Leadership Skills to Shift from “Volume” of Services to “Value of Care”

Presented by:
David Lloyd, Founder
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Q1 Select the topic area(s) that you would prefer Mr. Lloyd to train on. You may select more than one.

Answered: 40  Skipped: 0

<table>
<thead>
<tr>
<th>Answer Choices</th>
<th>Responses</th>
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<td>Leadership Skills Needed for Transformational Change to Support a Shift to a Managed Care</td>
<td>47.50% 19</td>
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<td>How to Develop a “Business Case” to Support your Organization in a Competitive Healthcare Environment</td>
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<td>How to look at Partnerships/Collaborations/Mergers in an Integrated (Behavioral/Physical) Care Environment</td>
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<td>How to Shift From a “Volume of Services” to “Value of Care Model”</td>
<td>57.50% 23</td>
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Total Respondents: 40

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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
“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.”

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

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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?”)

4. Ability of all staff to develop a dynamic tension between “quality” and “cost” as if they are on a pendulum
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, Illinois, 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 2016

- Accountable Care Organizations (ACOs) are being certified by CMS with over 600 announced Federal Certifications for both Medicare and 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 10,000 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

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Growth in Numbers of ACOs Nationally

Chart 2: Total Accountable Care Organizations by Sponsoring Entity

Source: Leavitt Partners Center for Accountable Care Intelligence

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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

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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

Figure 1. ACOs by Hospital Referral Region

ACO map August 2013 from Leavitt Partners
Accountable Care Organizations

Definitive Healthcare’s Connected Care database features the most up-to-date and in-depth data on over 800 Accountable Care Organizations (ACOs) and 200 Health Information Exchanges (HIEs), as well as Clinically Integrated Networks (CINs) and Community-Based Care Transitions Program (CCTP) Partnerships. This list of accountable care organizations and related organizations includes:

- Detailed ACO profiles including start date, patient population, number of physicians, and Medicare Shared Saving Program data
- Key executive contacts with phone number and email (where available)
- Organization members including hospitals, payors, physician groups, and other healthcare providers
- Technology implementations

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Accountable Care Organizations

Accountable care organizations (ACOs) are a model of care in which physicians, hospitals, and other institutions work across settings to coordinate and improve care for a population of patients and take part in any cost-savings achieved.

American Academy of Family Physicians Resources

- Joint Principles for Accountable Care Organizations
- Frequently Asked Questions About ACOs
- Everything You Need to Know About Accountable Care Organizations
- Medicare Shared Savings Program: Accountable Care Organizations Final Rule
- The Family Physician’s Blueprint for Success
- The Family Physician’s Practico Affiliation Guide
- ACOs: Can They Rein in Health Care Spending for States?
Accountable Care Organization

University Hospitals Provides Quality, Innovative, Coordinated and Patient-Centered Health Care

University Hospitals in Cleveland, Ohio, is a comprehensive health system recognized for providing quality and personalized coordinated health care through accountable care organizations (ACOs) built on the principles of population health. University Hospitals’ ACOs include:

- Pediatric ACO
- Employee ACO
- Medicare ACO

As one of the most comprehensive medical centers in the nation, UH has the advanced technology and specialized medical services in place to effectively coordinate someone’s health care needs from birth through their senior years.

University Hospitals Accountable Care Organization (UHACO) fosters long-term provider relationships that help promote preventive care, increase wellness and healthy behaviors, decrease emergency episodes, and prevent hospitalizations. Additionally, our ACO clinical care coordinators help patients, primary care providers, and specialists work as an integrated team focused on keeping patients healthy and proactively managing their care.
Welcome

The Northwest Ohio Accountable Care Organization has chosen to participate in the Medicare Shared Savings Program, a new initiative sponsored by the Centers for Medicare & Medicaid Services (CMS) as an Accountable Care Organization (ACO).

Northwest Ohio ACO will work with Medicare to provide Medicare Fee-for Service beneficiaries with high quality care, while reducing growth in Medicare expenditures through enhanced care coordination. Northwest Ohio ACO is a partnership between the physicians and medical staff of The Toledo Clinic and the University of Toledo Medical Center.

Northwest Ohio ACO is not a health plan or managed care plan. Unlike a managed care plan, Medicare beneficiaries will not be locked into a restricted panel of providers. Beneficiaries seeing doctors participating in Northwest Ohio ACO will maintain the ability to see any doctor or healthcare providers, as well as receive the full benefits associated with Original Medicare.

Northwest Ohio ACO, 3000 Arlington Ave, Mailstop 1018, Toledo, OH 43614
419-318-9447, www.nwoaco.com
Growth in Numbers of Clients Served by FQHCs

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

Estimated Number of Total Health Center Patients Under Health Reform

Source: National Association of Community Health Centers, Inc., Bethesda, MD, June 2010
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**, covers three main checkpoints for all hospitals as they make this transition:

- **Population Health Focus**
- **Experience of Care**
- **Lower Per Capita Cost**


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<table>
<thead>
<tr>
<th>Dimension of the IHI Triple Aim</th>
<th>Outcome Measures</th>
</tr>
</thead>
</table>
| **Population Health**         | **Health Outcomes:**  
|                                | • 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  
| **Disease Burden:**           | Incidence (yearly rate of onset, average age of onset) and/or prevalence of major chronic conditions  
| **Behavioral and Physiological Factors:** | • Behavioral factors include smoking, alcohol consumption, physical activity, and diet  
|                                | • Physiological factors include blood pressure, body mass index (BMI), cholesterol, and blood glucose  
|                                | (Possible measure: A composite health risk assessment [HRA] score)  
| **Experience of Care**        | Standard questions from patient surveys, for example:  
|                                | • Global questions from Consumer Assessment of Healthcare Providers and Systems (CAHPS) or How’s Your Health surveys  
|                                | • Likelihood to recommend  
|                                | 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)  
| **Per Capita Cost**           | **Total cost** per member of the population per month  
| **Hospital and emergency department (ED)** utilization rate and/or cost  

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.
Historical Leadership Challenges…

1. Recruitment and HR issues related to staff performance, behaviors, aptitude and attitude HR issues
2. Staff training requirements
3. Timely and accurate documentation submission by staff
4. Internal customer service challenges within units or programs
5. Need to renew the state or county contracts for service
6. Need to send timely claims to Medicaid for services delivered
Historical Leadership Challenges
Produced:

“System Noise” that required leadership to focus energy on the internal challenges over and over again... This historical focus on the internal system needs was more workable when the external healthcare environment was not changing at a rapid pace...

However, NOW...
New Healthcare Reform Leadership Challenges...

1. Developing/participating an Integrated Care Unit (ICU) to support the total wellness needs of the population
2. Population Management Models instead of one client at a time model including levels of care criteria
3. Shifting from “volume of services” revenue model to VALUE of Services Revenue model
4. Operating in a Shared Risk/Saving Funding Model based on a bundled payments for a episode of care cycle
5. Identification of client centered outcomes in an integrated healthcare model instead of fidelity to process measurement outcomes
6. Cost finding for a process of treatment/episode of care per CPT Code used for population focused care linked to client outcomes achieved to determine the cost per client for the outcomes achieved
7. Making the business case for your agency to MCOs/ACOs

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The “Values” that Community BH Clinics Now Need...

- Community Behavioral Health Clinics (CBHCs) have an excellent opportunity to be helpful partners in the new integrated healthcare system if they can display the following specific values:
  1. Be Accessible (Provide fast access to all needed services).
  2. Be Efficient (Provide high quality services at lowest possible cost).
  3. Be Connected (Have the ability to share core clinical information electronically).
  4. Be Accountable (Produce measurement information about the clinical outcomes achieved).
  5. Be Resilient (Have ability or willingness to use alternative payment arrangements).

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Historical Strategic Change Challenges...

1. **Sequential Change** – Complete one goal and then address next goal, etc.

2. **Quality Improvement Process Focus (QI)** – Typically Supports Process/Lack of Forward Movement/Attainment

   Vs.

4. **“Transformational Change”** – Continuous change management model using Rapid Cycle Change Model (PDSA)

5. **Continuous Quality Improvement Solution Focus (CQI)** – Implies Movement Forward/Action Has Happened to Provide Continuous Improvement
Largest Individual Leader’s Challenge...

- Leaders need to make some “tough” decisions in an era of change and stick with the decisions in the face of challenge..

- “Willingness for BH leaders to continually step across the Threshold of Risk to make bold and creative decisions about service delivery processes/methods!”

- What tools are needed to support minimizing the leadership decision-making “risks”? 

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Processing Crisis Vs. Managing Change Model

1. **Supervisor:** Reactive and Retrospective Problem Solver Role, therefore, he/she Processes Crisis

2. **Manager:** Dynamic Awareness of Current Issues that Provides Proactive Solution-Focused Decision-Making, therefore she/he Manages Complexities

3. **Leader/Coach/Mentor:** Possess Dynamic Awareness and Uses this information to envision possibilities for the organization, therefore he/she Manages/Sustains Change
Stages of the Need to Change and Leadership “Blinking”

1. Denial
2. Negotiation
3. Anger – Blaming – Outside then Inside
4. Drop Out – “It’s Awful!”
5. Acceptance of the Need to Change
6. Excited about the taking advantage of the opportunities
Comparison in For Profit Corporation and Non-Profit Entity

For Profit:
1. Direct equation between Responsibility to Manage linked with assumed Authority to Execute
2. Risk taking is a trained skill
3. Communicates in Bullets
4. CQI change management model
5. Knowledge of process and services costs and net revenues needed

Non-Profit:
1. Focus on Responsibility without assuming Adequate Authority to Execute
2. Risk aversion is comfortable
3. Communicates in Paragraphs/Chapters
4. QI change management model
5. Low/No knowledge of process and services costs and net revenues

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Leadership Performance Requirements:

Typical Focus Areas:
1. Willingness to make tough decisions
2. Willingness to stay with tough decisions
3. Willingness to change based on evaluation of outcomes achieved
4. Never ending communication skills
5. Accuracy
6. Ability to use objective information to support solution development
7. Knowledge of outcomes being achieved

Leadership Behaviors Desired:

Typical Focus Areas:
1. Fully involved and supportive of staff – Good Coach/Mentor
2. Timely Decision-Maker
3. Responsiveness to work requirements (i.e., timeliness to work, meets deadlines, etc.)
4. Good time Manager
5. Priority Setting Capable
6. Good Stress/Anger Management
7. Appropriate boundaries with staff and clients
8. Solution-Focused in every situation – “Okay, what are we going to do...?”
9. Low Crisis Orientation/Seems that they are “enough” to handle the situation
Leadership Aptitude Traits:

Typical Focus Areas:
1. Knowledge of skills required in work place
2. Willingness to let “ego” go to support team development
3. Willing to learn
4. Ability to change
5. Willing to teach and provide leadership to other clinical staff and programs

Positive Leadership Attitude Characteristics:

Typical Focus Areas:
1. Positive- We can do this...
2. Respectful of others
3. Cooperative
4. Creative in solution development
5. Flexible
6. Responsibility matched to authority to act...
7. Adaptive to changing environments
8. Responsive to needs of organization and staff
9. Team Player
10. Professional solution-focused approach that supports “respect factor”
Spectrum of Disruptive Staff Behaviors

**Aggressive**
- Inappropriate anger, threats
- Yelling publicly, disregarding team members
- Intimidating staff, patients colleagues
- Pushing throwing objects
- Swearing
- Outbursts of anger and physical abuse

**Passive. Aggressive**
- Hostile notes and e-mails
- Derogatory comments about institution, team, management
- Inappropriate joking
- Sexual harassment
- Complaining, blaming

**Passive**
- Chronically late
- Failure to return calls
- Inappropriate/inadequate chart notes
- Avoiding meetings and individuals
- Non-Participation
- Ill-prepared, not prepared
- Chronic excuses


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“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.

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“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

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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.

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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

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Just In Time Access to Services
Solution Outcomes at InterCommunity

Figure 1: Intake Show-Rate

Figure 2: Completed Intake Assessments

<table>
<thead>
<tr>
<th></th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>% increase</th>
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<td>42</td>
<td>52</td>
<td>81</td>
<td>76</td>
<td>66</td>
<td>70</td>
<td></td>
</tr>
<tr>
<td>2013</td>
<td>116</td>
<td>113</td>
<td>136</td>
<td>112</td>
<td>138</td>
<td>119</td>
<td>90%</td>
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Figure 3: No-Show Percentage Comparison

Figure 4: Days From First Call to Medication Evaluation

Figure 5: Medical Services Comparison

Figure 6: Client Survey Results

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

<table>
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<tr>
<th>Year</th>
<th>Assessment FTEs</th>
<th>Adult Clinician FTEs</th>
<th>Medical Team FTEs</th>
<th>Administrative Support FTEs</th>
<th>Total FTEs (Rounded)</th>
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<td>5.875</td>
<td>3</td>
<td>15.5</td>
<td>29</td>
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<tr>
<td>2012</td>
<td>5</td>
<td>5.875</td>
<td>3.62*</td>
<td>14.62</td>
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<td>2013</td>
<td>5</td>
<td>6.875</td>
<td>4.77*</td>
<td>13.62</td>
<td>30</td>
</tr>
</tbody>
</table>

Figure 8: Staffing Levels for Same Fiscal Years:

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“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.

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National No Show/ Cancel Measures

National Standard for Appointment Types:

- Appointment Kept
- No Show (less than 36 to 24 hrs notice)
- Appointment Canceled by Client (36 to 24 hrs or more notice)
- Appointment Canceled by Staff
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.
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

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Healthcare Home Neighbor

- A provider that partners to deliver specialty, subspecialty, or inpatient care
- American College of Physicians’ PCMH-N principles: The healthcare home & the specialist should:
  - Determine type(s) of clinical relationships the specialist is willing to enter into:
    - Pre-consultation exchange ("curbside consult")
    - Formal consultation
    - Co-management
    - Transfer to specialty care
  - Formalize the structure of these relationships through care coordination agreements
    - With financial and nonfinancial incentives to encourage specialist’s participation

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“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 completed 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: In 2015, 16 FADAA and FCCMH members completed 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 type.
- 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.**

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National Data from 112 Centers in 6 states:

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David Lloyd, Founder
### SAMPLE Cost vs. Revenue
Per CPT/HCPCS Code/Per Hour

<table>
<thead>
<tr>
<th>Row Labels</th>
<th>Sum of Total Hours Per Code</th>
<th>Average of Average Cost per Code</th>
<th>Average of NET Revenue per Code Per Hour</th>
<th>Average of Total Margin Per Code</th>
<th>Sum of Total Gain/Loss Per Code</th>
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<td>90837</td>
<td>92932.58</td>
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<td>$127.25</td>
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<tr>
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<td>($2,612,021.28)</td>
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</tbody>
</table>

Presented By:
David Lloyd, Founder
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?

<table>
<thead>
<tr>
<th>H0036</th>
<th>Average of Average Cost per Code</th>
<th>Average of NET Revenue per Code Per Hour</th>
<th>Average of Total Margin Per Code</th>
</tr>
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<tbody>
<tr>
<td>Local CHC</td>
<td>$171.23</td>
<td>$79.55</td>
<td>($91.68)</td>
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<tr>
<td>Statewide Weighted Average</td>
<td>$98.00</td>
<td>$114.33</td>
<td>$16.33</td>
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</table>

Presented By:
David Lloyd, Founder
### 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

<table>
<thead>
<tr>
<th>Staff to Client Ratio Standard</th>
<th>Actual Staff to Client Ratio</th>
<th>Net Diff Client to Staff</th>
<th>Total Beds</th>
<th>Total Bed Days Avail.</th>
<th>Actual Bed Days Utilized</th>
<th>Percent Beds Utilized</th>
<th>Target Bed Utilization Rate</th>
<th>Over (Under) Bed Utilization Rate</th>
<th>Math Drug Costs</th>
<th>Over/Under Drug Budget</th>
<th>Math Repair Costs</th>
<th>Over/Under Repair Budget</th>
<th>Math Food Costs</th>
<th>Over/Under Food Budget</th>
<th>YTD Total Salary and Fringes</th>
<th>YTD Total Admin/Overhead</th>
</tr>
</thead>
<tbody>
<tr>
<td>1:7</td>
<td>1:6</td>
<td>+1</td>
<td>24</td>
<td>720</td>
<td>600</td>
<td>83%</td>
<td>90%</td>
<td>(7%)</td>
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#### Residential Programs

<table>
<thead>
<tr>
<th>Staff to Client Ratio Standard</th>
<th>Actual Staff to Client Ratio</th>
<th>Net Diff Client to Staff</th>
<th>Total Beds</th>
<th>Total Bed Days Avail.</th>
<th>Actual Bed Days Utilized</th>
<th>Percent Beds Utilized</th>
<th>Target Bed Utilization Rate</th>
<th>Over (Under) Bed Utilization Rate</th>
<th>Math Rent/Mort Costs</th>
<th>Over/Under Budget</th>
<th>Math Repair Costs</th>
<th>Over/Under Repair Budget</th>
<th>Math Food Costs</th>
<th>Over/Under Food Budget</th>
<th>YTD Total Salary and Fringes</th>
<th>YTD Total Admin/Overhead</th>
</tr>
</thead>
<tbody>
<tr>
<td>1:6</td>
<td>1:4</td>
<td>+2</td>
<td>5</td>
<td>180</td>
<td>120</td>
<td>63%</td>
<td>90%</td>
<td>(22%)</td>
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#### Day/Night Programs

<table>
<thead>
<tr>
<th>Staff to Client Ratio Standard</th>
<th>Actual Staff to Client Ratio</th>
<th>Net Diff Client to Staff</th>
<th>Total Per Day Cap.</th>
<th>Total Client Capacity</th>
<th>Actual Client Capacity Utilized</th>
<th>Percent Capacity Utilized</th>
<th>Target Capacity Utilization Rate</th>
<th>Over (Under) Target</th>
<th>Math Trans. Costs</th>
<th>Over/Under Budget</th>
<th>Math Repair Costs</th>
<th>Over/Under Repair Budget</th>
<th>Total # FIEs</th>
<th>YTD Total Salary and Fringes</th>
<th>YTD Total Admin/Overhead</th>
</tr>
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<tbody>
<tr>
<td>1:4</td>
<td>1:3</td>
<td>+1</td>
<td>25</td>
<td>537.5</td>
<td>400</td>
<td>73%</td>
<td>90%</td>
<td>(17%)</td>
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*Efficiency Scale:  “A” Rating = Met or exceeded 95% of all indicators; “B” Rating = Met or exceeded 85% of all indicators; “C” Rating = Met or exceeded 75% of all indicators; and “D” Rating = Met or exceeded 70% of all indicators.*

Presented By:
David Lloyd, Founder
Cost Based Direct Service Performance Standards

<table>
<thead>
<tr>
<th>PSYCHOSOCIAL. REHABILITATION</th>
<th>STAFF</th>
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<tbody>
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<td></td>
<td>AVG.</td>
<td>YEARLY</td>
<td>SALARY</td>
<td>SALARY</td>
<td>FRINGE</td>
<td>OVERHEAD</td>
<td>TOTAL EXPENSES</td>
<td>GRANT REVENUE</td>
<td>REIMBURSE RATE</td>
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<tr>
<td>Community Support Counselor 1</td>
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<td>Community Support Counselor 6.5</td>
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<td>Community Support Counselor 7.5</td>
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<td>SALARY</td>
<td>SALARY</td>
<td>FRINGE</td>
<td>OVERHEAD</td>
<td>TOTAL EXPENSES</td>
<td>GRANT REVENUE</td>
<td>REIMBURSE RATE</td>
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<td>Clinician 1</td>
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<td>57,383.02</td>
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<td>SALARY</td>
<td>SALARY</td>
<td>FRINGE</td>
<td>OVERHEAD</td>
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<td>Day TX Counselor 3</td>
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<td>AVG.</td>
<td>YEARLY</td>
<td>SALARY</td>
<td>SALARY</td>
<td>FRINGE</td>
<td>OVERHEAD</td>
<td>TOTAL EXPENSES</td>
<td>GRANT REVENUE</td>
<td>REIMBURSE RATE</td>
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<tr>
<td>Psychosocial</td>
<td>1,038.18</td>
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<td>7,474.90</td>
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<td>1,257.14</td>
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Presented By:
David Lloyd, Founder

### Cost Based Direct Service Performance Standards

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<th>Prevention &amp; Children's</th>
<th>1,038.18</th>
<th>24,916.32</th>
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<th>6,393.83</th>
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### Substance Abuse Intensive Outpatient

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<th>YEARLY SALARY</th>
<th>FRINGE</th>
<th>OVERHEAD</th>
<th>TOTAL EXPENSES</th>
<th>GRANT REVENUE</th>
<th>REIMBURSE RATE</th>
<th>UNITS NEEDED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chemical Dep. Counselor 1</td>
<td>1,038.18</td>
<td>24,916.32</td>
<td>7,474.90</td>
<td>11,336.93</td>
<td>43,728.14</td>
<td>7,149.00</td>
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<td>Chemical Dep. Counselor 2</td>
<td>1,038.18</td>
<td>24,916.32</td>
<td>7,474.90</td>
<td>11,336.93</td>
<td>43,728.14</td>
<td>15,252.50</td>
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<td>1,038.18</td>
<td>24,916.32</td>
<td>7,474.90</td>
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<td>43,728.14</td>
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### EARLY INTERVENTION

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<th>AVG. SALARY</th>
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<th>FRINGE</th>
<th>OVERHEAD</th>
<th>TOTAL EXPENSES</th>
<th>GRANT REVENUE</th>
<th>REIMBURSE RATE</th>
<th>UNITS NEEDED</th>
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</thead>
<tbody>
<tr>
<td>Early Childhood Educator 1</td>
<td>1,072.43</td>
<td>25,738.32</td>
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<tr>
<td>Service Coordinator</td>
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### EMPLOYMENT SERVICES

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<th>YEARLY SALARY</th>
<th>FRINGE</th>
<th>OVERHEAD</th>
<th>TOTAL EXPENSES</th>
<th>GRANT REVENUE</th>
<th>REIMBURSE RATE</th>
<th>UNITS NEEDED</th>
</tr>
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<tbody>
<tr>
<td>Lead Employment Specialist</td>
<td>924.52</td>
<td>22,168.48</td>
<td>6,656.54</td>
<td>10,095.76</td>
<td>38,940.73</td>
<td>14,770.18</td>
<td>$42.66</td>
<td>557</td>
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<tr>
<td>Employment Specialist 2</td>
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<td>Employment Specialist 3</td>
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</tr>
<tr>
<td>Job Coach</td>
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<tr>
<td>Employment Specialist 4</td>
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### SUBSTANCE ABUSE COUNSELORS

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<th>YEARLY SALARY</th>
<th>FRINGE</th>
<th>OVERHEAD</th>
<th>TOTAL EXPENSES</th>
<th>GRANT REVENUE</th>
<th>NET REIMBURSE RATE</th>
<th>UNITS NEEDED</th>
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<td>1</td>
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## Cost Based Direct Service Performance Standards

### IDD Residential

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<th>Fringe</th>
<th>Overhead</th>
<th>Total Expenses</th>
<th>Grant Revenue</th>
<th>Reimburse Rate</th>
<th>Units Needed for Breakeven</th>
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<tbody>
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<td>Residential Counselor 1</td>
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<td>6,366.38</td>
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<td><strong>PER UNIT</strong></td>
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<tr>
<td>Residential Counselor 6</td>
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<td></td>
<td></td>
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<tr>
<td>Residential Counselor 7</td>
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<td></td>
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<tr>
<td>Residential Counselor 7.5</td>
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### MH Residential

<table>
<thead>
<tr>
<th>Position</th>
<th>AVG. Salary</th>
<th>Yearly Salary</th>
<th>Fringe</th>
<th>Overhead</th>
<th>Total Expenses</th>
<th>Grant Revenue</th>
<th>Reimburse Rate</th>
<th>Units Needed for Breakeven</th>
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</thead>
<tbody>
<tr>
<td>Residential Counselor 1</td>
<td>884.22</td>
<td>21,221.28</td>
<td>6,366.38</td>
<td>9,665.68</td>
<td>37,243.36</td>
<td>36,464.25</td>
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<td>Residential Counselor 2</td>
<td></td>
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<td></td>
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<td></td>
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<tr>
<td>Residential Counselor 3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(1-3 HR)</td>
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<tr>
<td>Residential Counselor 4</td>
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### Emergency Services

<table>
<thead>
<tr>
<th>Position</th>
<th>AVG. Salary</th>
<th>Yearly Salary</th>
<th>Fringe</th>
<th>Overhead</th>
<th>Total Expenses</th>
<th>Grant Revenue</th>
<th>Reimburse Rate</th>
<th>Units Needed for Breakeven</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supervisor</td>
<td>1,264.30</td>
<td>30,343.20</td>
<td>9,102.96</td>
<td>13,806.16</td>
<td>53,252.32</td>
<td>11,825.00</td>
<td><strong>$9.96</strong></td>
<td>1,040</td>
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<tr>
<td></td>
<td>2</td>
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<td></td>
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<td></td>
<td><strong>UNITS</strong></td>
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### Day Support

<table>
<thead>
<tr>
<th>Position</th>
<th>AVG. Salary</th>
<th>Yearly Salary</th>
<th>Fringe</th>
<th>Overhead</th>
<th>Total Expenses</th>
<th>Grant Revenue</th>
<th>Reimburse Rate</th>
<th>Units Needed for Breakeven</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supervisor</td>
<td>865.72</td>
<td>20,777.28</td>
<td>6,233.18</td>
<td>9,453.66</td>
<td>36,464.13</td>
<td>1,073.50</td>
<td><strong>$29.07</strong></td>
<td>1,217</td>
</tr>
<tr>
<td>Trainer 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>PER UNIT</strong></td>
<td></td>
</tr>
<tr>
<td>Trainer 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(1-3 HR)</td>
<td></td>
</tr>
<tr>
<td>Trainer 3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trainer 4</td>
<td></td>
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<td></td>
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<td></td>
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<td></td>
</tr>
</tbody>
</table>
Payer Diversity is a MUST!

- Over reliance on Medicaid and County/State Grant funding creates a “survival agency” model
- Because of the Affordable Care Act and Insurance Parity, behavioral health agencies today need a minimum of 30% third party private insurance funding.

Presented By: David Lloyd, Founder
Third Party/Managed Care Utilization Management Plan Components:

1. 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
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.)?

Presented By:
David Lloyd, Founder
Roles of Support Staff In Third Party Billing

1. Centralized Scheduling is needed to ensure referral is made to clinician on the appropriate insurance panel
   - Ability to know at all times the availability of clinical staff that are credential on third party panels will be critical to timely acceptance of new referrals

2. Re-think Front Desk functions/needs
   - Collection of Co-Pays prior to Service
   - Confirmation of Insurance via copy of Insurance cards prior to service

Presented By:
David Lloyd, Founder
Roles of Clinical and Financial Staff In Third Party Billing

3. 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 – (i.e., Case study from DuPage County MHS, IL - 99.9% contained within day of service)

4. Filing timely and accurate claims will be critical

5. Monitoring level of unreimbursed third party care – determine reasons for non payment and correct issues
Revenue Cycle Management

A greater understanding of cash flows and management of billing practices will be needed in the new environment

- How long is your billing process?
  - Are you billing weekly?
  - Can you process third party claims daily?
- What is your percent of denials?
- What is your performance standard on reconciliation of billing errors?
- What percent of co-pays and self pay amounts are you collecting daily
  - Do you establish a daily collection figure for your front desk?
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)
“Value” of Care Equation

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

Presented By:
David Lloyd, Founder
Treat to Target Attainment Levels:

1. Most of our clinicians use a “treat to target” approach to planning, service delivery, and adjusting the care plan if it’s not working.

2. The majority of clinicians and supervisors have studied the treat to target literature and develop care plans that include measureable targets (e.g. 25% improvement in DLA-20 aggregate score, 50% reduction in PHQ-9 scores within 12 weeks), measure progress at least monthly, and work with consumers to adjust the care plan if targets are not being met.

3. Part of this process includes the use of clinical tools that measure improvement in symptomology, functional status, and recovery and resilience-building for the children, families and adults we serve.

Presented By:
David Lloyd, Founder
Cobb Douglas Avg. DLA-20 GAF Estimate (n=20)

DLA 23. Average Client GAF Score

<table>
<thead>
<tr>
<th>Review</th>
<th>GAF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review 1</td>
<td>33.63</td>
</tr>
<tr>
<td>Review 2</td>
<td>37.53</td>
</tr>
<tr>
<td>Review 3</td>
<td>40.26</td>
</tr>
<tr>
<td>Review 4</td>
<td>43.84</td>
</tr>
</tbody>
</table>

Groups ran 1X per week (Day Program & Peer Led Group in Day Program)
Overall Improvement In GAF

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

Presented By:
David Lloyd, Founder
Overall Improvement In 20 Activities of Daily Living (ADLs) Measured in the DLA-20

Average Baseline and Final DLA20 Scores Overall

Presented By:
David Lloyd, Founder
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.

<table>
<thead>
<tr>
<th>Scale</th>
<th>Baseline</th>
<th>60 Day</th>
<th>120 Day</th>
<th>180 Day</th>
<th>F</th>
<th>Significance</th>
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</thead>
<tbody>
<tr>
<td>1. Health Practices</td>
<td>3.73</td>
<td>3.95</td>
<td>4.08</td>
<td>4.38</td>
<td>32.248</td>
<td>0.000</td>
</tr>
<tr>
<td>2. Housing Stability &amp; Maintenance</td>
<td>3.96</td>
<td>4.06</td>
<td>4.20</td>
<td>4.42</td>
<td>14.321</td>
<td>0.000</td>
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<tr>
<td>3. Communication</td>
<td>3.64</td>
<td>3.81</td>
<td>4.07</td>
<td>4.34</td>
<td>36.768</td>
<td>0.000</td>
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<tr>
<td>4. Safety</td>
<td>4.30</td>
<td>4.34</td>
<td>4.48</td>
<td>4.74</td>
<td>14.233</td>
<td>0.000</td>
</tr>
<tr>
<td>5. Managing Time</td>
<td>3.61</td>
<td>3.76</td>
<td>3.95</td>
<td>4.07</td>
<td>15.059</td>
<td>0.000</td>
</tr>
<tr>
<td>6. Managing Money</td>
<td>3.34</td>
<td>3.47</td>
<td>3.60</td>
<td>3.87</td>
<td>20.755</td>
<td>0.000</td>
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<tr>
<td>7. Nutrition</td>
<td>3.61</td>
<td>3.78</td>
<td>3.94</td>
<td>4.13</td>
<td>20.508</td>
<td>0.000</td>
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<tr>
<td>8. Problem Solving</td>
<td>3.51</td>
<td>3.63</td>
<td>3.85</td>
<td>4.09</td>
<td>29.861</td>
<td>0.000</td>
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<tr>
<td>9. Family Relationships</td>
<td>3.61</td>
<td>3.64</td>
<td>3.82</td>
<td>4.01</td>
<td>12.668</td>
<td>0.000</td>
</tr>
<tr>
<td>10. Alcohol/ Drug Use</td>
<td>4.60</td>
<td>4.75</td>
<td>4.93</td>
<td>4.98</td>
<td>9.047</td>
<td>0.000</td>
</tr>
<tr>
<td>11. Leisure</td>
<td>3.62</td>
<td>3.75</td>
<td>3.96</td>
<td>4.18</td>
<td>27.023</td>
<td>0.000</td>
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<tr>
<td>12. Community Resources</td>
<td>3.85</td>
<td>4.06</td>
<td>4.23</td>
<td>4.47</td>
<td>26.289</td>
<td>0.000</td>
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<tr>
<td>13. Social Network</td>
<td>3.90</td>
<td>3.99</td>
<td>4.26</td>
<td>4.42</td>
<td>20.500</td>
<td>0.000</td>
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<tr>
<td>14. Sexuality</td>
<td>4.76</td>
<td>4.85</td>
<td>5.06</td>
<td>5.16</td>
<td>16.296</td>
<td>0.000</td>
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<tr>
<td>15. Productivity</td>
<td>3.12</td>
<td>3.30</td>
<td>3.61</td>
<td>3.92</td>
<td>46.358</td>
<td>0.000</td>
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<tr>
<td>16. Coping Skills</td>
<td>3.56</td>
<td>3.76</td>
<td>4.03</td>
<td>4.27</td>
<td>39.292</td>
<td>0.000</td>
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<tr>
<td>17. Behavior Norms</td>
<td>4.60</td>
<td>4.66</td>
<td>4.82</td>
<td>5.01</td>
<td>13.972</td>
<td>0.000</td>
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<tr>
<td>18. Personal Hygiene</td>
<td>4.67</td>
<td>4.79</td>
<td>4.90</td>
<td>5.15</td>
<td>21.217</td>
<td>0.000</td>
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<tr>
<td>19. Grooming</td>
<td>4.90</td>
<td>4.99</td>
<td>5.10</td>
<td>5.24</td>
<td>11.551</td>
<td>0.000</td>
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<tr>
<td>20. Dress</td>
<td>5.07</td>
<td>5.07</td>
<td>5.20</td>
<td>5.38</td>
<td>12.349</td>
<td>0.000</td>
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<tr>
<td>GAF</td>
<td>39.98</td>
<td>41.21</td>
<td>43.04</td>
<td>45.12</td>
<td>87.787</td>
<td>0.000</td>
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</tbody>
</table>

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

Presented By:
David Lloyd, Founder
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

Presented By:
David Lloyd, Founder
## G1. DLA Risk Group Dashboard

<table>
<thead>
<tr>
<th>InitialDLARiskGroup</th>
<th>AvgAdmitDLA</th>
<th>AvgServiceMix</th>
<th>CohortPersonCount</th>
<th>SixMonthAvgChange</th>
<th>YearOneAvgChange</th>
<th>PopulationAvgAnnualCost</th>
<th>AnnualAttritionPct</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extremely Severe Impairment</td>
<td>20.00</td>
<td>5.80</td>
<td>169.00</td>
<td>27.00</td>
<td>36.00</td>
<td>$8,719,095.32</td>
<td>8.40</td>
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<tr>
<td>Severe Impairment</td>
<td>24.00</td>
<td>4.60</td>
<td>3,789.00</td>
<td>30.00</td>
<td>39.00</td>
<td>$147,568,402.20</td>
<td>13.80</td>
</tr>
<tr>
<td>Serious Impairment</td>
<td>36.00</td>
<td>4.40</td>
<td>7,478.00</td>
<td>38.00</td>
<td>47.00</td>
<td>$52,638,388.04</td>
<td>14.70</td>
</tr>
<tr>
<td>Moderate Impairment</td>
<td>43.00</td>
<td>3.70</td>
<td>17,284.00</td>
<td>47.00</td>
<td>51.00</td>
<td>$63,748,577.20</td>
<td>6.20</td>
</tr>
<tr>
<td>Mild Impairment</td>
<td>56.00</td>
<td>2.80</td>
<td>8,346.00</td>
<td>59.00</td>
<td>60.00</td>
<td>$22,400,997.84</td>
<td>13.90</td>
</tr>
<tr>
<td>Adequate Independence</td>
<td>62.00</td>
<td>1.90</td>
<td>349.00</td>
<td>68.00</td>
<td>71.00</td>
<td>$410,657.83</td>
<td>39.50</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>241.00</strong></td>
<td><strong>23.20</strong></td>
<td><strong>37,415.00</strong></td>
<td><strong>269.00</strong></td>
<td><strong>304.00</strong></td>
<td><strong>$295,486,718.43</strong></td>
<td><strong>96.50</strong></td>
</tr>
</tbody>
</table>

### AvgAnnualMemberCost by InitialDLARiskGroup

- **Extremely Severe Impairment**: $51.59K
- **Severe Impairment**: $38.95K
- **Serious Impairment**: $7.04K
- **Moderate Impairment**: $3.69K
- **Mild Impairment**: $2.68K
- **Adequate Independence**: $1.18K

### AnnualAttritionPct, and AvgAdmitDLA by InitialDLARiskGroup

- **Extremely Severe Impairment**: AnnualAttritionPct: 8.40, AvgAdmitDLA: 20.00
- **Serious Impairment**: AnnualAttritionPct: 13.90, AvgAdmitDLA: 56.00
- **Mild Impairment**: AnnualAttritionPct: 6.20, AvgAdmitDLA: 43.00
- **Moderate Impairment**: AnnualAttritionPct: 14.70, AvgAdmitDLA: 43.00
- **Severe Impairment**: AnnualAttritionPct: 13.80, AvgAdmitDLA: 24.00

---

For Behavioral Health
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

Presented By:
David Lloyd, Founder
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

Presented By:
David Lloyd, Founder
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)
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.)

Presented By:
David Lloyd, Founder
Core Elements of Strategic Business Development

First Step is the need to identify and adopt a “Business Model”- focused on either:

- How to **earn additional revenues** to support expenses in a changing shared risk funding environment; and/or
- How to **reduce costs** through process re-engineering/increased staff performance; and/or
- **Willingness to participate** in partnerships and mergers to grow your market base; and/or
- **Ability to diversify your services** to attract a large share of the current market base with new service types.

Presented By: David Lloyd, Founder
Rapid Cycle Improvement - Plan Do Study Act (PDSA) Cycles

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

1. Plan
   - Establish the Parameters for the change.

2. Do
   - Implement the planned changes.

3. Study
   - Evaluate the effectiveness of the change.

4. Act
   - React to the results of the evaluation.

Presented By:
David Lloyd, Founder
## Sample Rapid Cycle Change Plan

### Implementation Scope of Work and Timeline

<table>
<thead>
<tr>
<th>Task Description</th>
<th>May 09</th>
<th>Jun 09</th>
<th>Jul 09</th>
<th>Aug 09</th>
<th>Sep 09</th>
<th>Oct 09</th>
<th>Nov 09</th>
<th>Dec 09</th>
<th>Jan 10</th>
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<td>1. Enhance Access to Services</td>
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<td>➤ Define scheduling needs in urban and rural regions and illuminate differences</td>
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<td>➤ Involve clients and family feedback to improve access (be person centered)</td>
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<td>➤ Design Clinical and Medical Intake Services (Access)/Centralized scheduling</td>
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<td>➤ Develop and implement plan for increasing 83 Service Volume</td>
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<td>➤ Standardize reminder call, waitlist, and apt backfill procedures</td>
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<td>➤ Develop clinical and medical capacity for post-intake services</td>
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<td>➤ Develop and implement plan for “Immediate access” or “Walk-in” Intake and what that means in most rural sites</td>
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<td>➤ Develop implement plan for initial verification of benefits and continual Rerification</td>
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<td>➤ Review and redesign “client assignment staffing” and follow up</td>
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<td>➤ Determine feasibility of implementing centralized phone intake</td>
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<td>➤ Develop intake paperwork completed by client and staff</td>
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<td>➤ Staff engagement in change process (coaching &amp; supervision techniques)</td>
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<td>➤ Develop linked clinical and medical services to manage intake and on-going No Show/Cancellations</td>
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<td>➤ Develop customer service expectations and strategies for clinical staff</td>
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<td>➤ Evaluation of Action Steps Implemented for Possible Redesign</td>
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<td>2. Enhance Staff Direct Service Levels</td>
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<td>➤ Implement revised CFTE process</td>
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<td>➤ Confirm billable services to be included in Productivity (billable encounters)</td>
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<td>➤ Implement Business Staff Productivity and Staffing Levels</td>
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<td>➤ Validate staff available time exists in Scheduler to meet Productivity standard, Centralized Scheduling</td>
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<td>➤ Distribute Productivity Report to Directors monthly</td>
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**Presented By:**
David Lloyd, Founder
# Moving from a Good Idea to an Implementable Solution

## Implementation Planning Recommendation

<table>
<thead>
<tr>
<th>Name of Team:</th>
<th>Date:</th>
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<tbody>
<tr>
<td>Name of Key Contact:</td>
<td>Phone #:</td>
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</table>

**Solution Description Summary:**

**Recommendations (short narrative with bulleted points):**

**Justification:**

**Barriers to Implementation:**

**Action Objectives to Overcome Implementation Barriers: (CQI Process)**

**Accreditation and Compliance Reviews:**

**Recommended Timeline (Begin/End):**

**Implementation and Training Resources and Requirements:**

**Anticipated Outcomes:**

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Presented By:
David Lloyd, Founder
Questions and Feedback

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

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E-mail: david.lloyd@mtmservices.org
Web Site: mtmservices.org