

Developing Effective Practices in Operational Management

9:00am to 12:00pm EDST

Presented by:

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Overview..

- Identifying internal operational challenges to service delivery within your community mental health center that is critical to your organizations overall success.
- Ensuring appropriate documentation timeliness and completeness, service delivery wait times, access to care, and quality improvement models all drive the success or failure of a healthcare organization.
- Developing staff flow processes that assist a community mental health in understanding utilization requirements against reimbursable billing rates is also an important consideration.
- Attend this session to better understand how all these important factors influence the ability of your organization to respond to changing healthcare service delivery dynamics.

What External forces or opportunities are coming into play that will both force and support a shift from “Volume of Services” model to the “Value of Care” Model?

Shared Risk/Shared Savings Funding Models

- ACA contains an outcome based “race to the top” requirement for Medicare funding related to the prevalence of potentially avoidable conditions (PACs) that resulted from Medicare eligible persons receiving treatment. PACs consist of such avoidable conditions such as postoperative infection rates, high 30 day post discharge readmission rates for the same condition, etc.
- Below is the summary of the two phases of this program and the respective “bonus” and “penalty” that hospital and medical center providers of Medicare service will experience during each phase:
 - *October 2011 – Medicare will launch VBP for hospitals - +1% to – 1% rate adjustment based on quality measures*
 - *In 2017 = +2% to – 2% Medicare rate adjustment based on benchmarks that get higher each year – “race to the top” in hospital quality*

Shared Risk/Shared Savings Funding Models

- *“Medicare is penalizing 721 hospitals with high rates of potentially avoidable mistakes that can harm patients, known as “hospital-acquired conditions.” Penalized hospitals will have their Medicare payments reduced by 1 percent over the fiscal year that runs from October 2014 through September 2015. To determine penalties, Medicare evaluated three types of HACs. One is central-line associated bloodstream infections, or CLABSIs. The second is catheter-associated urinary tract infections, or CAUTIs. The final one, Serious Complications, is based on eight types of injuries, including blood clots, bed sores and falls.”*

Source: *“Medicare penalizes 721 hospitals over medical errors”, Healthcare Finance*, (December 22, 2014), Rau, Jordan (website to access a complete list of the 721 hospitals by state: http://www.healthcarefinancenews.com/news/medicare-penalizes-721-hospitals-over-medical-errors-full-list#.VNjncwu_fpk.email)

Institute for Healthcare Improvement - The Triple Aim

- With hospitals moving toward a value-based payment system there is **more demand now than ever for strategies that will help healthcare systems hone in on population health**. The Triple Aim, an initiative set forth by the [Institute for Healthcare Improvement](http://www.IHI.org), covers three main checkpoints for all hospitals as they make this transition
 - **Population Health Focus**
 - **Experience of Care**
 - **Lower Per Capita Cost**

Source: Stiefel M, Nolan K. *A Guide to Measuring the Triple Aim: Population Health, Experience of Care, and Per Capita Cost*. IHI Innovation Series white paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2012. (Available on www.IHI.org)

| Dimension of the IHI Triple Aim | Outcome Measures |
|--|---|
| Population Health | <p>Health Outcomes:</p> <ul style="list-style-type: none"> • Mortality: Years of potential life lost; life expectancy; standardized mortality ratio • Health and Functional Status: Single-question assessment (e.g., from CDC HRQOL-4) or multi-domain assessment (e.g., VR-12, PROMIS Global-10) • Healthy Life Expectancy (HLE): Combines life expectancy and health status into a single measure, reflecting remaining years of life in good health |
| | <p>Disease Burden: Incidence (yearly rate of onset, average age of onset) and/or prevalence of major chronic conditions</p> |
| | <p>Behavioral and Physiological Factors:</p> <ul style="list-style-type: none"> • Behavioral factors include smoking, alcohol consumption, physical activity, and diet • Physiological factors include blood pressure, body mass index (BMI), cholesterol, and blood glucose <p>(Possible measure: A composite health risk assessment [HRA] score)</p> |
| Experience of Care | <p>Standard questions from patient surveys, for example:</p> <ul style="list-style-type: none"> • Global questions from Consumer Assessment of Healthcare Providers and Systems (CAHPS) or How's Your Health surveys • Likelihood to recommend |
| | <p>Set of measures based on key dimensions (e.g., Institute of Medicine's six aims for improvement: safe, effective, timely, efficient, equitable, and patient-centered)</p> |
| Per Capita Cost | <p>Total cost per member of the population per month</p> |
| | <p>Hospital and emergency department (ED) utilization rate and/or cost</p> |

Source: Stiefel M, Nolan K. *A Guide to Measuring the Triple Aim: Population Health, Experience of Care, and Per Capita Cost*. IHI Innovation Series white paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2012. (Available on www.IHI.org)

The New Healthcare Paradigm

*Optimizing performance through data
analytics and benchmarking*

Midwest Region



Baker Tilly Report Summary:

INTRODUCTION

The new normal in healthcare has arrived. The implementation of the Patient Protection & Affordable Care Act has rapidly changed the economic landscape for both payers and providers. Reimbursement methods are rapidly changing. Both public and private payers are transitioning to new payment models that are increasingly focused on patient outcomes, population health, and patient satisfaction.

As indicated by the data observations in this report, succeeding in the new normal will require providers to focus on results rather than the delivery of discrete services. They will need to collaborate with other providers to create treatment plans that optimize patient outcomes and minimize total costs. Successful organizations will implement systems to effectively gather and analyze critical data that will drive strategies that improve results. Leading hospitals will use this information to better understand and manage the overall health of the population they are serving, including finding new ways to educate their patient population while improving the availability and efficiency of their care models.

This report observes and analyzes three critical areas that will drive sustainability and profitability of healthcare organizations in the future: population health, cost management, and patient outcomes.

Healthcare Reform Shared Risk/Shared Savings Payment Models

- Full Risk Capitation/Sub-Capitation Rates (Per Member per Month) – MCO/BHO Risk
- Partial Risk Outpatient Only Capitation/Sub-Capitation Rates – Provider Network Risk
- Bundled Rates/Episodes of Care Rates – Shared Risk
- Stratified Case Rates – Shared Risk
- Case Rates – Shared Risk
- Prospective Payment System (PPS) – Shared Risk
- Global Payments – Shared Risk (Payment based on a zero-based budgeting exercise that integrates complexity and severity of population served which will determine how many and what types of clinicians are needed to support a team based health and wellness approach.)
- Capped Grant Funding – Shared Risk
- Performance Based Fee for Service – Shared Risk
- Fee for Service – High Payer Risk

Shift in Payment Model...

1. As parity and national integrated healthcare provided under the Affordable Care Act (ACA) are implemented, new models of “shared risk” funding are being introduced.
2. A shift by payers such as Medicaid, Medicare and Third Party Insurance from “**paying for volume**” to “**paying for value**” provides a significant challenge for CBHOs.
3. A large majority of CBHOs do not have an ongoing awareness of their cost of services or cost of processes involved in the delivery of services (i.e., “What is your cost and time to treatment?”)

Shared Risk Funding Model Requirements

1. **Important definition of Value/Quality:** The outcomes achieved to objectively demonstrate that the client is getting better combined with the service array frequency and duration provided, and the cost of the process of treatment linked to the outcomes achieved.
2. Ability of all staff to develop a **dynamic tension between "quality" and "cost"** as if they are on a pendulum
3. Ability to know levels of NET revenue received for services provided – NOT RATE for service billed
 - a. What is the claim denial/error rate last week, month, quarter, etc.?
 - b. What is the level of over utilization of capped/grant funding received that reduces the net revenue earned per service (i.e., \$82 per hour therapy rate reduced to \$39.75 per hour net revenues earned due to over utilization of capped/grant funding contracts)

States Shifting From 1915 (b), (c) Carve Out Medicaid Waivers

- Shift from carve out Medicaid BH funding to Section 1115 General Integrated Waivers (Alabama, Arizona, Arkansas, California, Colorado, Delaware, Florida, Illinois, Iowa, Kansas, Kentucky, Louisiana, Maryland, Massachusetts, Maine, Minnesota, New Mexico, New Hampshire, New York, North Carolina, Oklahoma, Oregon, Tennessee, Texas, Utah, Vermont, Washington, Wisconsin, etc.)
- Over 40 states have modified their State Medicaid Plans since March 2010

Healthcare Reform Trends in 2015

- Accountable Care Organizations (ACOs) are being certified by CMS with over 600 announced Federal Certifications for both Medicare and Now Medicaid Share Savings Plans
- 14 plus states have applied under Section 2703 of the ACA to develop Integrated Care Health Homes (e.g., Missouri)
- FQHCs have over 12,000 Federally Certified locations nationally and are still growing

Growth in Numbers of ACOs Nationally

Chart 1: Total Accountable Care Organizations by Quarter beginning Q4 2010

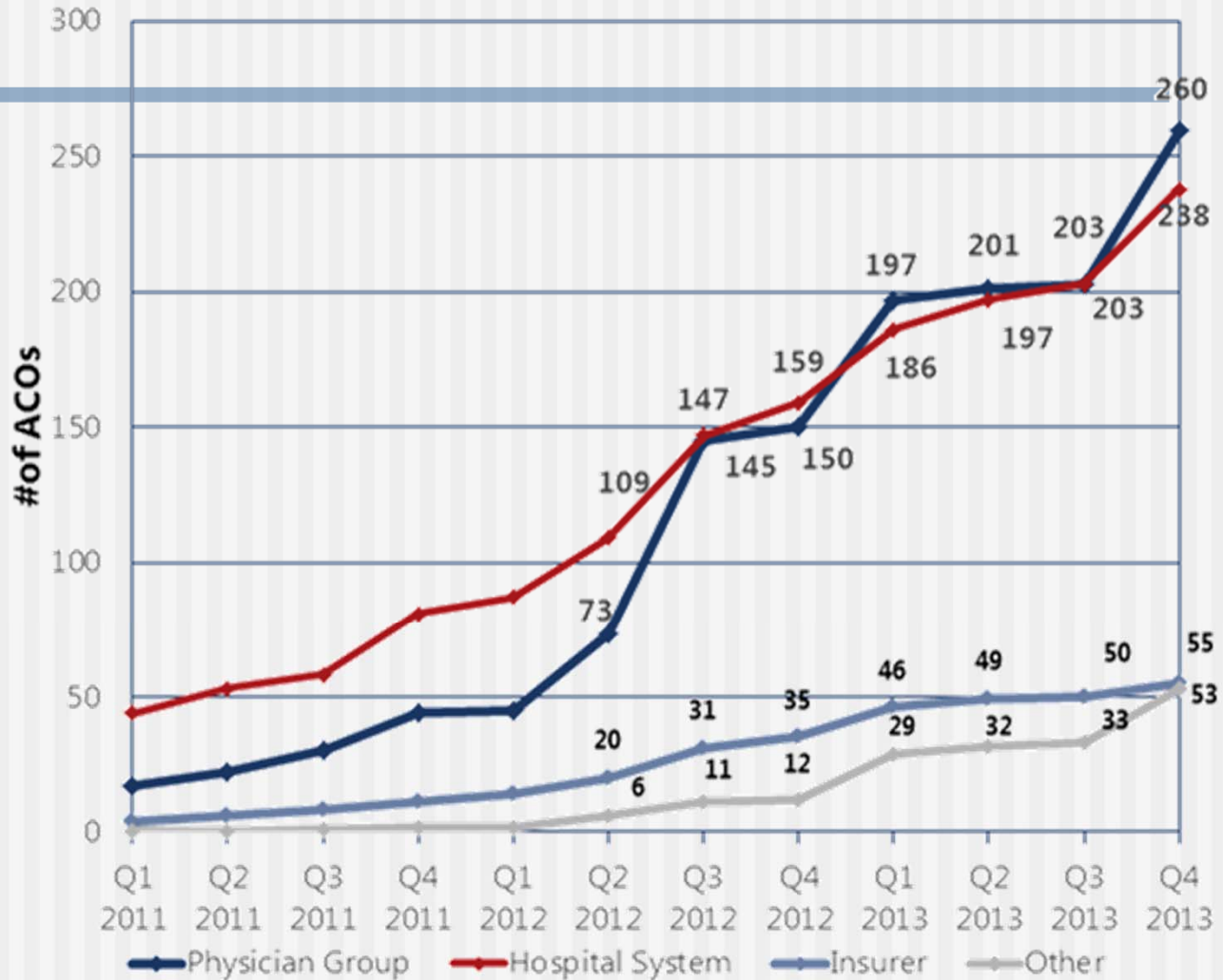
Source: Leavitt Partners Center for Accountable Care Intelligence



Growth in Numbers of ACOs Nationally

Chart 2: Total Accountable Care Organizations by Sponsoring Entity

Source: Leavitt Partners Center for Accountable Care Intelligence

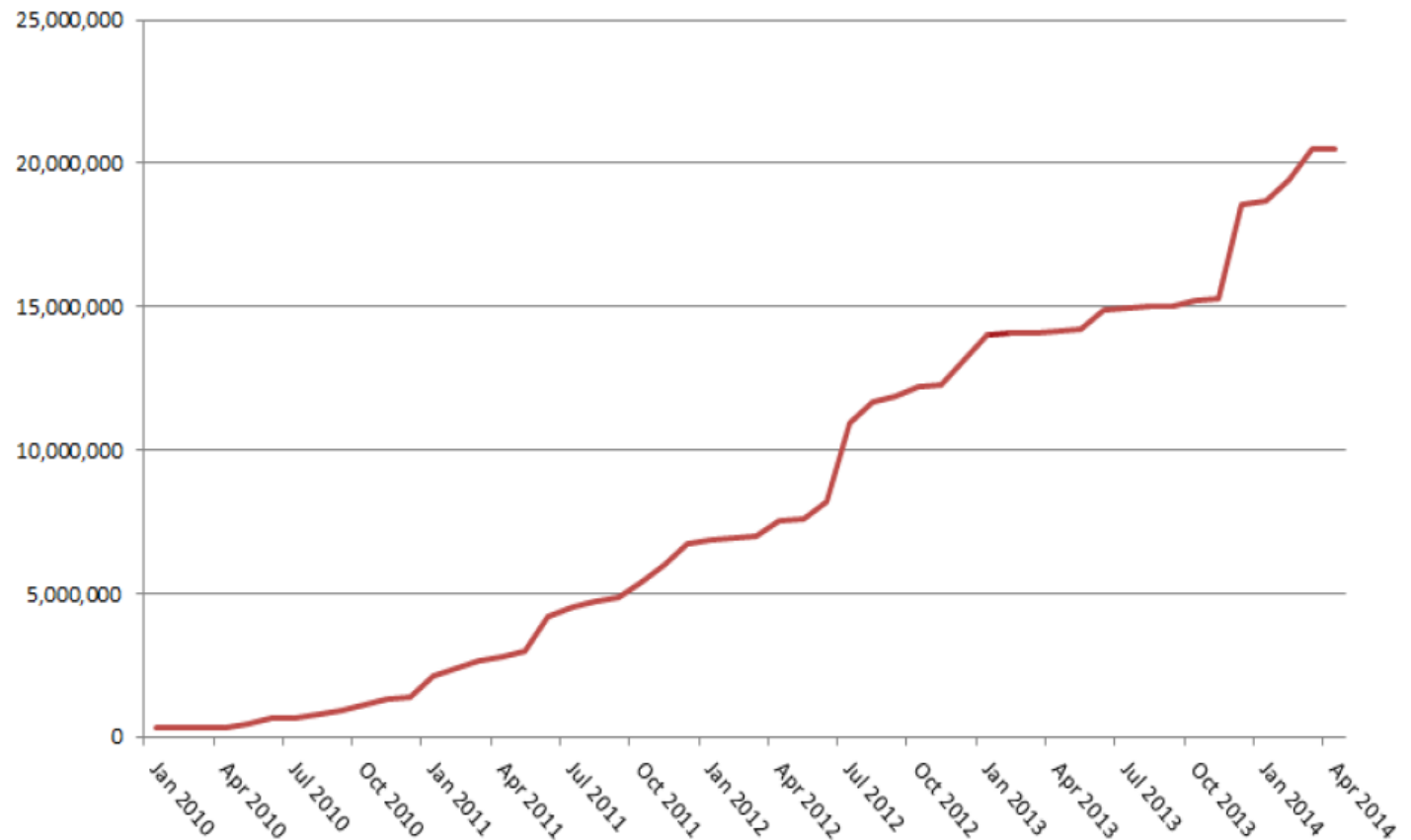


Growth in Number of ACO Covered Lives

Chart 3: Total Covered Lives Growth for ACOs Beginning January 2010

Source: Leavitt Partners Center for Accountable Care Intelligence

Growth of ACO Covered Lives Over Time



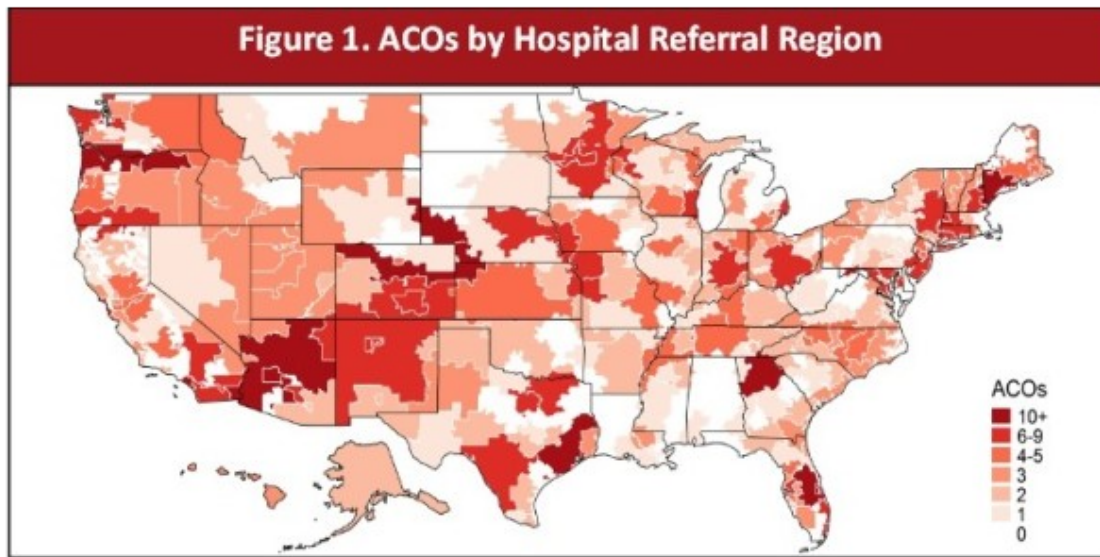
Survey: Digital Health Startups – Tell us what you think about corporate strategies.

HEALTH IT

ACOs by the numbers: Where are we now?

By DEANNA POGORELC

💬 Post a comment / ➦ 77 Shares / Aug 16, 2013 at 11:57 AM




ACO map August 2013 from Leavitt Partners

✉ GOT NEWS? SEND US A TIP

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But we also know better adherence is *key* to better outcomes.

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Walgreens AT THE CORNER



ACOs start the new year with a growth spurt that includes Indiana

e-Reports, Feb. 4, 2013



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Health care delivery in Indiana has entered an era of significant change, evidenced by growing numbers of accountable care organizations (ACOs) and entities. If you're not part of an ACO, or have not yet felt their influence, it's likely you will soon.

The year started with an ACO growth spurt after a federal announcement of 106 new Medicare contracts. That includes three based here in Indiana and another two, KentuckyOne Health Partners, LLC, and Owensboro ACO, LLC, based in Kentucky to serve patients in Indiana and Kentucky. That brings Indiana's ACO count to around 10 and the national total to more than 250 since passage of the 2010 Patient Protection and Affordable Care Act.

The Indiana players are familiar. Franciscan Alliance is establishing a Medicare ACO partnership with Union Health System in the greater Terre Haute area, effective Jan. 1. Premier Healthcare in Bloomington joined with American Health Network to create the Indiana Care Organization LLC. The recently announced Indiana Lakes ACO, LLC, based at IU Health Goshen, has a separate charter and LLC than IU Health in Indianapolis.

In October, two large central Indiana health systems and six area Suburban Health Organization hospitals formed an "accountable care consortium," (ACC) with the goal of improving quality and lowering the cost of health care. The ACC, which has its own board and CEO, is not connected to federal initiatives and all partners have equal ownership.

Franciscan Alliance and Cigna just launched an accountable care initiative for the

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The Indiana University Health ACO



What is an ACO?

An Accountable Care Organization (ACO) is a group of doctors and other healthcare providers who agree to work together with Medicare to give you the best possible care. ACOs may take different approaches to giving you coordinated care. Some ACOs may have special nurses that help you set up appointments or make sure your medications are in order when you enter or leave a hospital. Other ACOs may help your doctors get you equipment for monitoring your medical conditions better at home, if you need it. Most ACOs use advanced systems that let them more carefully track your care, and make sure your doctor has the most up-to-date information

Indiana University Health ACO, Inc.'s Participants:

- Indiana University Health, Inc.
- Indiana University Health North Hospital, Inc.
- Indiana University Health West Hospital Inc.
- Cardiothoracic Surgeons Inc.
- Clarian Transplant Institute, Inc.
- Indiana University Psychiatric Associates, Inc.
- Indiana University Radiology Associates, Inc.
- I.U. Anesthesiology Associates, LLC
- Indiana University Pain Medicine Center, LLC
- I.U. Anesthesiology Associates - ICU, LLC
- Indiana University Eye Care, Inc.
- Indiana University Medical Genetics Service, Inc.
- University Clinical Pathology Associates, Inc.
- University Dermatology, Inc.
- University Family Physicians Inc.
- University Medical Diagnostic Associates, Inc.
- University Obstetricians - Gynecologists Inc.
- University Orthopaedic Associates, Inc.
- University Otolaryngology Associates Inc.
- University Physiatric Associates, Inc.
- University Plastic Surgery Associates, P.C.
- University Radiation Oncology Associates, Inc.
- University Surgeons, Inc.
- University Urologists, Inc., P.C.
- University Vascular Surgery P.C.
- Indiana Clinic - Neurology, LLC
- ICEM - Wishard LLC
- Indiana University Health Care Associates, Inc.
- Indiana Clinic - Critical Care LLC
- Indiana Clinic - Urology, LLC
- Thomas A. Brady Sports Medicine Center P.C.
- Oncology & Hematology Associates, LLC
- HealthNet, Inc.
- Arnett Clinic, LLC
- Indiana University Health Arnett, Inc.
- Indiana University Health Ball Memorial Physicians, Inc.
- Indiana University Health Ball Memorial Hospital, Inc.
- Indiana University Health Southern Indiana Physicians, Inc.
- Indiana University Health Bedford Physicians, LLC

Quality Performance Results

| | 2012 Reporting Period | | 2013 Reporting Period | | 2014 Reporting Period | |
|--|-----------------------|-------------------------------------|-----------------------|-------------------------------------|-----------------------|-------------------------------------|
| | ACO Performance Rate | Mean Performance Rate for All ACO's | ACO Performance Rate | Mean Performance Rate for All ACO's | ACO Performance Rate | Mean Performance Rate for All ACO's |
| Getting Timely Care, Appointments, and Information | | | | | 78.44 | 80.13 |
| How Well Your Doctors Communicate | | | | | 92.69 | 92.39 |
| Patients' Rating of Doctor | | | | | 92.58 | 91.58 |
| Access to Specialists | | | | | 87.67 | 83.97 |
| Health Promotion and Education | | | | | 55.88 | 58.29 |
| Shared Decision Making | | | | | 72.30 | 74.60 |
| Health Status / Functional Status | | | | | 70.65 | 71.10 |

| | | | | | | |
|--|--|--|--|--|--------------|--------------|
| Medication Reconciliation | | | | | 60.35 | 82.61 |
| Falls: Screening for Fall Risk | | | | | 48.06 | 45.60 |
| Influenza Immunization | | | | | 66.99 | 57.51 |
| Pneumococcal Vaccination | | | | | 79.38 | 55.03 |
| Adult Weight Screening and Follow-up | | | | | 44.47 | 66.75 |
| Tobacco Use Assessment and Cessation Intervention | | | | | 91.04 | 86.79 |
| Depression Screening | | | | | 12.11 | 39.27 |
| Colorectal Cancer Screening | | | | | 57.77 | 56.14 |
| Mammography Screening | | | | | 66.35 | 61.41 |
| Proportion of Adults who had blood pressure | | | | | 45.74 | 60.24 |



THE INDIANA LAKES ACO

HOME THE INDIANA LAKES ACO



WHAT IS AN ACO?

An Accountable Care Organization (ACO) is a group of doctors and other healthcare providers who agree to work together with Medicare to give you the best possible care.

ACOs may take different approaches to giving you coordinated care. Some ACOs may have special nurses that help you set up appointments or make sure your medications are in order w
ACOs may help your doctors get you equipment for monitoring your medical conditions better at home, if you need it. Most ACOs use advanced systems that let them more carefully track y
the most up-to-date information about your health.



Franciscan Alliance ACO

MEDICARE ACOS

- Franciscan Alliance ACO
- Franciscan AHN ACO
- Franciscan Riverview Health ACO, LLC
- Franciscan Union ACO

COMMERCIAL ACOS

- Anthem
- Cigna

CONTACT

Contact Franciscan Alliance ACO

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 FONT SIZE SHARE PRINT

Franciscan Alliance ACO

In 2011, Franciscan Alliance was chosen to participate in the Pioneer Accountable Care Organization (ACO) program with the Centers for Medicare & Medicaid Innovation Center. With the launch of the Franciscan Alliance Pioneer ACO in 2012, Franciscan Alliance began pursuing a more quality-centered system of care that focused on providing an optimal healthcare experience to people with Medicare Fee-for-Service we are fortunate to serve.

In 2015, Franciscan Alliance ACO transitioned to the Medicare Shared Savings Program (MSSP).

Franciscan Alliance continues to expand Accountable Care Organization programming to include partnerships in both Medicare and commercially insured populations.

These partnerships currently include:

Medicare ACO partnerships

- + American Health Network
- + Riverview Health
- + Union Hospital
- + Anthem Medicare Advantage
- + Humana Medicare Advantage

Contact the Franciscan Alliance Accountable Care Organization

Central Indiana
700 E. Southport Road
Indianapolis, IN 46227
toll-free 1 (855) 268-9086

Northern Indiana Region
7509 Calumet Ave.
Munster, IN 46321
(219) 836-3310
toll-free 1 (800) 931-3322

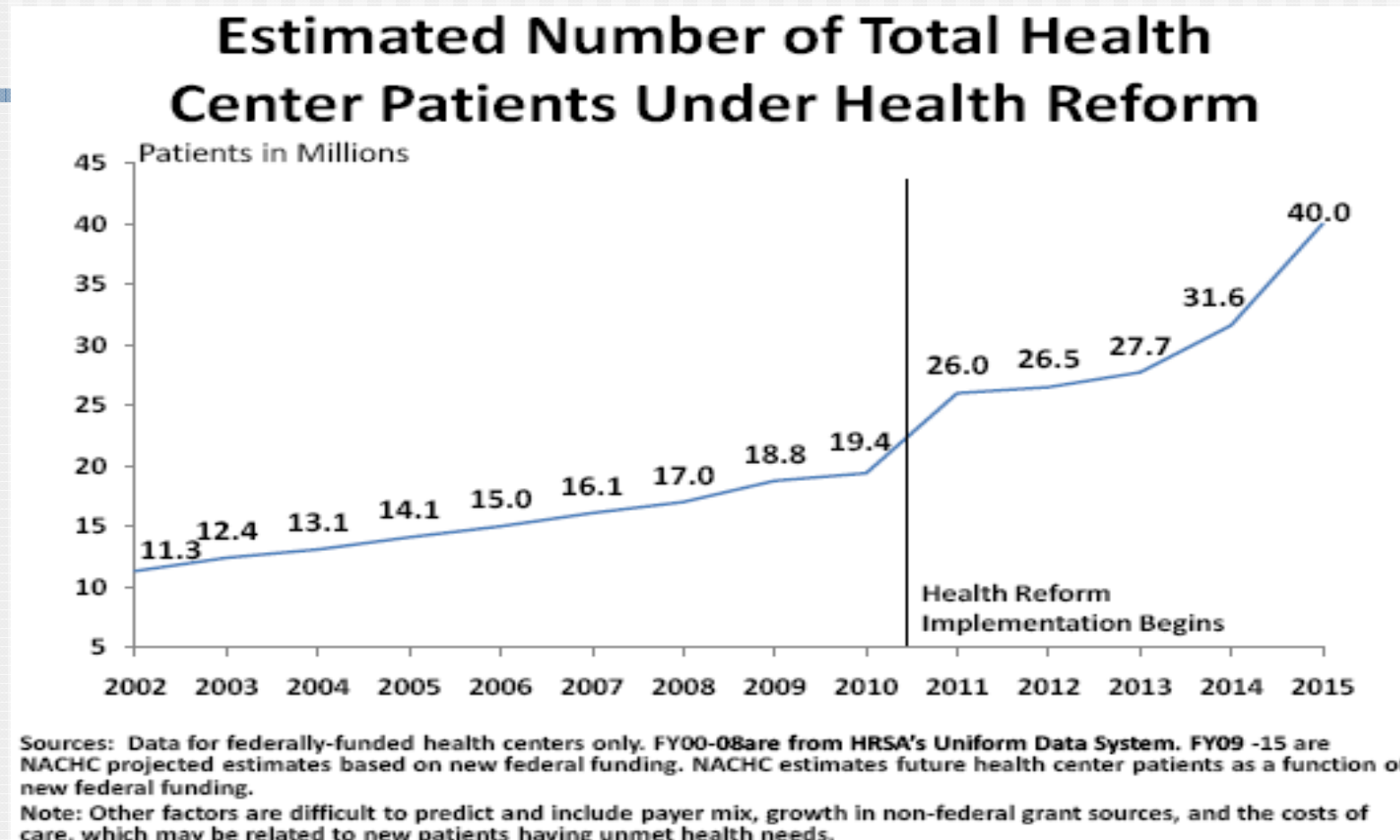
Western Indiana Region
1701 S. Creasy Lane
Lafayette, IN 47905
toll-free 1 (877) 806-1207

South-Suburban Chicago Region
(708) 679-2375

Media Contacts

Growth in Numbers of Clients Served by FQHCs

Chart 4: Estimate Growth of Patients for Community Health Centers (FQHCs):



Source: National Association of Community Health Centers, Inc., Bethesda, MD, June 2010

Major Value Change on the Horizon...

Excellence in Mental Health Act:

The Excellence Act passed in March 2014 will increase Americans' access to community mental health and substance use treatment services while improving Medicaid reimbursement for these services. This legislation:

- **Creates criteria for “Certified Community Behavioral Health Clinics”** as entities designed to serve individuals with serious mental illnesses and substance use disorders that provide intensive, person-centered, multidisciplinary, evidence-based screening, assessment, diagnostics, treatment, prevention, and wellness services. The Secretary of the Department of Health and Human Services is directed to establish a process for selecting states to participate in a 2-year pilot program.
- **Provides \$25,000,000 that will be available to states as planning grants** to develop applications to participate in the 2- year pilot. Only states that have received a planning grant will be eligible to apply to participate in the pilot.
- **Stipulates that eight (8) states will be selected to participate** in the 2-year pilot program. Participating states will receive 90% FMAP for all of the required services provided by the Certified Community Behavioral Health Clinics.
- **Requires participating states to develop a Prospective Payment System (PPS)** for reimbursing Certified Behavioral Health Clinics for required services provided by these entities.

CBHC's "Business Case" Core Elements

1. Incorporate as much objective data as possible to support awareness of service delivery capacity being delivered by association members
2. Provide demographic, diagnostic and population groups served information.
3. Provide service locations/clinics by county/region with a companion service array table to support awareness of services/programs available
4. Identify qualitative outcomes that provide a shift from "providing services" to focus on "VALUE of Care"
5. Identify the cost of services delivered and outcomes achieved to objectively measure "Value"
6. Identify "unique factors" that association members can provide (i.e., historical community based case management/ coordination of care experience, etc.)

Value of Care Components

“Value” of Care Equation

1. **Services provided** – Timely access to clinical and medical services, service array, duration and density of services through Level of Care/Benefit Design Criteria and/or EBPs that focuses on population based service needs
2. **Cost of services** provided based on current service delivery processes by CPT/HCPCS code and staff type
3. **Outcomes achieved** (i.e., how do we demonstrate that people are getting “better” such as with the DLA-20 Activities of Daily Living)
4. **Value is determined** based on can you achieve the same or better outcomes with a change of services delivered or change in service process costs which makes the outcomes under the new clinical model a better value for the payer.

“Value” of Care Equation

Services Provided: Timely access to clinical and medical services, service array, duration and density of services through Level of Care/Benefit Design Criteria and/or EBPs that focuses on population based service needs

Access to Treatment Is a Leadership Requirement...

1. 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 – **Same Day/Open Access Model implemented at over 500 CBHCs nationally**
 - b. **Secondary Access** – Time to provide client face to face service with his/her treating clinician following intake/assessment date – **3 to 5 days but not later than 8 days after same day assessment provided**
 - c. **Tertiary Access** – Time to first face to face service with Psychiatrist/APRN following the intake/assessment date - **3 to 5 days but no later than 8 days after the same day assessment provided.**
- NOTE: New 72 hour Just in Time Medical Services Models have been implemented by CBHOs in 15 states**



InterCommunity's Road To Immediate Access Services

- Kim Beauregard, CEO
 - Dr. Ann Price, CMO
 - Tyler Booth, COO
 - Phone 860-291-1313
 - Email: tylerbooth@intercommunityct.org
- InterCommunity, Inc.

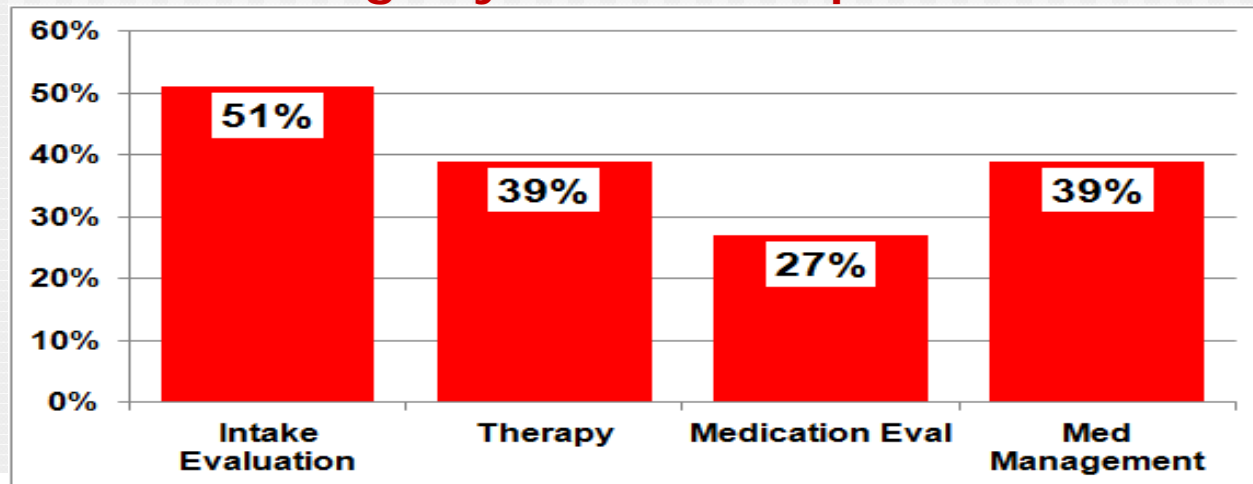
Identifying The Problem at InterCommunity BH, East Hartford, CT

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



Just In Time Access to Services Solution Outcomes at InterCommunity

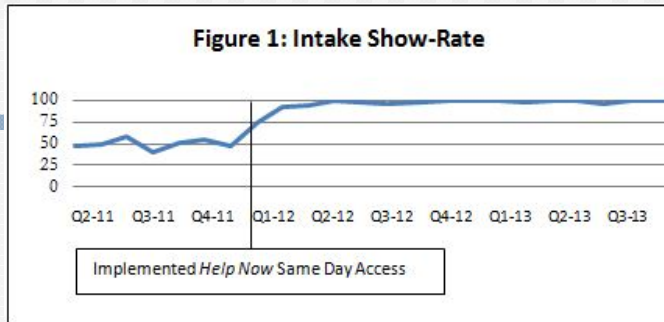


Figure 2: Completed Intake Assessments

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

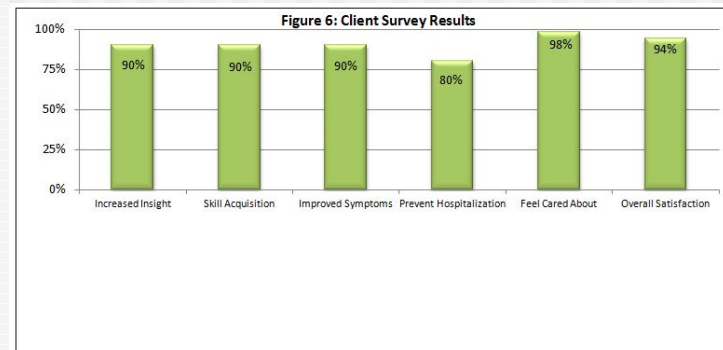
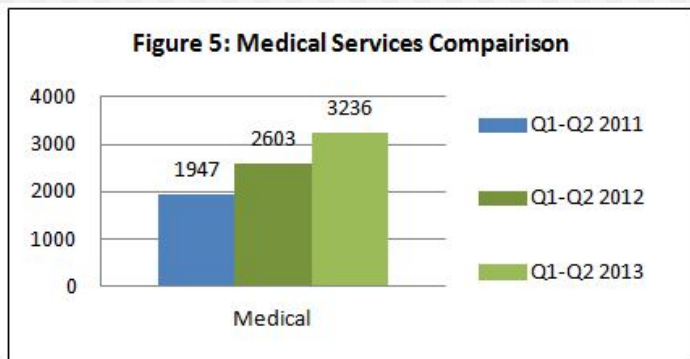
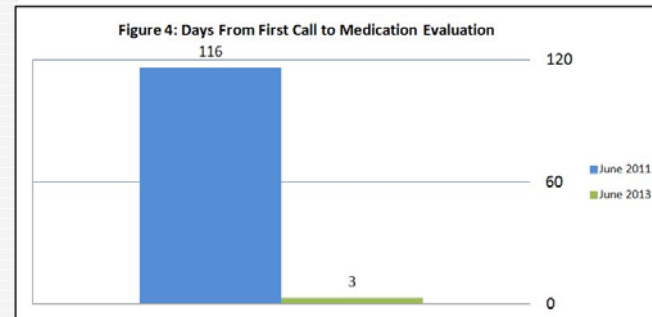
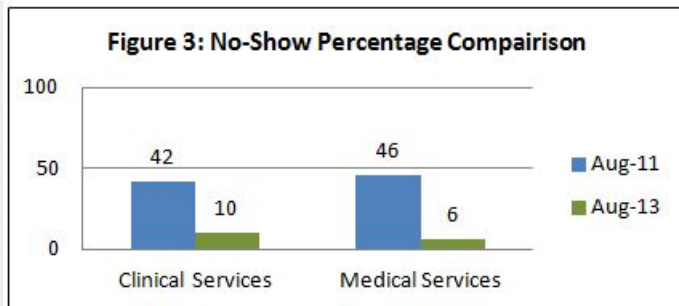


Figure 7: Services Delivered and Staffing Q1 and Q2 For Each Fiscal Year Below

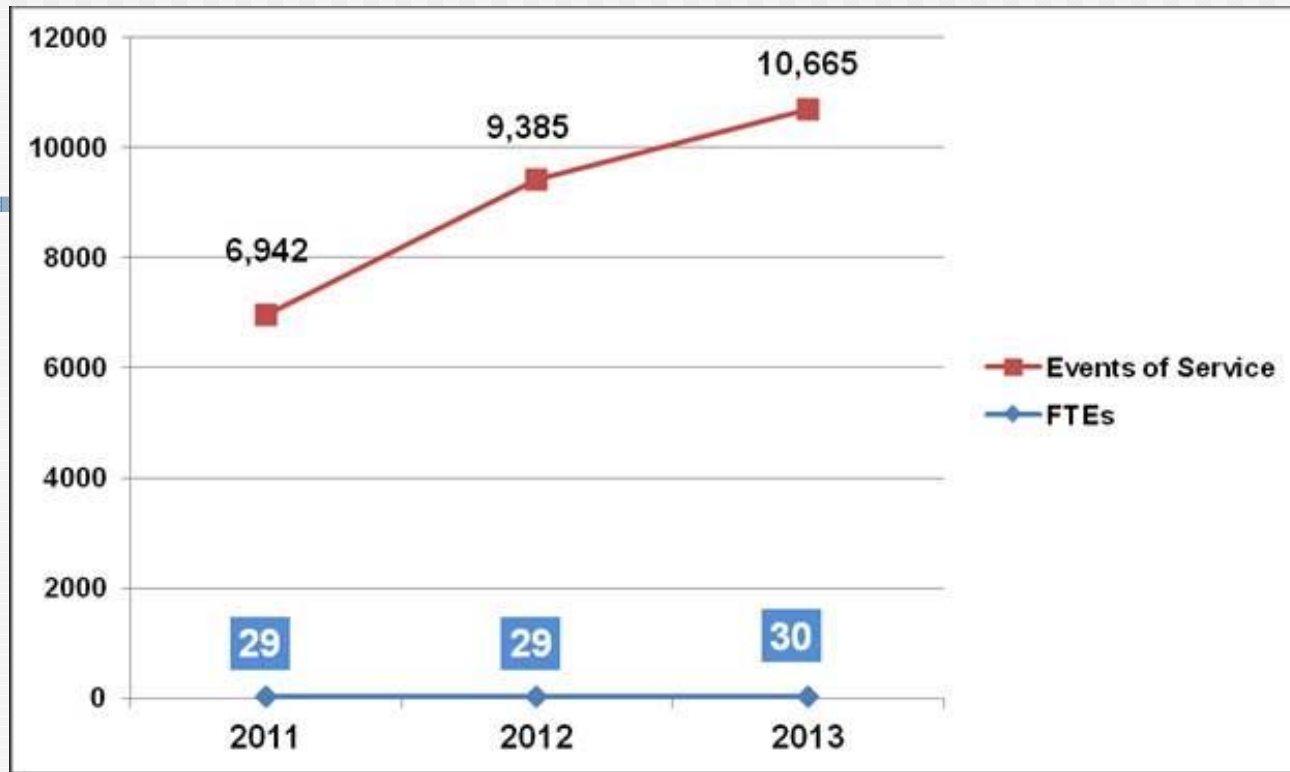


Figure 8: Staffing Levels for Same Fiscal Years:

| 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 at InterCommunity

- 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.

National No Show/ Cancel Key Performance Indicators

1. Initial Intake/Diagnostic Assessment Services = 0% No Show/Cancel rate based on Same Day access models
2. Ongoing Therapy Services = 8% - 12% No Show/Late Cancelled
3. Initial Psychiatric Evaluations = 12% to 15% No Show/Late Cancelled
4. Ongoing Medication Follow Up Services – 5% - 8% No Show/Late Cancelled - NOTE: Medications provided by phone to clients that missed their appointments will have to be addressed to positively impact ongoing no show rates.

Why Learn About Collaborative Documentation?

- Documentation has Become “The ENEMY”
- Clinicians report that documentation competes with time spent with clients
- Clinicians count on “no-shows” to complete paperwork
- Clinician’s paperwork and clinical work are divided.

Collaborative Documentation – What is it?

What is Collaborative (Collaborative) Documentation?

- ▶ Collaborative Documentation often referred to as Concurrent Documentation, is an important tool/method to facilitate Recovery/Rehabilitation Focused services through client participation/ response
- ▶ Collaborative Documentation, is a process in which clinicians and clients collaborate in the documentation of the Assessment, Service Planning, and ongoing Client-Practitioner Interactions (Progress Notes).
- ▶ The Client must be present and engaged in the process of documentation development.

Collaborative Documentation:

▶ Collaborative Documentation has demonstrated:

1. Improved client engagement and involvement
2. Helped focus clinical work on change and positive outcomes
3. Improved compliance
4. Saves you time and create capacity
5. **Improved quality of life of clinicians**

Collaborative Documentation

- Effective for use in documenting:
 - Assessment
 - Assessment Updates
 - Service (Tx) Planning
 - Service (Tx) Plan Updates/ Reviews
 - **Progress Notes**
 - Individual , Group, Community Based

Collaborative Documentation

Needed to Support:

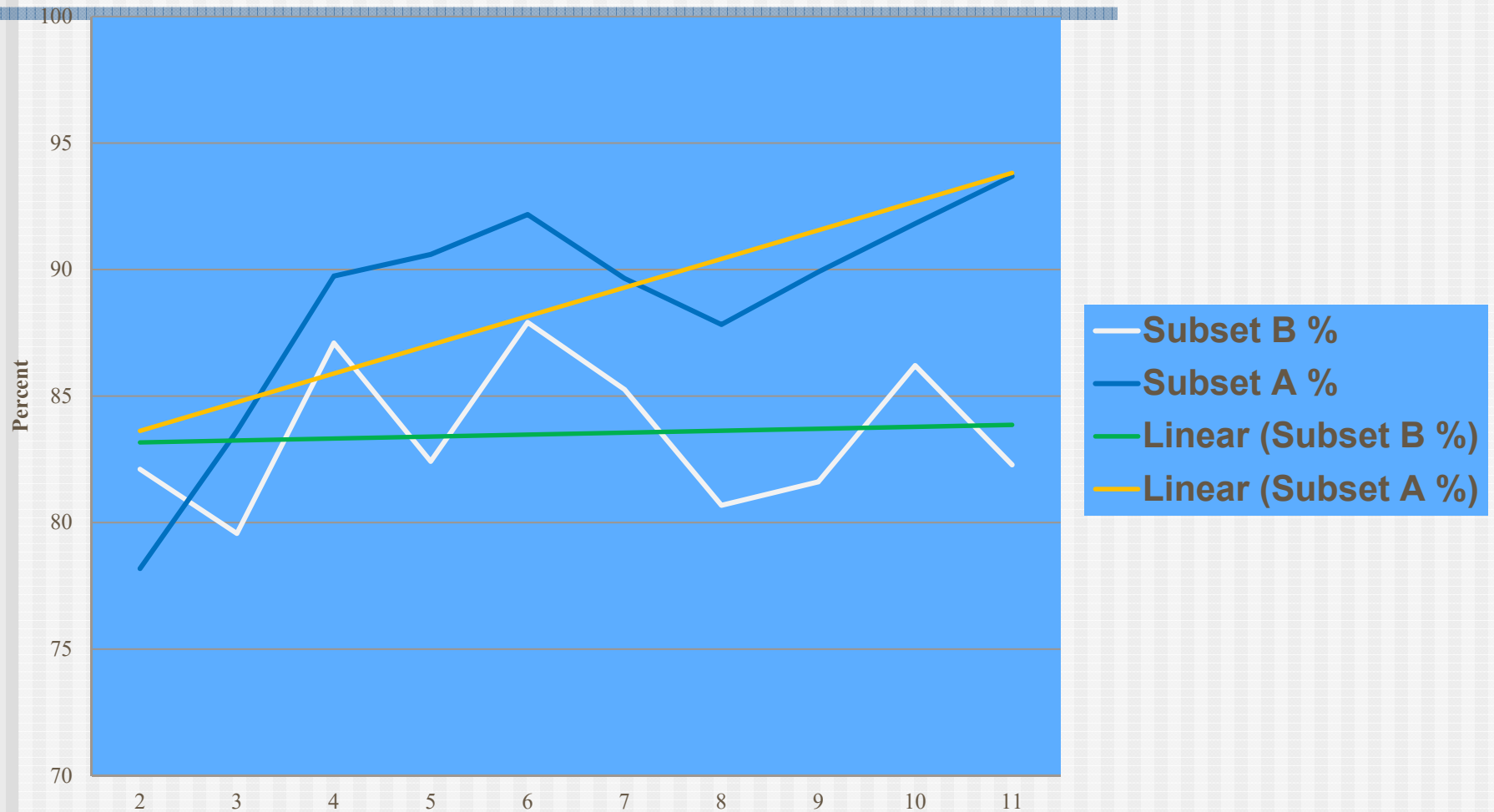
- “Meaningful Use” of electronic records
- Client communication / education and documentation accessibility
- Real time communication with other providers both within and outside the organization (e.g. Physical Health Partners)
- Needed increased capacity / productivity
- Same Day Access and Just in Time Medical Services
- Centralized Scheduling and Cancellation Backfill Management

Person Centered Engagement Strategies Implemented At Subset A Teams:

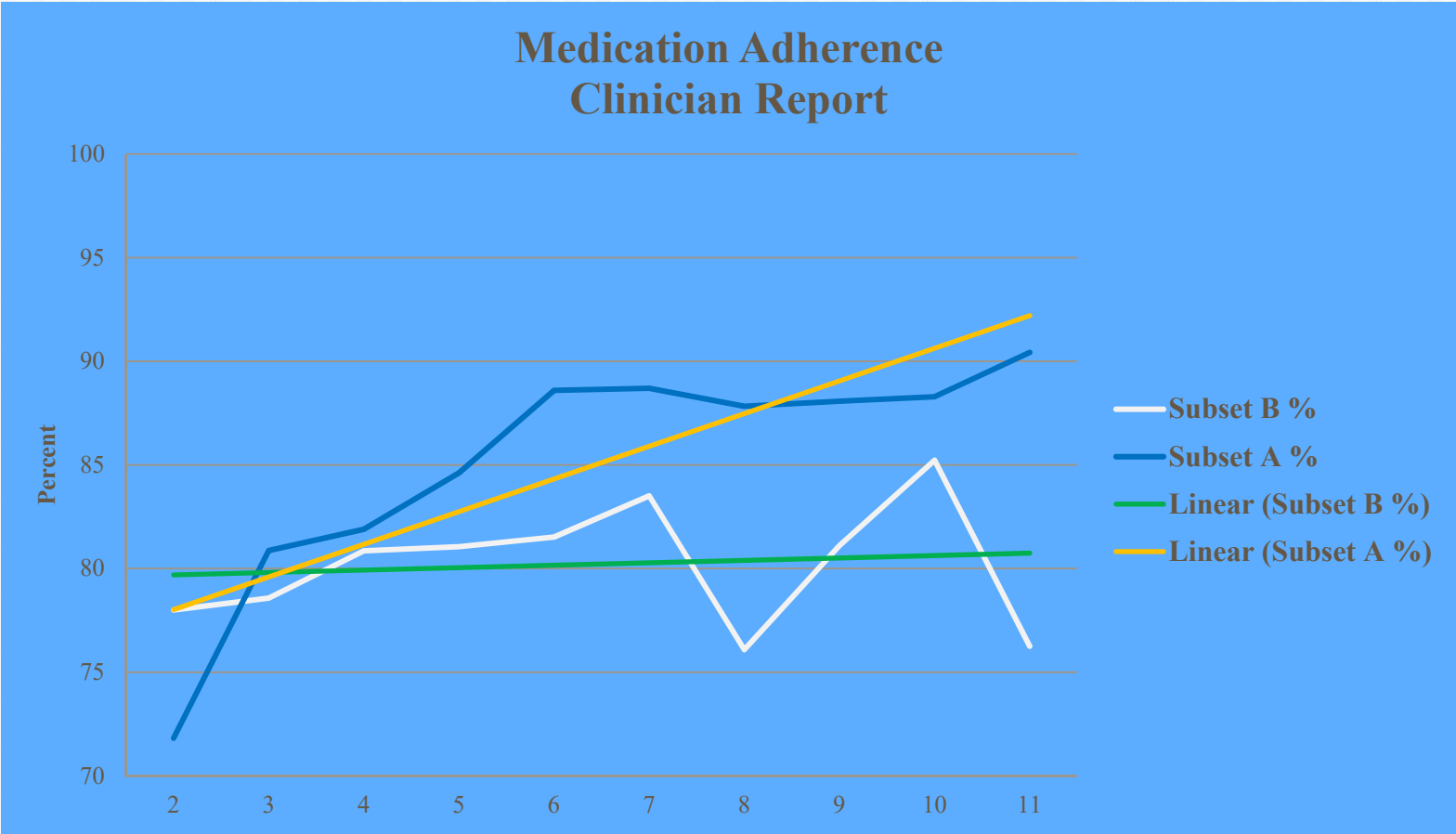
- A. Collaborative Documentation
- B. Person Centered Linkage Between Personal-Life Goals, Identified BH Needs, Tx Plan Goals and Objectives, and Client/Clinician Interactions
- C. Addressing Specific Engagement Barriers
- D. Relapse Prevention/ WRAP Plans

Medication Adherence: Client Report

Medication Adherence Client Report



Medication Adherence: Clinician Report





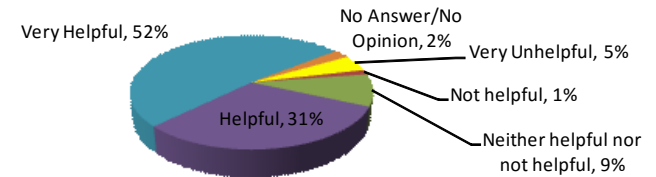
Responses for All Participating Centers

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!**

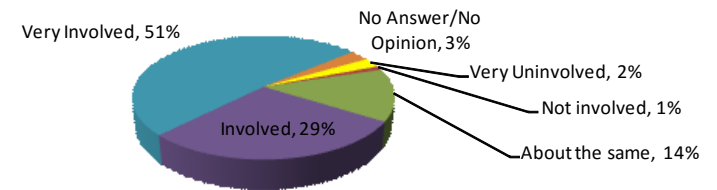
| 1. On a scale of 1 to 5, how helpful was it to you to have your provider review your note with you at the end of the session? | Percentages | |
|---|---------------|------------|
| | Total | Total % |
| 1 Very Unhelpful | 982 | 5% |
| 2 Not helpful | 283 | 1% |
| 3 Neither helpful nor not helpful | 1950 | 9% |
| 4 Helpful | 6617 | 31% |
| 5 Very Helpful | 11017 | 52% |
| NA No Answer/No Opinion | 529 | 2% |
| Total/Approval %: | 21,378 | 94% |

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?



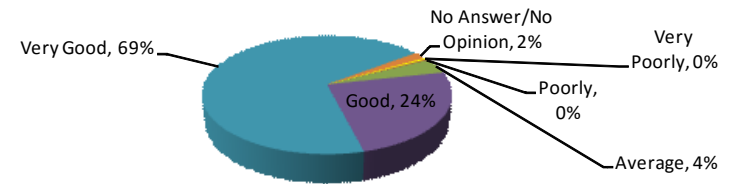
| 2. On a scale of 1 to 5, how involved did you feel in your care compared to past experiences (either with this or other agencies)? | Total | Total % |
|--|---------------|------------|
| 1 Very Uninvolved | 510 | 2% |
| 2 Not involved | 203 | 1% |
| 3 About the same | 2806 | 14% |
| 4 Involved | 5842 | 29% |
| 5 Very Involved | 10503 | 51% |
| NA No Answer/No Opinion | 577 | 3% |
| Total/Approval %: | 20,441 | 96% |

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)?



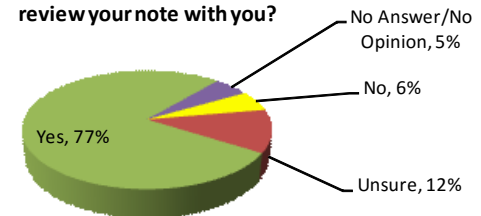
| 3. On a scale of 1 to 5, how well do you think your provider did in introducing and using this new system? | Total | Total % |
|--|---------------|------------|
| 1 Very Poorly | 91 | 0% |
| 2 Poorly | 47 | 0% |
| 3 Average | 859 | 4% |
| 4 Good | 4977 | 24% |
| 5 Very Good | 13990 | 69% |
| NA No Answer/No Opinion | 407 | 2% |
| Total/Approval %: | 20,371 | 99% |

3. On a scale of 1 to 5, how well do you think your provider did in introducing and using this new system?



| 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 | 1095 | 6% |
| 2 Unsure | 2291 | 12% |
| 3 Yes | 15134 | 77% |
| NA No Answer/No Opinion | 1061 | 5% |
| | 0 | 0% |
| | 0 | 0% |
| Total/Approval %: | 19,580 | 94% |

4. On a scale of 1 to 3, in the future, would you want your provider to continue to review your note with you?





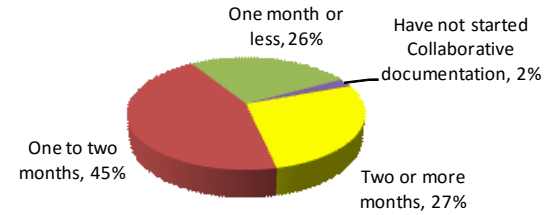
Responses for All Participating Centers

Collaborative Documentation STAFF Survey

Staff, please take a moment and answer the following questions concerning Collaborative Documentation. Your responses will assist in evaluating the process as it relates to not only client care, but employee workplace satisfaction. Thanks! . We value your opinion!

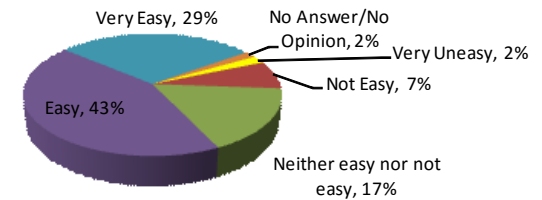
| 1. How long have you been doing Collaborative documentation? | Percentages | |
|--|-------------|---------|
| | Total | Total % |
| 1 Two or more months | 371 | 27% |
| 2 One to two months | 611 | 45% |
| 3 One month or less | 356 | 26% |
| 4 Have not started Collaborative documentation | 33 | 2% |
| Total/Approval %: | 1371 | |

1. How long have you been doing Collaborative documentation?



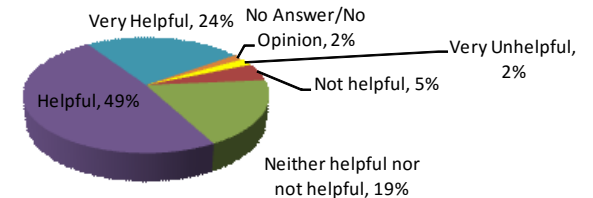
| 2. On a scale of 1 to 5, how easy was it to learn to do Collaborative documentation? | Percentages | |
|--|-------------|------------|
| | Total | Total % |
| 1 Very Uneasy | 27 | 2% |
| 2 Not Easy | 103 | 7% |
| 3 Neither easy nor not easy | 230 | 17% |
| 4 Easy | 594 | 43% |
| 5 Very Easy | 397 | 29% |
| NA No Answer/No Opinion | 23 | 2% |
| Total/Approval %: | 1374 | 91% |

2. On a scale of 1 to 5, how easy was it to learn to do Collaborative documentation?



| 3. On a scale of 1 to 5, how helpful is Collaborative documentation to the treatment process? | Percentages | |
|---|-------------|------------|
| | Total | Total % |
| 1 Very Unhelpful | 27 | 2% |
| 2 Not helpful | 67 | 5% |
| 3 Neither helpful nor not helpful | 253 | 19% |
| 4 Helpful | 660 | 49% |
| 5 Very Helpful | 331 | 24% |
| NA No Answer/No Opinion | 22 | 2% |
| Total/Approval %: | 1360 | 93% |

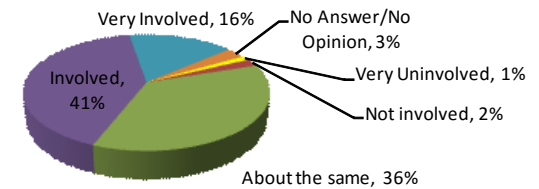
3. On a scale of 1 to 5, how helpful is Collaborative documentation to the treatment process?



4. On a scale of 1 to 5, how involved are your clients in the treatment process as a result of using Collaborative documentation?

| | Total | Total % |
|--------------------------|-------------|------------|
| 1 Very Uninvolved | 16 | 1% |
| 2 Not involved | 28 | 2% |
| 3 About the same | 491 | 36% |
| 4 Involved | 563 | 41% |
| 5 Very Involved | 222 | 16% |
| NA No Answer/No Opinion | 41 | 3% |
| Total/Approval %: | 1361 | 97% |

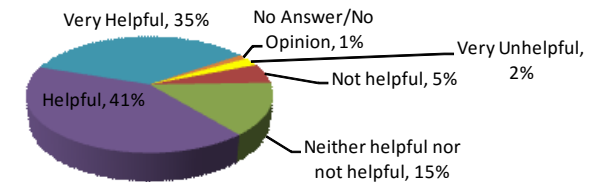
4. On a scale of 1 to 5, how involved are your clients in the treatment process as a result of using Collaborative documentation?



5. On a scale of 1 to 5, how helpful has Collaborative documentation been on your paperwork proficiency?

| | Total | Total % |
|-----------------------------------|-------------|------------|
| 1 Very Unhelpful | 32 | 2% |
| 2 Not helpful | 75 | 5% |
| 3 Neither helpful nor not helpful | 198 | 15% |
| 4 Helpful | 561 | 41% |
| 5 Very Helpful | 480 | 35% |
| NA No Answer/No Opinion | 18 | 1% |
| Total/Approval %: | 1364 | 92% |

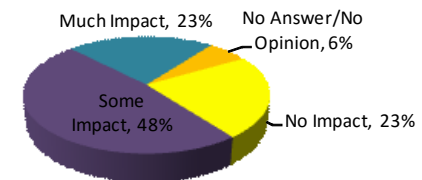
5. On a scale of 1 to 5, how helpful has Collaborative documentation been on your paperwork proficiency?



6. On a scale of 1 to 3, has Collaborative documentation had any positive impact on your workplace satisfaction?

| | Total | Total % |
|--------------------------|-------------|------------|
| 1 No Impact | 309 | 23% |
| 2 Some Impact | 648 | 48% |
| 3 Much Impact | 306 | 23% |
| NA No Answer/No Opinion | 85 | 6% |
| Total/Approval %: | 1348 | 77% |

6. On a scale of 1 to 3, has Collaborative documentation had any positive impact on your workplace satisfaction?



“Value” of Care Equation

Cost of services provided
based on current service
delivery processes by CPT
code and staff type

Statewide Cost and Revenue Finding Support

- Connecticut: In 2013, 47 CCPA members have completed a MTM Cost and Revenue Finding by CPT/HCPCS Code and staff type
- Kansas: In 2011, 27 ACMHCK members have complete the MTM phase one costing support based on hourly costs/revenues by staff type. In 2014 completing a MTM Phase Two Cost and Revenue Finding by CPT/HCPCS Code by staff type
- Arkansas: In 2013-14, 17 MHCA members completed MTM's Cost and Revenue Finding by CPT/HCPCS Code and staff type
- Georgia: In 2015, 14 GACSB members completed MTM's Cost and Revenue Finding by CPT/HCPCS Code and staff type
- Florida: 2015, 16 FADAA and FCCMH members complete MTM's Cost and Revenue Finding by CPT/HCPCS Code and staff type
- Illinois: In 2014-15, 10 Community Support Housing (CSH) members are completed MTM's Cost and Revenue Finding by CPT/HCPCS Code and staff type., MTM designed and provided a custom data collection tool to support collection of required data elements
- Illinois: In 2015, 15 IADDA members are completing MTM's Cost and Revenue Findings by CPT/HCPCS Code and staff types
- Missouri: In 2015, 27 Health Homes and FQHCs are completing MTM's Cost and Revenue Finding by CPT/HCPCS Code and staff type

MTM's Cost and Net Revenue Finding Template

Our Costing Methodology Defined –

Total Cost for Service Delivery

- Direct Service Staff Salary
- Direct Service Staff Fringe Benefits
- Non-Direct Costs (All other costs)

Total Revenue for Service Delivery

- Net Reimbursement actually Attained/
Deposited. *(This takes into account
Denial Rate, Self Pay, Sliding Fee Scale, etc.)*

- Divided By -

Total Billable Direct Service Hours Delivered **

- All Direct Service Hours Delivered by Direct Service Staff that are eligible to be billed via a CPT Code or against a Grant.

** Utilizing the common denominator of total Billable Direct Service Hours instead of total hours worked per year assures an apples to apples comparison of an organization's true cost versus revenue per direct service hour.

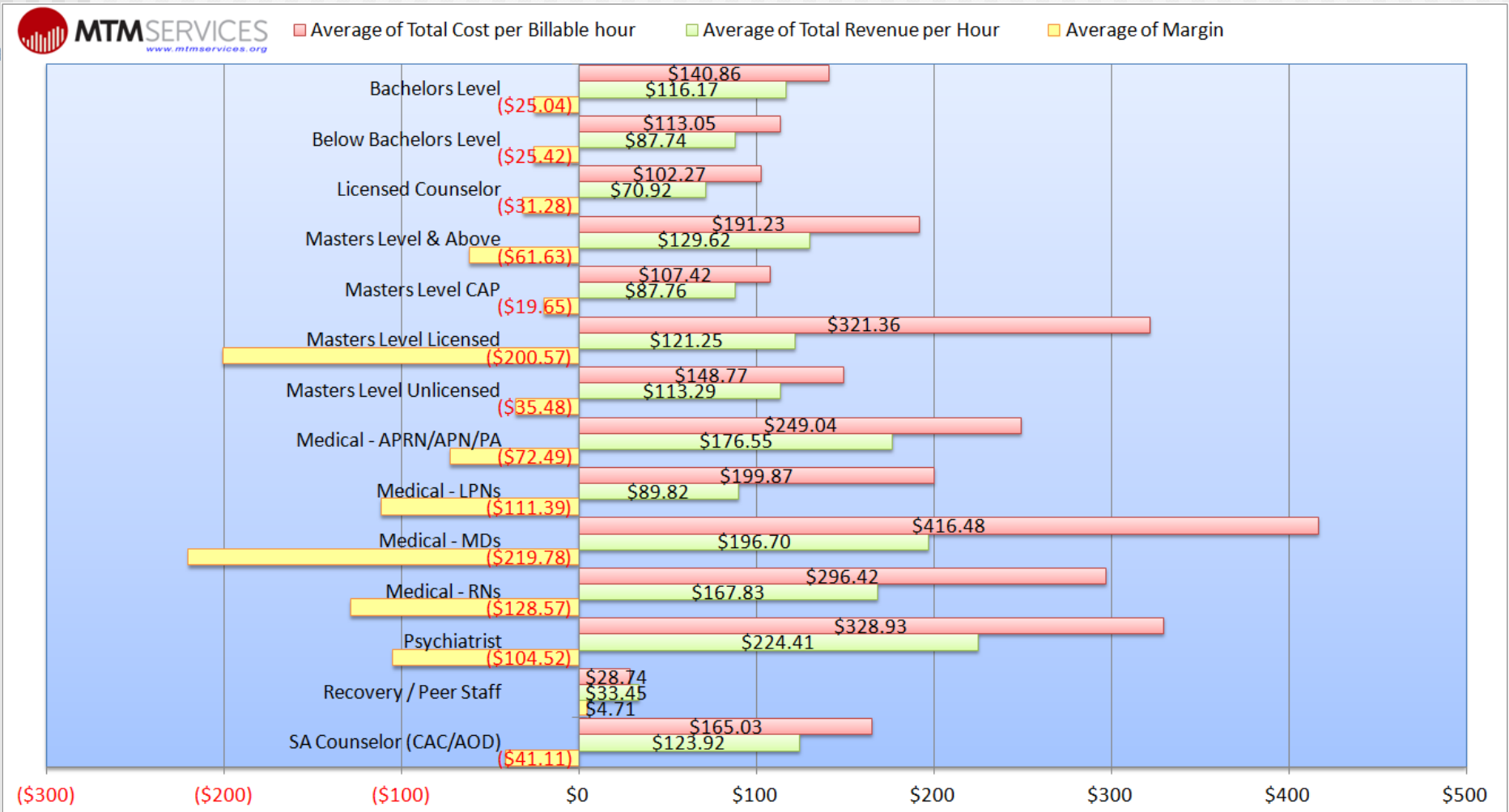
Current Funding Model Requirements

1. Ability to know levels of NET revenue received for services provided – NOT RATE for service billed
 - a. What is the claim denial/error rate last week, month, quarter, etc.?
 - b. What is the level of over utilization of capped/grant funding received that reduces the net revenue earned per service (i.e., \$82 per hour therapy rate reduced to \$39.75 per hour net revenues earned due to over utilization of capped/grant funding contracts)

Using Cost Per CPT/HCPCS Code Awareness...

1. Needed to Support Alternative Payment methodologies and what the risks are for the providers. (i.e., in one state we are calculating the cost of a bundled service array based on each provider's cost and density of services provided).
2. In CCBHC PPS-1 and PPS-2 Rates, the cost per service by provider type will be needed as a base to support calculation of individual CCBHC daily or monthly rates..

National Data from 112 Centers in 6 states:



SAMPLE Cost vs. Revenue Per CPT/HCPCS Code/Per Hour

| Row Labels | Sum of Total Hours Per Code | Average of Average Cost per Code | Average of NET Revenue per Code Per Hour | Average of Total Margin Per Code | Sum of Total Gain/Loss Per Code |
|------------|-----------------------------|----------------------------------|--|----------------------------------|---------------------------------|
| H0036 | 231277.90 | \$98.00 | \$114.33 | \$16.33 | \$2,117,932.15 |
| H2017 | 187723.11 | \$93.49 | \$80.10 | (\$13.39) | (\$1,217,336.92) |
| 90837 | 92932.58 | \$130.06 | \$75.65 | (\$58.29) | (\$5,639,781.59) |
| H2011 | 56644.59 | \$121.53 | \$112.81 | (\$8.72) | (\$1,541,679.19) |
| 90834 | 47188.28 | \$118.06 | \$61.98 | (\$60.39) | (\$2,147,496.02) |
| 90847 | 27610.46 | \$127.25 | \$77.53 | (\$49.73) | (\$1,497,335.00) |
| 90791 | 26502.86 | \$156.18 | \$82.35 | (\$73.83) | (\$2,185,508.73) |
| 99213 | 18884.73 | \$293.80 | \$103.43 | (\$190.37) | (\$3,800,176.63) |
| H0038 | 15549.18 | \$87.97 | \$52.64 | (\$35.33) | (\$355,617.48) |
| 99214 | 14084.81 | \$287.01 | \$115.97 | (\$171.04) | (\$2,612,021.28) |

Statewide Association Cost Finding Benefits for Each CBHC

Based on the below comparison of the local CBHC and statewide weighted average cost and net revenues per billable hour for the H0036 - Community Psychiatric Supportive Treatment service, why are the local CBHC cost per billable hour higher and the net revenues received per billable hour lower?

| H0036 | Average of Average Cost per Code | Average of NET Revenue per Code Per Hour | Average of Total Margin Per Code |
|-----------------------------------|---|---|---|
| Local CHC | \$171.23 | \$79.55 | (\$91.68) |
| Statewide Weighted Average | \$98.00 | \$114.33 | \$16.33 |

“Value” of Care Equation

Outcomes achieved

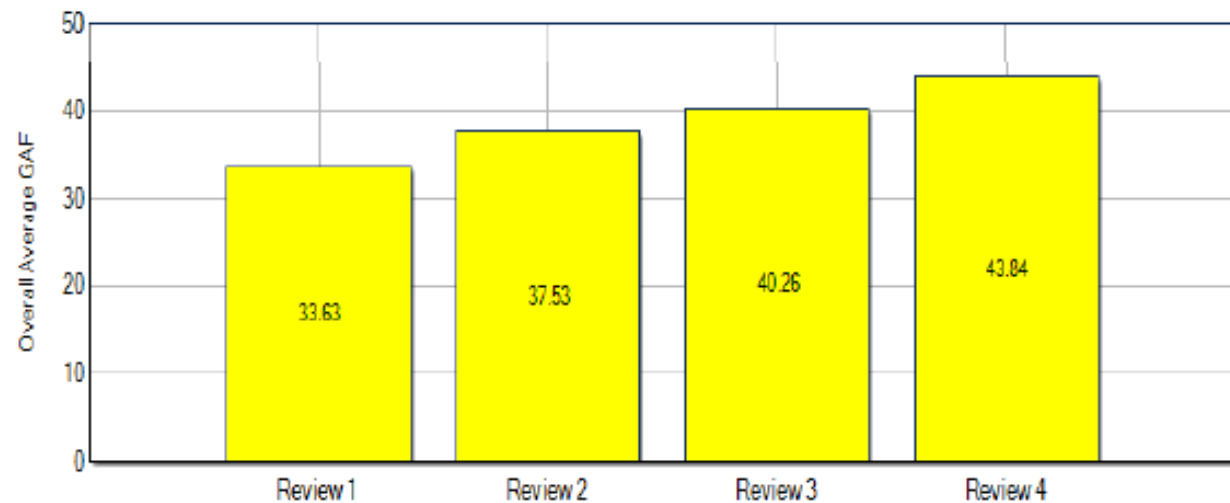
(i.e., how do we demonstrate that people are getting “better”



Cobb Douglas Avg. DLA-20 GAF Estimate (n=20)

DLA 23. Average Client GAF Score

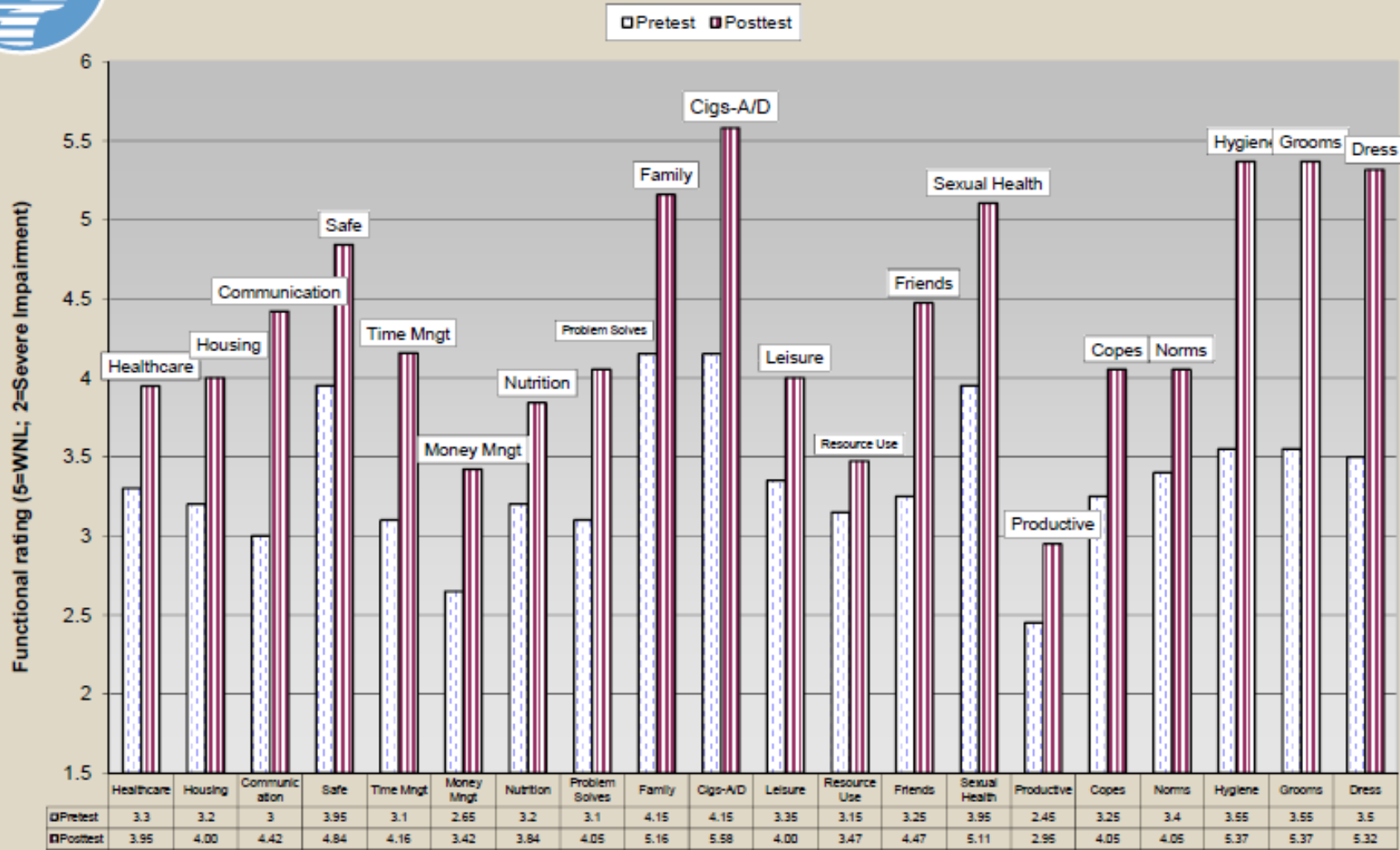
| Review | GAF |
|----------|-------|
| Review 1 | 33.63 |
| Review 2 | 37.53 |
| Review 3 | 40.26 |
| Review 4 | 43.84 |
| | 38.82 |



Groups ran 1X per week (Day Program & Peer Led Group in Day Program)



Cobb_Douglas Functional Results

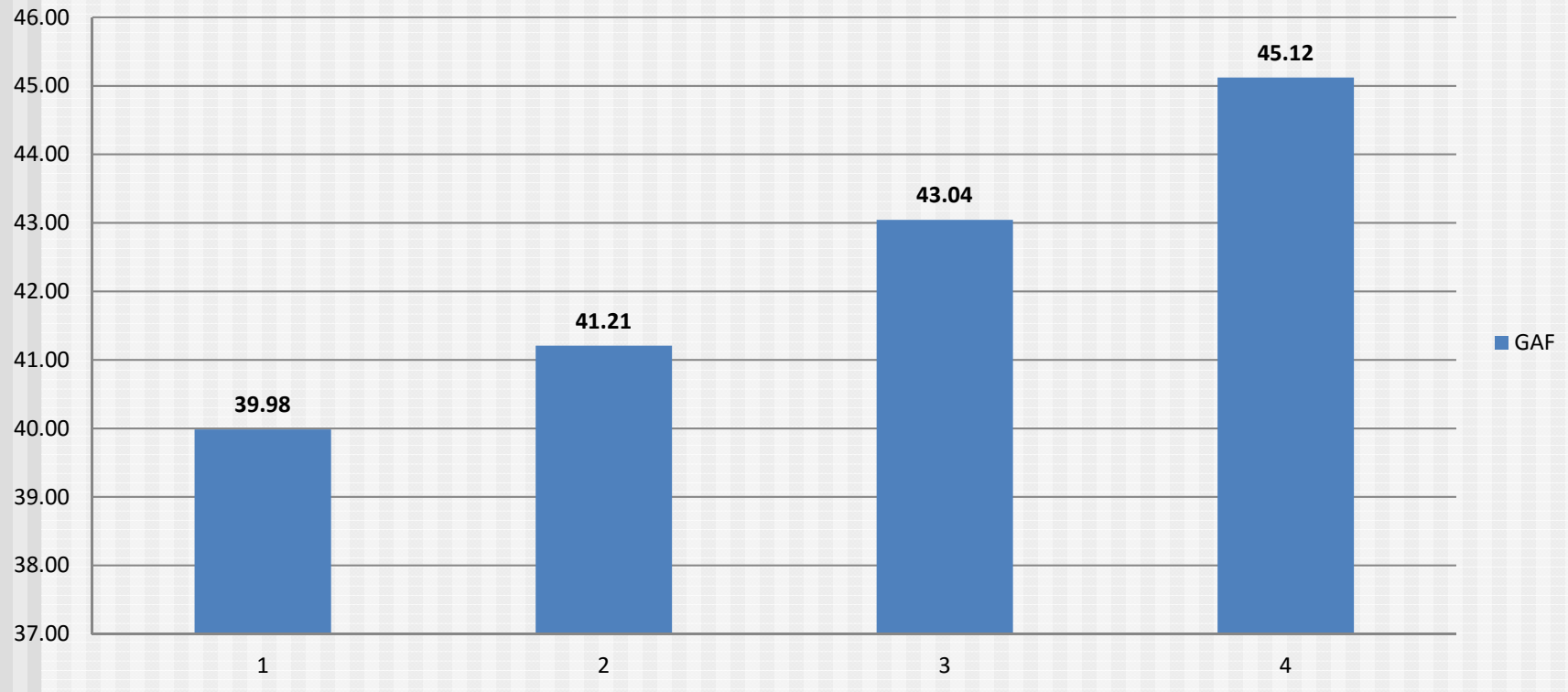


Highlighted Areas improved by >= .3 points

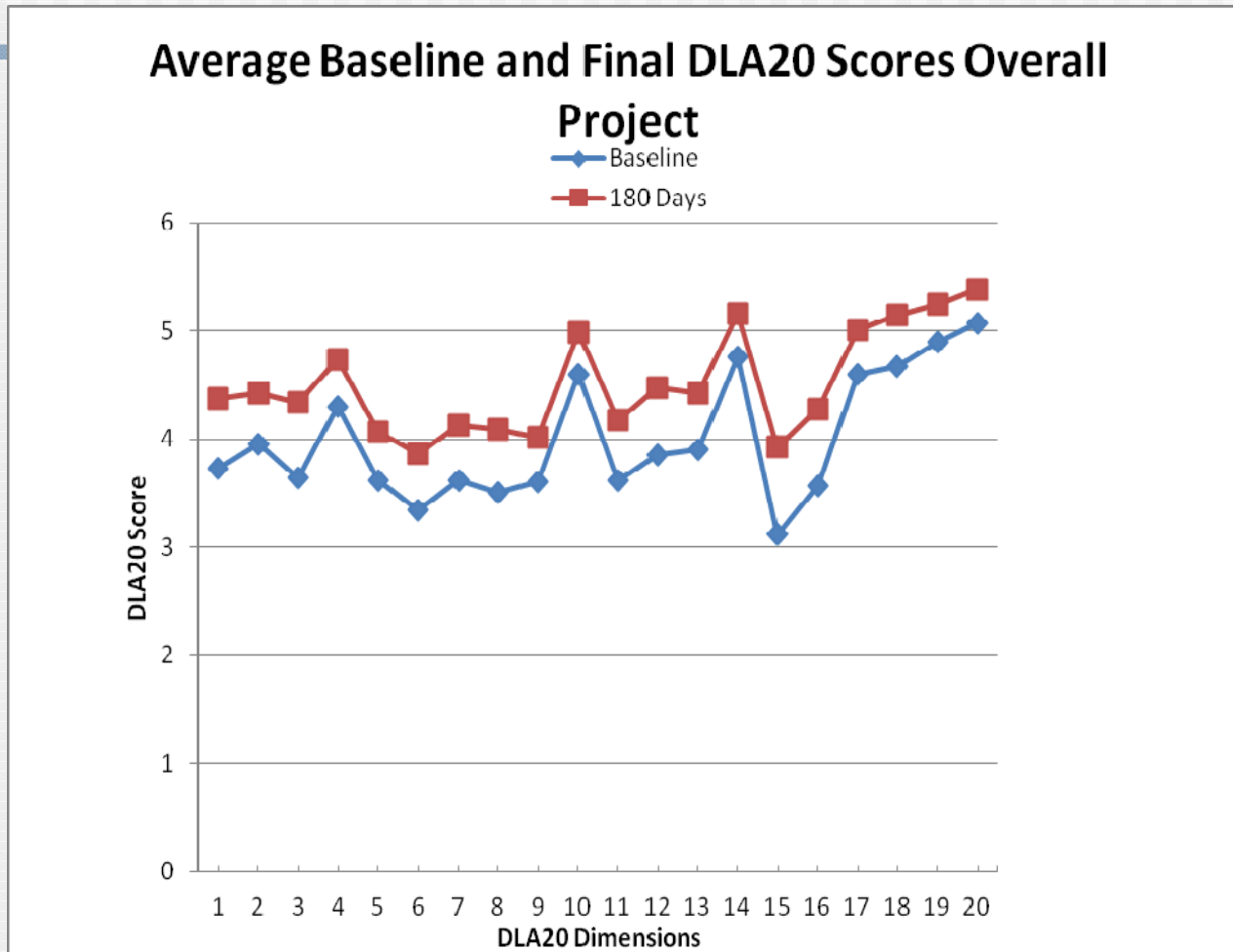
DLA

Overall Improvement In GAF

Mean Calculated GAF Over 4 Administrations
Total Timeframe is 6 Months
(All Organizations)



Overall Improvement In 20 Activities of Daily Living (ADLs) Measured in the DLA-20



Statistical Analysis of 20 ADLs:

As the table shows there were statistically significant improvements in all DLA20 areas of functioning as well as in the overall estimated GAF.

| Scale | Mean DLA20 Score | | | | F | Significance |
|------------------------------------|------------------|--------------|--------------|--------------|---------------|--------------|
| | Baseline | 60 Day | 120 Day | 180 Day | | |
| 1. Health Practices | 3.73 | 3.95 | 4.08 | 4.38 | 32.248 | 0.000 |
| 2. Housing Stability & Maintenance | 3.96 | 4.06 | 4.20 | 4.42 | 14.321 | 0.000 |
| 3. Communication | 3.64 | 3.81 | 4.07 | 4.34 | 36.768 | 0.000 |
| 4. Safety | 4.30 | 4.34 | 4.48 | 4.74 | 14.233 | 0.000 |
| 5. Managing Time | 3.61 | 3.76 | 3.95 | 4.07 | 15.059 | 0.000 |
| 6. Managing Money | 3.34 | 3.47 | 3.60 | 3.87 | 20.755 | 0.000 |
| 7. Nutrition | 3.61 | 3.78 | 3.94 | 4.13 | 20.508 | 0.000 |
| 8. Problem Solving | 3.51 | 3.63 | 3.85 | 4.09 | 29.861 | 0.000 |
| 9. Family Relationships | 3.61 | 3.64 | 3.82 | 4.01 | 12.668 | 0.000 |
| 10. Alcohol/ Drug Use | 4.60 | 4.75 | 4.93 | 4.98 | 9.047 | 0.000 |
| 11. Leisure | 3.62 | 3.75 | 3.96 | 4.18 | 27.023 | 0.000 |
| 12. Community Resources | 3.85 | 4.06 | 4.23 | 4.47 | 26.289 | 0.000 |
| 13. Social Network | 3.90 | 3.99 | 4.26 | 4.42 | 20.590 | 0.000 |
| 14. Sexuality | 4.76 | 4.85 | 5.06 | 5.16 | 16.296 | 0.000 |
| 15. Productivity | 3.12 | 3.30 | 3.61 | 3.92 | 46.358 | 0.000 |
| 16. Coping Skills | 3.56 | 3.76 | 4.03 | 4.27 | 39.292 | 0.000 |
| 17. Behavior Norms | 4.60 | 4.66 | 4.82 | 5.01 | 13.972 | 0.000 |
| 18. Personal Hygiene | 4.67 | 4.79 | 4.90 | 5.15 | 21.217 | 0.000 |
| 19. Grooming | 4.90 | 4.99 | 5.10 | 5.24 | 11.551 | 0.000 |
| 20. Dress | 5.07 | 5.07 | 5.20 | 5.38 | 12.349 | 0.000 |
| GAF | 39.98 | 41.21 | 43.04 | 45.12 | 87.787 | 0.000 |

(Note: All statistical analyses were conducted by Brian Dates Director of Evaluation and Research, Southwest Counseling Solutions)

Value of Care Determination

- After implementation of the essential performance indicators for the above three components of Value of Care have been completed the individual results need to be integrated so that the resulting data from each of the components supports an objective determination of the level of “value” that your CBHC is providing.
- This level of objectivity can be very helpful to support individual CBHC and state association’s “business case” to differentiate member CBHCs from other providers

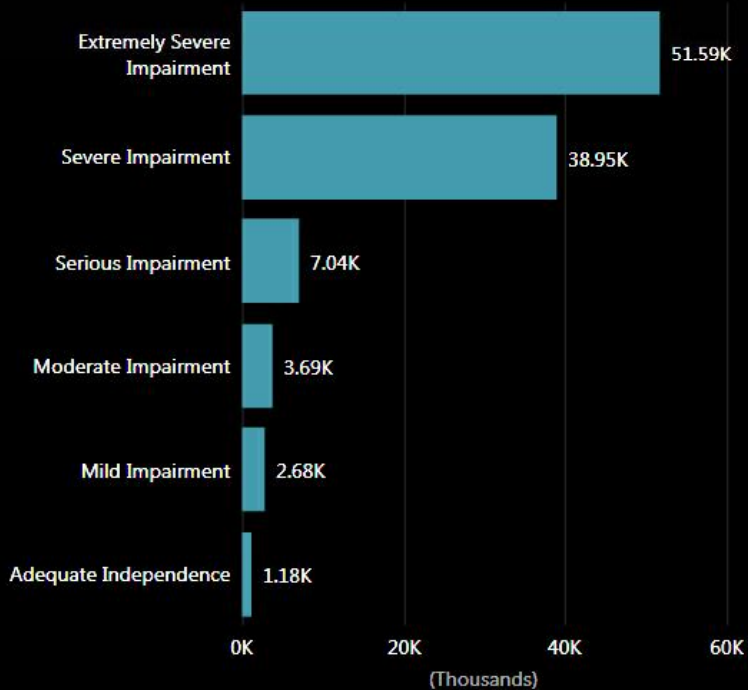
Value of Care Measurement Indicators

1. Average percentage change in DLA20 based Functionality Achieved from Baseline Level compared to levels at 90 days, 180 days, 270 days and 12 months
2. Total Annual Cost of Services provided per severity level
3. Number of clients in the cohort for each severity level
4. Total average annual cost of services per client
5. Equals the average cost per client per percentage point of improvement in functionality achieved

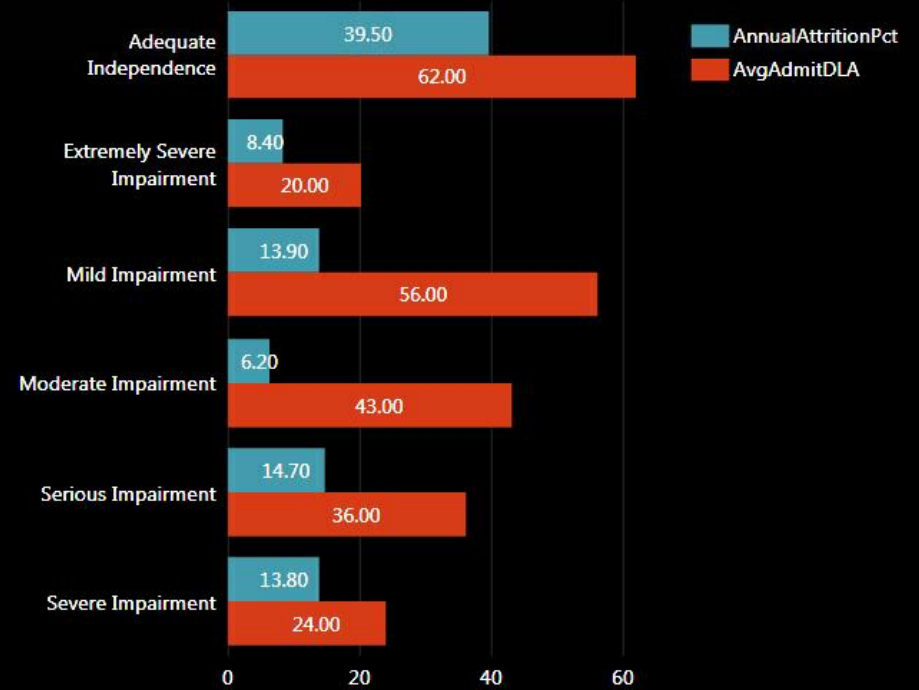
G1. DLA Risk Group Dashboard

| InitialDLARiskGroup | AvgAdmitDLA ▲ | AvgServiceMix | CohortPersonCount | SixMonthAvgChange | YearOneAvgChange | PopulationAvgAnnualCost | AnnualAttritionPct |
|-----------------------------|---------------|---------------|-------------------|-------------------|------------------|-------------------------|--------------------|
| Extremely Severe Impairment | 20.00 | 5.80 | 169.00 | 27.00 | 36.00 | \$8,719,095.32 | 8.40 |
| Severe Impairment | 24.00 | 4.60 | 3,789.00 | 30.00 | 39.00 | \$147,568,402.20 | 13.80 |
| Serious Impairment | 36.00 | 4.40 | 7,478.00 | 38.00 | 47.00 | \$52,638,988.04 | 14.70 |
| Moderate Impairment | 43.00 | 3.70 | 17,284.00 | 47.00 | 51.00 | \$63,748,577.20 | 6.20 |
| Mild Impairment | 56.00 | 2.80 | 8,346.00 | 59.00 | 60.00 | \$22,400,997.84 | 13.90 |
| Adequate Independence | 62.00 | 1.90 | 349.00 | 68.00 | 71.00 | \$410,657.83 | 39.50 |
| Total | 241.00 | 23.20 | 37,415.00 | 269.00 | 304.00 | \$295,486,718.43 | 96.50 |

AvgAnnualMemberCost by InitialDLARiskGroup



AnnualAttritionPct, and AvgAdmitDLA by InitialDLARiskGroup



What Do we Need to Begin to Measure to Support Value of Care?

Need to Measure if Clients are Getting “Better”

- What **standardized** outcome measurement tool is your center using and, alternatively, which standardized tool is being used by all CBHCs statewide?
- Is the measure symptom focused or functionality focused?
- Is there good inter-rater reliability?
- Do the direct care staff that are using the measure consider it “helpful” to support initial and updated treatment planning needs?
- Can the outcome measurement be directly linked to the level of severity for DSM 5 and the fourth digit modifier for ICD-10?
- Do you have data measurement and reporting capacity to graphically share with staff and clients the progress being achieved tied to the cost of services being provided?

Example of Outcome Score Measurement Linked to Level of Severity

SEVERITY OF ILLNESS: Average Composite DLA-20 Scores are correlated and can be converted to ICD-10 4th digit modifier:

- ≥ 6.0 = Adequate Independence; No significant to slight impairment in functioning
mGAF tallies # symptoms few and mild
- 5.1- 6.0 = **Mild impairments, minimal interruptions in recovery**
ICD 10 4th digit modifier = 0
- 4.1- 5.0 = **Moderate impairment in functioning**
ICD 10 4th digit modifier = 1
mGAF tallies number of symptoms = 1-3
- 3.1- 4.0 = **Serious impairments in functioning**
ICD 10 4th digit modifier = 2
mGAF tallies number of symptoms = 4-6
- 2.1- 3.0 = **Severe impairments in functioning**
ICD 10 4th digit modifier = 3
mGAF tallies number of symptoms = 7-10
- 2.0 = **Extremely severe impairments in functioning**
ICD10 4th digit modifier = 3
mGAF identifies intensely high-risk symptoms

States Adopting Statewide Standardize DLA-20 Functionality Outcome Measure

- Kansas
- Maryland
- Mississippi
- Missouri
- North Dakota
- Rhode Island
- South Carolina
- Utah

Eleven CCBHC Data and Quality Measures Required Reporting

1. Number/percent of new clients with initial evaluation provided within 10 business days, and mean number of days until initial evaluation for new clients
2. **Patient and Family experience of care survey**
3. Preventive Care and Screening: Adult Body Mass Index (BMI) Screening and Follow-Up
4. Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) (see Medicaid Child Core Set)
5. Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention
6. Preventive Care and Screening: Unhealthy Alcohol Use: Screening and Brief Counseling

Eleven CCBHC Data and Quality Measures Required Reporting

7. Initiation and engagement of alcohol and other drug dependence treatment (see Medicaid Adult Core Set)
8. Child and adolescent major depressive disorder (MDD): Suicide Risk Assessment (see Medicaid Child Core Set)
9. Adult major depressive disorder (MDD): Suicide risk assessment (use EHR Incentive Program version of measure)
10. Screening for Clinical Depression and Follow-Up Plan (see Medicaid Adult Core Set)
11. Depression Remission at 12 months

Ten State CCBHC Data and Quality Measures Required Reporting

1. Housing Status (Residential Status at Admission or Start of the Reporting Period Compared to Residential Status at Discharge or End of the Reporting Period)
2. Follow-Up After Discharge from the Emergency Department for Mental Health
3. Follow-Up After Discharge from the Emergency Department Alcohol or Other Dependence
4. Plan All-Cause Readmission Rate (PCR-AD) (see Medicaid Adult Core Set)
5. Diabetes Screening for People with Schizophrenia or Bipolar Disorder who Are Using Antipsychotic Medications

Ten State CCBHC Data and Quality Measures Required Reporting

6. Adherence to Antipsychotic Medications for Individuals with Schizophrenia (see Medicaid Adult Core Set)
7. Follow-Up After Hospitalization for Mental Illness, ages 21+ (adult) (see Medicaid Adult Core Set)
8. Follow-Up After Hospitalization for Mental Illness, ages 6 to 21 (child/adolescent) (see Medicaid Child Core Set)
9. Follow-up care for children prescribed ADHD medication (see Medicaid Child Core Set)
10. Antidepressant Medication Management (see Medicaid Adult Core Set)

Questions and Feedback

- Questions?
- Feedback?
- Next Steps?
- Contact Information:

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