

Provider Readiness Self-Assessment

In Preparation for

Implementation of MRO Services: ACT
and Community Support

Connecticut Department of Mental Health and
Addiction Services

National Council for Community Behavioral
Healthcare Consulting Services

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Table of Contents

TABLE OF CONTENTS	2
EXECUTIVE SUMMARY	3
KEY CONCLUSIONS	3
RECOMMENDATIONS.....	4
SECTION 1: ASSESSMENT PROCESS	7
ASSESSMENT TOOL.....	8
SECTION 2: ANALYSIS	11
NETWORK PROFILE	11
PROVIDER READINESS RESULTS	12
QUESTION LEVEL DETAIL	14
SECTION 3: RECOMMENDATIONS	18
CASH FLOW SUPPORT	18
CLINICAL AND SERVICE PROVISION.....	19
INFRASTRUCTURE	20
OPERATIONS	22
TRANSITION ISSUES	23
SEQUENCING.....	25
APPENDIX A	26
PROVIDER READINESS DATA.....	26
APPENDIX B	34
INFORMATION SYSTEMS IN USE	34
APPENDIX C:	35
PROVIDER READINESS WORKGROUP DRAFT RECOMMENDATIONS	35
APPENDIX D	38
TRAINING TOPICS USED IN OTHER STATES.....	38
APPENDIX E	40
PROVIDERS PARTICIPATING IN SURVEY	40
APPENDIX F	41
MEMBERSHIP IN PROVIDER READINESS WORKGROUP.....	41

Executive Summary

The Connecticut Department of Mental Health and Addiction Services (DMHAS) is preparing for implementation of the Medicaid Rehabilitation Option for up to 25,000 clients who will receive the new MRO services of Assertive Community Treatment and Community Support. This transformation will require changes in provider functioning at core business levels as services will be reimbursed retrospectively through a fee-for-service methodology for clients with Medicaid. The readiness assessment process described below was designed to establish a baseline for existing provider competencies and functions in all areas that will be affected by this change. The outcome of this process will assist providers to identify areas within their operations that may need development. In addition, this process will identify priority areas where additional training or technical assistance may be needed across the system as the transformation proceeds. The results of this assessment will contribute to the development of a long-term training and technical assistance plan to aid providers with making a successful transition in partnership with DMHAS.

The readiness assessment process focused on the approximately 40 organizational providers that are likely to be providing the new MRO services based on their current DMHAS contracts. Thirty-five providers registered with the on-line survey tool; thirty-two (32) completed the tool. This represents an 80% response rate. The resulting data should be sufficient to indicate general competencies and areas in need of development in the DMHAS mental health provider network likely to be most effected by the conversion of ACT and Community Support to the MRO. While technology difficulties rendered some data incomplete, the overall dataset is valid for indicating priorities.

Key Conclusions

A summary of the assessment responses, analysis of the assessment data, and recommendations for next steps and follow-up activities are presented below.

- **Representative of the DMHAS network** – Of the 32 respondents, 6 were state-operated LMHAs, 8 were private-nonprofit (PNP) LMHAs, and the remaining 18 were PNP providers.
- **Predominantly “clinical” providers** – Providers were asked to characterize themselves either as being comprehensive clinical providers with the internal ability to diagnose and develop clinical and community-based treatment plans OR as “specialty” providers of specific services such as residential, case management, or vocational. Twenty (20) or 63% of the respondents characterized themselves as being clinical providers.
- **Large budget size** – More than two-thirds (22 or 69%) of the respondents had total annual budgets of more than \$5 million, with the remaining 21% in the \$1 - \$5 million range. Organizations of at least \$1 million tend to be able to sustain and absorb

some business changes and be small enough to more easily make operational changes.

- **Moderate to high reliance on DMHAS contracts** – More than half (19 of 32 or 59%) of the respondents rely on DMHAS funding for 76-100% of their funding. Another 25% (8 providers) receive 50-75% of their funding through DMHAS. This results in a network that will be sensitive to changes in DMHAS funding. A moderating influence could be the proportion of Medicaid clients served within the responding agencies. However, a majority of the respondents (24 of 32 or 75%) reported that more than half of their DMHAS clients were Medicaid beneficiaries.
- **Differences between Clinical and Specialty Providers** – The most dramatic result from the survey is the difference in “readiness” between the clinical and specialty providers. In aggregate, Connecticut providers scored 53% readiness in all domains. Clinical providers scored 60% readiness across all domains while specialty providers scored 44%. This indicates that there is a substantially higher need for transitional supports – training, technical assistance, infrastructure, and resources – among specialty providers than within the clinical providers. Specialty providers as a group will likely require fairly intensive supports, and strong commitment on their part to make changes. Conversely, the clinical providers, as a group, are much more likely to be operationally ready. The availability of overall training and supports along with targeted training and technical assistance and focused provider efforts will increase the likelihood that these organizations will be successful in weathering the transformation within a relatively short period of time. Individual provider circumstances may vary.

Recommendations

Recommendations based on this provider readiness survey process fall into five major categories.

1. Cash Flow Support

Since slightly more than half of the provider network has less than 60 days of cash reserves, and the majority of the network is highly dependent on DMHAS contracts, any increase in the amount of services subject to fee-for-service reimbursement could jeopardize providers who are accustomed to advance payment of grants. Specific areas within this recommendation include:

- Cash Flow Transition Plan that includes both grants and fee-for-service billing.
- Provider training and technical assistance to improve and sustain cash flow during the transition and beyond, with an emphasis on those providers that have never billed or have only billed for group home services.
- DMHAS contingency plans to support providers with cash flow difficulties.
- Monitoring of critical indicators for early identification and intervention to providers with cash flow difficulties.

2. Clinical and Service Provision

- Training on new services, rehabilitation and documentation for all providers
- Targeted training on assessment, treatment planning to relevant providers
- Targeted technical assistance to providers of ACT services and those that are providing Community Support to clients needing intensive services
- Development of internal DMHAS and provider capacity to continue the development of and to sustain clinical and service fidelity post-implementation
- DMHAS development of clear indicators and reporting mechanisms for post-monitoring implementation to highlight any providers that might be having difficulty meeting client needs, along with contingency plans both for supporting the provider and ensuring a safety net for clients

3. Infrastructure

- Specialty providers will need infrastructure support to acquire and use information systems, clinical supervision, and core functions such as quality, medical records, and documentation.
- The certification process should be used to assess further the adequacy of clinical providers' existing infrastructure in a fee-for-service environment, and how their current staffing resources may need to be reallocated (and potential retrained or replaced) in order to function under the MRO.
- All providers will need to allocate resources to support community-based care.
- Tools to assist with staffing decisions, including sample job descriptions and ratios will be helpful.
- More detailed information system recommendations are included in the body of the report.

4. Operations

Experience in other states indicates that operational readiness is a key success factor in a major change such as this. Therefore, all providers in the system will require information, tools, and training on a variety of operational issues.

- Toolkits and resources such as those outlined in the Resource Library section of Appendix C should be developed and/or acquired and made accessible to all providers.
- Training on certification requirements made available to all providers during the certification processes. Follow-up individual technical assistance may be made available based on needs identified during certification process.
- Training on operational requirements specific to the MRO and fee-for-service requirements should be made available to the entire provider network. Additionally, operational requirements specific to either Clinical Providers or Specialty Providers should be offered as well.
- Key performance indicators should be developed and distributed prior to implementation, and closely monitored following implementation. These should serve as early warning systems for providers that may need additional support to be successful during the transition.

5. Transition Issues

Connecticut's service delivery system has unique shapes that are only hinted at by the provider readiness assessment process. Changes in CAC policies, the relationships between specialty and clinical providers, movement of clients among levels of care, and increased choice of providers by clients complicate an already complex transition process.

- Business Model and Decision Support for all providers to determine if moving to the MRO makes sense within the context of their mission and business plans.
- Use of pilots to phase in the services in incremental stages through pilots of selected providers and systems will allow DMHAS to develop and evaluate implementation and transition strategies in a more controlled fashion than implementing throughout the system at once. Ongoing evaluation and data collection will aid the subsequent implementation of service changes throughout the state.
- Development of tools and resources to assist providers with their own transition issues, including development of transition plans, reassigning and retraining staff, and allocating sufficient resources to the change process.
- This report focuses on provider needs and readiness, and assumes a parallel Client Transition process. However, providers are the primary source of information and support to clients during system transitions. Therefore, providers will need resources and support to implement a Client Transition plan.
- Network Support. To support and sustain this implementation, DMHAS needs systems and staff in place to provide coordinated, consistent provider network functions including certification, contracting, operational and fidelity monitoring, claims data monitoring, technical assistance, data management, and clinical management functions. DMHAS needs to develop clear plans for providing these functions, either internally or through contract.

Section 1: Assessment Process

The provider self-assessment project was undertaken as part of the overall DMHAS preparation process in anticipation of the implementation of new Medicaid Rehabilitation Option Services of ACT and Community Support under a fee-for-service reimbursement methodology. The process focused on operational and infrastructure requirements that have been found to be important to success in changing environments, especially those with conversions from grant to fee-for-service reimbursement. The provider readiness self assessment process used in Connecticut is similar to one that has been used or is being used in three other states—Illinois, New Mexico, and Maine. The process, self-assessment tool and desired outcomes have been tailored to each state's planned changes to its publicly funded behavioral health delivery system.

The readiness assessment process in Connecticut included the following major components:

- A self-assessment tool that measured provider operational capabilities, procedures and financial resources that contribute to successful performance in an environment that includes changing payer requirements.
- Training sessions were held in two locations on three different dates for all available, targeted providers. The training offered didactic instruction regarding provider core competencies and successful practices in a rapidly changing environment. It also included information about the readiness assessment process, its purpose and benefits to the providers, and instructions regarding how to complete and return the tool. More than 200 individuals from more than 35 agencies participated.
- Targeted provider agencies completed the survey on-line, or returned it by fax for data entry.
- A compilation of results was assembled and reviewed with a Provider Readiness Workgroup, composed of representatives of twelve (12) agencies. The agencies represented state-operated, private nonprofit, LMHA, non-LMHA, hospital providers, and specialty providers throughout the state delivering DMHAS-funded mental health services.
- The Provider Readiness Workgroup recommended issues and strategies to be incorporated into readiness activities, and reviewed the training, technical assistance, and infrastructure support activities outlined within this report.

The readiness self-assessment was designed to measure overall provider competencies in all areas in order to gather data that could be used as the transformation process evolves. The underlying theme for the assessment was to measure the competencies that contribute to a provider's ability to successfully weather and manage change based on new requirements in services and payment.

Training sessions were held in New Haven and Middletown in March, 2006 with completed tools due in by the end of March. Providers were asked to submit an online version of the tool. Because of submission difficulties, some surveys were accepted by fax and entered by the NCCBH Consultants.

Assessment Tool

NCCBH consultants have assessed readiness of more than 400 public-sector behavioral health providers throughout the country and have found very common operational domains and competencies that are essential to success in a fee-for-service reimbursement or other accountability-oriented environments. These operational domains include:

Governance and Leadership – a governance structure that involves consumers and stakeholders, understands the organizational changes dictated by changing payer requirements, and the operational leadership to lead an organization through a substantive change process in a structured manner

Access and Intake – ‘front door’ operational systems that appropriately combine clinical and resource/funding triage including timely access to crisis, assessment and initial service planning, eligibility screening, and effective business practices (sliding scale, copay collection, etc)

Clinical Operations – clinical processes and services that are congruent with a recovery/resilience philosophy, applied consistently, in compliance with Medicaid and local service rules, and are productivity oriented

Billing and Financial Management – business functions and financial position that support effective cash balances, timely billing and collections, cost of services consistent with reimbursement, and effective financial management tools

Compliance – systems and processes that reasonably increase the likelihood of compliance with key federal, state and local rules and regulations, especially those directly related to Medicaid

Management Information – computer hardware and software that supports the operational processes essential to success in a fee-for-service or other accountability-oriented environments, including reporting and tracking functions

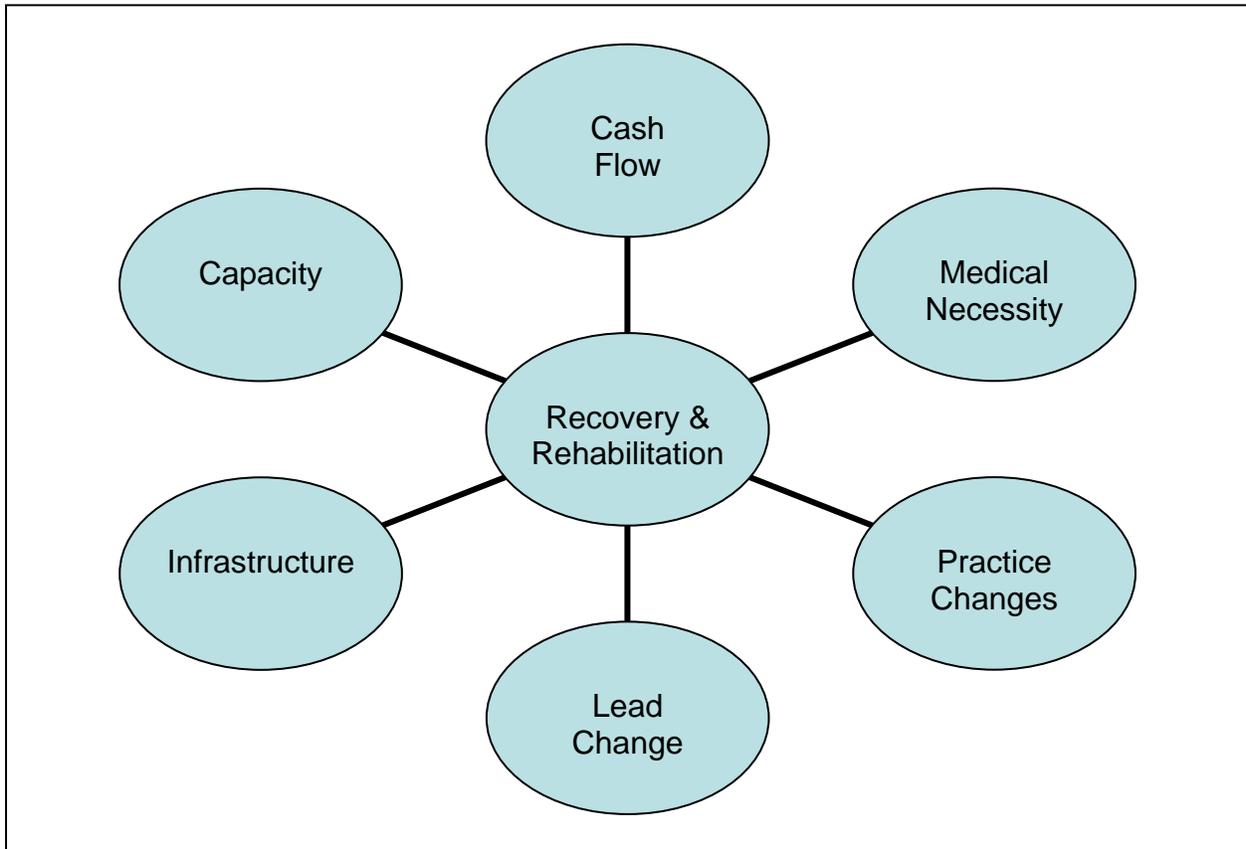
Outreach – extent to which consumers and families are involved and supported in shaping the agency that serves them, and the extent to which the agency reaches out to the community it serves via education, information, and involvement

Human Resources and Labor Relations – internal staffing factors, including work week, ability to change schedules, and hire, that can effect the flexibility of organizations in responding to changing requirements.

The tool was structured in these operational domains, with training and analysis of the data focused on the following core competencies for success in a fee-for-service MRO environment:

- A central organizing focus on **recovery and rehabilitation**: All operations and service delivery organized around these guiding principles.
- **Managing cash flow**: Proactive management and monitoring systems in place to ensure adequate cash flow following conversion from grant to fee-for service reimbursement.
- **Medical necessity**: Ensuring that all Medicaid-funded services meet clinical criteria for medical necessity, through diagnostic assessment, treatment planning, service planning, and documentation as well as compliance systems.
- **Practice Change**: The capacity to train and supervise staff at all levels to assist them in changing practice patterns for fidelity to new service definitions and requirements.
- **Leading Change** efforts within agency: Leadership and governance activities to promote, communicate and implement positive change with all stakeholders: clients, families, the community, referring sources, and staff.
- **Infrastructure**: Ensuring adequate resources, including information & financial management, clinical resources, and organizational relationships, to meet the needs of providing MRO services.
- **Capacity Management**: Ability to manage all factors that effect the agency's ability to quickly and effectively service clients who choose to be served by it, including productivity, intake, assessment, and internal utilization management.

These factors are illustrated in the following diagram:



Appendix A includes a copy of the self-assessment tool, with aggregated responses to each question stratified by the type of the responding agency.

Section 2: Analysis

The readiness assessment process targeted 40 organizational providers that currently offer Assertive Community Treatment Teams, mental health case management and supported housing funded through DMHAS. Thirty-five providers registered with the on-line survey tool; thirty-two (32) completed the tool. This represents an 80% response rate. The resulting data should be sufficient to indicate general competencies and areas in need of development in the DMHAS mental health provider network likely to be most effected by the conversion of ACT and Community Support to the MRO.

The voluntary, self-assessment process has two inherent mitigating factors that must be acknowledged in interpreting the data. First, a self-assessment process carries the risk that providers will overstate competencies to avoid appearing poorly positioned in comparison to peers or competitors. It is addressed in the training by encouraging providers to be rigorous in assessing their competencies. When a similar process and tool were used in Illinois, site visits were conducted for approximately 10% of the providers to determine differences between self-reported data and results from consultants experienced with provider assessments. This test of the validity of self-assessment data compared to assessments by professionals showed that scores for both groups were very consistent.

The second possible risk is that though data are not available to confirm it, based on experience with other provider systems, NCCBH believes it is likely that those providers which elected not to participate in the self-assessment process may have lower scores and therefore somewhat greater training and technical assistance needs. The resulting training and technical assistance plan needs to emphasize engaging the providers who did not participate in the assessment, as well as addressing the needs of the lower scoring providers.

During this process, there were server difficulties with the online site hosting the survey. As a result, some random data was unrecoverable. Review of the resulting data indicates that the trends and conclusions are likely to be valid in aggregate and when comparing the two groups of providers (clinical and specialty). Some results might be slightly understated, although this should hold true across the board.

Network Profile

To fully understand the impact of provider readiness issues, it is helpful to understand the nature of the providers sampled in terms of size, organizational structure and funding. Key information collected from respondents indicates the MRO network is:

Representative of the DMHAS network – Of the 32 respondents, 6 were state-operated LMHAs, 8 were private-nonprofit (PNP) LMHAs, and the remaining 18 were PNP providers.

Predominantly “clinical” providers – Providers were asked to characterize themselves either as being comprehensive clinical providers with the internal ability to diagnose and develop clinical and community-based treatment plans OR as “specialty” providers of specific services such as residential, case management, or vocational. Twenty (20) or 63% of the respondents characterized themselves as being clinical providers. (It should be noted that there are some other clinical providers in the DMHAS network – mainly hospitals – that did not participate in this process because they do not offer case management, ACT, Young Adult, or housing services directly. Representatives from this type of provider did participate on the Workgroup, and all indications are that the data collected is representative of this other group as well.)

Large budget size – More than two-thirds (22 or 69%) of the respondents had total annual budgets of more than \$5 million, with the remaining 21% in the \$1 - \$5 million range. Organizations of at least \$1 million tend to be able to sustain and absorb some business changes and be small enough to more easily make operational changes.

Moderate to high reliance on DMHAS contracts – More than half (19 of 32 or 59%) of the respondents rely on DMHAS funding for 76-100% of their funding. Another 25% (8 providers) receive 50-75% of their funding through DMHAS. This results in a network that will be sensitive to changes in DMHAS funding. A moderating influence could be the proportion of Medicaid clients served within the responding agencies. However, a majority of the respondents (24 of 32 or 75%) reported that more than half of their DMHAS clients were Medicaid beneficiaries. (This was true in both state-operated and private-non-profit respondents.)

Provider Readiness Results

A threshold of 75% is used to indicate readiness to implement new requirements successfully. Scores of less than 50% indicate significant deficits in basic provider competencies. This may cause system transformation to be extremely challenging to implement and sustain without some provider failures. Scores between 50 – 75% indicate that providers can implement changes with some transitional supports. It should be noted that the purpose of the scoring and associated percentages was intended to offer an ‘order of magnitude’ summary and to identify patterns and trends. To that end, the scoring may suggest a level of precision that is not fully validated.

In aggregate, Connecticut providers scored 53% readiness in all domains. Overall, these results suggest that the Connecticut MRO provider network is more advanced in their operational capabilities than what is typically found in a network at this stage of the system transformation.

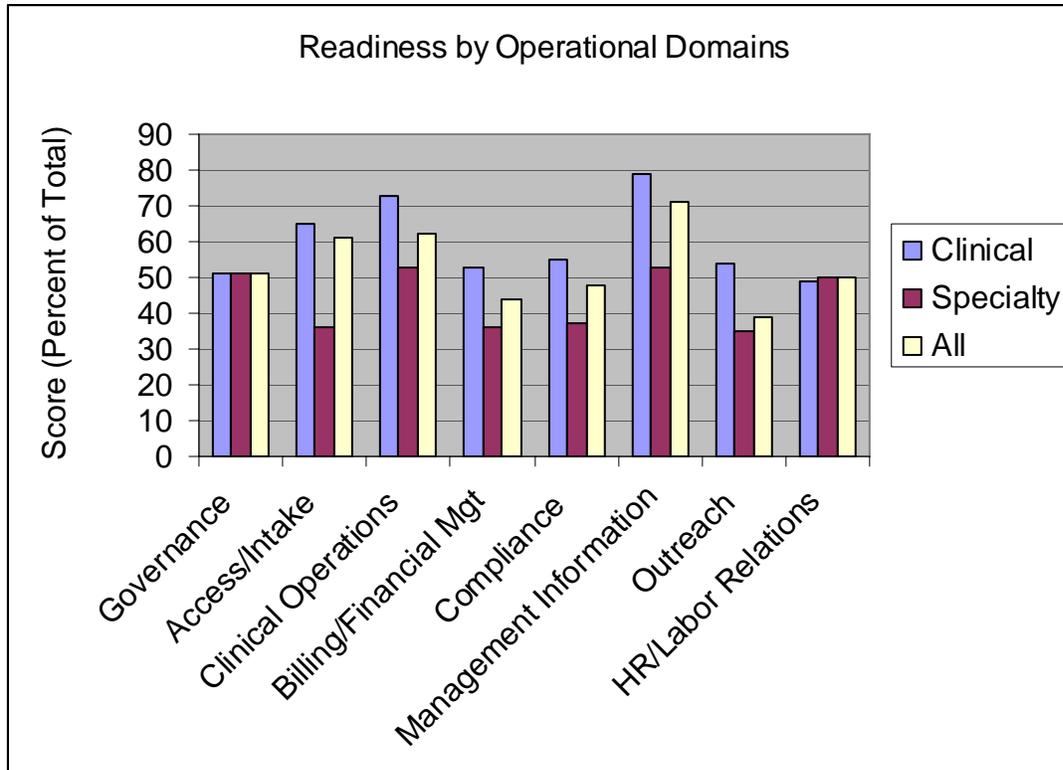
However, when divided into clinical providers and specialty providers, the results look different. Clinical providers scored 60% readiness across all domains while specialty providers scored 44%. This indicates that there is a substantially higher need for transitional supports – training, technical assistance, infrastructure, and resources – among specialty providers than within the clinical providers. Specialty providers as a group will likely require fairly intensive supports, and strong commitment on their part to make changes.

Conversely, the clinical providers, as a group, are much more likely to be operationally ready. The availability of overall training and supports along with targeted training and technical assistance and focused provider efforts will increase the likelihood that these organizations will be successful in weathering the transformation within a relatively short period of time. Individual provider circumstances may vary.

The graph below summarizes scores on each of the eight domains, stratified by agency type. These data show the greatest readiness in the domains of Access & Intake, Clinical Operations, and Management Information. The lowest scoring domains overall are Billing and Financial Management, Compliance, and Outreach. Even within these overall trends, however, there is significant variation between clinical and specialty providers, except in the domains of Governance and Human Resources/Labor Relations.

The domains with the largest differences between clinical and specialty providers were:

- Intake & Assessment (29 percentage points)
- Management Information (26 percentage points)
- Clinical Operations (20 percentage points)
- Outreach (20 percentage points)
- Compliance (18 percentage points)
- Billing & Financial Management (17 percentage points)



Question Level Detail

Questions With Highest Scores: All Providers

91%	MIS4: Does the information system include eligibility/payer source for each consumer?
85%	CO-12: Are more than half of case management service units delivered in the community/natural setting (not office locations)? (Will be important for the development of community support services)
81%	MIS2: Do at least 80% of employees have access to both a work station and e-mail?
78%	G2: Does the board composition include a primary consumer and/or family member, and at least one business oriented professional (CPA, attorney, senior manager)? (must have both to answer yes)
75%	CO16: Does the organization have policies and practices for comprehensive, confidential medical/service records that incorporate assessment information, treatment plan, and ongoing encounter and/or progress notes?
75%	HR4: In general, is the agency able to post and fill vacant positions in less than 120 days?

Questions With Lowest Scores: All Providers

19%	BF10: Have efforts been made during the past 12 months to reduce unit costs? (If unit costs have not been calculated, answer "no".)
22%	O2: Does the organization offer financial assistance (reimbursement for travel and/or time) for consumer participation in governance and work groups?
23%	O6: Does the organization have a process to collect information regarding consumer/family satisfaction and can demonstrate the information has been used to change practice or processes? (Both parts must be present for a "yes" answer.)
25%	BF9: Has the organization calculated costs per unit (including delineation of direct and indirect cost components) for each service provided? (Based on units of service and not total program costs.)
25%	G5: Does the organization have a written plan (goals, tasks, resources, and timelines) to transition to new funding methods and related systems and report progress regularly (at least monthly) to senior management and the board? (This plan can include references to actions needed once more information becomes available.)

Questions With Highest Scores: Clinical Providers

100%	IS-4: Does the information system include eligibility/payer source for each consumer?
90%	IA-10: Is eligibility for Medicaid, SAGA, Medicare and other third party benefits checked and documented in the record at first appointment?
90%	CO-2: Does the agency currently have a Licensed Practitioner of the Healing Arts (LPHA) – M.D., licensed psychologist, LCSW, or APRN – on staff who can diagnose and sign treatment plans ordering Medicaid services?
90%	IS-1: Does the organization have an information system that is capable of tracking client demographics and billing information?
85%	CO-3: Does the agency have licensed clinicians on staff who would be available for supervision of MRO services and staff?
85%	CO-16: Does the organization have policies and practices for comprehensive, confidential medical/service records that incorporate assessment information, treatment plan, and ongoing encounter and/or progress notes?
85%	IS-2: Do at least 80% of employees have access to both a work station and e-mail?

Questions With Lowest Scores: Clinical Providers

25%	HR-2: In general, is the agency able to post and fill vacant positions in less than 60 days?
30%	BF-9 Has the organization calculated costs per unit (including delineation of direct and indirect cost components) for each service provided? (Based on units of service and not total program costs.)
30%	G-5: Does the organization have a written plan (goals, tasks, resources, and timelines) to transition to new funding methods and related systems and report progress regularly (at least monthly) to senior management and the board? (This plan can include references to actions needed once more information becomes available.)
30%	O-2 Does the organization offer financial assistance (reimbursement for travel and/or time) for consumer participation in governance and work groups?

Questions With Highest Scores: Specialty Providers

100%	CO-12: Are more than half of case management service units delivered in the community/natural setting (not office locations)?
92%	G-2: Does the board composition include a primary consumer and/or family member, and at least one business oriented professional (CPA, attorney, senior manager)? (must have both to answer yes)
75%	G-4: Has the board received training regarding behavioral health environment/funding changes and the potential impact of those changes on the organization as well as on governance and leadership? (The training must have been provided to answer yes.)
75%	CO-7: At least 75% of the time, do consumers participate in the treatment planning process as evidenced by participation in treatment planning conferences and their signature on the treatment plan? (Both parts must be present for a "yes" answer.)
75%	IS-2: Do at least 80% of employees have access to both a work station and e-mail?

Questions With Lowest Scores: Specialty Providers

0%	IA-12: Do front desk (reception or clerical support) staff review financial resources, screen for possible Medicaid eligibility and apply a sliding fee scale to individuals who present without Medicaid or other third party benefits? (All parts must be present for a "yes" answer.)
8%	IA-13: Are front desk or other staff able to determine the amount of any co-payment (from the record or the billing system)?
8%	IA-14: Are front desk staff or other staff expected to collect co-payment at the time of service?
8%	O-2: Does the organization offer financial assistance (reimbursement for travel and/or time) for consumer participation in governance and work groups?
10%	HR-8: Does the agency have a training program to assist staff in learning new requirements or refreshing skills when external requirements change?

Future Use of Provider Readiness Review

For providers that have participated in the provider readiness review process thus far, NCCBH does not recommend formal re-surveying using this tool. These providers can use the tool as an internal education aid, help set implementation and technical assistance priorities, and establish bench marks in key operational areas. DMHAS can keep the results current by revalidating when making visits to these providers for technical assistance, data gathering, or other MRO work.

We would recommend that those providers who have not participated in the readiness review process be encouraged to do so. Should a provider request technical or financial assistance, we would recommend that the tool be considered as one means to help assess likely areas in need of operational development.

Section 3: Recommendations

Recommendations based on this provider readiness survey process fall into five major categories, each of which will be addressed separately:

- Cash Flow Support
- Clinical and Service Provision.
- Infrastructure
- Operations
- Transition Issues

Cash Flow Support

Since slightly more than half of the provider network has less than 60 days of cash reserves, and the majority of the network is highly dependent on DMHAS contracts, any increase in the amount of services subject to fee-for-service reimbursement could jeopardize providers who are accustomed to advance payment of grants. Since fee-for-service is paid after a service is delivered and a claim is submitted, the difference in cash flow to the provider can be 15 – 45 days later depending on when grants have been paid, timeliness of claims submission, and timeliness of claims processing and payment. Recommendations to assist with an increase in fee-for-service include the following:

- **Cash flow transition plan**—To decrease the potential of cash-flow interruptions caused by the transition to fee-for-service for Medicaid services, DMHAS should develop and communicate transitional cash-flow support strategies. Ideally, these decisions would be finalized with each provider at least 90-days prior to the “go-live” date. Strategies include periods of shadow claims submissions while grants are still paid, overlapping early months of grant payments with fee-for-service, and some type of front-end advance that is then recovered over several months following the conversion. DMHAS will need to incorporate the financial impact of this plan into their budget planning for FY08.
- **Provider training and technical assistance relative to cash flow**—There are three levels within this area:
 - Toolkits and sample forms and processes for tracking and reporting should be available to all providers. Specific examples include:
 - Financial modeling tools to assist providers with budgeting, decision making, and securing lines-of-credit based on the Medicaid rates and grant amounts and including such factors as productivity and payor-mix should be available to providers.

- Tools and self-assessments that assist DMHAS and providers in identifying priorities for action should be available in the immediate post-implementation period. (These can be similar to the checklists that were used with group homes in the first month following go-live.)
 - Those providers that have never billed before, or that have billing experience limited to group homes, should receive targeted on-site technical assistance to develop and implement billing processes. This assistance should occur in the six-to-twelve months prior to the go-live date. (Note: Providers that need to also acquire – either through purchase or partnership – an electronic billing system will need assistance in the twelve months prior to go-live date.)
 - Training on topics such as billing forms and flows, timeliness requirements for each step in the process, productivity measurement and management, and accounts receivable management, as well as specific billing requirements for these services should be system-wide and available to all interested providers. The training should be prior to and immediately following the go-live date.
- **Contingency plans**—DMHAS should develop mechanisms for early identification of at-risk risk providers along with intervention strategies to avoid disruptions in service. The plan should include criteria for any additional advances, payback requirements, and identification of alternative providers in critical or high risk areas, as well as budget allocations for assistance. These contingency plans should focus both on the immediate transition period as well as the one-to-three years following the go-live dates.

Providers should also develop contingency plans based on internal monitoring systems with clear indicators to assist them with early warnings about potential financial and cash flow issues.

- **Timely payment**—Requirements for timely claims payment should be in place including plans and or penalties for failure to meet the requirements. DMHAS will need to develop tools for monitoring timeliness of claims submissions, and intervening when providers fail to meet requirements. (Providers should have internal monitoring systems as well.)

Clinical and Service Provision

- All providers that are certified to deliver MRO services will require training and technical assistance on the new services of ACT and Community Support. Additionally, Clinical Providers, whether they will be delivering ACT and Community Support or not, will require training in the assessment and treatment planning modifications necessary to ensure medical necessity and to support

rehabilitation services. All providers will need training and technical assistance on documentation and rehabilitation. Prior to implementation, the training can be targeted to clinical directors and supervisors to support them in assisting their staff members to make the transition. Assessment and treatment planning training for clinical providers should be targeted to the clinical directors, supervisors and actual clinicians who perform assessments and work to develop treatment plans. Technical assistance in the form of toolkits, sample forms, and training materials can be available for all providers.

- Targeted on-site technical assistance prior to and immediately after implementation should be directed at two sets of providers:
 - Those delivering ACT services, to assist with a successful transition to the new service expectations and population, and
 - Those providers that have a significant number of high-need clients receiving Community Support, especially if these clients were formerly in ACT programs. Technical assistance should be targeted to ensuring that the Community Support teams “hit the ground” running with delivering assessment-based, flexible services to this population.
- Tools and self-assessments that assist DMHAS and providers in identifying priorities for action should be available in the immediate post-implementation period. (These can be similar to the checklists that were used with group homes in the first month following go-live.)
- Experience in other states indicates that clinical and service fidelity to service definitions is often the last capacity to develop after a major system change, and may take as long as three years to be consistently applied across all providers. As part of the pre-implementation training, DMHAS therefore should develop internal expertise in all the clinical and service delivery aspects, along with the capacity to provide coaching and ongoing technical assistance to its providers. Providers should develop internal mechanisms (such as staff training, internal audits, and quality improvement strategies) for building and sustaining service fidelity. This assists in the sustainability of the service models over time.
- DMHAS needs to develop clear indicators and reporting mechanisms for post-monitoring implementation to highlight any providers that might be having difficulty meeting client needs, and have contingency plans both for supporting the provider and ensuring a safety net for clients.

Infrastructure

This assessment process highlights that infrastructure needs are most striking among the specialty providers. (The Clinical Providers as a group scored a very high 71% on this dimension.)

- 8 of 12 specialty providers indicated they did not have an information system capable of tracking client demographics and billing information. This is a core capacity. (While not all of the clinical providers reported having this capability, they all reported a billing system that would give them at least limited functionality in this area.)
- While 85% of the Clinical Providers report having a Licensed Clinician on staff who can provide supervision of services and staff, only 42% of the specialty providers do. All providers will need to have this level of supervision available either on staff, through contract, or through an affiliation agreement.
- Because of smaller size, specialty providers are less likely to have “corporate” staff resources in such areas as medical records, information systems, finance, billing, quality improvement, and compliance.

Thus the recommendations for promoting readiness differ between the two groups.

- **Specialty Providers** will require assistance in assessing essential functionality, and then acquiring and implementing it. This will be true in areas of information systems, clinical supervision, and core functions such as quality, medical records, and documentation. On-site technical consultation can assist providers to develop plans for accessing these requirements, whether those be through purchase, contract, or partnership. DMHAS will need to develop formulas for infrastructure financial support. This might be based on number of clients served, or level of need, or other criteria.
- **Clinical Providers** may have infrastructure in place, but will need to assess its adequacy in a fee-for-service environment, and how current staffing resources may need to be reallocated (and potentially retrained or replaced) in order to function under the MRO. The Certification Process can be used as a tool to ascertain the extent of need assistance – training, consultation, and/or financial – needed by individual providers to allow them to meet core requirements.
- **All providers** will need to allocate resources to support community-based care. This might include such infrastructure as cell phones and/or PDAs, voice mail, and e-mail.
- Staffing changes and decisions are often the hardest for providers in the pre-implementation phase, as they are making their best-guesses on what kinds of staff resources and in what proportions they will need. Tools and information from other states that describe staffing ratios (e.g., how many medical records staff are needed per client?) can be helpful. Sample job descriptions and key qualifications for functions are another tool that can be incorporated in the Resource Library.
- Toolkits for standardized reports, tracking systems, and business office functions should be part of the Resource Library and addressed during training.

Recommendations specific to information system infrastructure:

- DMHAS OOC staff should compile and distribute a directory of the available information systems currently in use among the providers.
- Decision assistance tools (such as listings of available systems, prices and functionality) can be made available to all providers. The tools should focus on affordable solutions, include key functions (such as scheduling, billing and productivity data), and estimated initial and on-going costs. This tool will assist providers with quantifying the expense and identifying potential vendors in their price range.
- Identification of user groups. When multiple providers select the same system, DMHAS can assist with the development of user groups for that system. Examples of MIS user groups currently exist in Connecticut, and can help with vendor problem resolution, implementation of new features, or cost sharing for customized reports or other tools that are specific to the state.
- Increased functionality for state-operated providers to support their provider reporting and tracking needs.

Operations

Experience in other states indicates that operational readiness is a key success factor in a major change such as this. Therefore, all providers in the system will require information, tools, and training on a variety of operational issues. Some of this has begun with the Provider Readiness training that accompanied the self-assessment process. Those providers that are able to develop and implement necessary systems and make key operational changes before and during the early months of a major change are more financially stable and provide more consistent services to clients. Building and supporting operational competence is thus a critical task that impacts all the other tasks.

- Toolkits and resources such as those outlined in the Resource Library section of Appendix C should be developed and/or acquired and made accessible to all providers.
- Training on certification requirements made available to all providers during the certification processes. Follow-up individual technical assistance may be made available based on needs identified during certification process.
- Training on operational requirements specific to the MRO and fee-for-service requirements, should be made available to the entire provider network. Additionally, operational requirements specific to either Clinical Providers or Specialty Providers

should be offered as well. This training should be in the six months prior to implementation.

- Key performance indicators should be developed and distributed prior to implementation, and closely monitored following implementation. These should serve as early warning systems for providers that may need additional support to be successful during the transition.

Transition Issues

Connecticut's service delivery system has unique shapes that are only hinted at by the provider readiness assessment process. Changes in CAC policies, the relationships between specialty and clinical providers, movement of clients among levels of care, and increased choice of providers by clients complicate an already complex transition process.

- **Business Model and Decision Support.** DMHAS is moving from a funder of services to a purchaser of services. This leads to a corresponding change for providers – to develop business models to determine whether they want to transition into MRO service providers. This is especially true for smaller providers that may serve less than 100 clients who would be eligible for MRO services. Providers may choose to negotiate with DMHAS to provide different services and not transition to the MRO, or to phase out particular service lines. Providers need decision support tools and may need individual consultation to determine if moving to the MRO makes sense within the context of their mission and business plans.
- **Pilots.** One strategy for easing the transition of the DMHAS provider system is to do a phased-in implementation of service changes prior to the reimbursement changes. Choosing to phase in the services in incremental stages through pilots of selected providers and systems will allow DMHAS to develop and evaluate implementation and transition strategies in a more controlled fashion than implementing throughout the system at once. Ongoing evaluation and data collection will aid the subsequent implementation of service changes throughout the state. Goals of a pilot process that incorporates both state-operated and private nonprofit LMHAS can include:
 - Within existing billing and licensing rules, convert practice to new service definitions.
 - Develop and use tools to collect “shadow billing” and other system delivery information on services during the conversion.
 - Develop and implement training and technical assistance relative to the conversion that can be used state-wide.
 - Use ongoing information from pilot-sites to inform provider development and consumer transition processes state-wide.
 - Develop models for intra-agency coordination and communication that can be applied statewide.
 - Refine provider readiness activities based on data from pilots.

- **Provider Transition Planning Support.** Providers need to develop plans and structures for implementing the many changes required in an effort of this size. Assistance with templates and tools that outline plans, timelines, and strategies can assist providers with developing and implementing their own transition and change-management plans. A beginning strategy is for providers to use the self-assessment readiness survey as a diagnostic tool to assist them with setting priorities for action.

One of the major transitions many providers will need to address is the assignment and/or reorganization of staff to meet the changing requirements. Supervisors will need to build in time to orient and train staff, and to provide guidance in the delivery of the new services and requirements. In many cases, this will involve client transitions and changes as well. Adequate time and resources need to be allocated.

- **Client Transition Support.** This report focuses on provider needs and readiness, and assumes a parallel Client Transition process. However, providers are the primary source of information and support to clients during system transitions. Therefore, providers will need resources and support to implement a Client Transition plan. Examples of the kinds of supports provided in other states include:
 - Office of Consumer Affairs conducting focus groups and communications meetings throughout the state that are accessible to a majority of clients. These might be held at provider sites, at social clubs, or other sites where consumers congregate.
 - Office of Consumer Affairs and/or workgroups composed of providers and clients develop templates of communication devices to help inform clients and families about system changes. Examples include websites, newsletters, or sample letters that providers can send to clients.
 - Development of toolkits that give providers – both for agencies and individual staff members – tools and language to use to explain changes to clients and families. These might include strategies to train clients to communicate with other clients.
- **Network Support Services.** To support and sustain this implementation, DMHAS needs systems and staff in place to provide coordinated, consistent provider network functions including certification, contracting, operational and fidelity monitoring, claims data monitoring, technical assistance, data management, and clinical management functions. These functions currently exist at many levels and locations, and at varying levels of importance, DMHAS needs to develop clear plans for providing these functions, either internally or through contract.

Additional Recommendations:

Provider Readiness Workgroup Recommendations are outlined in Appendix C. While some of the detail in that outline is incorporated into the narrative of this report, the recommendations from the workgroup are rich in additional detail.

Appendix D includes a list of general training topics that have been found helpful in other states.

Sequencing

Experience in other states has demonstrated preferred sequencing and timing for provider readiness activities.

Those items that require the most (12-15 months) lead time include strategies for building infrastructure and pilot projects. Intermediate timelines (6-12 months) are required for training and technical assistance that supports certification, including training in service definitions and certification requirements, and transition planning (for staff and clients). Shorter term activities (the six months prior to implementation) include contracting of cash flow support strategies and specific training relative to services and operations. The goal prior to implementation is to get providers “ready enough” to begin. Intensive follow up, technical assistance, and support in the first six months after implementation assist providers with applying what they learned prior to going live. Ongoing support and technical assistance targets areas that are need to a majority of providers as well as delivering individualized assistance to any providers that may be struggling.

Appendix A

Provider Readiness Data

Demographics and General Information

Ownership structure:

Government	6 (19%)
Non Profit	26 (81%)

Total annual budget size of the total organization in any location (If the agency is part of a larger agency, report the total budget of the larger agency or system.)

\$1,000,000 – 4,999,999	10 (31%)
Over \$5,000,000	22 (69%)

Percentage of current annual budget from the following payers combined: DMHAS contracts, SAGA, and Medicaid, (Use total organization, CT only)

More than 90%	8 (25%)
76 – 90%	11 (34%)
50 – 75%	7 (22%)
Less than 50%	5 (16%)

Percentage of current annual budget from the following payers combined: Medicaid, Medicare & 3rd Party Insurance (Use total organization, CT only)

76 – 90%	2 (6%)
50 – 75%	2 (6%)
Less than 50%	28 (88%)

Approximate total, unduplicated number of consumers served under DMHAS contracts, SAGA and self-pay during FY05 (Total organization, CT only)(7/1/04 – 6/30/05):

Less than 100	3 (9%)
100 - 199	5 (16%)
200 - 499	12 (38%)
More than 500	12 (38%)

Percentage of DMHAS clients served who were enrolled in Medicaid during 7/1/04 – 6/30/05

Less than 25%	3 (9%)
25 – 49%	5 (16%)
50 – 74%	12 (38%)
More than 75%	12 (38%)

Which description best describes the range of services covered through DMHAS contracts, SAGA, and Medicaid?

Clinical provider with ability to diagnose, develop clinical and community-based treatment plans	20 (63%)
Specialty provider for services, such as residential, case management or vocational services	12 (38%)

If the agency is accredited by a national organization, which one?

CARF	8 (25%)
COA	1 (3%)
JCAHO	13 (41%)

What DPH licenses does the agency currently hold? (Check all that apply.)

Substance Abuse or Dependence Facility	9 (28%)
Mental Health Day Treatment Facility	4 (13%)
Mental Health Psychiatric Outpatient Facility	11 (34%)
Mental Health Community Residence	5 (16%)
Mental Health Intermediate Treatment Facility	0
Residential Living Center	7 (22%)
Home Health Care Agency	0
Hospital Licensure: Mentally Ill Persons	2 (6%)
Home Licensure: Residential Care	1 (3%)

Operational Questions

#	Dimension	ALL (%)	Clinical Providers (%)	Specialty Providers (%)
1.	Do current versions of organization's mission/vision/values include an expressed commitment to best practices including recovery/resilience? <i>(should be expressly stated and not just implied)</i>	72%	80%	58%
2.	Does the board composition include of a primary consumer and/or family member, and at least one business oriented professional (CPA, attorney, senior manager)? <i>(must have both to answer yes)</i>	78%	70%	92%
3.	Have all members of the board participated in education regarding both fiduciary responsibilities (related to holding a governance position as a member of the board) and establishing/monitoring organizational performance indicators? <i>(To answer yes, the training must have been offered and all Board members must have participated.)</i>	38%	35%	42%
4.	Has the board received training regarding behavioral health environment/funding changes and the specific impact of those changes on the organization as well as on governance and leadership? <i>(The training must have been provided to answer yes.)</i>	50%	35%	75%
5.	Does the organization have a written plan (goals, tasks, resources, and timelines) to transition to new funding methods and related systems and report progress regularly (at least monthly) to senior management and the board?	25%	30%	17%
6.	Has the organization developed and communicated a process for managing change (including what to expect in the process, plan for ongoing communication, changes in procedures/responsibilities) to staff and consumers/families? <i>(There should be written evidence of this process and the communication.)</i>	34%	35%	33%

7.	Does organization have <u>all</u> of the following performance indicator information? <i>(Please check each area that is currently in place)</i>	59%	70%	42%
	Written indicators	(69%)	75%	58%
	Regular measurement against those indicators that is reported to leadership and board	(69%)	75%	58%
	Demonstrated impact on operations resulting from measuring and monitoring performance indicators	(59%)	70%	42%
Total Governance and Leadership		51%	51%	51%
8.	Is the average time from first call to first appointment/contact less than or equal to ten calendar days?	53%	50%	58%
9.	If agency does not provide assessments, does the referral include assessment information, including a recent (within one year) diagnosis?	92%	--	92%
10.	Is eligibility for Medicaid, Medicare and other third party benefits checked and documented in the record at first appointment? <i>(Both parts must be present for a "yes" answer.)</i>	75%	90%	50%
11.	Is eligibility for Medicaid, SAGA, Medicare and other third party benefits checked and documented in the record at least once a month throughout active service?	34%	50%	33%
12.	Do front desk (reception or clerical support) staff review financial resources, screen for possible Medicaid eligibility and apply a sliding fee scale to individuals who present without Medicaid or other third party benefits? <i>(All parts must be present for a "yes" answer.)</i>	28%	45%	0%
13.	Are front desk staff able to determine the amount of any co-payment (from the record or the billing system)?	34%	50%	8%
14.	Are front desk staff or other staff expected to collect co-payment at the time of service?	44%	65%	8%
The following questions should be answered only by agencies that currently deliver clinical assessments, including a diagnosis.				
15.	Does the assessment process include <u>all</u> of the following? <i>(Please check each area included in the assessment)</i>	35%	35%	--
	Consistent form (adult and youth forms may be different)	(90%)		--
	Completed on a timely basis (within 45 days of admission)	(90%)		--
	Standardized functional assessments (e.g., LOCUS, CALOCUS, CAFAS, Multnomah, ASAM)	(35%)		--
	Diagnostic components (including all five axis per the most recent edition of DSM)	(90%)		--
16.	Does the initial assessment include both a preliminary treatment recommendation and diagnosis?	100%	100%	--
17.	Is the average time from first call to initiation of assessment less than or equal to ten calendar days? <i>(should include all categories of clients—urgent, emergent, routine—and all levels of care)</i>	60%	60%	--
18.	When indicated by client need (urgent/emergent), does the organization have the ability to provide same day face-to-face assessment appointments?	80%	80%	--
19.	When indicated by client need (urgent/emergent), does the organization have the ability to provide same day face-to-face psychiatrist appointments?	85%	85%	--

20	Does the organization have a centralized scheduling process (manual or automated) where appointments are scheduled using a master schedule with ability to schedule urgent, next or missed appointments into any available slot?	70%	70%	--
Total Access and Intake		61%	65%	36%
1.	Which of the following services does the agency currently provide? (<i>Check all that apply.</i>)			
	Case Management	81%	95%	58%
	Intensive Case Management	38%	40%	33%
	ACT	34%	55%	0%
	Young Adult Services (including YAS ACT)	31%	50%	0%
	Supported Housing	63%	60%	67%
2.	Does the agency currently have a Licensed Practitioner of the Healing Arts (LPHA) – M.D., licensed psychologist, LCSW, or APRN – on staff who can diagnose and sign treatment plans ordering Medicaid services?	69%	90%	33%
2a	If no to the above, does the agency have formal linkages with clinical provider agencies with LPHAs on staff, and the capacity to diagnose and develop treatment plans ordering Medicaid services?	60%	100%	50%
3.	Does the agency have licensed clinicians on staff who would be available for supervision of MRO services and staff?	69%	85%	42%
4.	If the answer to the question 3 above is no,	30%	100%	0%
	a. does the agency have access to contract licensed staff who would be available for supervision of MRO services and staff?			
4b	b. does the agency have formal linkages with clinical providers that might provide supervision of MRO services and staff?	20%	33%	14%
5.	Are current treatment plans for case management and supportive housing clients developed from a diagnostic assessment?	63%	75%	42%
6.	Are case management (or supportive housing) treatment plans coordinated with the client's other treatment goals and services?	69%	80%	50%
6a	If the answer above is yes, is this done by:	64%	63%	67%
	Case management plan is one part of a master treatment plan			
	Sharing of individual service treatment plans	68%	88%	50%
	Treatment plan meetings	73%	75%	67%
7.	At least 75% of the time, do consumers and parent/guardians (minors) participate in the treatment planning process as evidenced by participation in treatment planning conferences and their signature on the treatment plan? (<i>Both parts must be present for a "yes" answer.</i>)	69%	65%	75%
8.	Do at least 75% of treatment plans directly reflect diagnosis, assessed functional needs, consumer preferences, consumer strengths, and natural supports? (<i>All parts must be present for a "yes" answer.</i>)	53%	50%	58%
9.	Are at least 75% of treatment plans reviewed and updated at least once every 90 days including signature by an LPHA?	53%	65%	33%

10	Are at least 75% of treatment plans reviewed and updated at least once every 90 days inclusive of consumer/family participation in the review process?	50%	45%	58%
11	Are core services (case management and/or ACT) available at times appropriate to consumer needs and preferences, including evenings and weekends?	50%	45%	58%
12	Are more than half of case management service units delivered in the community/natural setting (not office locations)? <i>(Will be important for the development of community support services)</i>	85%	79%	100%
13	Is the time from referral to first routine service less than 10 days?	53%	55%	50%
14	Do clinical/case management supervisors receive staff productivity reports at least monthly?	56%	70%	33%
15	Does the organization have a system to monitor and supervise line staff to ensure service delivery (type, frequency, duration), is consistent with the treatment plan?	47%	45%	50%
16	Does the organization have policies and practices for comprehensive, confidential medical/service records that incorporate assessment information, treatment plan, and ongoing encounter and/or progress notes?	75%	85%	58%
Total Clinical Operations		62%	73%	53%
1..	Does the organization require service staff to submit billing/encounter information within 1-2 business days from the delivery of service and does data indicate at least a 75% compliance rate with this policy? <i>(Both parts must be present for a "yes" answer.)</i>	38%	45%	25%
Questions 2 – 5 are for the 25 agencies that indicated that they bill any payer.				
2.	Does the organization track average time from date of service to claims submission? ¹	52%	45%	67%
2a	If yes, is the average time less than or equal to 14 calendar days?	69%	67%	75%
3.	Does the organization consistently bill Medicare (for Medicare eligible services) prior to Medicaid when a consumer is dually eligible?	60%	75%	17%
4..	Does the organization submit claims to any payor at least twice per month?	67%	55%	50%
5.	Does the organization submit claims to any payor at least once per week?	44%	55%	0%
6.	Does the organization have at least 30 days of cash reserves (Days of cash reserves = Cash + Investments/{Average monthly expenses/30 days})?	53%	55%	50%
7.	Does the organization have at least 60 days of cash reserves?	44%	40%	50%
8.	For agencies that bill, is there a process to reconcile amounts billed to paid/accepted claims within ten business days of receipt of reports/remittance advice and resubmit claims as indicated?	56%	45%	83%
9.	Has the organization calculated costs per unit (including delineation of direct and indirect cost components) for each service provided? <i>(Based on units of service and not total program costs)</i>	25%	30%	17%

¹ N= 25 for agencies that bill

10	Have efforts been made during the past 12 months to reduce unit costs? (If unit costs have not been calculated, answer "no".	19%	67%	100%
11	Does agency have productivity targets or standards for a majority (more than half) of direct service staff?	53%	75%	17%
12	Do average productivity rates for all clinical staff equal or exceed 50%?	41%	55%	17%
13	Are <u>all</u> of the following financial elements available via report for management review and use? (<i>Please mark each element present in current system</i>)	28%	45%	0%
	Number of consumers by payment source served per month	(44%)	(55%)	(25%)
	Number of units of each type of service per month	(50%)	(65%)	(25%)
	Number of each type of staff and corresponding salary/benefit costs	(44%)	(50%)	(33%)
	Actual productivity rate for each direct service staff	(41%)	(50%)	(25%)
	Indirect costs for each program (i.e. staff training, mileage, food)	(50%)	(60%)	(33%)
	General and administrative overhead rate (corporate costs such as finance department, insurance, MIS)	(44%)	(50%)	(33%)
Total Billing and Financial Management		44%	53%	36%
1.	Does the organization have a compliance plan that has been approved by leadership and the board of directors, and a staff person assigned who is responsible for monitoring and updating the compliance plan? (<i>Both parts must be present for a "yes" answer. The compliance plan must be written.</i>)	47%	55%	33%
2.	Is there evidence that all current staff and new hires are trained on compliance requirements including confidentiality, fraud/abuse, and clinical record documentation requirements (for clinical staff)?	69%	70%	67%
3.	Does the organization have a consistent and reliable process to ensure all delivered services are included on a treatment plan that covers the date of service? (There should be evidence of this process for a "yes" answer.)	44%	50%	33%
4.	Does the organization have a consistent and reliable process to monitor the accuracy, completeness and timeliness of clinical record documentation for each billed/encountered service including matching service documentation to units billed? (There should be evidence of this process for a "yes" answer.)	38%	50%	17%
5.	Does the organization have a consistent and reliable process to monitor whether services delivered demonstrate consistency with payor/regulatory body service definitions and programmatic requirements? (There should be evidence of this process for a "yes" answer.)	44%	50%	33%
6.	Does the organization have a written plan to monitor medical/clinical necessity? (There should be evidence of this process for a "yes" answer.)	38%	40%	33%
7.	Does the organization have a consistent and reliable process to ensure that services are delivered by staff with credentials required by regulation and/or service definitions? (There should be evidence of this process for a "yes" answer.)	59%	70%	42%
Total Compliance		48%	55%	37%

1.	Does the organization have an information system that is capable of tracking client demographics and billing information?	72%	90%	42%
2.	Do at least 80% of employees have access to both a work station and e-mail?	81%	85%	75%
3.	Does the information system track treatment plan expiration dates to ensure that services are not being delivered under an expired treatment plan? ²	61%	61%	60%
4.	Does the information system include eligibility/payer source for each consumer?	91%	100%	60%
5.	Are monthly productivity reports produced within 15 days of the preceding month for each direct service staff and program?	61%	67%	40%
6.	Are sufficient resources available for information system functions to ensure production of routine reports according to established deadlines, provide help desk functions within one business day, and produce 80% of ad hoc reporting within 14 business days of request? (All parts must be present for a "yes" answer.)	61%	67%	40%
Total Management Information		71%	79%	53%
1.	Are consumers who have been asked to participate in governance, quality or policy activities been offered assistance, training, and ongoing support to maximize their comfort and effectiveness consistent with the nature of their involvement? (To answer yes, consumers must have been asked to participate, AND they must be able to report that they received assistance/ training/on-going support.)	34	40%	25%
2.	Does the organization offer financial assistance (reimbursement for travel and/or time) for consumer participation in governance and work groups?	22	30%	8%
3.	Does the organization have a plan (goals, tasks, resources, timelines) to participate in community activities designed to educate referral sources, consumers, and families regarding availability of services and supports? (To answer yes, there must be written evidence of a plan.)	28	35%	17%
4.	Does the organization demonstrate cultural responsiveness through promotion of inclusion, prohibiting discrimination, staff race/ethnicity reflective of program participants, requiring competency training for all, and availability of translators? (All parts must be present for a "yes" answer.)	69	75%	58%
5.	Does the organization have a process to focus outreach efforts to encourage active engagement for consumers/families in need (both enrolled and new clients)? (Process must be functioning to be counted as a "yes".)	56	65%	42%
6.	Does the organization have a process to collect information regarding consumer/family satisfaction and can demonstrate the information has been used to change practice or processes? (Both parts must be present for a "yes" answer.)	23%	80%	58%
Total Outreach		39%	54%	35%

² N= 23 providers with information systems

1.	Are the majority of direct service staff providing ACT, case management, and/or supported housing services covered by a union contract?	28%	45%	0%
1a	If yes, how much notice must be given to change staff schedules based on payer requirements? (N=9)	78%	78%	0%
	None to 1 month			
	1 to 2 months	11%	11%	0%
	More than 2 months	11%	11%	0%
2.	In general, is the agency able to post and fill vacant positions in less than 60 days?	38%	25%	58%
3.	In general, is the agency able to post and fill vacant positions in less than 90 days?	59%	55%	67%
4.	In general, is the agency able to post and fill vacant positions in less than 120 days?	75%	70%	83%
5.	What is the work week for fulltime staff who provide either ACT, case management, or supportive housing services? (Check all that apply)	59%	55%	67%
	40 hours			
	37.5 hours	28%	35%	17%
	35 hours	19%	20%	17%
6.	Does your agency have an internal staff credentialing process?	41%	55%	17%
7.	Does the agency have an orientation program that trains new staff (both administrative and direct service) in the specific services and payer requirements of the jobs they do?	56%	50%	67%
8.	Does the agency have a training program to assist staff in learning new requirements or refreshing skills when external requirements change?	56%	40%	10%
Total HR & Labor Relations		45%	49%	50%
Grand Total		53%	60%	44%

Appendix B

Information Systems in Use

The following list includes all responses to question 9b regarding the names of management information systems used by the providers participating in the self-assessment process.

- EMDEON AND SSI
- Unicare Profiler
- Advanced Data Systems-Medic Elite
- ECHO
- Last Word
- CMHC
- Pcase 32
- Easy Billing System
- SSIMED
- EDS software

APPENDIX C:

Provider Readiness Workgroup Draft Recommendations

1. Information Systems & Technology

- 1.1. Survey of Existing Systems
 - 1.1.1. Develop listing of all current providers and their IS capability
 - 1.1.2. Outline specific capabilities:
 - 1.1.2.1. Electronic billing
 - 1.1.2.2. Tracking utilization
 - 1.1.2.3. Productivity reports
 - 1.1.2.4. Clinical tracking
 - 1.1.2.4.1. Tx Plan dates
 - 1.1.2.4.2. Documentation
 - 1.1.2.4.3. Compliance timelines
 - 1.1.2.5.
- 1.2. Distribute vendor list of behavioral health software systems
- 1.3. Develop strategies to encourage group purchase, use, development etc. of IS capabilities
- 1.4. Outline priorities for financial support
- 1.5. Outline areas for needed staffing (or other) resources
- 1.6. Address data integrity issues in reporting

2. Resource Library

- 2.1. Catalog of functional assessments with samples, along with evaluation
- 2.2. Samples of compliance plans, policies & procedures
- 2.3. Samples of self-pay fee schedules and procedures
- 2.4. Documentation tool kit with guidance and samples
- 2.5. Treatment planning tool kit with samples and guidance
- 2.6. Tool kit for minimal staffing resources for FFS
 - 2.6.1. Include staffing ratios, job descriptions, etc
- 2.7. Quality Assurance and internal auditing tool kit
- 2.8. Samples of recommended productivity reports
 - 2.8.1. incorporate formulas for standards
 - 2.8.2. samples policies & procedures
- 2.9. Samples of standard reports
- 2.10. Samples of Clinical assessments that incorporate rehabilitation concepts
- 2.11. Administrative Tools
 - 2.11.1. Methodologies for assessing unit costs
 - 2.11.2. tracking systems
 - 2.11.3. forms
 - 2.11.4. "front desk" functions
- 2.12. "How to's: for AR functions, including reconciliation, resubmissions, "working claims" etc.

- 2.13. Compliance System Design
- 2.14. Catalog of Other Resource materials
 - 2.14.1. Include APS materials from Georgia
 - 2.14.2. Include Curriculum materials

3. Phase-In of Services

- 3.1. Develop plan for phasing in services prior to reimbursement changes

4. Transition Issues (whether phased in or not)

- 4.1. Communication with Staff & clients
- 4.2. Decision trees on transition of staff & clients
 - 4.2.1. note: need certification guidelines & decisions on which providers do services, especially ACT
- 4.3. Support for system-wide (or regional) transitions
- 4.4. System-wide tracking during transition
- 4.5. Any implementation "windows"
- 4.6. Clear information on rates and grant changes
- 4.7. Promoting organizational culture change

5. Promoting regional cooperation among providers

- 5.1. For technology and infrastructure
- 5.2. For clinical supervision and other clinical staffing issues
- 5.3. For care coordination
- 5.4. "Back Office" Functions
 - 5.4.1. Billing
 - 5.4.2. Auditing/Monitoring/QA/Compliance
 - 5.4.3. Medical records

6. Training & Technical Assistance

- 6.1. Training Plan for Pre-Implementation Period
 - 6.1.1. varies depending on phase-in of services, may be a regional training plan if phase-in is regional
 - 6.1.2. Some immediate priorities:
 - 6.1.2.1.1. Rehab 101
 - 6.1.2.1.2. Documentation and person-centered planning
 - 6.1.2.1.3. Compliance systems
 - 6.1.2.1.4. Functional assessments
 - 6.1.2.1.5. Financial issues, especially cost accounting, core systems for FFS readiness, budgeting for FFS
- 6.2. Training Plan for Immediate Implementation period (3 months prior to go-live)
- 6.3. Technical assistance and system monitoring plan for immediate post implementation period
 - 6.3.1. Priorities for technical assistance

6.3.2. Use immediate system monitoring to set priorities for ongoing training & technical assistance

7. Misc Issues

7.1. Liability Insurance may be more difficult to get with increased c-b care; May need financial assistance and/or listing of vendors. Potential for group purchase to reduce rates. Explore incidence of problems getting insurance.

8. Policy & Design Issues

- 8.1. Catchment area & CAC issues
- 8.2. Clinical assessment and care access and capacity system issues
- 8.3. Linkages among providers
- 8.4. Ensuring core provider-specialty provider linkages are functional
- 8.5. Clarity about services and service boundaries
 - 8.5.1. Reducing overlap among services
 - 8.5.2. TCM
- 8.6. Financial policy issues on retention of Medicaid dollars (and start-up cash flow support?) across fiscal years
- 8.7. Work with DSS to reduce burden of spend-downs and re-eligibility issues
- 8.8. Consider converting clinic-option services to rehab option as well
- 8.9. Certification Time Line along with training & communications plans

9. Infrastructure Support and Resources

- 9.1. Staffing
- 9.2. Billing
- 9.3. Information Systems
- 9.4. Quality Assurance
- 9.5. Compliance staff
- 9.6. Cell phones and other technology support for community-based staff
- 9.7. IS Support (e.g. to develop reports, transition existing systems)

10. Supervision/Team Leader Training & Skills

Appendix D

Training Topics Used in Other States

Provider Training Topics

- **Productivity management**
 - Methods to increase productivity
 - Clinical model shifts/identifying unmet clinical need
 - Scheduling/management of clinical activities
 - Streamlining daily clinical operations
 - Supervision and supports

- **Compliance**
 - Prioritizing/focusing compliance issues
 - Cost effective compliance methodology
 - High risk areas
 - Tools to minimize risk
 - Integrating compliance into supervision

- **Recovery**
 - Operational definition and its importance to agencies
 - How recovery changes services and clinical approach
 - Role of consumers and families
 - Challenges and supports to expanding a recovery philosophy

- **Information systems**
 - Necessary core functions
 - Scalability/best fit for size/services of agency
 - Selection criteria
 - Options and alternatives
 - Reporting, data management, key indicators

- **Service documentation**
 - Assessment
 - Service planning
 - Service notes
 - Documentation strategies for specialty services
 - Supervision and monitoring of documentation quality and compliance

- **Functional assessment tools**
 - Options for functional assessment
 - Survey of frequently used functional assessment tools
 - Strategies for incorporation with minimal increase in costs

- **Expanding community based services**
 - Meeting consumer need with a recovery focus
 - Financial bottom line impact and cost effectiveness
 - Methods to shift clinical/service focus

- **Business office practices**
 - Billing best practices
 - Streamlining billing practices and improving timeliness
 - Role and interface with service staff in effective billing
 - Reconciliation of billing and claims
 - Tracking and resolution of billing errors (internal/state)

- **Financial analysis**
 - Financial modeling/impact analysis based on existing and targeted productivity
 - Cost of service determination by type and staff
 - Key financial indicators and benchmarks

Appendix E

Providers Participating in Survey

Provider	Clinical or Specialty	Partial Data	Provider	Clinical or Specialty	Partial Data
ALSO-Cornerstone	C		My Sisters' Place, Inc.	S	X
Bridge House Inc	S	X	New Haven Home Recovery, Inc	S	
Bridges.	C		Northwest Center for Family Service and Mental Health	C	
C.N.V. Help, Inc	S		Norwalk Hospital	C	
CCC YMCA	S		Pathways, Inc.	S	
Chrysalis Center, Inc.	S	X	Regional Network of Programs, Inc.	S	
Connecticut Mental Health Center	C		Reliance House, Inc.	S	
Community Health Resources	C		River Valley Services	C	
Community Mental Health Affiliates	C		Rushford Center Inc	C	
Capitol Region Mental Health Center	C		Southeastern Mental Health Authority	C	
Fellowship Place	S		Sound Community Services, Inc.	C	
Gilead Community Services, Inc.	C		Stamford Hospital Outpatient Behavioral Health	C	
Hall-Brooke Behavioral Health Services	S		Southwest Community Mental Health System	C	
Harbor Health Services	C		United Services, Inc	C	
Intercommunity Mental Health	C	X	Valley Mental Health Center	C	
Interlude	S		Western Connecticut Mental Health Network	C	
Mental Health Association of CT	S				

Appendix F

Membership in Provider Readiness Workgroup

Karen Evertson – Western Connecticut Mental Health Network*

Cheryl Jacques – SMHA*

Mary Gillette – CMHA

Luis Perez – CRMHC*

Rick Persky – CRMHC

Sharon Castelli – Chrysalis

Sue Niemitz– Hartford Behavioral Health

Bert Mercado – Mental Health Association

Diane Manning – United Services

Barry Kasden – Bridges

Margaret Beglinger – Reliance House

Patrick McCabe – Norwalk Hospital

Bob Walsh – CNV Help

* Affiliation at time of workgroup