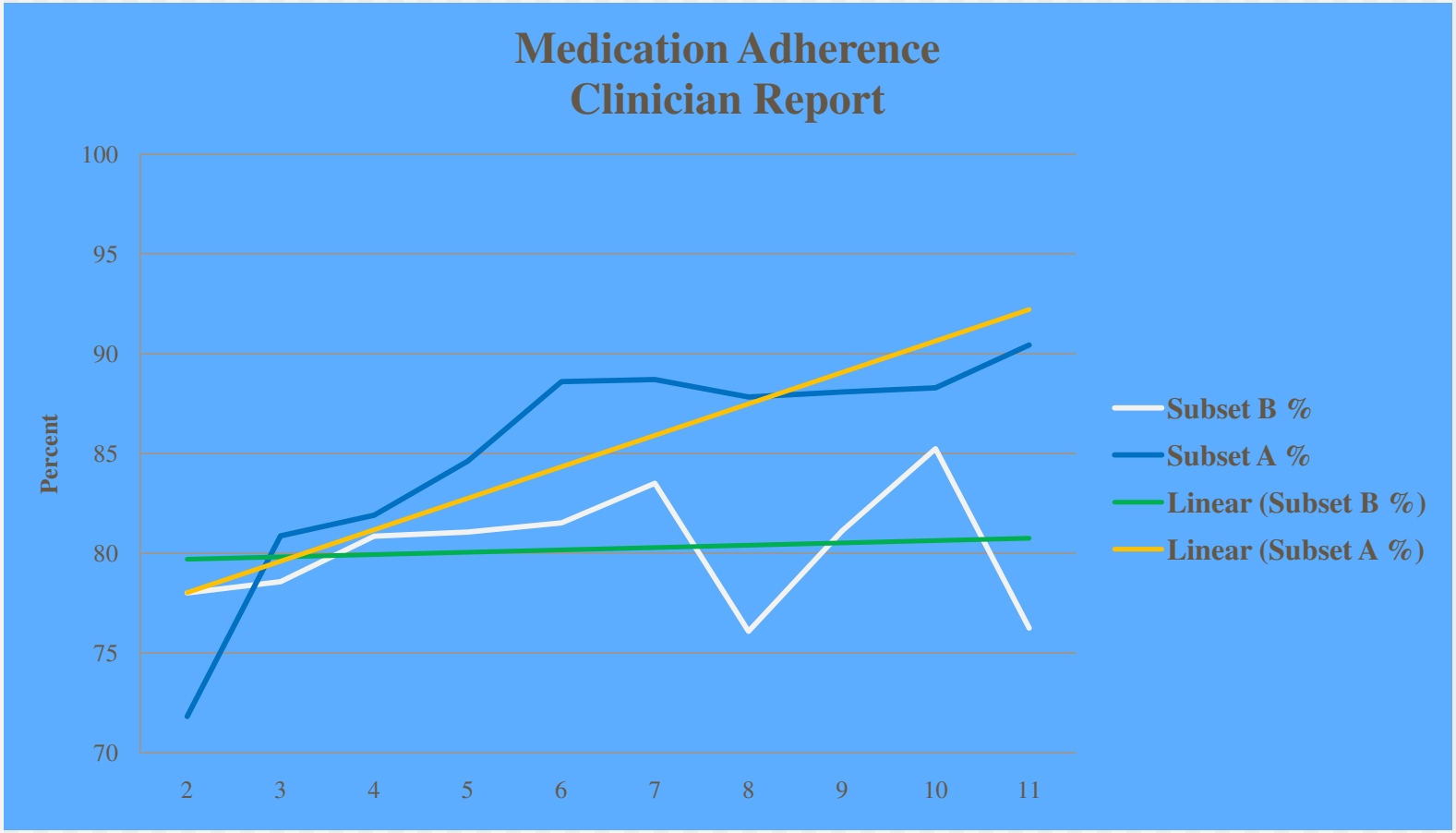
Person Centered Engagement Strategies Implemented At Subset A Teams:

A. Collaborative Documentation
B. Person Centered Linkage Between Personal-Life Goals, Identified BH Needs, Tx Plan Goals and Objectives, and Client/Clinician Interactions
C. Addressing Specific Engagement Barriers
D. Relapse Prevention/ WRAP Plans

Medication Adherence: Client Report



Medication Adherence: Clinician Report



Presented By:
David Lloyd, Founder

MHC of Greater Manchester Collaborative Concurrent Documentation Case Study

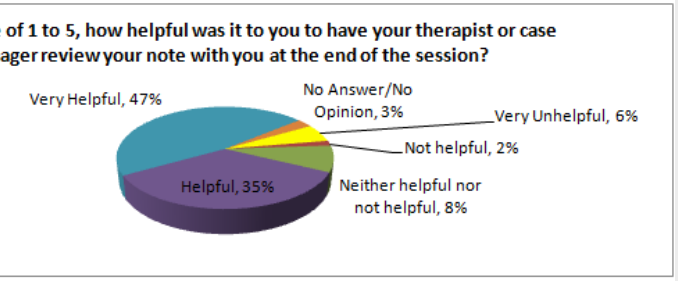
- **Client Satisfaction Results:**
- 927 Clients Responded
  - 83.9% felt the practice was helpful
  - 13.7% found it neutral
  - 2.3% disagree that it is helpful

Responses for All Participating Centers

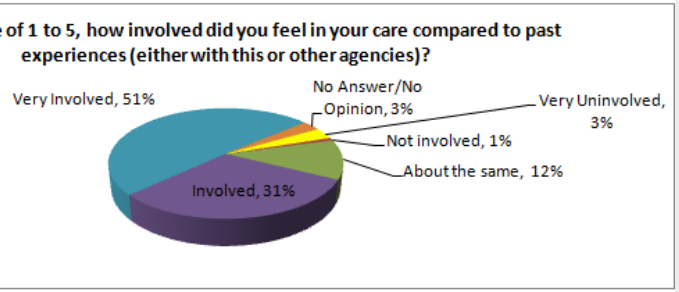
Concurrent Documentation Survey

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!***

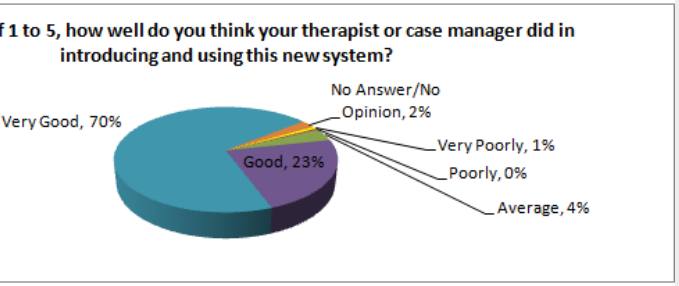
1. On a scale of 1 to 5, how helpful was it to you to have your therapist or case manager review your note with you at the end of the session?	Percentages Total	Total %
1 Very Unhelpful	107	6%
2 Not helpful	30	2%
3 Neither helpful nor not helpful	158	8%
4 Helpful	656	35%
5 Very Helpful	894	47%
NA No Answer/No Opinion	52	3%
Total/Approval %:	1897	93%



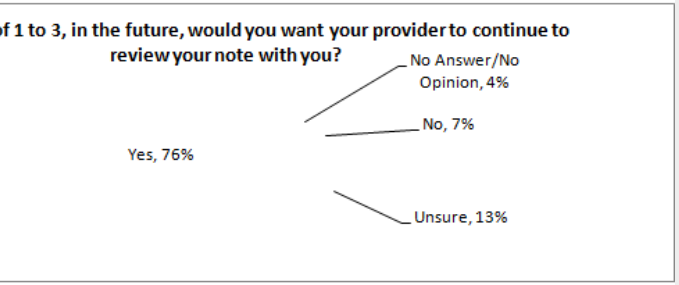
2. On a scale of 1 to 5, how involved did you feel in your care compared to past experiences (either with this or other agencies)?	Total	Total %
1 Very Uninvolved	62	3%
2 Not involved	16	1%
3 About the same	220	12%
4 Involved	583	31%
5 Very Involved	959	51%
NA No Answer/No Opinion	56	3%
Total/Approval %:	1896	96%



3. On a scale of 1 to 5, how well do you think your therapist or case manager did in introducing and using this new system?	Total	Total %
1 Very Poorly	12	1%
2 Poorly	8	0%
3 Average	69	4%
4 Good	410	23%
5 Very Good	1259	70%
NA No Answer/No Opinion	45	2%
Total/Approval %:	1803	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	78	7%
2 Unsure	157	13%
3 Yes	886	76%
NA No Answer/No Opinion	51	4%
	0	0%
	0	0%
Total/Approval %:	1172	93%



Metropolitan Family Services in Chicago - Concurrent Documentation Pilot Outcomes

- Metropolitan provided an evaluation of the concurrent documentation pilot prior to rolling it out. The results were:
  - Pilot over 6 weeks
  - Pilot therapists rate quality of the working alliance with clients equal to therapists in the control group.
  - Pilot client/therapist pairs show almost identical levels of agreement with client/therapist control group pairs regarding working alliance
  - On average pilot therapists spent 9 fewer post session hours on paperwork per week than control group therapists.

Effects on practice style: A Case Study by John Kern, MD

- Briefer and more focused sessions.
- Less time spent searching for data, labs, old session notes, etc.
- Possible for me to provide services to a larger number of clients in the same period of time.
- Obvious implications for center – waiting list went down from hundreds to close to zero.

Mid Western Colorado: Benefits of Concurrent Documentation

To CBHO Staff:

- Can save up to 8 hours per week (or 384 hours per year) in documentation time.
- With increased time availability, this allows clinicians to be less anxious about accepting and seeing more consumers on their caseload at any one time.
- Conversion to CD is accompanied by a drop of up to 25% in staff sick time usage
- Less anxiety and stress to direct service staff would result in enhanced morale greater job satisfaction, and improved quality of life/sense of well-being.

Mid Western Colorado: Concurrent Documentation Guidelines

Transitioning to CD In the session

- Use the traditional "wrap up" at the end of the session to try and transition to the documentation. This is something that many clinicians are used to doing as they try to synthesize what was done during the session and bring some closure to the process. You might say "We're getting close to the end of the session. Let's stop here and review what we talked about." The only difference is that instead of just doing a verbal recap we write it down on paper or it's done directly on the computer ECR.

Some Staff Competency Challenges to Conversion to Concurrent Documentation

1. Computer hardware and software skills for EMR Use
2. Ability of staff to provide a more focused/objective information gathering/recording model/clinical formulation
3. Provide training to provide permission to write less words and identify which words need to be written to support Medical Necessity documentation linkages

Transition from Post Documentation to Concurrent Documentation Model

1. "Do As Much As You Can" approach
    a. Client's response to the intervention section of the progress note
    b. Add Goal and Objective addressed today
    c. Add interventions provided
    d. Add mental status/functioning levels
    e. Complete progress note in session

"Do As Much As You Can" Model Using Individual Progress Note

Goal(s)/Objective(s) Addressed from ISP ☐ ISP ☐ ISP Review Dated: 2
Therapeutic Interventions Provided 3
Response to Intervention/Progress Toward Goals and Objectives 1
Additional Information/Plan (if applicable) 4

"Do As Much As You Can" Model Using Group Progress Note – Pre-Populate

GROUP PROGRESS NOTE

Client Name (First, MI, Last)		Client No.
Type of Service ☐ Client No Show/Cancelled ☐ CPST ☐ Counseling/Psychotherapy ☐ AoD Group Counseling ☐ IOP ☐ Other:		
Group Name	No. in Group	No. of Staff
General Group Information		
Group Activity/Topic		

"Do As Much As You Can" Model Using Group Progress Note

Goal(s)/Objective(s) Addressed from ISP
2
Therapeutic Interventions Provided
Response to Intervention/Progress Toward Goals and Objectives
1

Implementing Concurrent Documentation

1. Establish a formal Collaborative Concurrent Documentation Pilot Program
2. Include direct care staff from different programs and staff types (i.e., Therapists, Community Support, Psychiatrists, Nurses, etc.)
3. Recommend a six to twelve week pilot period
4. Develop Pilot Training Curriculum and Learning Objectives

Pilot Program Outcomes

- Will the pilot program outcomes be used to implement concurrent documentation center-wide?
- Identify surveys that will be used to measure the following outcomes:
  - Quality of life improvement for staff
  - Enhanced compliance with documentation submission standards
  - Consumer satisfaction

Training Resources

- Training DVD:
  - DuPage County MH Services
  - Training DVDs from The National Council Web site: http://www.thenationalcouncil.org/
- Curriculum for Training and Case Studies
- Pilot Program Outcome
- URL address for Concurrent Documentation Resources: http://www.mtmservices.org/MTM-Resources_NCCBH-Conference-Boston_4-30-08.html

Tools for Successfully Working with Integrated Healthcare Entities

Internal utilization management processes and support staff to help ensure:

a. Pre-Certification, authorizations and re-authorizations are obtained
b. Referrals are made to only clinicians credentialed on the appropriate third party panels
c. Appropriate front desk co-pay collections
d. Timely/Accurate claim submission to support payment for services provided

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: ____ / ____ / ____			

UM Plan Clinical 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
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 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.)?

Roles of Clinical and Financial Staff In Third Party Billing

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

Questions and Feedback

- Questions?
- Feedback?
- Next Steps?