Accountable Care: Seizing the Opportunities Under the Affordable Care Act (ACA) – How New Strategies Can Be Developed

Presented by:

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Overview and Justification:

1. As parity and national healthcare reform are implemented, more people than ever before will have access to treatment for mental health and addiction services through expanded public and private insurance coverage.
2. Specialty behavioral healthcare organizations must expand capacity to meet increased demand and offer measurable, high-performing prevention, early intervention, recovery, and wellness services and supports.
3. We must also be ready to work with the expanded Medicaid systems and be able to bill through the new health insurance exchanges, Accountable Care Organizations (ACOs), and other funding sources.

Overview: HealthCare Reform Opportunities and Challenges

- **Accountable Care Organizations (ACOs)** Model of Service Delivery

Healthcare Reform: Accountable Care Organizations (ACOs) Next Healthcare Model…

1. **Congress and CMS:** an ACO would have at least one hospital, a minimum of 50 physicians (primary care and specialists); commit to be in business for at least 3-5 years, and serve at least 5,000 patients

   a. If the ACO met pre-established quality goals, it would receive an incentive payment

   b. Penalties would be assessed if care did not meet the quality goals established

   c. Incentive payments and penalties would be split between the members of the ACO

   d. The providers in the ACO would follow best practices, be patient-centered and contribute to the development of best clinical practices to build standards of evidenced-based medicine

Source: Dale Jarvis, CPA, MCPP Healthcare Consulting

Healthcare Reform: Accountable Care Organizations (ACOs) Next Healthcare Model…

2. **Medicare:** Allow providers organized as ACOs that voluntarily meet quality thresholds to share in the cost savings they achieve (2012); foundation for bundled payments
3. **Medicaid Demonstration Projects:**

a. Pay bundled payments for episodes of care that include hospitalizations (2010-2016)

b. Make global capitated payments to safety net hospital systems (FY2010-2012)

c. Allow pediatric medical providers organized as ACOs to share in cost-savings (2012-2016)

Source: Dale Jarvis, CPA, MCPP Healthcare Consulting

Milliman **On Healthcare**

INSIGHTS AND ANALYSIS FOR A SYSTEM IN TRANSITION

- "While not explicitly in the law, cost effectiveness will be central. Health plans are revisiting provider risk-sharing methods as a way to help control costs and to create quality incentives… **Accountable care organizations are one example of this risk sharing**."

Source: "Milliman Identified Strategic Considerations for a Post Healthcare Reform Environment", March 27, 2010

Examples of New Healthcare Models – ACO Type Pilot in Illinois

1. Capitated based Full Integration of primary care, oral health, behavioral health and MR/DD needs
   - Two HMOs have been contracted to manage the Illinois Integrated Health Program for five years with five year renewal effective January 2011 (Aetna and Centene)
   - Consumer Choice Focused
   - Cost containment (i.e., $200,000,000 per year in Illinois for 40,000 Medicaid Eligible Persons

Overview: HealthCare Reform Opportunities and Challenges

- **Primary Care Practice Medical Homes** – Integration of primary care, and behavioral health needs available through and coordinated by the PCP

Overview: HealthCare Reform Opportunities and Challenges

- **Primary Care Practice Medical Homes** – Integration of primary care, and behavioral health needs available through and coordinated by the PCP
- Pennsylvania has contracted with Aetna to create a PCP medical home for all persons with Medicaid in a multi year pilot.
- All Healthcare, including BH must be accessed through the eligible person's medical home care manager/coordinator

Overview: HealthCare Reform Opportunities and Challenges

1. **Healthcare Plans Medical Home** – The state of Washington has filed a plan with CMS that will provide a medical home for all Medicaid eligible persons through their state health plans (HMOs)
2. The 1915b Behavioral Health carve out waiver is being amended to shift the capitated payments from the form carve out Regional Service Networks based on chronicity level of clients.

Overview: HealthCare Reform Opportunities and Challenges

1. **CBHO Medical Homes** - Integration of primary care, and behavioral health needs available through and coordinated by the CBHO
2. IT capacity to fully integrate EHRs with all other providers
3. Provide care management/care coordination for all integrated health care needs

CBHC Position on Healthcare Reform and Integration Approved CBHC Board of Directors May 2010

CBHC's Role:

- Advocate for a reformed healthcare delivery system for Colorado that includes mental health and substance use treatment as essential to overall health and wellness.
- Actively work together with other organizations that demonstrate commitment to service integration.
- Engage at the State and National level in collaborations, innovations, policy development, and legislative efforts that are dedicated to improving care and integrating mental health and substance use into overall healthcare.
- Expand collaborations with other community and healthcare stakeholders, including health plans.
- Provide communication, educational information, and training to its members and other stakeholders regarding an integrated service delivery system that includes mental health and substance use treatment as a part of healthcare.
- Support the message/value of integration at the local, state, and national levels.
- Pursue a full substance abuse benefit for Medicaid to be managed by the BHOs

CBHC Position on Healthcare Reform and Integration Approved CBHC Board of Directors May 2010

Core Principles (partial list):

- Colorado's community mental health system should be utilized as experts in behavior change to promote overall health outcomes
- Development of integrated service delivery systems begins with providing mental and physical health services in both settings.
- Community Mental Health Centers and Clinics (CMHC) may serve as the healthcare home of choice for adults with serious mental illness and children with serious emotional disturbance.
- The cost of healthcare can be reduced if the mental health and substance use treatment needs of the population are addressed in conjunction with their physical healthcare needs.
- Services should be integrated at the point of delivery, actively involve patients as partners in their care, and be coordinated with other community resources.
- Technology and health information exchange should be used to enhance services and support the highest quality services and health outcomes…

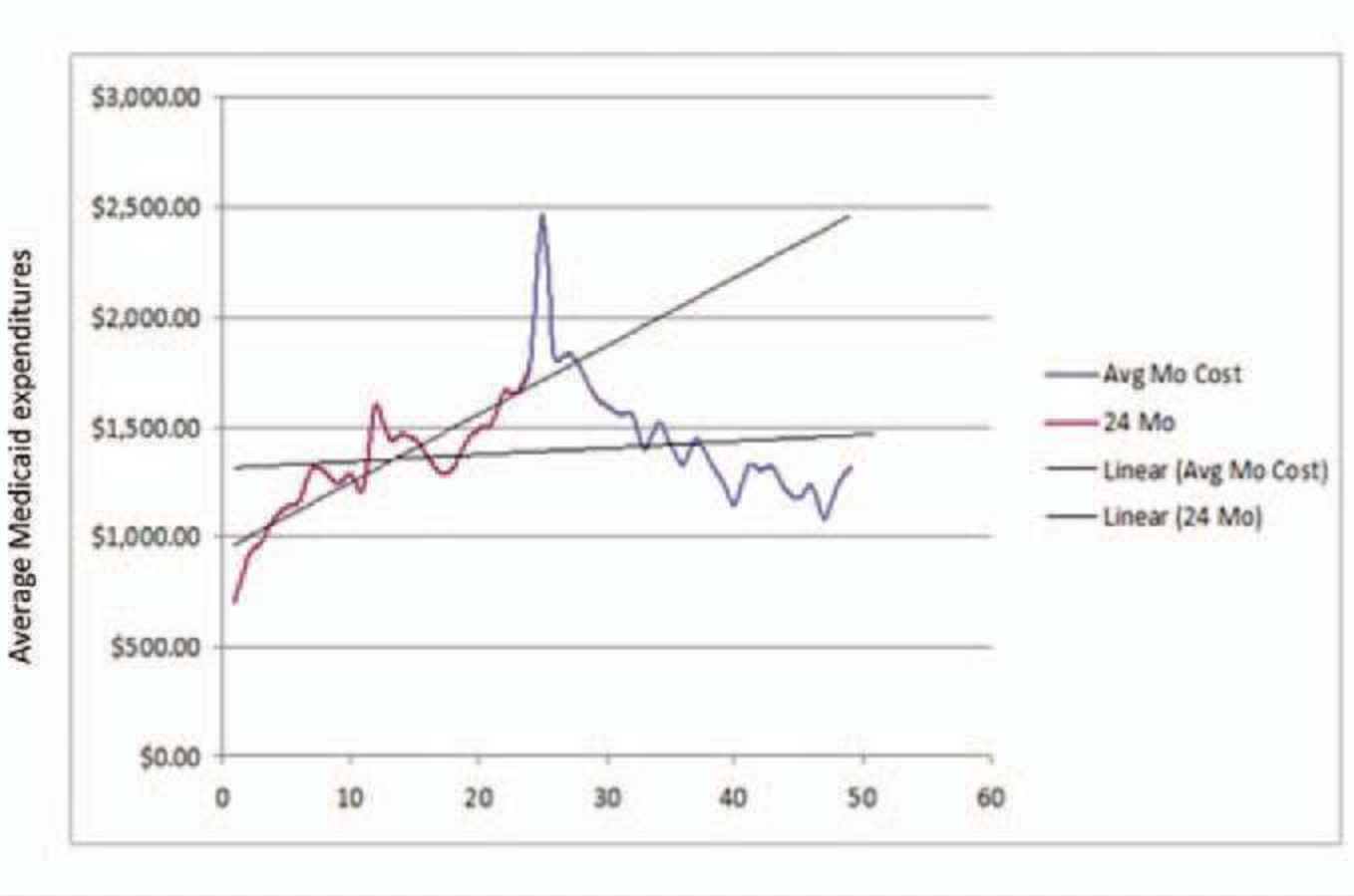
Mental Health and Substance Use Disorders Have to Be Included to Bend the Cost Curve

California Fee for Service Medi-Cal Analysis - 2007			
	Medi-Cal FFS Total	Medi-Cal FFS SMI	Metric
Medi-Cal FFS Enrollees	1,580,440	166,786	11% SMI % of Total
Medi-Cal FFS Costs	$6,186,331,620	$2,395,938,298	39% SMI % of Total
Medi-Cal FFS Cost/Enrollee	$3,914	$14,365	3.7 SMI/Non-Ratio
Diabetes	4%	11%	2.8 SMI/Non-Ratio
Ischemic Heart Disease	2%	6%	3.0 SMI/Non-Ratio
Cerebrovascular Disease	1%	3%	3.0 SMI/Non-Ratio
Chronic Respiratory Disease	5%	13%	2.6 SMI/Non-Ratio
Arthritis	2%	7%	3.5 SMI/Non-Ratio
Health Failure	1%	3%	3.0 SMI/Non-Ratio
Inpatient Episodes	100	293	2.9 SMI/Non-Ratio
ER Visits	337	1,167	3.5 SMI/Non-Ratio
Inpatient Acute Days	609	2,094	3.4 SMI/Non-Ratio
Primary CareVisits	128	492	3.8 SMI/Non-Ratio
Specialist Visits	1,211	6,058	5.0 SMI/Non-Ratio
Prepared by JEN Associates, Cambridge, MA			

"Mental Health Community Case Management and Its Effect on Healthcare Expenditures"

By: Joseph J. Parks, MD; Tim Swinfard, MS; and Paul Stuve, PhD
Missouri Department of Mental Health
Source: PSYCHIATRIC ANNALS 40:8 | **AUGUST 2010**

- People with severe mental illness served by public mental health systems have rates of co-occurring chronic medical illnesses that of two to three times higher than the general population, with a corresponding life expectancy of 25 years less.
- Treatment of these chronic medical conditions ……. comes from costly ER visits and inpatient stays, rather than routine screenings and preventive medicine.
- **In 2003, in Missouri, for example, more than 19,000 participants in Missouri Medicaid had a diagnosis of schizophrenia. The top 2,000 of these had a combined cost of $100 million in Missouri Medicaid claims, with about 80% of these costs being related not to pharmacy, but to numerous urgent care, emergency room, and inpatient episodes.**
- The $100 million spent on these 2,000 patients represented 2.4% of all Missouri Medicaid expenditures for the state's 1 million eligible recipients in 2003.



- Total healthcare utilization per user per month, pre- and post-community mental health case management. The graph shows rising total costs for the sample during the 2 years before enrolling in CMHCM, with the average per user per month (PUPM), with total Medicaid costs increasing by over $750 during that time. This trend was reversed by the implementation of CMHCM. Following a brief spike in costs during the CMHCM enrollment month, the graph shows a steady decline over the next year of $500 PUPM, even with the overall costs now including CMHCM services.

Source: PSYCHIATRIC ANNALS 40:8 | **AUGUST 2010**

Overview: HealthCare Reform Opportunities and Challenges

- **Federally Qualified Health Centers (FQHCs)** - Integration of primary care, oral health, and behavioral health needs)

FQHCs – Community Health Centers

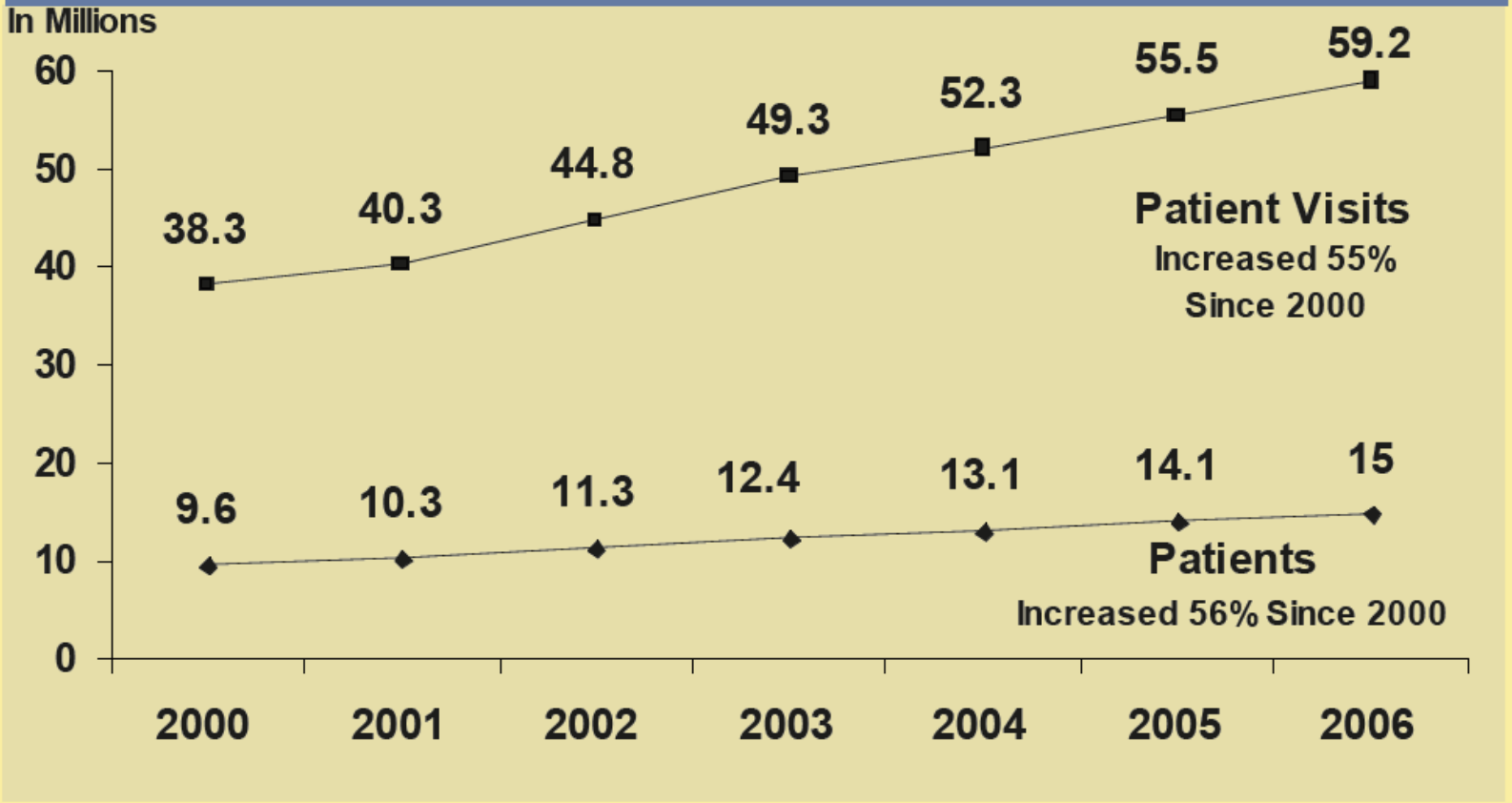
- "With federal encouragement, the centers have made a major push this decade to expand dental and mental health services, open on-site pharmacies, extend hours to nights and weekends and accommodate recent immigrants — legal and otherwise — by employing bilingual staff."

  Source: "Expansion of Clinics Shapes Bush Legacy" by Kevin Sack , **NY Times ,** December 25, 2008
- The current 2009 Stimulus Package contains $1.5 Billion new dollars to fund FQHCs - $1 Billion to build new facilities and $500 million to open new FQHCs. The $500 million will be annualized and added to the $2 Billion annual funding in 2008 for FQHCs
- SAMHSA did not receive any primary additional funding in the stimulus package

ANNUAL REPORT
2007

NATIONAL ASSOCIATION OF COMMUNITY HEALTH CENTERS

The Number of Health Center Patients and Patient Visits Continues to Grow



** Note: Excludes patients at non-Federally funded health centers, which treats an additional 1.5 million patients annually.*

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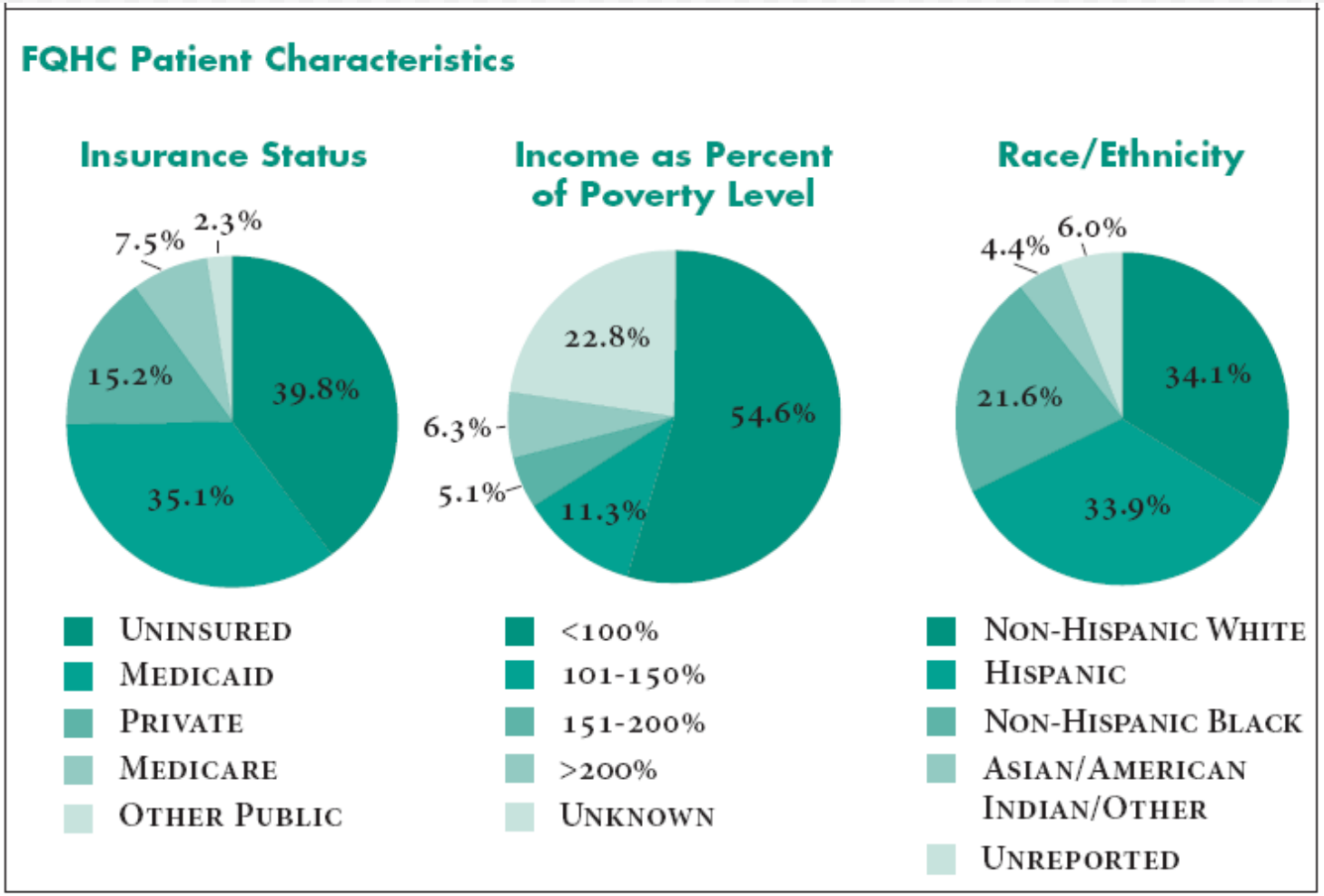
Source: Center for Studying Health System Change
Issue Brief No. 116 • December 2007



Source: Health Resources and Services Administration, The Health Center Program, 2006 National Aggregate UDS Data

Community Health Centers and Health Reform

Summary of Key Health Center Provisions

On March 18, 2010, the House Democratic Leadership released the text of the Reconciliation Act of 2010, which makes changes to H.R. 3590, the Senate-passed Patient Protection and Affordable Care Act. Taken together, the Reconciliation Act and H.R. 3590 are considered the health care reform package. There are numerous provisions in health reform that impact community health centers both directly and indirectly. The summary below highlights key provisions of health reform for health centers.

Community Health Centers and National Health Service Corps Trust Fund

- **$11 Billion for Health Center Program Expansion- Beginning in FY2011**
  The health reform package contains a total of $11 billion in *new* funding for the Health Centers program over five years. $9.5 billion of this funding will allow health centers to expand their operational capacity to serve nearly 20 million new patients and to enhance their medical, oral, and behavioral health services. $1.5 billion of this funding will allow health centers to begin to meet their extraordinary capital needs, by expanding and improving existing facilities and constructing new sites.

- **$1.5 Billion for the National Health Service Corps**
  The health reform package also includes $1.5 billion over five years for the National Health Service Corps, which will place an estimated 15,000 primary care providers in provider-short communities. The bill also makes programmatic improvements to the Corps.

Medicaid Expansions

- **Expands Medicaid to 133% of the Federal Poverty Level (FPL) in FY2014**
  Expands Medicaid to 133% of FPL in FY2014, without any categorical restrictions, newly insuring 16 million Americans.

Payment Protections and Improvements

- **Requires that health centers receive no less than their Medicaid PPS rate from private insurers offering plans through the new health insurance exchanges and requires that these plans contract with health centers.**
  Ensures that health center patients will not be excluded from new insurance products and that health centers are not underpaid for their services.
- **Adds preventative services to the Federally-Qualified Health Center (FQHC) Medicare payment rate and eliminates the outdated Medicare payment cap on FQHC payments.**
  Begins to modernize health center Medicare payments to ensure health centers are able to provide the highest quality care to our Medicare beneficiaries.

Teaching Health Centers

- **Acknowledges the growing role of health centers in teaching the next generation of primary care providers by authorizing and funding new programs for health center-based residencies.**
  Authorizes a new Title VII grant program for the development of residency programs at health centers and establishes a new Title III program that would provide payments to community-based entities that operate teaching programs. Directly appropriates $230 million over 5 years for the Title III payments.

Federally Qualified Health Centers (FQHCs) Take the Lead to Form Accountable Care Organizations – October 6, 2010

- **"Interested in learning about Accountable Care Organizations? Find out more about them, and how your CHC or PCA can take a leadership role in their development at NACHC's upcoming Developing Successful Community Collaborations Training seminar."**
- **Developing Successful Community Partnerships and Effective Accountable Care Organizations**
  Planet Hollywood Las Vegas
  November 18-19, 2010
- Refer to full notice

Levels of Local CBHO Provider Integration with FQHCs

1. No Relationship with FQHCs
2. Referral Agreements between CBHO Provider and FQHC
3. Technical Assistance Provided to FQHC by CBHO Provider
4. CBHO Provider's Staff provide Services within the FQHC at enhanced Medicaid rates
5. CBHO Provider is Partner in the FQHC with other Community Health Care Agencies
6. CBHO Provider applies for Look Alike Grant and Owns/Operates the FQHC as subsidiary

Healthcare Reform Context:

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

1. Be Accessible (Fast Access to all Needed Services)
2. Be Efficient (Provide high Quality Services at Lowest Possible Cost)
3. Produce Outcomes!
   - Engaged Clients and Natural Support Network
   - Help Clients Self Manage Their Wellness and Recovery
   - Greatly Reduce Need for Disruptive/ High Cost Services

Poll Results based on over 600 Registrants for the NC LIVE Webinar on Enhanced Revenue Presented by David Lloyd, MTM Services on December 15, 2009 and January 12, 2010

1. From the clinicians' perspective, are the caseloads in your organization "full" at this time?

   Yes = 74% No = 26%

2. Do you know the cost and days of wait for your organization's first call to treatment plan completion process?

   Yes = 41% **No = 59%**

3. Indicate the no show/cancellation percentage last quarter in your organization for the intake/assessment appointments:

   A. 0 to 19% = 20%

   B. 20 to 39% = 42%

   C. 40 to 59% = 15%

   D. Not aware of percentage = 23%

4. Indicate the no show/cancellation percentage last quarter in your organization for Individual Therapy appointments:

   A. 0 to 19% = 24%

   B. 20% to 39% = 50%

   C. Not aware of percentage = 26%

Change Initiatives to Enhance CBHOs "Value" as a Partner in Healthcare Reform/Parity

1. Reduce access to treatment processes, time required and costs
2. Design and implement internal levels of care/benefit package designs
3. Develop and implement key performance indicators for all staff including cost-based direct service standards
4. Develop scheduling templates and standing appointment protocols linked to billable hour standards and no show/cancellation percentages
5. Develop Centralized Schedule Management with "Back Fill" management using the "Will Call" procedure
6. Design and implement No Show/Cancellation management using an Engagement Specialist
7. Design and Implement re-engagement/transition procedures for current cases not actively in treatment.
8. Collaborative Concurrent Documentation training and implementation

1. Accessibility to TREATMENT – A CORE Issue

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

National Access to Care Measures

Measure the following six Access Measures from December 1, 2007 (pilot start date) through June 30, 2008 (pilot end date) for all referrals to identified programs:

1. **a) Time from First Contact to first Offered Intake/ Assessment Appointment**: The average number of calendar days from initial contact date to the offered intake/ assessment appointment date.

   Standard:

   a. **Emergent** (life threatening) offered appointment is within one hour (or local standard)
   b. **Urgent** (high level of crisis) offered appointment is within 24 hours (or local standard)
   c. **Routine** offered appointment is within 10 calendar days (or local standard)

   b) Time from First Contact to Actual Intake/ Assessment Appointment: The average number of calendar days from initial contact date to the actual intake/ assessment date.

2. **a) Time from Intake/ Assessment to first Offered Therapist) Appointment:** The average number of calendar days from Intake/ Assessment to the offered therapist appointment date .

   Standard:

   Develop local standard (e.g. within 10 calendar days)

   b) **Time from Intake/ Assessment to actual Therapist Visit:** The average number of calendar days from Intake/ Assessment to the actual therapist visit.

3. **a) Time from Referral for Psychiatric Services to first offered Psychiatric Appointment:** The average number of calendar days from referral for Psychiatric Services to offered Psychiatric Appointment date.

   Standard:

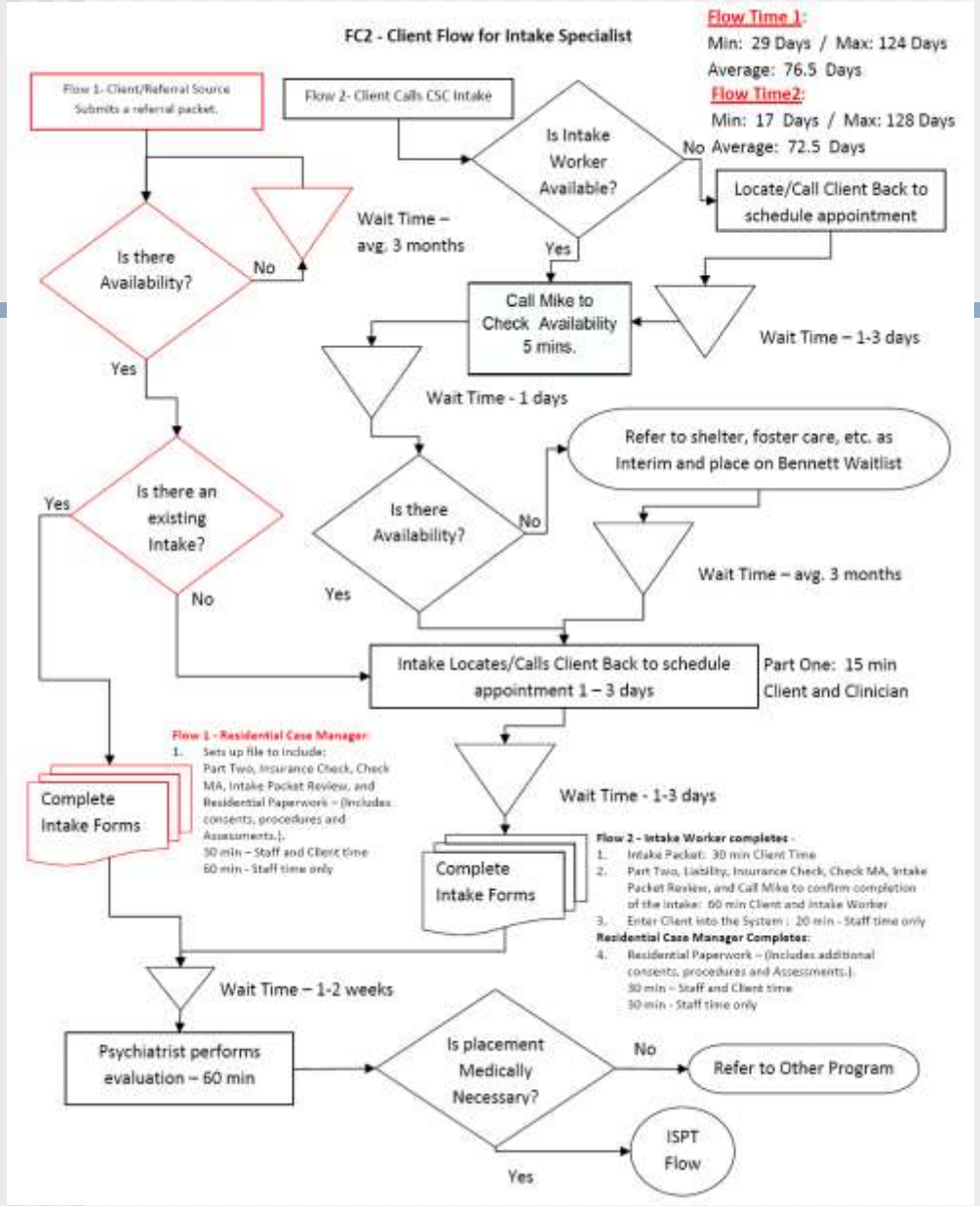
   Develop local standard (e.g. within 10 calendar days)

   b) Time from Referral for Psychiatric Services to actual Psychiatric Service date: The average number of calendar days from referral for Psychiatric Services to actual Psychiatric Service date.

Executive Walkthrough Outcomes from Access and Engagement Initiative

Top Seven Findings:

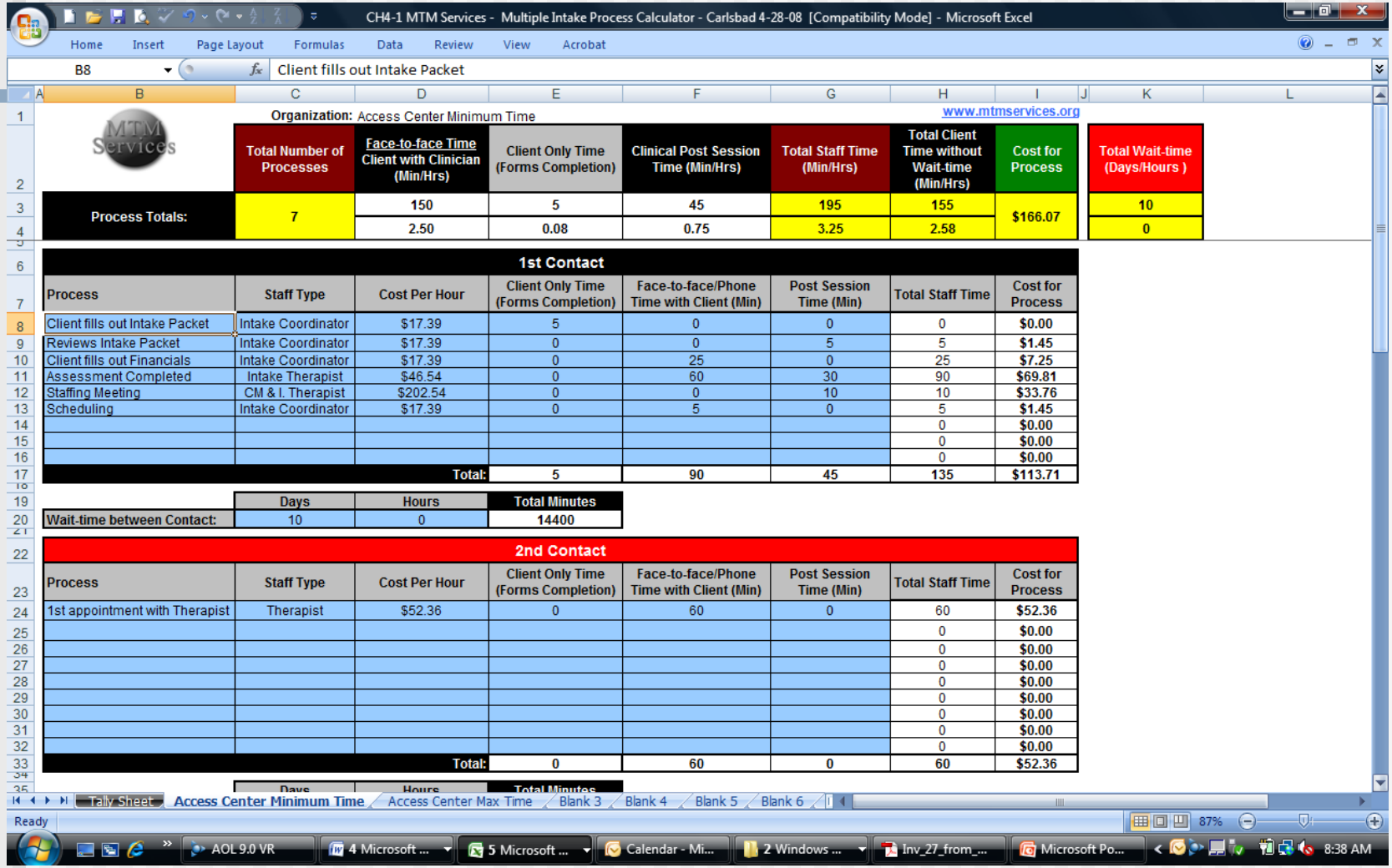
1. Paperwork too lengthy and confusing
2. Redundant paperwork/ data collection
3. Telephone response tree confusing/ lengthy
4. Unacceptable wait time for therapy services
5. Unacceptable wait time for psychiatry services
6. Policies not being followed or misinterpreted
7. Staff seemed very concerned in the process, however, just could not get treatment



Measurement Tools/ Processes

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

Measurement Tools/Processes



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

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

B8: Client fills out Intake Packet

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

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

1st Contact

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

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

2nd Contact

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

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

Ready — 87% — 8:38 AM

AOL 9.0 VR | 4 Microsoft ... | 5 Microsoft ... | Calendar - Mi... | 2 Windows ... | Inv_27_from_... | Microsoft Po...

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Access and Engagement Initiative Centers

#	Location	Division	Total Number of Processes	Total Staff Time (Hrs)	Total Client Time without Wait-time (Hrs)	Cost for Process	Total Wait-time (Days)
1	Northside	CSP	3	7.18	5.04	$411.38	9
2	Cascadia - CAIR ONLY	Adult Mental Health	5	7.13	3.92	$676.88	43
3	Cascadia	Adult MH	9	7.44	4.09	$704.84	45
4	Atlanticare	Adult MH	4	3.32	2.17	$256.67	55
5	Ozark Guidance	Adult MH	5	2.55	1.71	$137.00	78
6	Colorado West - Urban	Adult MH	7	3.76	3.26	$320.55	36
7	Colorado West - Rural	Adult MH	6	3.63	3.03	$218.06	30
8	CSEA	Adult MH	4	4.04	2.78	$245.00	27
9	Avita - Blairsville	Adult MH	3	2.08	2.08	$122.44	22
10	Avita - Demorist	Adult MH	3	1.83	1.83	$106.02	70
11	Avita - Hartwell	Adult MH	3	1.96	1.96	$114.23	42
12	Avita - Gainesville	Adult MH	3	2.03	1.78	$121.13	95
13	Avita - Tocca	Adult MH	3	1.58	1.58	$89.60	45
14	H Group	Adult MH	5	3.50	3.04	$262.79	33
15	Northside	Adult MH	4	2.88	2.63	$172.77	35
16	Carlsbad	Adult MH	10	3.86	3.71	$199.60	15
17	Consortium UC	Adult MH	4	3.87	3.33	$267.50	97
18	Consortium SWC	Adult MH	3	4.20	2.62	$309.17	65
		Averages:	4.67	3.71	2.81	($263.09)	46.56

MTM Services

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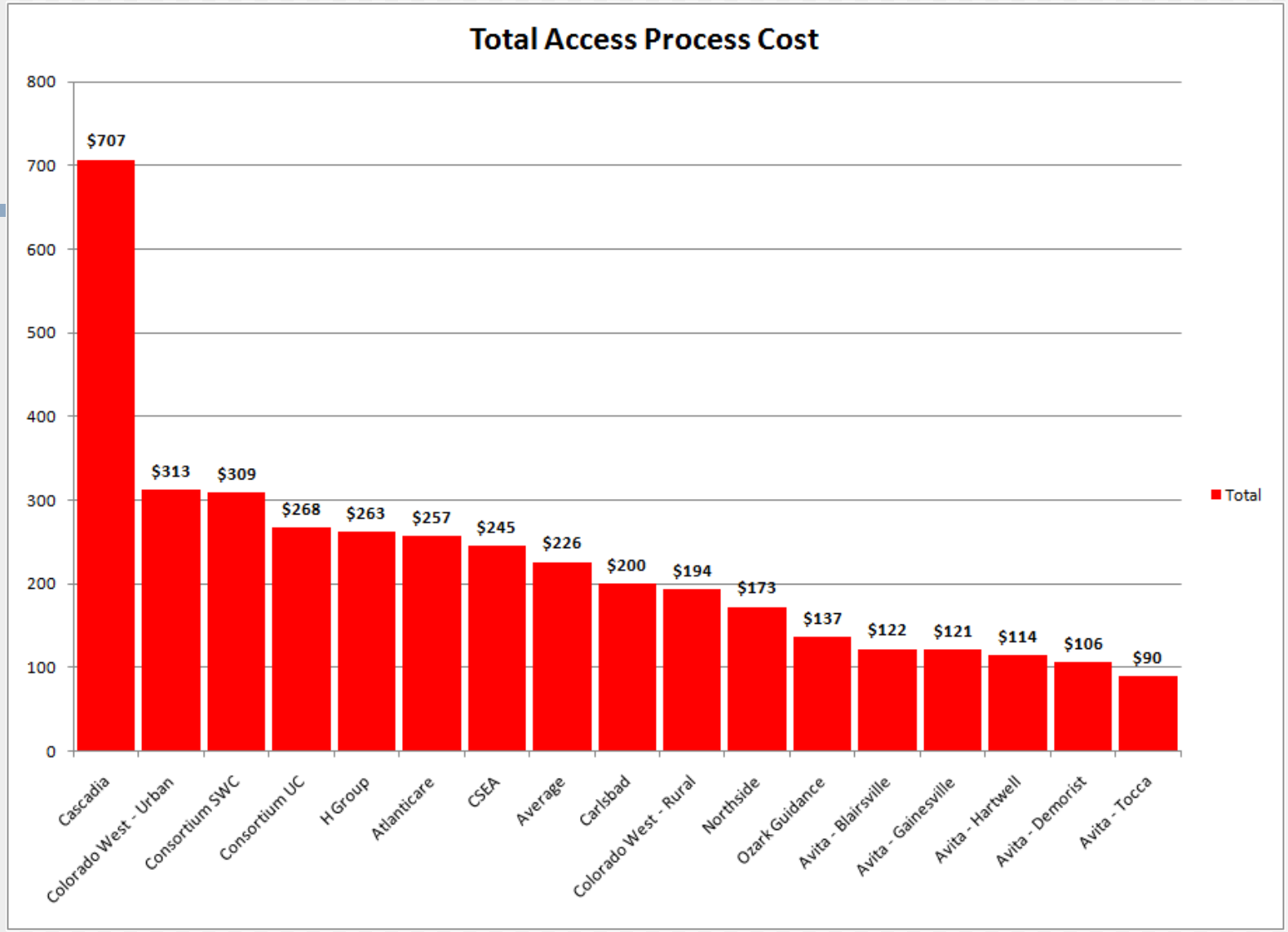

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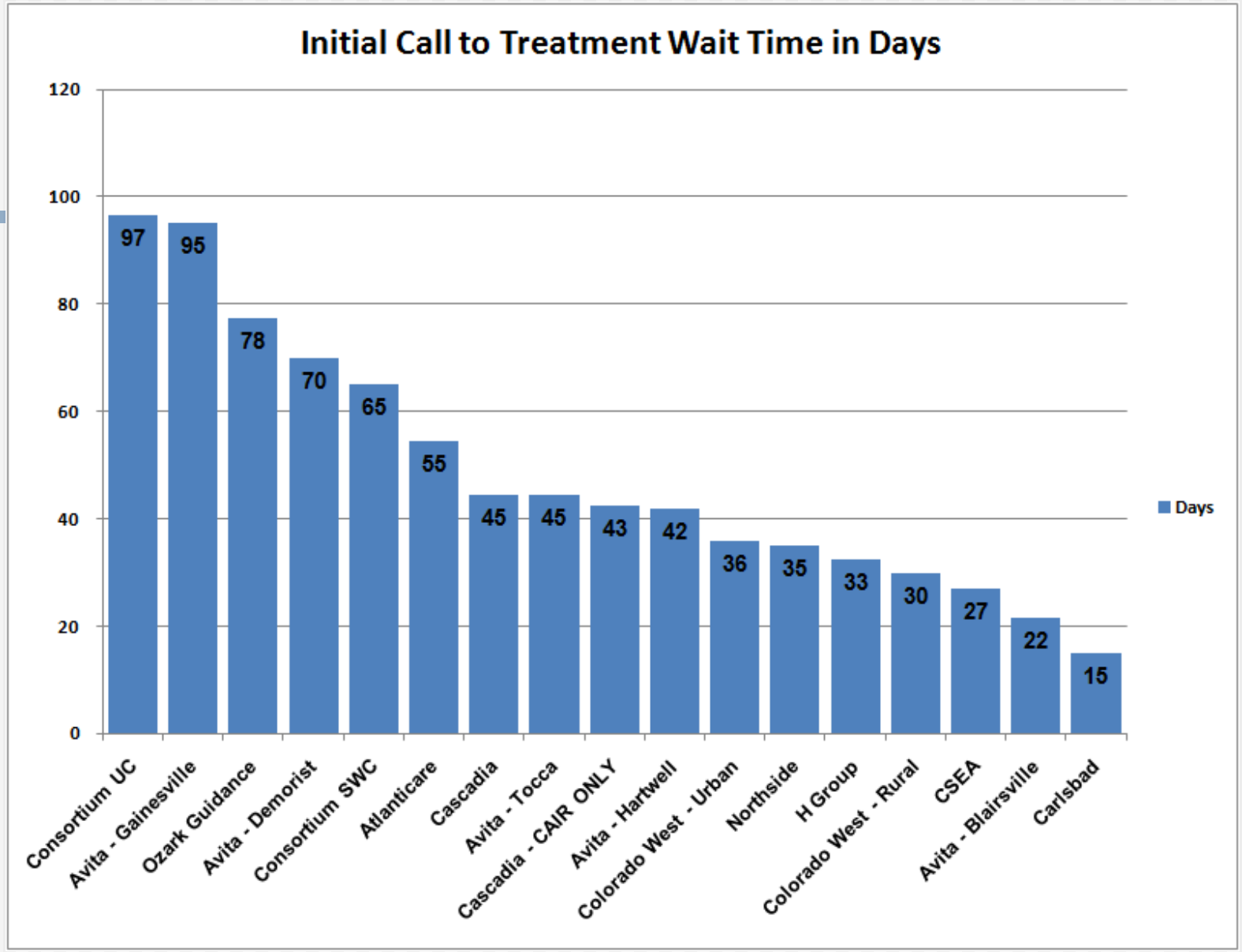
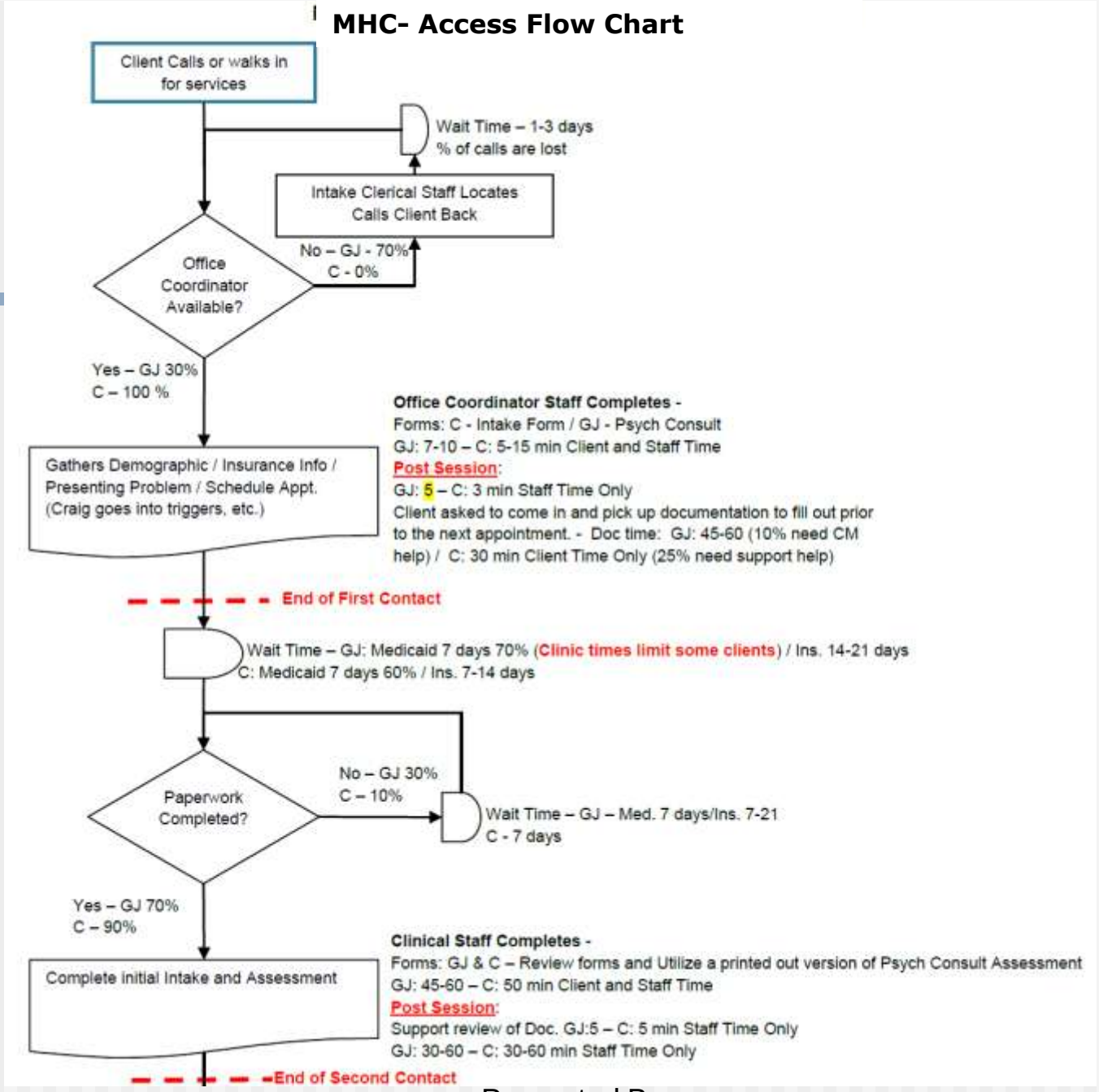

Initial Call to Treatment Wait Time in Days
120
100
80
60
40
20
0
97
95
78
70
65
55
45
45
43
42
36
35
33
30
27
22
15
Consortium UC
Avita - Gainesville
Ozark Guidance
Avita - Demorist
Consortium SWC
Atlanticare
Cascadia
Avita - Tocca
Cascadia - CAIR ONLY
Avita - Hartwell
Colorado West - Urban
Northside
H Group
Colorado West - Rural
CSEA
Avita - Blairsville
Carlsbad
Days

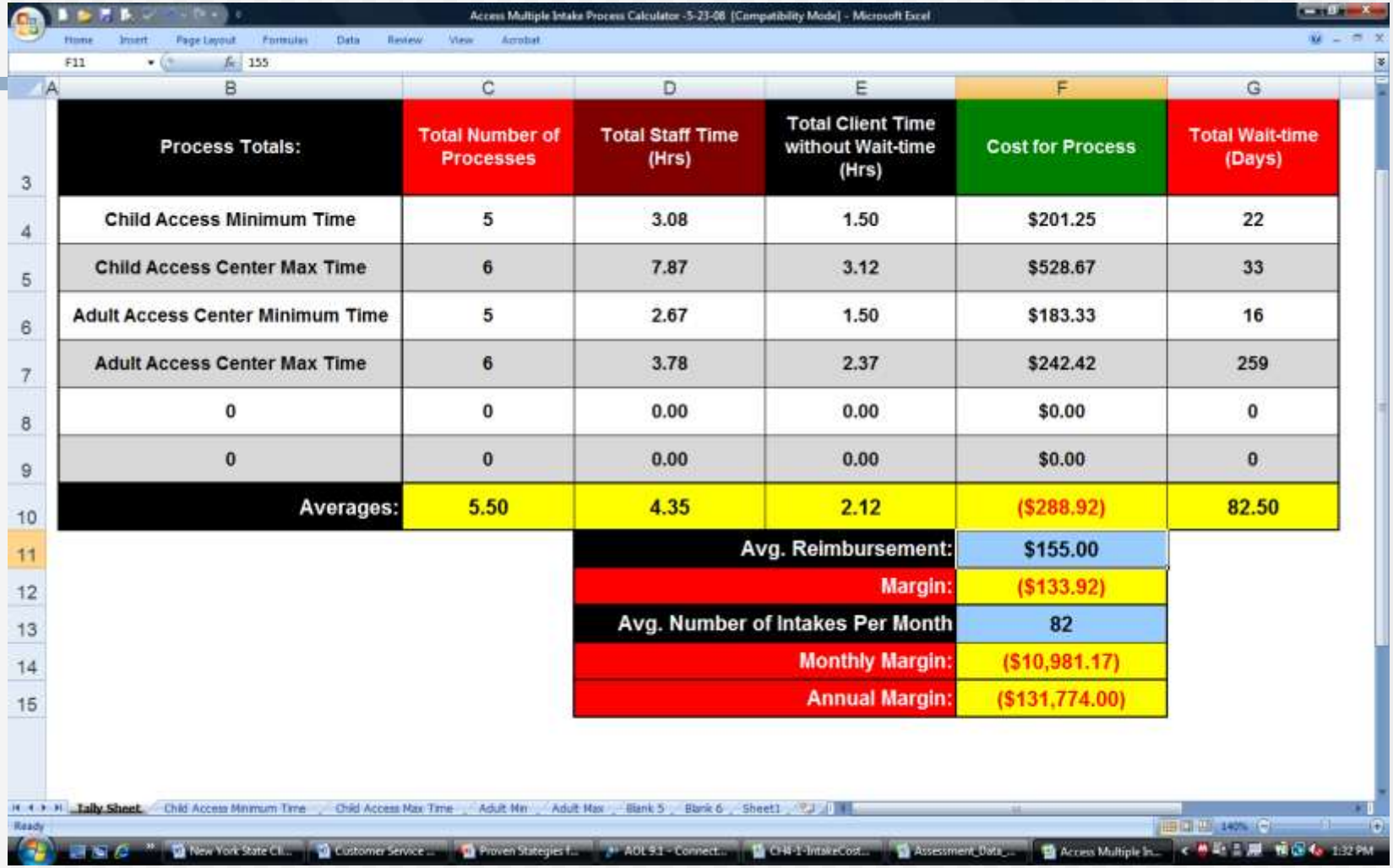
Solution Areas That Need to Be Addressed:

Develop a new access to care process flow with procedures to support more timely and cost effective access to treatment.

MHC- Access Flow Chart



Measurement Tools/Processes



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

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

Data Mapping Sample

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

Data Mapping to Reduce Access Time

- **Case Study of Exhaustive Data Collection Model:** M.T.M. Services provides project management and consultation services for the Access and Retention Grant. In their work with CBHOs they provide data mapping of the number of data elements each center collects from the first call for services through the completion of the diagnostic assessment/intake. A recent data mapping effort for a community provider produced the following outcomes:
  1. Total number of data elements collected in the process = **1,854**
  2. Total number of redundant data elements collected in the process = **564**
  3. Total number of data elements really required for access to treatment planning processes = **957**
  4. Total staff time required to administer the original flow process = **Four hours ten minutes**
  5. Total staff time required to administer the revised flow process = **One hours twenty minutes**

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

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

MTM Services

Standardize Service Flow Processes

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

National Access Redesign Grant Outcomes

	Total Number of Processes	Total Staff Time (Hrs)	Total Client Time without Wait-time (Hrs)	Cost for Process	Total Wait-time (Days)
Old Process Averages:	5.70	5.06	3.65	(331.63)	49.25
New Process Averages:	5.04	3.34	2.99	(210.20)	29.31
Savings:	0.66	1.73	0.65	$121.43	19.94
Change %:	12%	34%	18%	37%	40%
		Avg. Number of Intakes Per Month		3,843	
			Monthly Savings:	$466,642.00	
			Annual Savings:	$5,599,704.00	

<u>Total Annual Savings</u>:

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

National Access and Engagement Grant Outcomes

	Total Number of Processes	Total Staff Time (Hrs)	Total Client Time without Wait-time (Hrs)	Cost for Process	Total Wait-time (Days)
Old Process Averages:	4.56	3.75	2.74	(276.84)	51.96
New Process Averages:	4.00	2.65	2.28	(167.77)	20.82
Savings:	0.56	1.10	0.46	$109.07	31.15
Change %:	12%	29%	17%	39%	60%

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

<u>Total Annual Savings</u>:

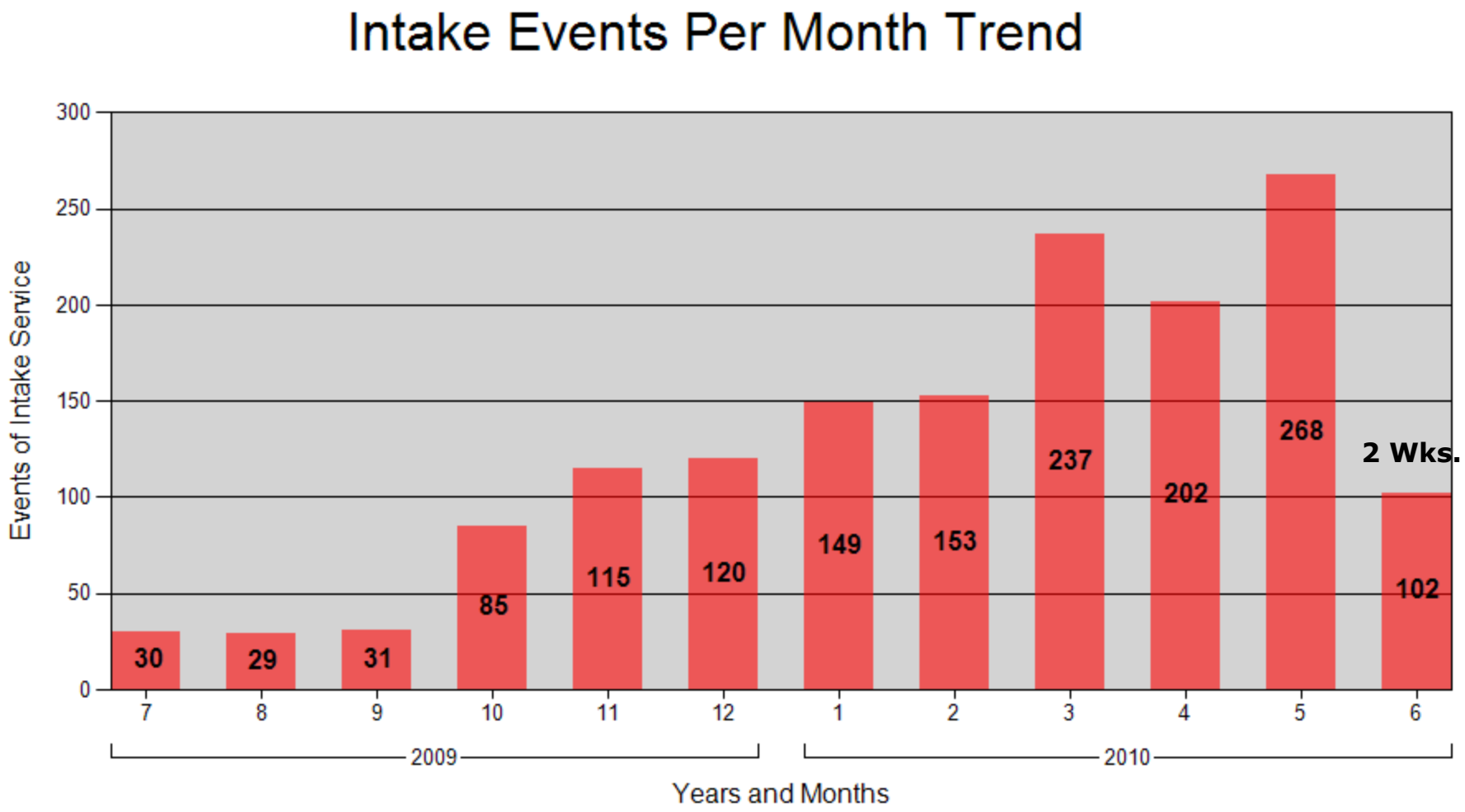
- Produced an average annual savings of **$231,764** per CBHO – 39% Reduction in costs
- **29% reduction** in staff time
- **17% reduction** in the client time
- **60% reduction** in wait time
- **26% increase** in Intake Volume Provided
- Based on eight first year A&E Centers from seven states - total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

Cascadia Behavioral Health Access to Treatment Plan Completion Outcomes – Old Process in June 2009 (Baseline) and New Process in After Initiative

Old Process Averages:	5.00	7.13	3.92	($676.88)	42.50
New Process Averages:	2.00	1.83	1.33	($146.67)	9.00
Savings:	3.00	5.29	2.58	$530.21	33.50
Change %:	60%	74%	66%	78%	79%

Avg. Number of Intakes Per Month	110
Intake Volume Change %:	38%
Monthly Savings:	$58,322.92
Annual Savings:	$699,875.00

Cascadia Assessments/Intakes Provided to Clients Per Month



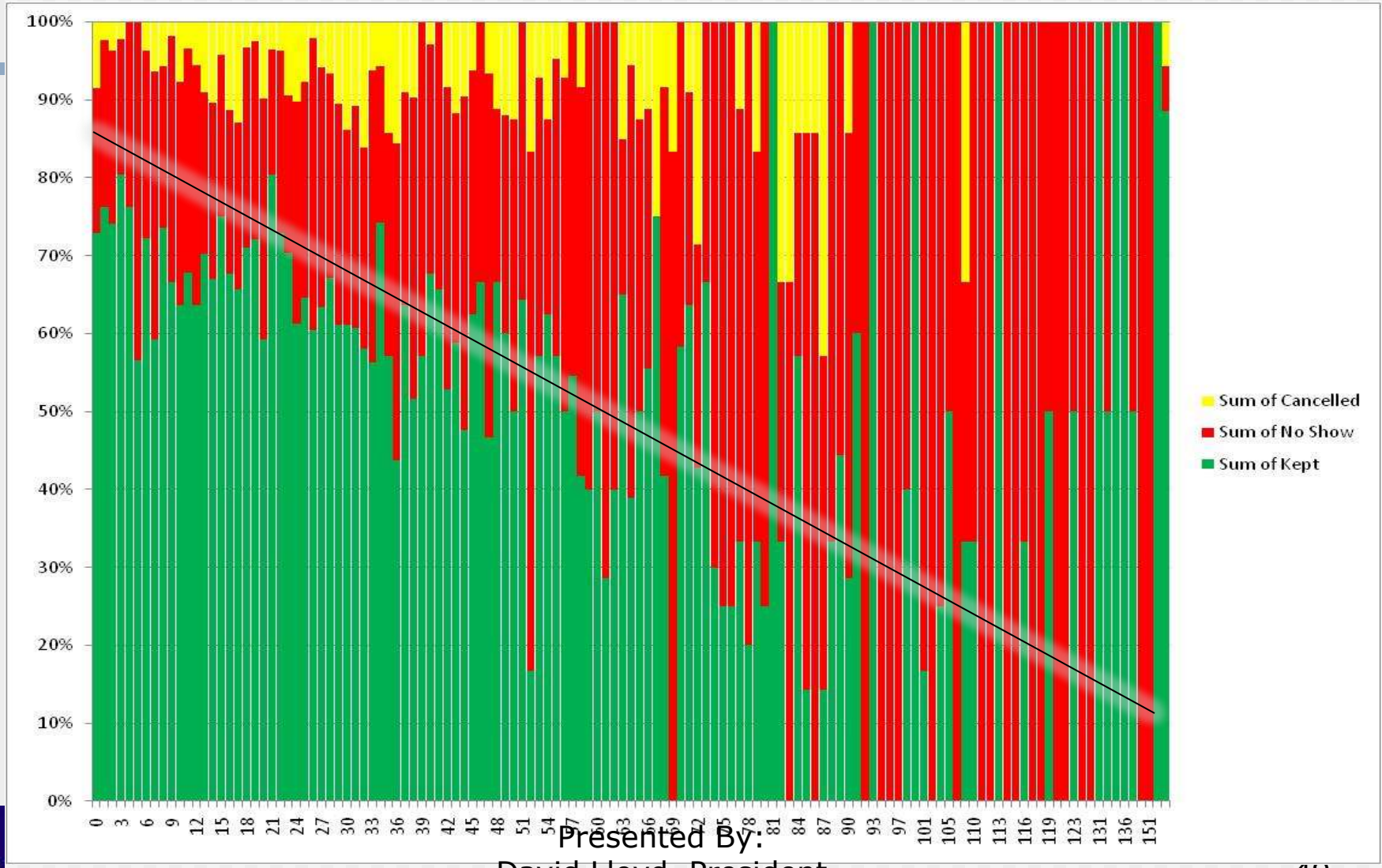
Intake/Diagnostic Assessment Model Can Contribute to No Shows/Cancellation Rates

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

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

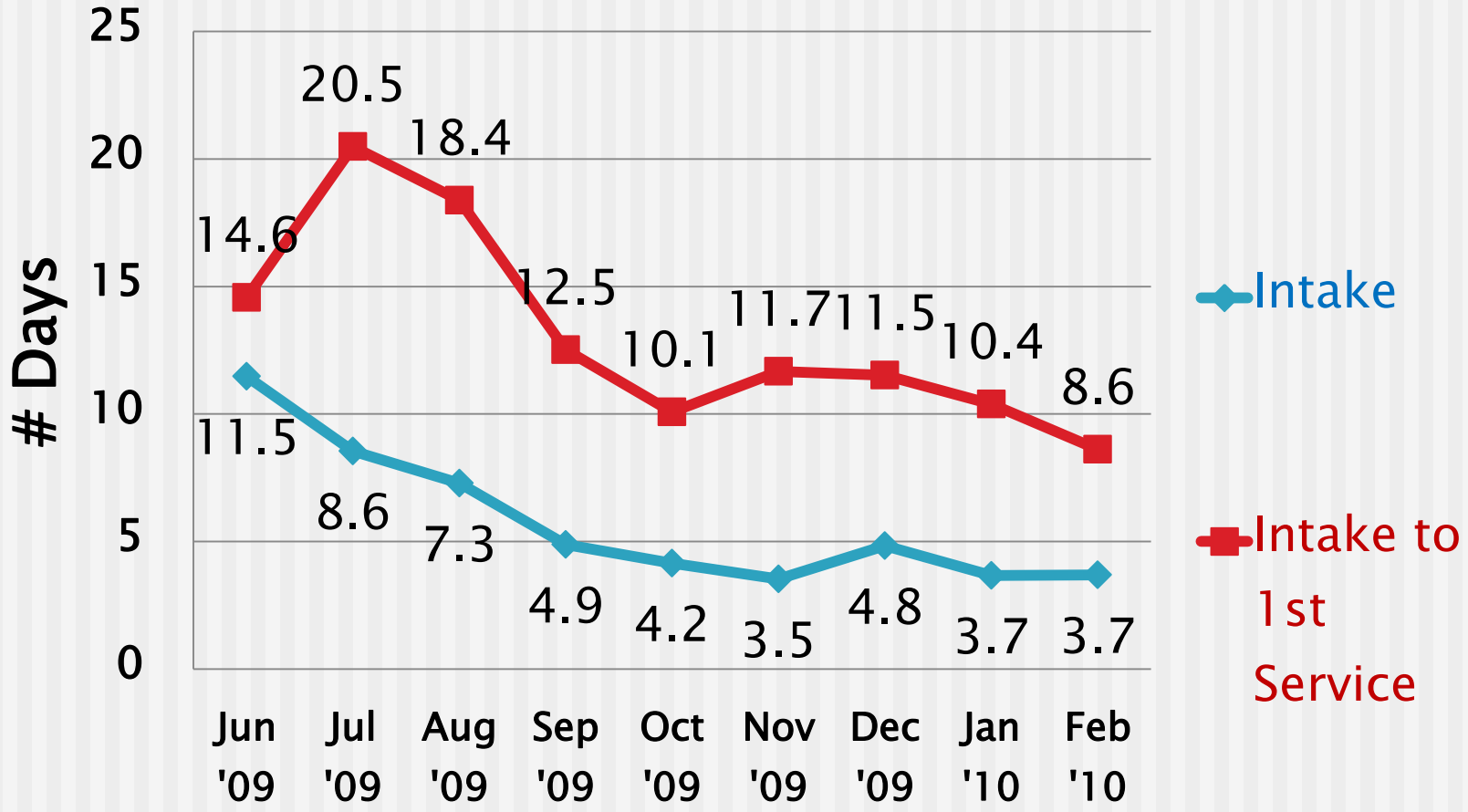
Presented By:
David Lloyd, President

Combined Access and Engagement and Access Redesign Initiatives Average Cancelled, No Show and Kept Percentage for Assessment and First Treatment Service Based on Days of Wait from First Call



Colorado West Access to Treatment and Enhanced Service Capacity Outcomes

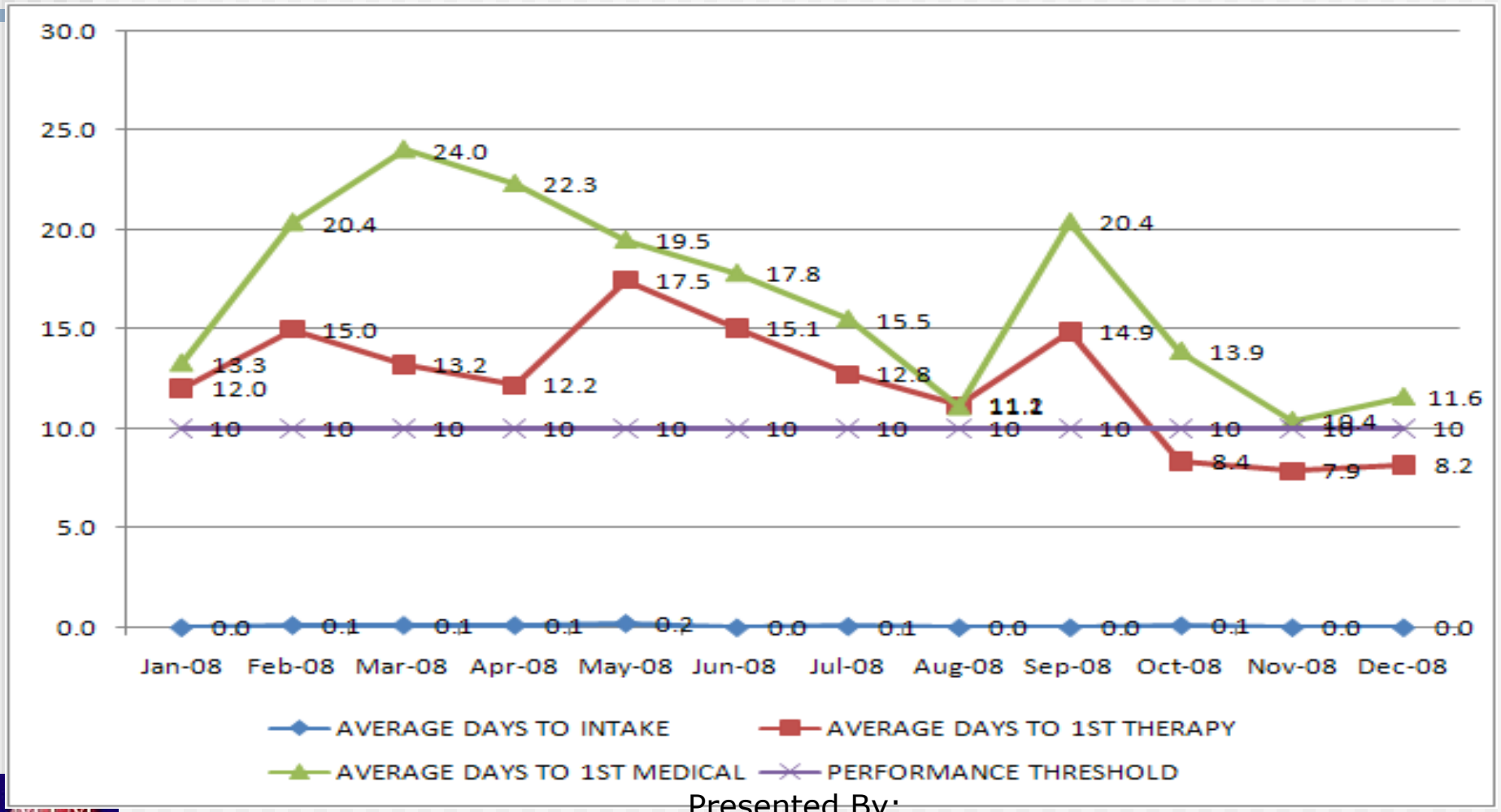
Time to Access to Care



Presented By:
David Lloyd, President

Carlsbad Mental Health Center: Days to Access Services

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



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

1. Open Scheduling Same Day Access - Master's Level assessment provided the same day of call or walk in for help (If the consumer calls after 3:00 p.m. they will be asked to come in the next morning unless in crisis or urgent need)
2. Initial diagnosis determined
3. Level of Care and Benefit Design Identified with consumer
4. Initial treatment plan Developed based on Benefit Design Package
   - 2nd clinical appointment for TREATMENT within 8 days of Initial Intake
   - 1st medical appointment within 10 days of Initial Intake

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

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

2. Internal Benefit Design to Create A Capacity for New Clients to Receive Treatment

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

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

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

Level of Functioning 4:	Service	Amount	Add-Ons	Average Cost
Indicators of Level: GAF 31 – 40 **and** High Priority Levels in at least 5 of the 10 Client/Family/Guardian Expression of Needs/Preferences Recovery Indicators **Recommended Length of Services:** • **1 to 3 years** **(Descriptors)** ▪ History of hospitalizations in past 2 years ▪ Co-occurring medical or substance abuse ▪ No imminent dangerousness to self or others ▪ Limited structure and limited supports ▪ Compliance is fair to poor ▪ Occasional crisis management needed **Transition Criteria:** Reduced LON when criteria are met. ** **Dual Diagnosis - Axis I and an Axis II Personality Disorder would be served under LOF 4**	**1. Diagnosis/Assessment** **2. Crisis Interventions** **3. Partial Hospitalization** **4. Counseling/Psychotherapy**: **5. Community Support Program (Intensive CSP)** ▪ Ongoing assessment of needs ▪ Assistance in achieving personal independence in managing basic needs as identified by the individual and/or parent ▪ Facilitation of further development of daily living skills, if identified by the individual and/or parent or guardian ▪ Coordination of the ISP, Including: a. Services identified in the ISP; b. assistance with accessing natural support systems in the community; and c. Linkages to formal community services/systems ▪ Symptom monitoring ▪ Coordination and/or assistance in crisis management and stabilization as needed ▪ Advocacy and outreach ▪ As appropriate to the care provided to individuals, and when, appropriate, to the family, education and training specific to the individual's assessed needs, abilities and readiness to learn ▪ Mental health interventions that address symptoms, behaviors, thought processes, etc., that assist in an individual in eliminating barriers to seeking or maintaining education and employment ▪ Activities that increase the individual's capacity to positively impact his/her own environment **6. Medication/Somatic Services**	1. Maximum of 4 contacts per episode of need 2. As needed, no maximum 3. Up to 40 days per episode of need 4. Up to 20 sessions per episode of need **5.** Minimum of 6 hrs/wk and up to 24 hrs/wk. Up to 30 hrs/wk for Dually Diagnosed or medically unstable 6. Psychiatric Evaluation completed at first contact within 4 weeks of admission. Minimum of 1 contact a month with MD, RN and/or other qualified provider if medications are required	▪ Supported Employment - at least 2 visits per month ▪ Supported Housing – At least 2 visits per month • Consumer operated services • Peer support • Social and recreational support • Hotline Services • Mental Health Education and Referral	

Level of Functioning 5:	Service	Amount	Add-Ons	Average Cost
Indicators of Level: GAF 21 – 30 **and** High Priority Levels in at least 5 of the 10 Client/Family/Guardian Expression of Needs/Preferences Recovery Indicators **Recommended Length of Services:** • **2 to 5 years** **(Descriptors)** ▪ Potential for harm to self or others if not managed well ▪ Recent hospitalizations, or ▪ Co-occurring medical or substance abuse which could be life threatening ▪ Compliance is poor ▪ Frequent crisis management needed ▪ If not with ACT or intensive programming on a weekly basis, the client is at risk ▪ Intractable symptoms ▪ No supports or very limited ▪ Structureless without BGC ▪ High use of psychiatric emergency services during the past 18 months ▪ Primary DSM-IV on Axis I of: Schizophrenia; Major Depressive Disorders; Bipolar Disorders; Other Psychotic Disorders; or Schizoaffective Disorder **Transition Criteria:** • Reduced LON when criteria are met. • Admission for Psychiatric Inpatient Treatment for six months with no imminent discharge date • Placed in a nursing home with no imminent discharge date • Incarceration with no imminent release date	**Assertive Community Treatment (ACT)** • Diagnosis/Assessment • Crisis Intervention • Medication/Somatic Services • Counseling/Psychotherapy • CSP Services	Staff must offer an average of three face to face contacts per week per consumer and average of one contact per week to persons providing support for the consumer. The frequency of contacts with an individual consumer at any one time will depend on the needs and preferences of the individual consumer. The team must have the capacity to increase intensity rapidly to meet the needs of a consumer, as well as the capacity to decrease intensity.	▪ Supported Housing - at least 4 visits per month ▪ Supported Employment ▪ Respite or close family supervision ▪ Substance abuse services ▪ Services for families and other members of the consumer's social network.	

3. Creating Service Capacity Through Implement No Show/Cancellation Management Principles and Practices

Centralized Scheduling An Area That Needs to Be Addressed:

Discussions About… to Managing No Show/Cancellations

- **Level One:** Little/no focus/discussions about No Shows/ Cancellations
- **Level Two:** Have discussions but cannot agree on how to define No Shows/ Cancellations between units/programs
- **Level Three:** Have standards and monitor No Shows/Cancellations with reports to managers
- **Level Four:** MANAGE No Show/ Cancellations to the meet performance standards

Key Qualitative Based No Show Management Question

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

Sample Definition of Treatment

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

  Sample Definition:

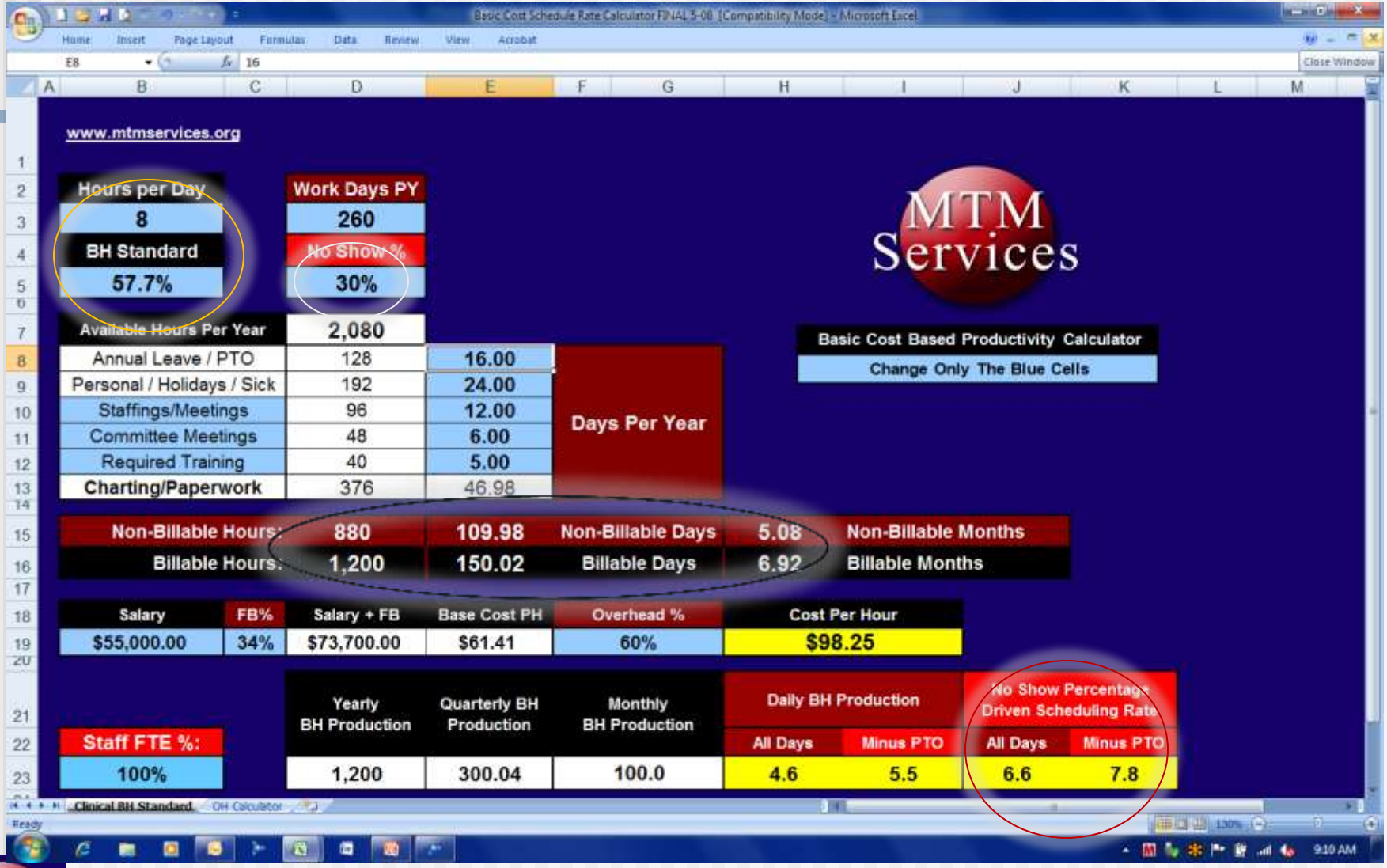
  “***Behavioral health therapeutic interventions provided by licensed or trained/certified staff either face to face or by payer recognized telephonic/ Telepsychiatry processes that address assessed needs in the areas of symptoms, behaviors, functional deficits, and other deficits/ barriers directly related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

National No Show/ Cancel Measures

National Standard for Appointment Types:

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

Individual Scheduling Template and Productivity Calculator



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Hours per Day	Work Days PY
8	260
BH Standard	**No Show %**
57.7%	30%

MTM Services

Basic Cost Based Productivity Calculator

Change Only The Blue Cells

Available Hours Per Year	2,080		
Annual Leave / PTO	128	16.00	Days Per Year
Personal / Holidays / Sick	192	24.00	
Staffings/Meetings	96	12.00	
Committee Meetings	48	6.00	
Required Training	40	5.00	
Charting/Paperwork	376	46.98	

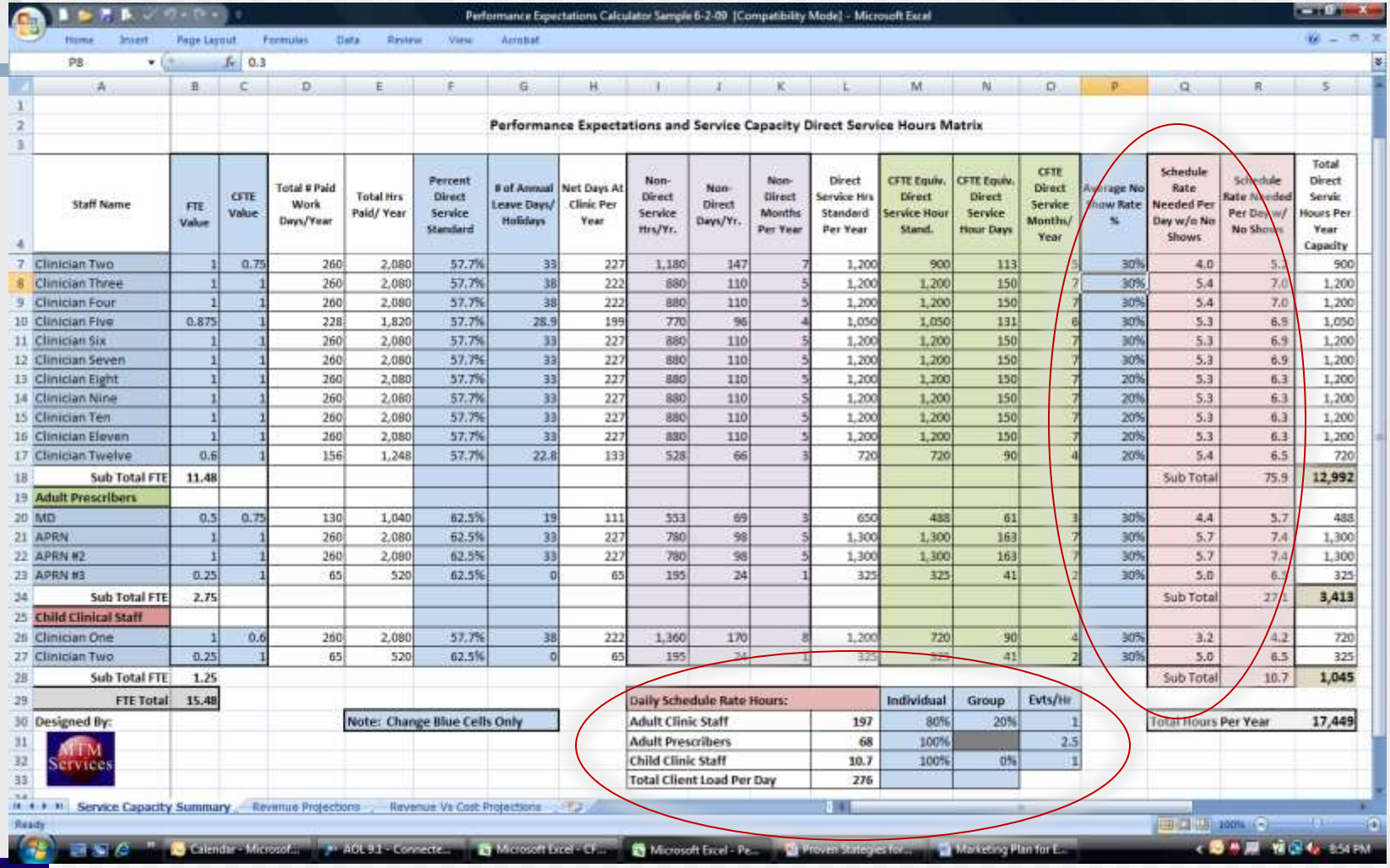
Non-Billable Hours:	880	109.98	Non-Billable Days	5.08	Non-Billable Months
Billable Hours:	1,200	150.02	Billable Days	6.92	Billable Months

Salary	FB%	Salary + FB	Base Cost PH	Overhead %	Cost Per Hour
$55,000.00	34%	$73,700.00	$61.41	60%	$98.25

Staff FTE %:	Yearly BH Production	Quarterly BH Production	Monthly BH Production	Daily BH Production		No Show Percentage Driven Scheduling Rate	
				All Days	Minus PTO	All Days	Minus PTO
100%	1,200	300.04	100.0	4.6	5.5	6.6	7.8

Presented By:
David Lloyd, President

Clinic Level Scheduling Template and Productivity Calculator



Performance Expectations Calculator Sample 6-2-09 [Compatibility Mode] - Microsoft Excel

Performance Expectations and Service Capacity Direct Service Hours Matrix

Staff Name	FTE Value	CFTE Value	Total # Paid Work Days/Year	Total Hrs Paid/ Year	Percent Direct Service Standard	# of Annual Leave Days/ Holidays	Net Days At Clinic Per Year	Non-Direct Service Hrs/Yr.	Non-Direct Days/Yr.	Non-Direct Months Per Year	Direct Service Hrs Standard Per Year	CFTE Equiv. Direct Service Hour Stand.	CFTE Equiv. Direct Service Hour Days	CFTE Direct Service Months/ Year	Average No Show Rate %	Schedule Rate Needed Per Day w/o No Shows	Schedule Rate Needed Per Day w/ No Shows	Total Direct Servic Hours Per Year Capacity
Clinician Two	1	0.75	260	2,080	57.7%	33	227	1,180	147	7	1,200	900	113	5	30%	4.0	5.1	900
Clinician Three	1	1	260	2,080	57.7%	38	222	880	110	5	1,200	1,200	150	7	30%	5.4	7.0	1,200
Clinician Four	1	1	260	2,080	57.7%	38	222	880	110	5	1,200	1,200	150	7	30%	5.4	7.0	1,200
Clinician Five	0.875	1	228	1,820	57.7%	28.9	199	770	96	4	1,050	1,050	131	6	30%	5.3	6.9	1,050
Clinician Six	1	1	260	2,080	57.7%	33	227	880	110	5	1,200	1,200	150	7	30%	5.3	6.9	1,200
Clinician Seven	1	1	260	2,080	57.7%	33	227	880	110	5	1,200	1,200	150	7	30%	5.3	6.9	1,200
Clinician Eight	1	1	260	2,080	57.7%	33	227	880	110	5	1,200	1,200	150	7	20%	5.3	6.3	1,200
Clinician Nine	1	1	260	2,080	57.7%	33	227	880	110	5	1,200	1,200	150	7	20%	5.3	6.3	1,200
Clinician Ten	1	1	260	2,080	57.7%	33	227	880	110	5	1,200	1,200	150	7	20%	5.3	6.3	1,200
Clinician Eleven	1	1	260	2,080	57.7%	33	227	880	110	5	1,200	1,200	150	7	20%	5.3	6.3	1,200
Clinician Twelve	0.6	1	156	1,248	57.7%	22.8	133	528	66	3	720	720	90	4	20%	5.4	6.5	720
Sub Total FTE	11.48															Sub Total	75.9	12,992
Adult Prescribers																		
MD	0.5	0.75	130	1,040	62.5%	19	111	553	69	3	650	488	61	3	30%	4.4	5.7	488
APRN	1	1	260	2,080	62.5%	33	227	780	98	5	1,300	1,300	163	7	30%	5.7	7.4	1,300
APRN #2	1	1	260	2,080	62.5%	33	227	780	98	5	1,300	1,300	163	7	30%	5.7	7.4	1,300
APRN #3	0.25	1	65	520	62.5%	0	65	195	24	1	325	325	41	2	30%	5.0	6.5	325
Sub Total FTE	2.75															Sub Total	27.1	3,413
Child Clinical Staff																		
Clinician One	1	0.6	260	2,080	57.7%	38	222	1,360	170	8	1,200	720	90	4	30%	3.2	4.2	720
Clinician Two	0.25	1	65	520	62.5%	0	65	195	24	1	325	325	41	2	30%	5.0	6.5	325
Sub Total FTE	1.25															Sub Total	10.7	1,045
FTE Total	15.48																	

Designed By:

Note: Change Blue Cells Only

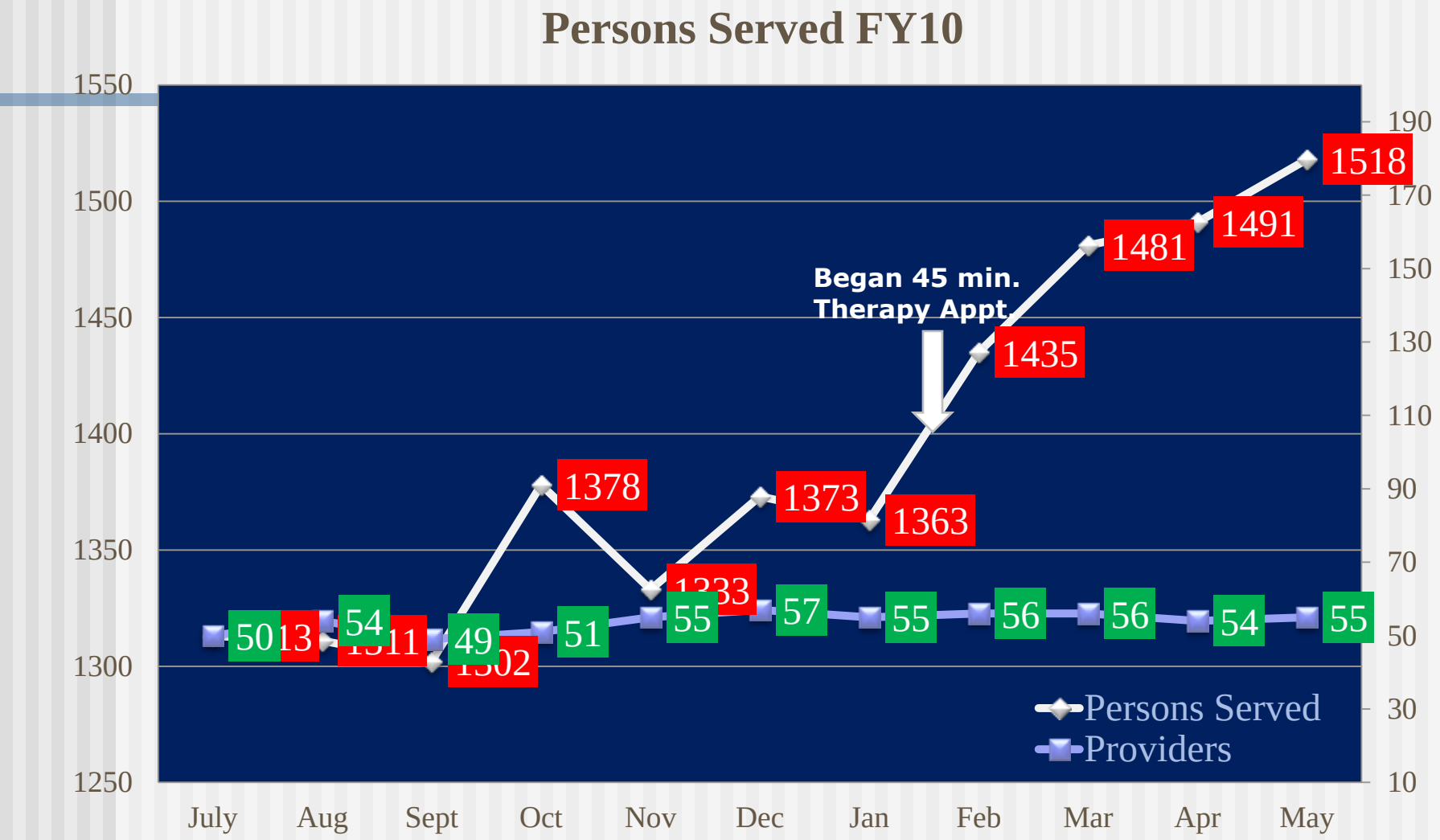
Daily Schedule Rate Hours:		Individual	Group	Evts/Hr
Adult Clinic Staff	197	80%	20%	1
Adult Prescribers	68	100%		2.5
Child Clinic Staff	10.7	100%	0%	1
Total Client Load Per Day	276			

Total Hours Per Year 17,449

Service Capacity Summary | Revenue Projections | Revenue Vs Cost Projections

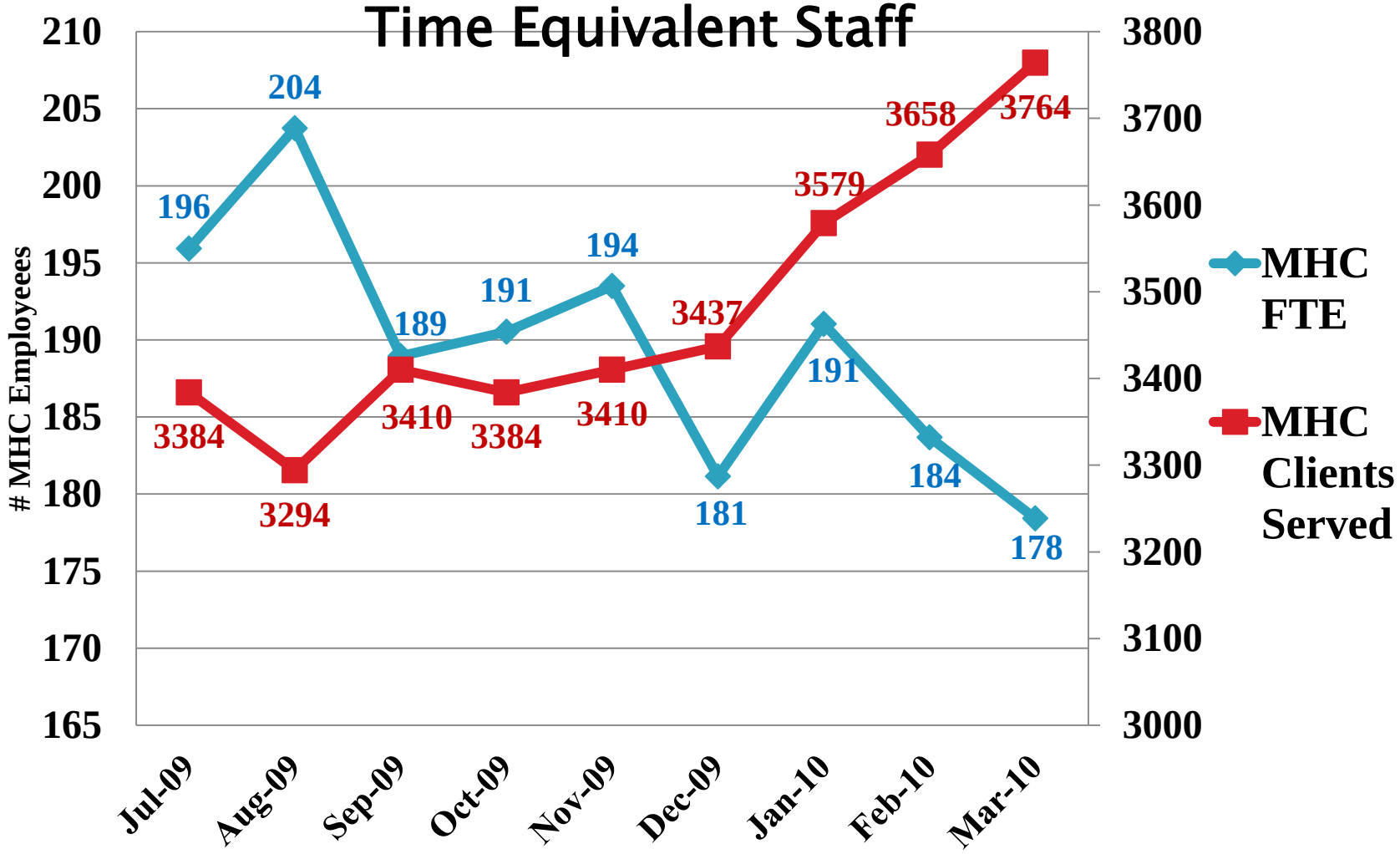
Presented By:
David Lloyd, President

Carlsbad Mental Health Center, Carlsbad, NM - Schedule Management Enhances Service Capacity for Therapy with Same Staff



Presented By:
David Lloyd, President

Colorado West Persons Served per Full Time Equivalent Staff



Service Capacity & Access Questions That Need to Be Managed Differently

- Who supports/manages the schedule? Schedule needs to be managed by centralize system/Schedule Manager
- What are our scheduling rates/scheduling templates?
  - What is blocked out on clinicians' schedules?
  - Does each direct care staff have a scheduling template based on performance standard, number of days on site per year and increased by no show rate?
- Are we managing Center Cancels? Need to Implement 90% Back fill Performance Standard
- What is the impact of no shows/cancels on capacity?
  - Must manage rescheduling efforts & reminder calls
- Really, how long does it take to see a masters level service provider?

Centralized Scheduling Standing Appointment Standards

- Have clinicians turn in their "standing appointments" at least three months in advance?
  - Supervision times
  - PTO
  - Lunch Breaks
  - Dinner Breaks
  - Required Training/Meetings/Committee work

Components of Centralized Schedule Management

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

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

Engagement Strategies to Reduce No Show Rates

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

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

Subset A
(experimental):

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

Subset B
(Control):

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

Person Centered Engagement Strategies Implemented At Subset A Teams:

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

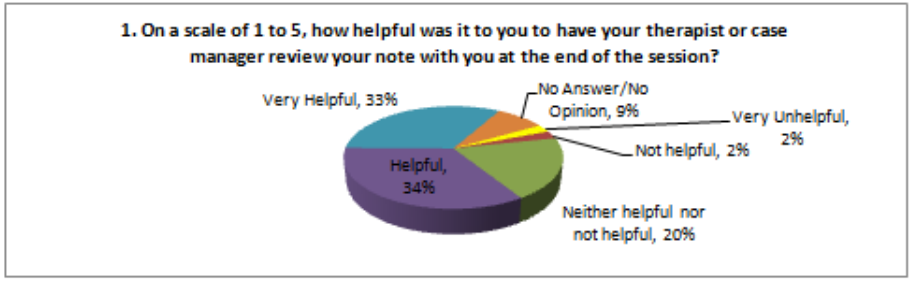
Collaborative Documentation Client Survey Results

Subset A - Client Response to Collaborative Documentation

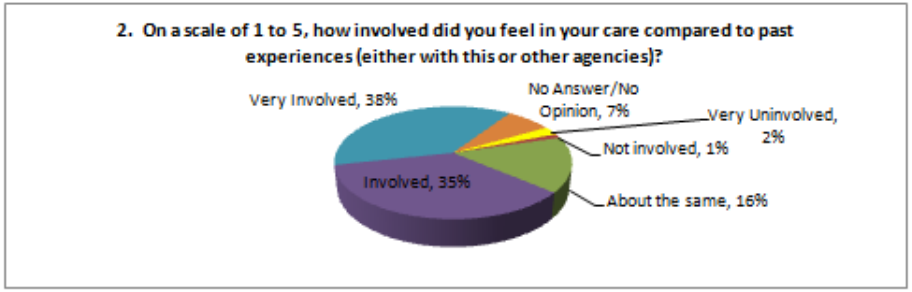
Concurrent Documentation Survey

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

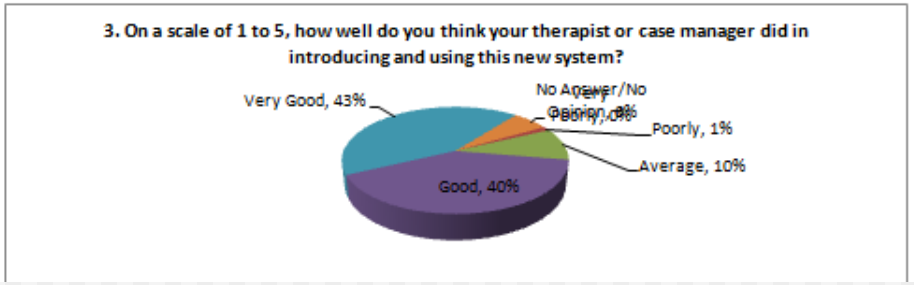
1. On a scale of 1 to 5, how helpful was it to you to have your therapist or case manager review your note with you at the end of the session?	Percentages Total	Total %
1 Very Unhelpful	2	2%
2 Not helpful	2	2%
3 Neither helpful nor not helpful	16	20%
4 Helpful	28	34%
5 Very Helpful	27	33%
NA No Answer/No Opinion	7	9%
Total/Approval %:	82	95%



2. On a scale of 1 to 5, how involved did you feel in your care compared to past experiences (either with this or other agencies)?	Total	Total %
1 Very Uninvolved	2	2%
2 Not involved	1	1%
3 About the same	13	16%
4 Involved	29	35%
5 Very Involved	31	38%
NA No Answer/No Opinion	6	7%
Total/Approval %:	82	96%



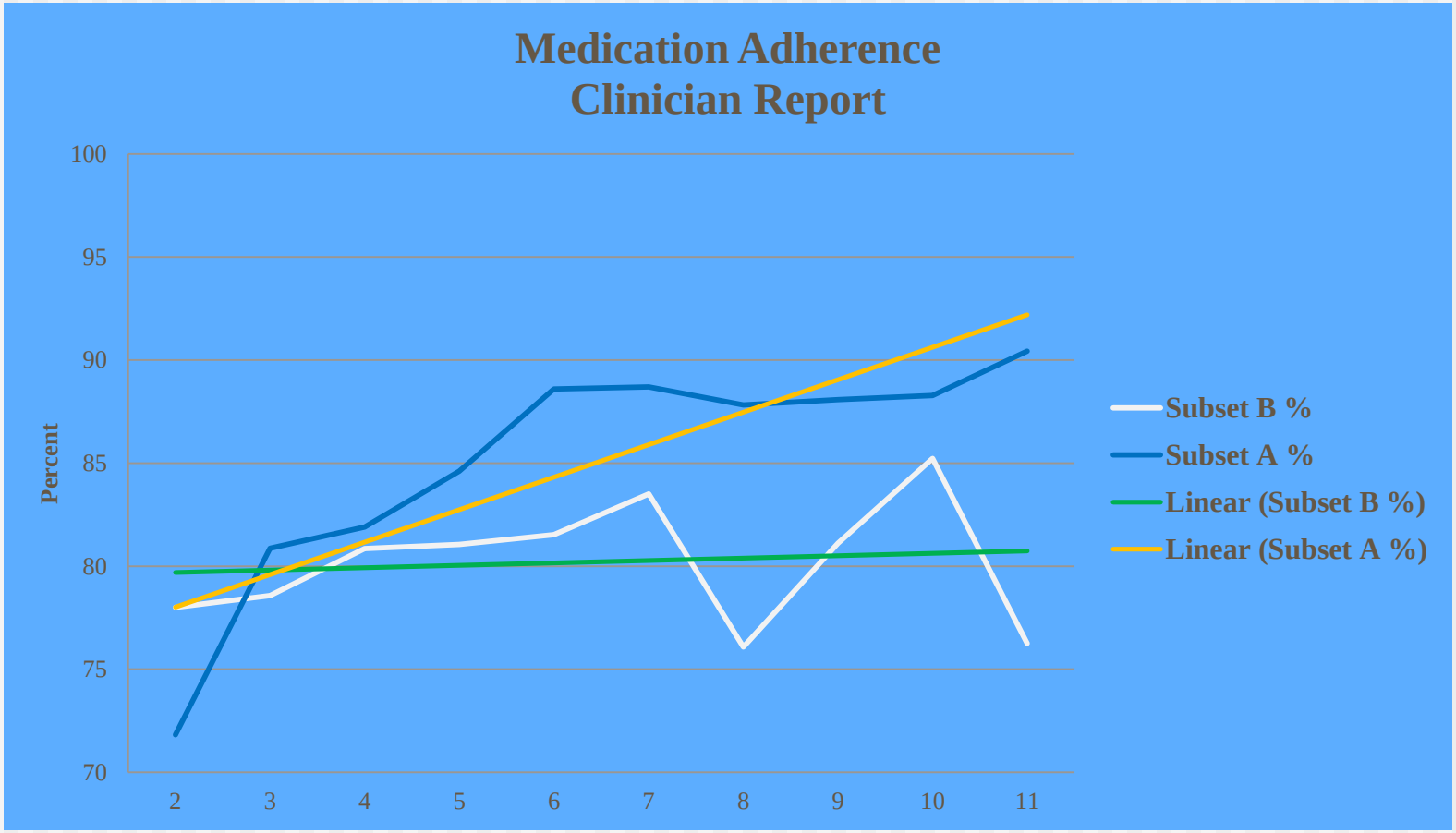
3. On a scale of 1 to 5, how well do you think your therapist or case manager did in introducing and using this new system?	Total	Total %
1 Very Poorly	0	0%
2 Poorly	1	1%
3 Average	8	10%
4 Good	33	40%
5 Very Good	35	43%
NA No Answer/No Opinion	5	6%
Total/Approval %:	82	99%



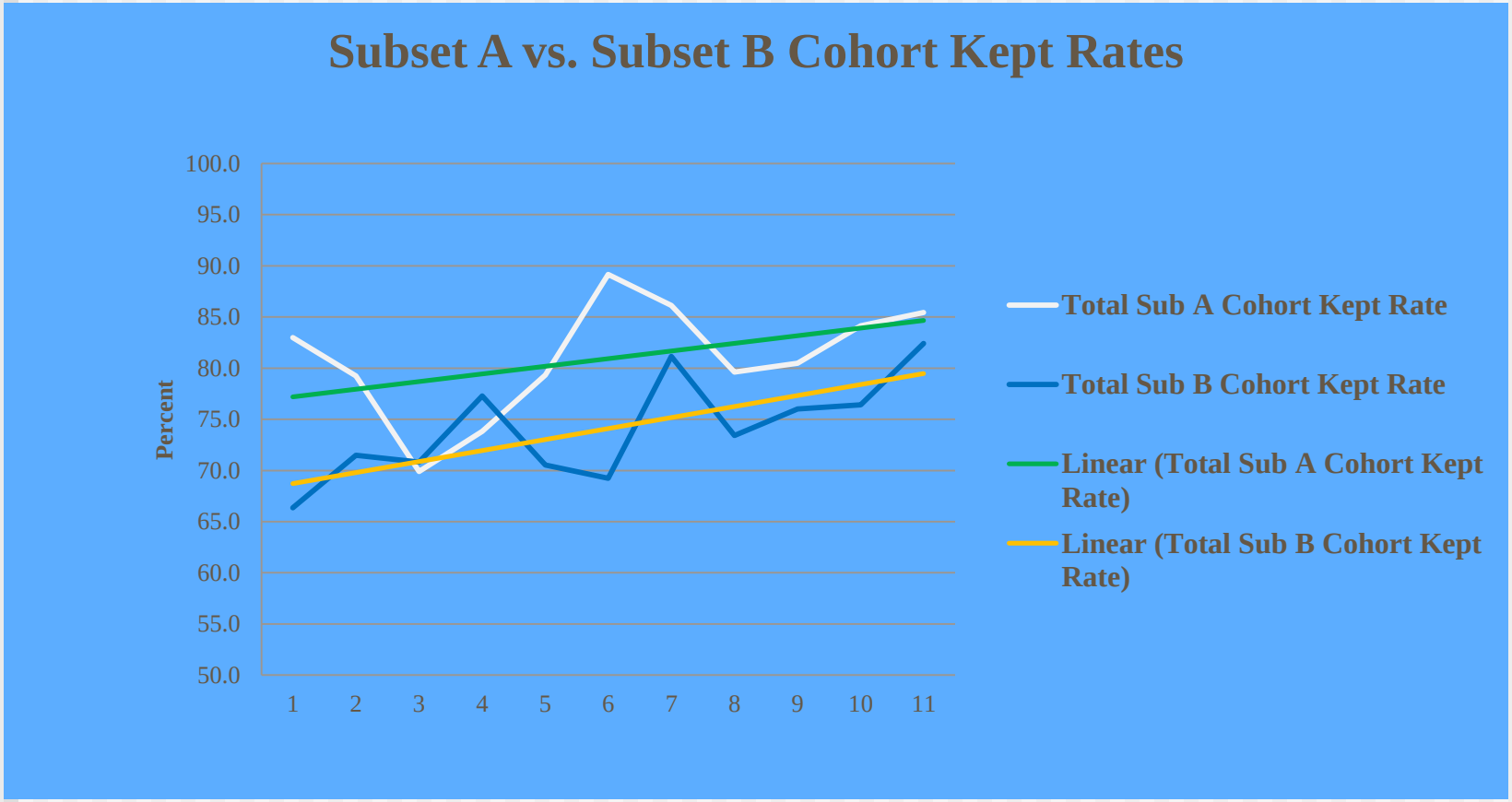
Presented By:
David Lloyd, President

Medication Adherence: Client Report

Medication Adherence: Clinician Report



Kept Appointment Rates for Individual, Group, Medication Management



Questions and Feedback

- Questions?
- Feedback?
- Next Steps?