Defining the Core Competencies in the New Healthcare Environment

October 14th 2021

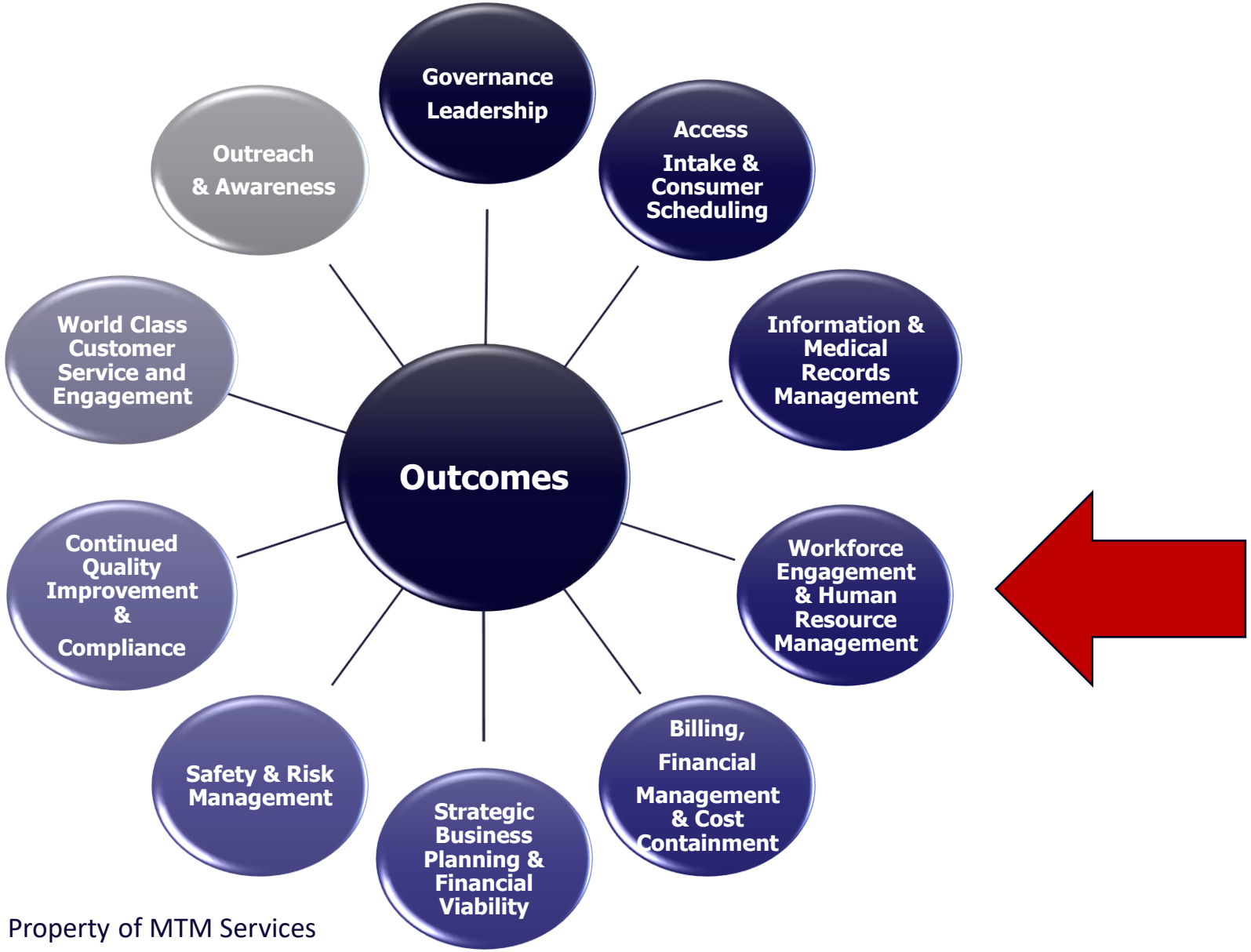
Agenda

Defining the Core Competencies in the New Healthcare Environment

i. Best Practices in Addressing Staff Shortages / Workforce Development
ii. Best Practices in addressing the impact of a Pandemic on care - the Changing Landscape
iii. Best Practices in managing a remote workforce
iv. Best Practices in Access to Care
v. Best Practices in Cost/Coding Awareness

Defining the Core Competencies

BH Core Competencies



Best Practices in Addressing Staff Shortages / Workforce Development

Presented by:

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Increased Demand

- The Census Bureau reported that **30% of American adults had symptoms consistent with an anxiety or depression diagnosis** as of May 24. While the pandemic has exacerbated underlying mental health issues for many Americans, barriers to receiving mental health care have existed for years.
- 65.53% of Indiana Residents live in a Mental Health Professional Shortage Area

- Source: usafacts.org 2021

Workforce Shortages

- **More Than 6398 Providers are Needed to Fix the Behavioral Health Workforce Shortage**
- According to Health Resources and Services Administration (HRSA) most recent USA FACTS Report, they found that 37% of Americans were living in behavioral health shortage areas as of March 31. It would take an additional **6,398** mental health professionals to fill those gaps.

- Source: https://usafacts.org/articles/over-one-third-of-americans-live-in-areas-lacking-mental-health-professionals/

Meeting the Staffing Needs in the new workforce environment

- Providers must prioritize workforce development, engagement, and retention for success in order to provide high-quality and cost-effective care that is valuable for their consumers and that aligns with their current and potentially changing payment models.
- Although many networks still operate under fee-for-service reimbursement models, organizations and their providers need to be prepared for a potential future shift toward value-based payment models. Value-based models can take a variety of different forms, but at a high level these typically look less at the quantity of services provided and more at the quality and outcomes of those services provided.
- Staff shortages and high rates of turnover impact not only the quality of care for consumers, but the financial viability of many organizations across the country. In a competitive system where payors contract with those who can demonstrate the best outcomes by moving from quantity to quality, behavioral health providers are challenged to allocate resources internally that bring the best value externally. This Core Competency on Workforce Engagement and Human Resource Management will present pathways to achieving high engagement and retention, and methods to recruit and empower staff to bring meaningful outcomes, regardless of an organization's budget.

Developing your Staffing Plan

What is a staffing plan?

- A staffing plan is used as a guide to align with your community needs assessment and agency goals and objectives.
- The Staffing Plan provides a strategic business plan for a future state to meet the staffing requirements, roles and compensation to support your focus population.

Source: Peabody M. (2011) Drafting a Staffing Plan for Your Organization. University of Vermont. UVM Extension's Building Capacity Project: Drafting a Staffing Plan

Developing your Staffing Plan

What are the advantages of having a staffing plan?

- A staffing plan allows providers to make good staffing decisions,
- Ability to review the skills, competencies and knowledge of the additional staff
- Organizations may be tempted to promote someone from within the organization due to staff shortages without considering the needs of the role or the attitude, aptitude performance and behaviors that will be required for the position.

Source: Peabody M. (2011) Drafting a Staffing Plan for Your Organization. University of Vermont. UVM Extension's Building Capacity Project: Drafting a Staffing Plan

Developing your Staffing Plan

What about compensation?

- The staffing plan will need to reflect current market demand and capacity to attract qualified candidates
- Organization may struggle internally as this may create inequities within the organization as you move to perspective payment.
  - Organizations will need to look at key roles and positions and review the % of work that will be completed with in the CBHO and align staff according. This may allow you to make market adjustments for new roles for existing staff.

Source: Peabody M. (2011) Drafting a Staffing Plan for Your Organization. University of Vermont. UVM Extension's Building Capacity Project: Drafting a Staffing Plan

Developing your Staffing Plan

Who should draft this staffing plan?

- Leadership and Human Resources will want to evaluate the needs assessment, the goals and objectives outlines in the grant response and determine how the new staff will be added.
- You will want to define the role, hour of work, reporting /supervision requirement,

How do we get started drafting our staffing plan?

Developing your Staffing Plan

How do we get started drafting our staffing plan?

- You will also need to consider the key functions that keep the grant in compliance, time lines for hiring, training etc. . If communicating with your clients/members is a critical activity, then you need someone

Source: Peabody M. (2011) Drafting a Staffing Plan for Your Organization. University of Vermont. UVM Extension's Building Capacity Project: Drafting a Staffing Plan

Developing your Staffing Plan

Function: [Ex. Care Coordination, Office Management; Fundraising; Outreach; communications; etc.]	**Hours/Week*** [Low-High] *note seasonal or infrequent tasks where applicable	**Primary Person:** Who is the person responsible for this function now? [B=Board Member; V=volunteer; C=Paid Consultant; S=Staff; N=No one]	**Relative Importance :** Of task to organization: C=Critical to mission; I=Important; OS=Organizational Support	**Estimated Cost:** ($/year) for this function. [Note: this should include salary/wage benefits (if any), office space, operating money, etc.]	**Notes**

Source: Peabody M. (2011) Drafting a Staffing Plan for Your Organization. University of Vermont. UVM Extension's Building Capacity Project: Drafting a Staffing Plan

Developing your Staffing Plan

Related Functions: Combine functions that would require a similar skill set from the previous table	Total hours/week:	Who would supervise this position?	Added cost to the organization?	Advantages to the organization:	Priority: Rank these positions as high-medium-low. [Reference these priorities when budgets and strategic plans are being developed].

Source: Peabody M. (2011) Drafting a Staffing Plan for Your Organization. University of Vermont. UVM Extension's Building Capacity Project: Drafting a Staffing Plan

Developing your Training and Competency Plan

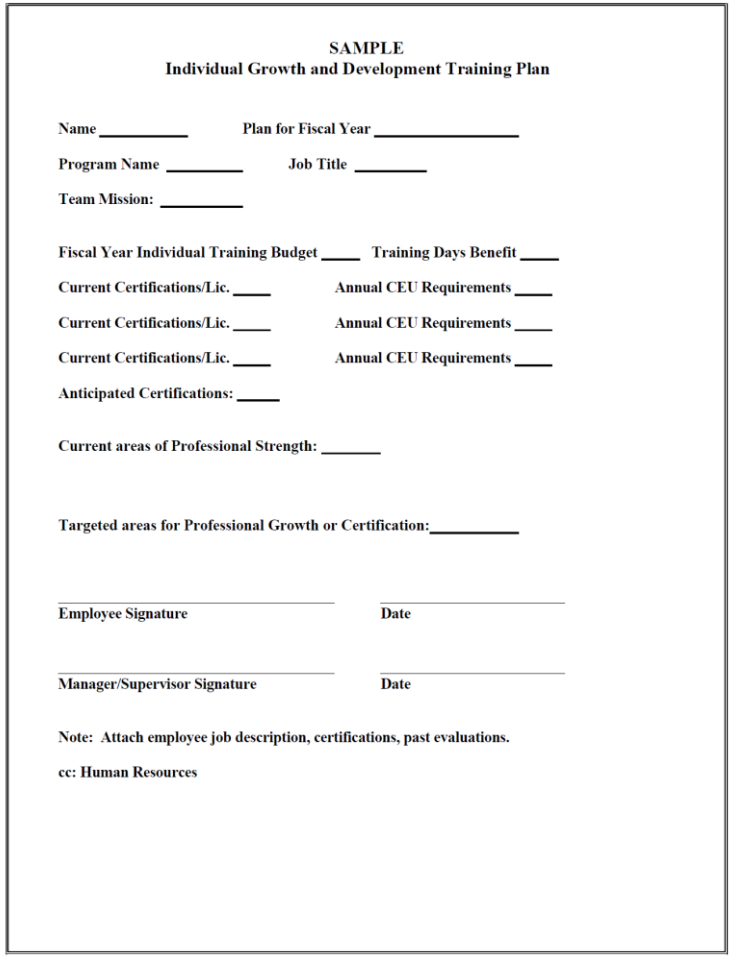
Assessing Competency

- Develop a list of the required competencies for the positions
- Align the competencies with the grant requirements (example: Cultural and linguistic competencies)
- Develop your required levels of training, documentation of completion

Measurement Tools

- P: Personal Observation
- S: Supervision
- E: Education/Training/CEUs
- V: Videos/Recordings
- O: Outcome Measurement
- U: Utilization Management
- C: Consumer Satisfaction

Developing your Training Plan



SAMPLE
Individual Growth and Development Training Plan

Name _____ **Plan for Fiscal Year** _____

Program Name _____ **Job Title** _____

Team Mission: _____

Fiscal Year Individual Training Budget ____ **Training Days Benefit** ____

Current Certifications/Lic. ____ **Annual CEU Requirements** ____

Current Certifications/Lic. ____ **Annual CEU Requirements** ____

Current Certifications/Lic. ____ **Annual CEU Requirements** ____

Anticipated Certifications: ____

Current areas of Professional Strength: _____

Targeted areas for Professional Growth or Certification: _____

_____ _____
Employee Signature **Date**

_____ _____
Manager/Supervisor Signature **Date**

Note: Attach employee job description, certifications, past evaluations.

cc: Human Resources

Training Plan

TRAINING DESCRIPTION	TRAINING GOAL	Priority	TIME LINE	PERSON (S) RESPONSIBLE	BUDGET NEEDED

Recruitment and Retention

- The organization should know the number of clinical staff available in their market. Providers can usually purchase licensure and certification lists to use for recruitment and retention purposes
- The organization should implement a formal screening process that includes formal background and reference checks, first source verification of education and licensure, and review of all appropriate exclusions database (i.e., U.S. Department of Health and Human Services, Office of Inspector General).
- The organization should develop and implement specific onboarding or employee orientation and training policy and procedures.

- The organization should identify the core competencies and skills needed for each clinical and non-clinical position. These core competences must align with the organization's key performance indicators in both the job description and performance evaluations.

- The organization should implement written policy and procedures and key performance indicators to monitor employee engagement and retention for proactive management of staff.
-

- The organization should calculate the selection rate for all open positions as a key performance measure for human resources:
  - Calculate the number of applicants vs. the number of candidates selected.
  - Of those selected for an interview, calculate the percent that follow through with the interview.
  - Calculate the number of candidates that met the criteria and were offered the position(s).

Developing Your Retention and Recruitment Plan

The organization should calculate the cost of turnover and develop a retention and recruitment strategy based on current turnover and retention data. Inability to effectively recruit and retain staff will extend and exacerbate turnover problems in the future. This cycle will worsen as turnover costs and lost revenues grow; the organization will be even further from investing in the very strategy that will solve turnover problems.

- Example: If the organization has 45 clinical staff and a 27% turnover, then the cost to orient and onboard a new staff member is $12,636.00. Additionally, if it takes the organization eight weeks to fill a position, then the organization will lose $24,960.00 over that eight-week period in lost direct service hours. Annualized, that would be a loss of $303,267.00. When you add in the orientation costs that would be $315,900

Change Only the Blue Cells

Turnover Costing Calculator

Total # of staff	Turnover %	Staff Lost Per Year	Avg. Training Hours Per Staff	Total Training Hours	Avg. Salary Cost Per Hour	Training Cost Per Year
45	27%	12.15	40	486	$26.00	$12,636.00

Avg. # of Weeks to Fill an Open Position	Average Weekly Productivity (Hours)	Average Net Revenue Billed Per Hour	Revenue Lost Per Staff Replacement	Total Revenue Lost During Replacement	Total Training Cost and Lost Revenue
8	26	$120.00	$24,960.00	$303,264.00	$315,900.00

This retention and recruitment strategy may include:

- Non-traditional recruitment strategies: social media, current staff members.
- Benefits offered (e.g., medical and dental, paid time off, tuition reimbursement, licensure preparation, covered education benefits, incentive or bonus compensation). Benchmark benefits annually or semi-annually.
- Compensation strategy with increases; for example, compensate staff 5 percent above current market and benchmark compensation annually.
- Monthly performance bonuses (meeting productivity and compliance standards).
- Supervision for licensure.
- Opportunities for professional development and advancement. Review with each employee their individual growth and professional development plans annually as part of the annual evaluation process.
- Philosophy of care, including mission, vision, and guideline principles.

- The organization should identify the key elements that attract and retain team members by program and by supervisor to improve understanding of employees' reasons for staying
- The organization should develop written protocol for maintaining clinical care when a staff member leaves the organization.
  - This includes a review of the current staff member's case load and payor mix.
- Send letters and/or make phone calls to consumers and families to identify the ongoing care plan as an interim measure to avoid a disruption in care

Best Practices for Recruitment and Retention

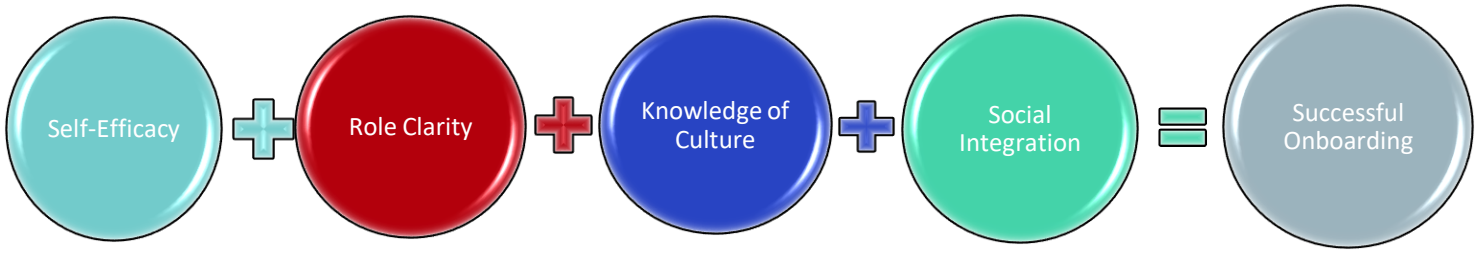
- Hire for attitude, train for aptitude. Define what qualities of attitude, aptitude, performance, and behavior are needed for the successful candidate.
- Review communication platforms with potential new hires to communicate with potential new hires where you are in the selection process as well as all next steps in the process.
- Develop standardized interview questions for each role in the company that get to the very essence of the qualities you are looking for in a candidate.
- The organization should provide specific job descriptions to potential new employees that indicate the performance measures and responsibilities for the position to assist them in understanding expectations early in the hiring process.

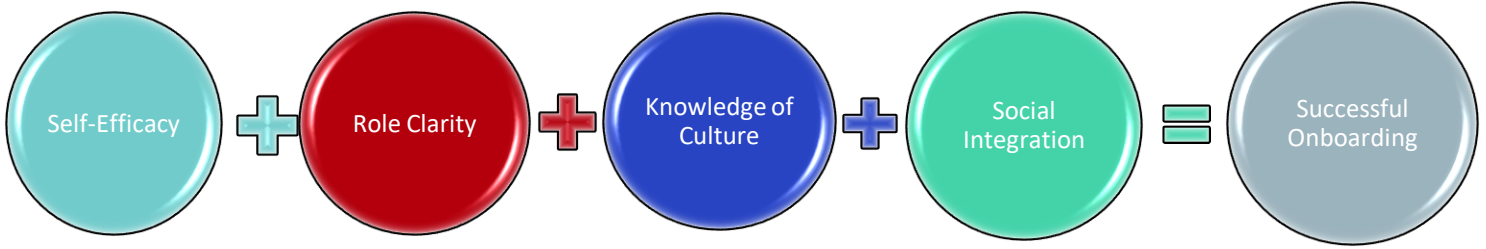
- The organization should have standardized onboarding agendas and timelines for training and expectations.

- Conduct regular employee listening sessions or stay/retention interviews outside of supervision or performance reviews to discuss the employee's general feelings of satisfaction and what the organization can do to increase the employee's satisfaction to decrease turnover and improve retention. The goal in these sessions is to identify what keeps employees with the organization, what is the organization doing right, and can expand on and what could the organization do better?

Onboarding and Continuing Staff Development

- Once a candidate is hired, the onboarding process is essential for retaining and maintaining productive teams. Organizations should use a written onboarding protocol and training schedule to orient staff to the organization, their specific position, and best practices.





- Self-Efficacy is the ability of the new staff member to see themselves being successful in the position and their ability to work independently to meet the requirements for the position.

- Role Clarity is the ability for the team member and the organization to have clearly defined roles and expectations. Developing KPIs aids in role clarity within an organization.

- Knowledge of Culture is the ability for the organization to define its culture to the new employee. The culture defines both written and unwritten ways the organization carries out their mission, vision, and philosophy of care; how they value the individual staff member's contributions; and the interconnectedness of the team to work together to meet the needs of the organization and those in care.

- Social integration is how the new employee is integrated into the organization or how they assimilate into the social and cultural norms of the organization. Social integration begins with the interview, then the selection and pre-hiring process, and also includes the formal orientation and training process.

Best Practices for Onboarding and Continuing Staff Development

- The goal of onboarding is to increase competency and retention by familiarizing new employees with their job, the workplace culture, and other employees so they feel welcome and prepared.
- With the high cost of recruiting, leaders must understand integrating new hires into the organization is an important step to ensure their success.
- Onboarding is an acclimation process that should engage new employees to quickly make them an effective worker while maximizing their satisfaction.

Source: Sonja Jacob. (2018). The 7 Benefits of an Onboarding Program. Retrieved from Workest.

- The organization should also conduct a post-orientation session with all new hires at the 21st day of employment to ensure that the employees have all the needed information and feel they are on a path to mastering their role.

Week One

Days One-Five

Greeted By Supervisor Tour of Facility New Employee Check List Productivity and KPIs Operations Supervision Assign Buddy Intro to Policy and Procedures Required E-Learning Begin New Employee orientation Core Values Corporate Compliance Crisis Services/De-Escalation

Customer Service Observation of Buddy Documentation Training Refining and Reinforcing Documentation in the E.M.R

Meet with Administration to review Agency Mission, Values and Philosophy

Front Desk Procedures

Weeks Two and Three

Days six -sixteen

Job Specific Training

Shadowing peers

Weekly Supervision

Review performance and Key Performance Indicators and expectations

Begin Working Independently

Day 21

Mini Review

Records Audit and Scoring

Competencies Assessment

Address Concerns as needed

Review Performance Against Key performance Indicators

Six Months-Year

Six Month Review

Continue to Work Independently

Weekly Supervision to review performance

Assess Progress and Training

One Year

Annual Review and Professional Development Plan

- Onboarding does not end after New Employee Orientation, but rather extends for the first six months of employment until the new employee is comfortable and skilled in performing their role. Successful onboarding is critical for maintaining an effective organization and an impactful team, ultimately improving the health of our most vulnerable population. Staff members should have their key performance indicators reviewed with them not only at the interview phase but also throughout their orientation process (Bauer, T. 2010).
- For clinical staff, these KPIs will be centered on measurable performance expectations such as meeting full productivity, documentation compliance expectations, corporate compliance, as well as other measures of performance.

Align KPIS with your CCBHC Goals

Clinical KPIs

Clinical Social Worker

- Will have 99% accuracy in entering information in the EHR.
- No show/cancellation rate will be below 10%
- Meet recovery goals through change of level of care within set time frame 90% of the time
- Complete targeted direct service hours, 1352 hours per year
- 100% of events provided will be on the active treatment plan.
- Collaborative documentation is the expectation and all notes completed same day of service

Non-Clinical KPIs

Front Desk Staff

- 99% of copays will be collected at the time of service
- 85% of all appointments that are canceled within 48 hours will be backfilled
- 100% of all confirmation calls will be completed prior to 48 hours of service
- All consumer financial and demographic information will be refreshed at each visit
- Will have 99% accuracy in entering information in EHR
- All calls are answered by 3rd ring
- Will have less than 2% dropped call rate
- Intake paperwork will be processed same day of service

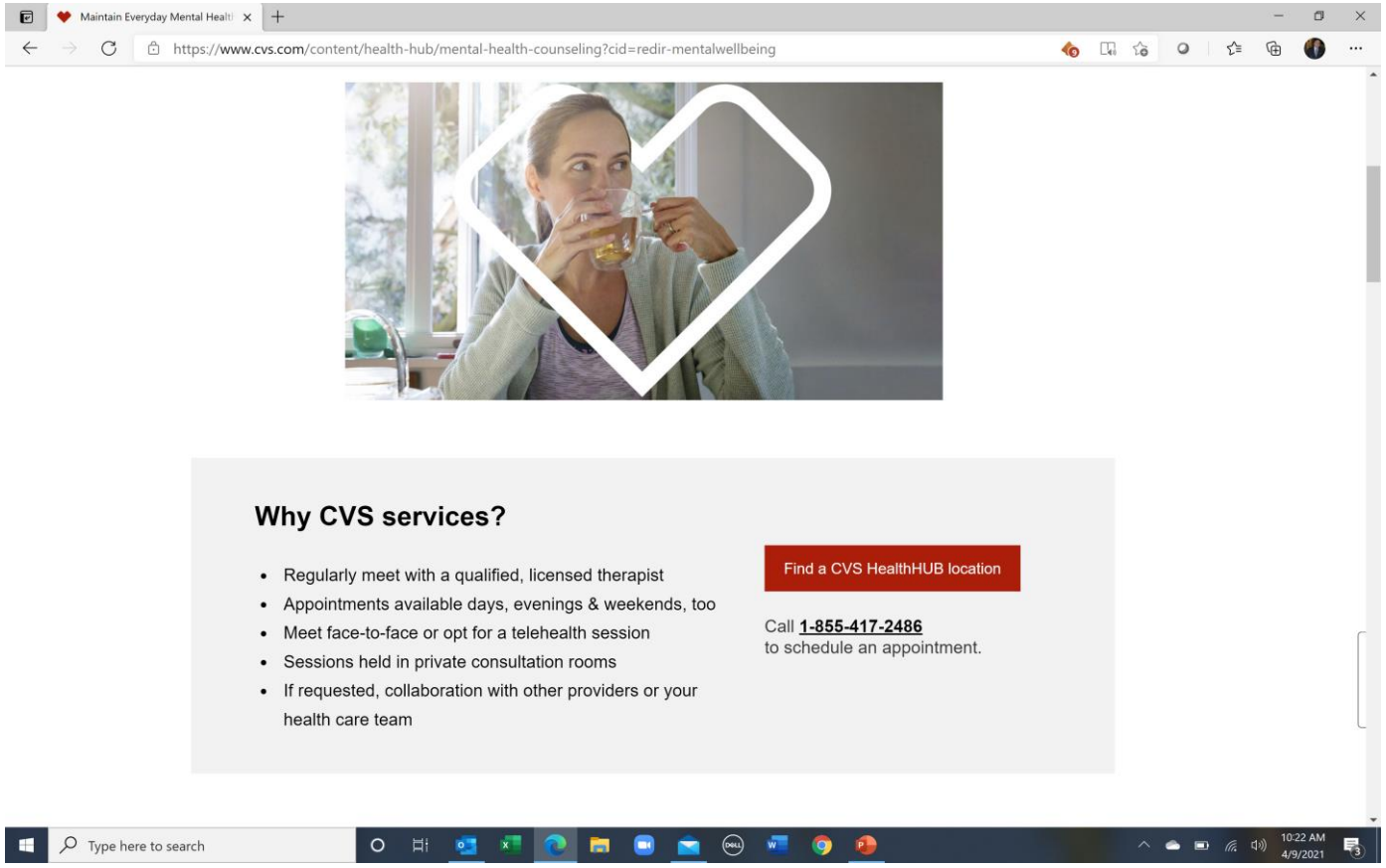
WHO WILL BE YOUR BIGGEST COMPETIOR ?

Behavioral Health Apps

Benefits of using mental health apps include:

- **Convenience**
- **Mostly free or low cost**
- **Improved mood**
- **Better coping skills**
- **Access to help whenever you need it**

CVS HealthHUB



Walmart Health

Dollar General

Dollar General plans to provide a "comprehensive network" of affordable health services. Residents have a hard time getting medical care in some of the towns where it has stores. Blake Farmer/WPLN News

Best Practices in addressing the impact of a Pandemic on care - the Changing Landscape

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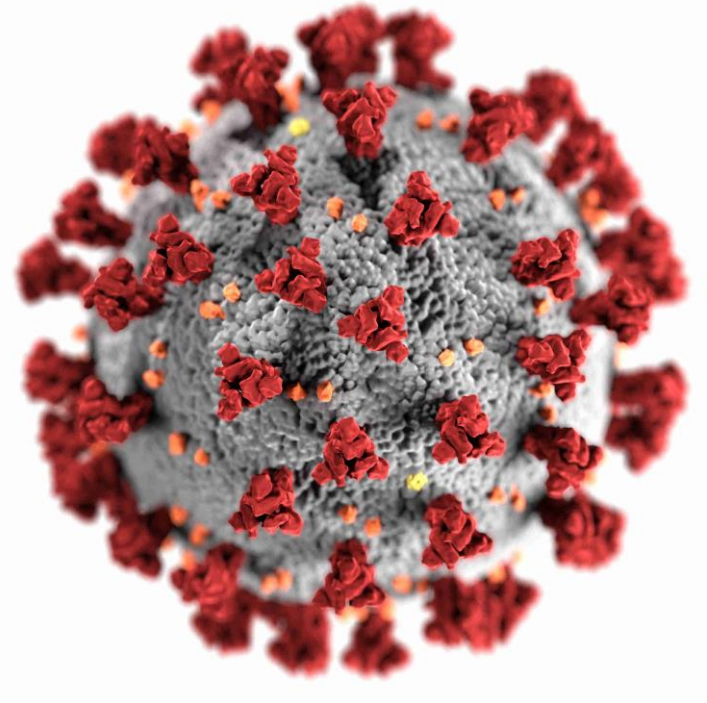
The Impact of the Pandemic on Behavioral Healthcare Operations

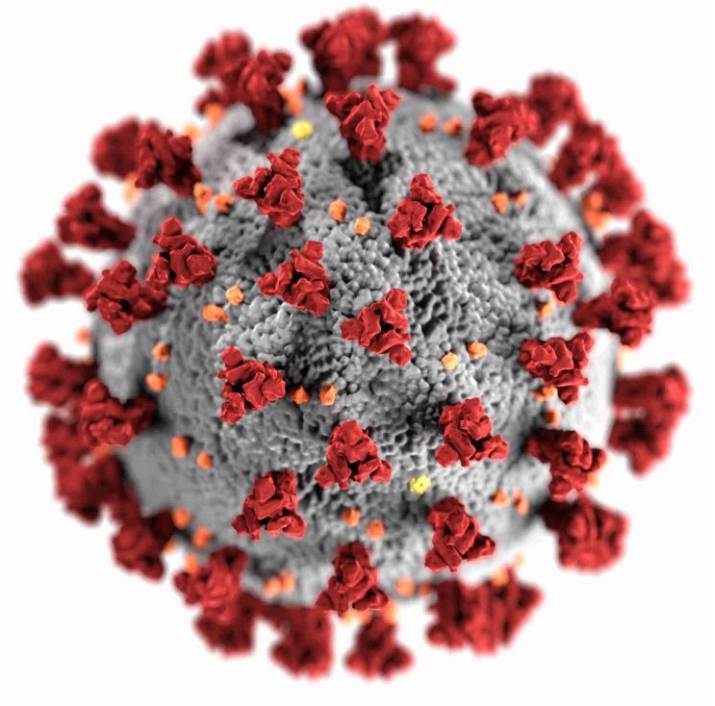
- Over the past year the pandemic has rapidly accelerated the trends that were already happening, such as:
- Implementation of telehealth,
- Use of digital health tools like wearables and artificial intelligence (AI),
- Treatment moving from long-term care and hospitals to the home.
- In addition, the pandemic has put higher demands in terms of access to mental health and substance treatment systems as additional individuals now need care due to depression, anxiety, and substance use disorders caused by illness, job loss, bereavement, and isolation.
- The impacts have aggravated a growing problem of limited access to behavioral health care and have the potential to worsen as the recovery from COVID-19 lingers.



Source: (2021) trends in Behavioral Health A Reference Guide on the US Behavioral Heath Financing ad Delivery System Third Edition .

The Impact of the Pandemic on Behavioral Healthcare Operations

NIMH and NSUDH data suggest that 5.2% of adults in the USA have SMI, and 3.8% of adults have both SMI and a substance use disorder. A 2017 meta-analysis of prevalence studies indicates that, pre-pandemic, 10.06% of American children and youth experienced SED.

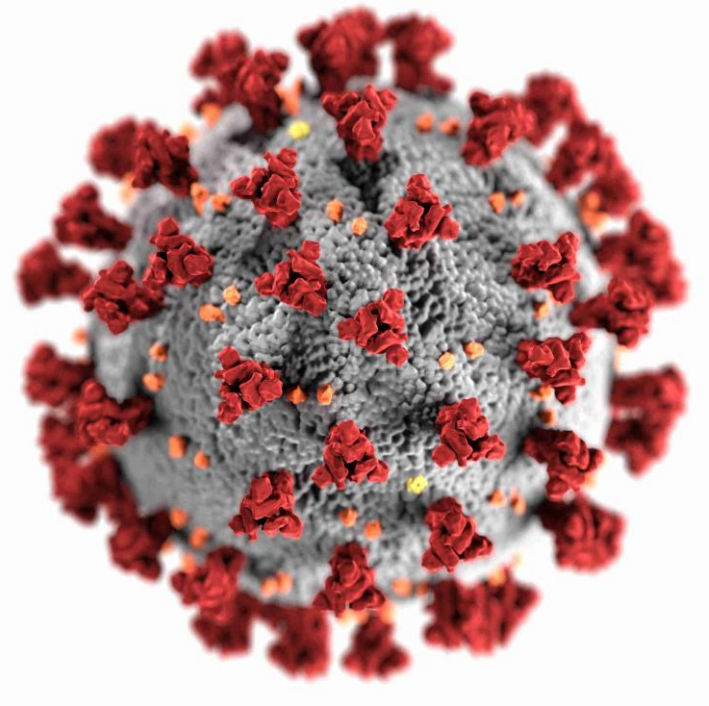


- Source:
- https://www.nimh.nih.gov/health/statistics/mental-illness.shtml
- https://nsduhweb.rti.org/respweb/homepage.cfm
- https://doi.org/10.1176/appi.ps.201700145

The Impact of the Pandemic on Behavioral Healthcare Operations

The Kaiser Family Foundation (KFF) has reported that throughout the pandemic, anxiety, depression, sleep disruptions, and thoughts of suicide have increased for many young adults – 56% of young adults as of December 2020 reporting symptoms of anxiety and / or depressive disorder.

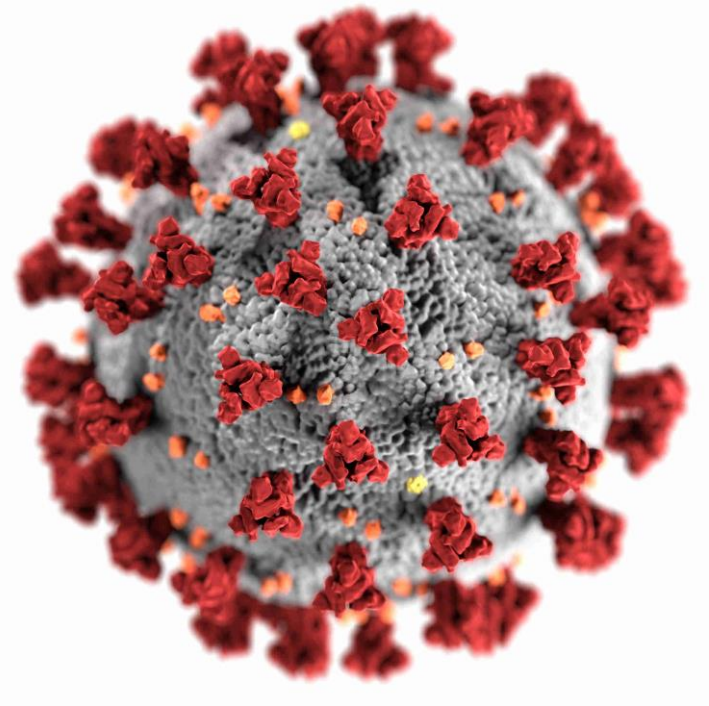
KFF also found that 25% of young adults started or increased substance use during the pandemic (compared to 13% of all adults), and 26% reported serious thoughts of suicide (compared to 11% of all adults).



Source: https://www.kff.org/coronavirus-covid-19/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use/

The Impact of the Pandemic on Behavioral Healthcare Operations

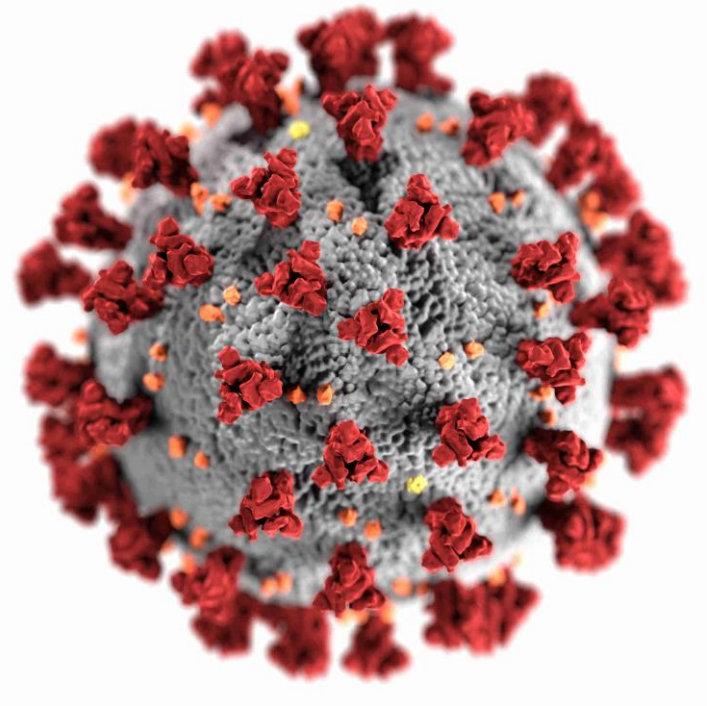
- MS has already said that many of the telehealth expansions allowed during COVID will be made permanent. There were 144 telehealth services temporarily covered by Medicare in 2020 during the height of the emergency, nine of which—such as group psychotherapy, some home visits for an established patient, and care planning services—will be covered permanently.
- About 80% of behavioral health provider organizations are using telehealth for at least 60% of consumer visits, according to a national survey. About 70% of the respondents said that going forward they believe that at least 40% of their services will be provided using telehealth and virtual care technologies. Regarding revenue, about 64% reported lower revenue during the COVID-19 public health emergency, and most reported a decrease in no-show rates.



Source: (2021) trends in Behavioral Health A Reference Guide on the US Behavioral Heath Financing ad Delivery System Third Edition .

COVID-19 Brings Telehealth to Behavioral Healthcare

- With data collected between November 2020 through February 2021, 33% of all mental health appointments were conducted virtually. Primary care followed, holding 17% of its visits virtually. Pediatrics held 9% of its visits virtually, cardiology 7%.
- One of the advantages to virtual care for behavioral health is that providers are twice as likely to offer appointments after hours and on weekends via telehealth.
- This added flexibility may allow patients to fit mental health care into their lives around work and family caregiving responsibilities. Another advantage of telehealth is that visits can often be quick, less than 15-minute appointments, according to the Telehealth Insights dashboard that tracks the telehealth activities of more than 60,000 health providers.



Source: (2021) trends in Behavioral Health A Reference Guide on the US Behavioral Heath Financing ad Delivery System Third Edition .

Telehealth

- In 2016, more than half of the 44.7 million adults in the U.S. with mental illness, and approximately 35% of the 10.4 million adults in the U.S. with serious mental illness, did not receive mental health services.1 Additionally, in 2016, an estimated 21 million individuals aged 12 years or older needed substance use disorder (SUD) treatment, but only 3.8 million (18%) received treatment.1

- Currently, 36 states and the District of Columbia have laws related to private payer reimbursement policies for telehealth. In 2016, a total of 29 states had telehealth parity laws in place for private insurers.

- Source: Thomas L, Capistrant G. (2016). 50 state telemedicine gaps analysis, coverage and reimbursement. http://c.ymcdn.com/sites/portal.americantelemed.org/resource/resmgr/Docs/2016_50state-telehealth_cove.pdf?hhSearchTerms=%22parity%22. Accessed March 15, 2018

Telehealth

- Over the course of the pandemic, insurers have paid out anywhere from two to ten times more per month for telehealth services in 2020 compared to 2019, with a huge surge in the spring, a reduction over the summer, and then a new resurgence as COVID cases spiked in the fall and winter.

- McKinsey survey found that 74% of telehealth users during the pandemic reported high satisfaction with the care they received. And, as long as government regulations allow, telehealth can provide behavioral health patients with convenient, continuous care, and providers with an efficient and cost-effective treatment option they should make a long-term investment in.

Source: Carey, J. and Turner M (2021) How Much Will Telehealth Go “Back to the Future” Following the Pandemic? How Much Will Telehealth Go “Back to the Future” Following the Pandemic? (managedhealthcareexecutive.com)
Source: (2020) Telehealth: A Tipping Point for Behavioral Health Providers. Telehealth: A Tipping Point for Behavioral Health Providers (managedhealthcareexecutive.com)

Telehealth Tips for Professional, Productive, and Technologically Transparent Provider Performance

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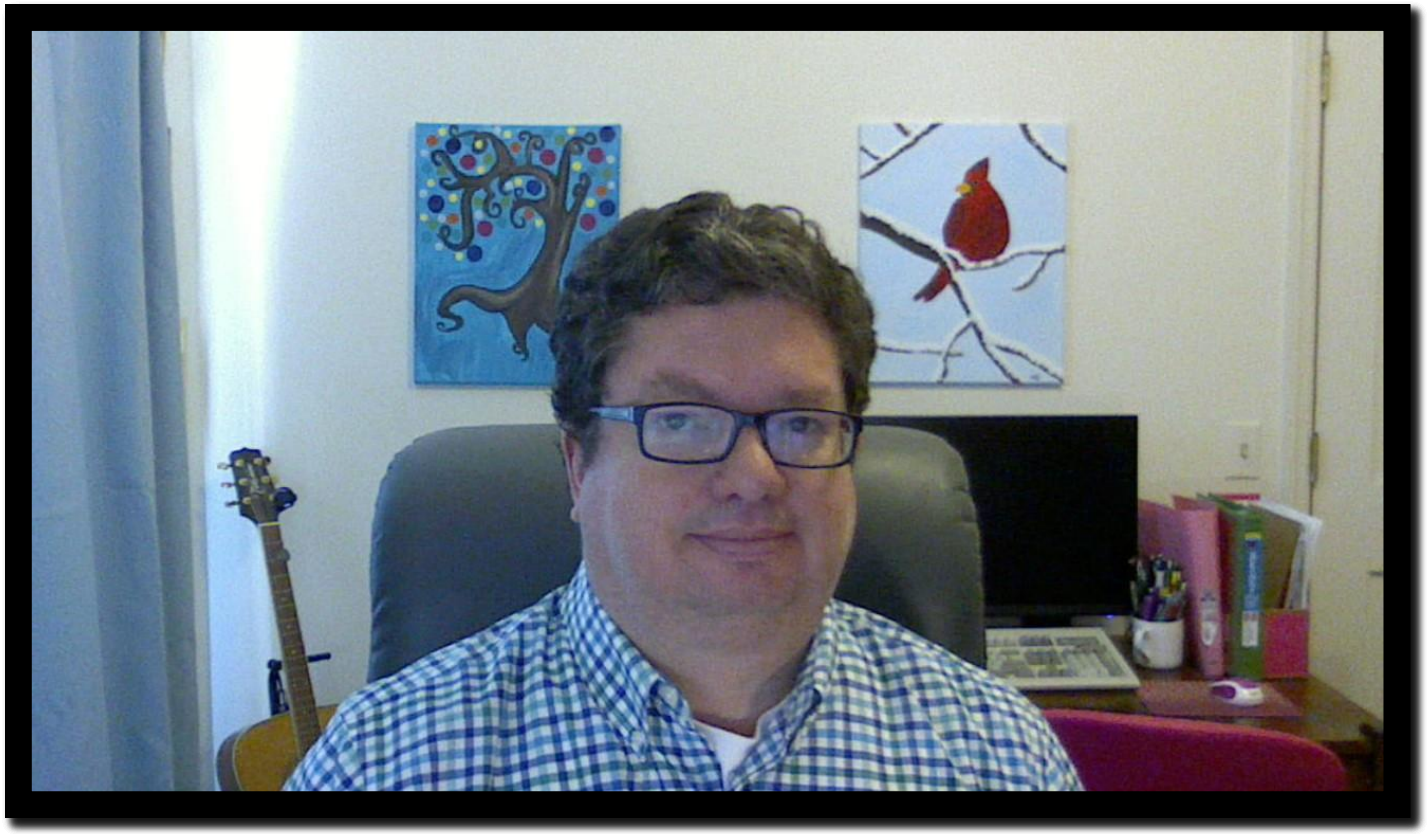
Setting the Scene is Critical

Camera Position and Lighting

- Camera Position
  - Optimal position is directly in front of face to slightly elevated
  - Avoid low camera angles
  - Landscape!
- Lighting
  - Optimal lighting is multiple diffused light sources
  - Watch out for reflections
  - Avoid bright backlighting



What's that behind me?

The Camera's Eye

- Background
  - Be mindful of what is behind you
  - Also, who is behind you
  - Virtual Backgrounds can be distracting
  - Using Virtual Backgrounds in a positive way

Can you hear me now?

- The importance of audio
  - Audio is either 50% or 100% of telehealth
  - Whatever technology you choose, make sure it is comfortable
  - Have a Backup!
- Keeping Conversations Private
  - Speak in low tones, close the door
  - Avoid the use of speakerphone mode

Hearing and Being Heard

Making it work.

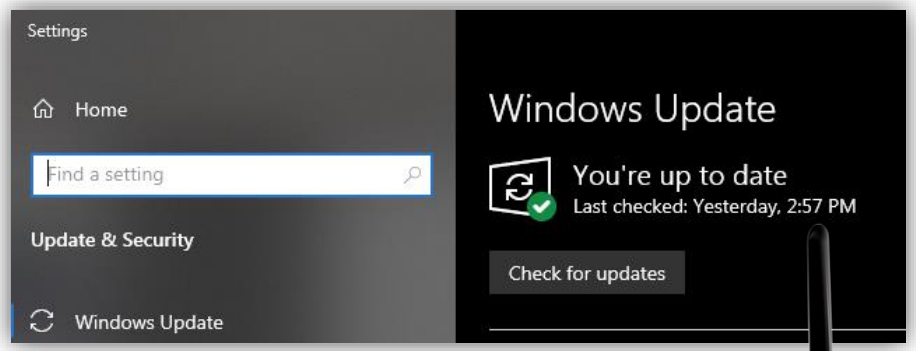
Tips for Staff and Clients alike

- Video Tips
  - No one likes “Shaky Cam”
  - Consider inexpensive tripods or phone mounts for phones
- Audio Tips
  - Audio problems will happen, be ready for them
  - Sound Transmission
  - Notification reduction methods

What are other Technology Related considerations?

A dispersed workforce can increase risk.

- Keep devices up to date
- Change default passwords
- Reboot equipment regularly
- Additional security measures
- Have a backup plan



NordVPN®
ExpressVPN
Norton Secure VPN

Supervision- Coaching Staff for Optimal Results in a telehealth environment

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Remote Based Supervision

- Knowing and engaging the strengths of your team in supervision style and using those strengths to achieve clinical and performance outcomes in a telehealth environment.
- Recognizing and the talents each brings to the remote environment enhances their effectiveness, improves morale, promotes improved teamwork, expands your unit's capabilities, and better serves the public.

Benefits of Remote Based Supervision

- Retention.
- Employee satisfaction and engagement.
- Skill acquisition.
- Customer service.
- Client outcomes.
- Employee motivation.

Remote Based Supervision

Requires more involved supervision in the beginning of the process, as you get to know your team and plan your supervision strategy, it should make your job easier in the long run, and allow you to become a more creative manager in your own right.

Source: Wayne McCashen, *The Strengths Approach*

Remote Based Supervision

- When Supervising remotely, all team members involved in the supervisory relationship take responsibility for organizing, structuring and determining the purpose of supervision.
- They also share responsibility for the outcomes that result from their decisions.

Source: Wayne McCashen, ***The Strengths Approach***

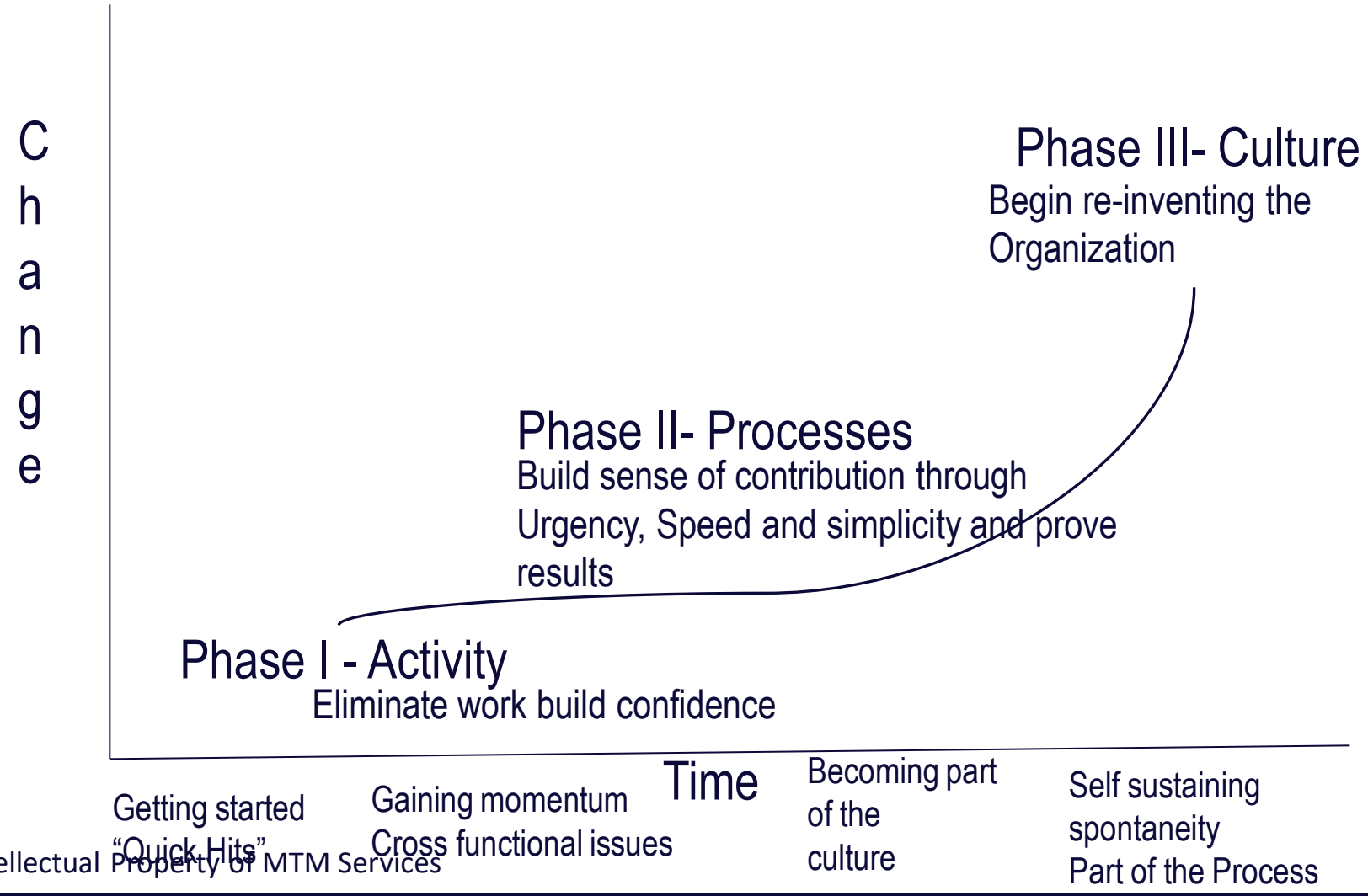
Remote Daily Manager Activity is Focused on Leadership/Coaching

Is About Coaching Staff…

- Buy-In by manager and staff
- Proactive Solution Focused Attitude “We can do this...”
- Creativity in determining “How we can do this…”
- Overcoming Resistance to Change with coaching staff
- Developing Self Leadership
- Taking a step back to see the horizon and the past
- Celebrate every possible victory (change)… Reinforce appropriate behavior/performance

Source: “Enlightened Leadership” by Ed Oakley and Doug Krug

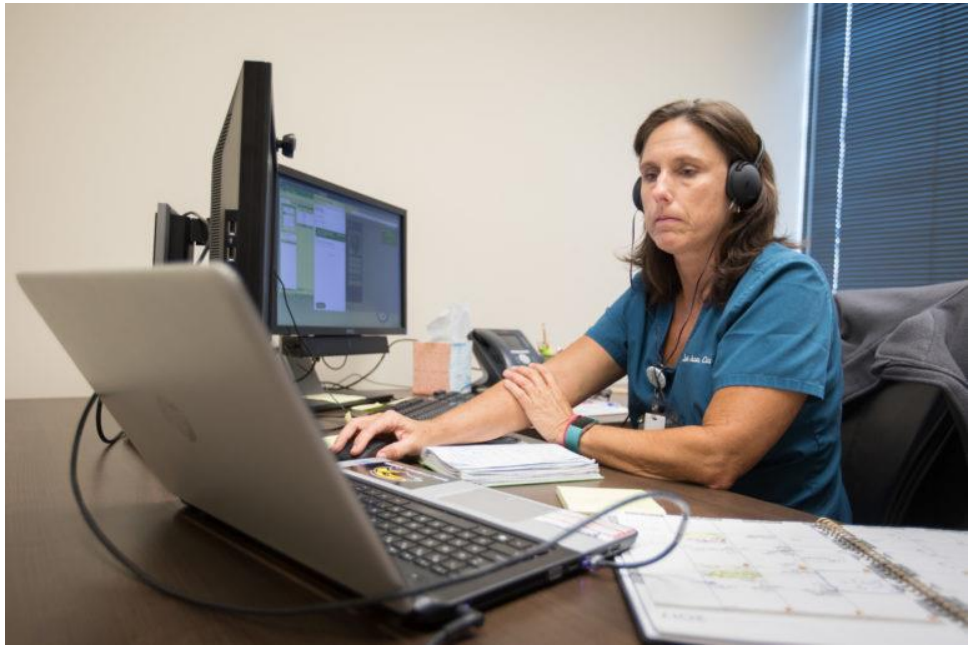
Finding a better way…..every day



Coaching as Supervision

- Direct and Targeted Feedback
- Identifies performance issues or challenges in the new environment
- Aids in supporting clinical and non clinical work
- Continually reviews agency goals
- Provides accountability between Manager and Staff

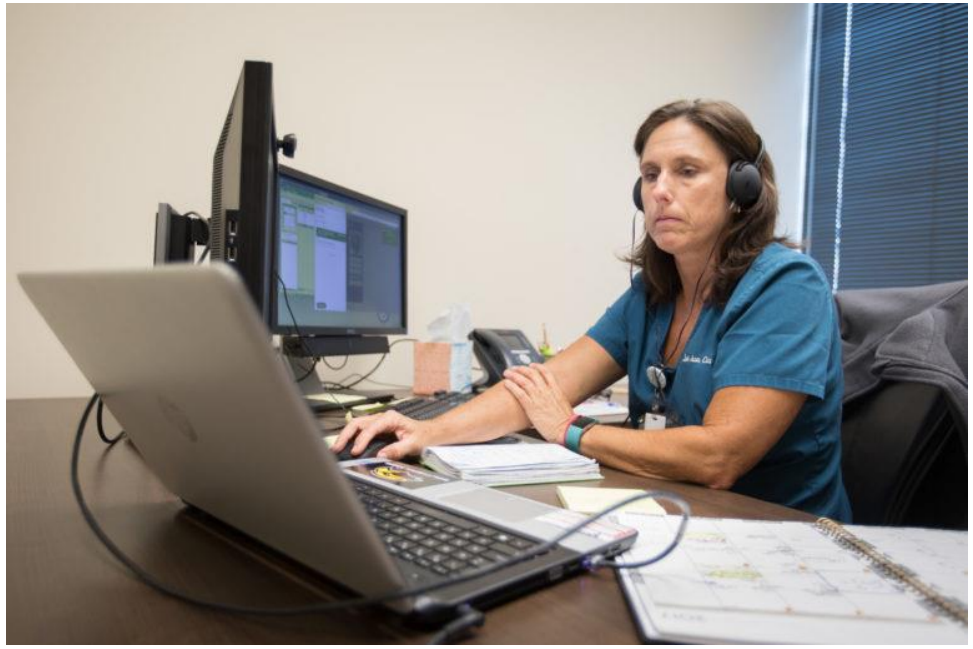
Implement the Coaching Model



- Structuring
- Selecting and Training
- Motivating
- Managing Information
- Team Building
- Promoting Change and Innovation

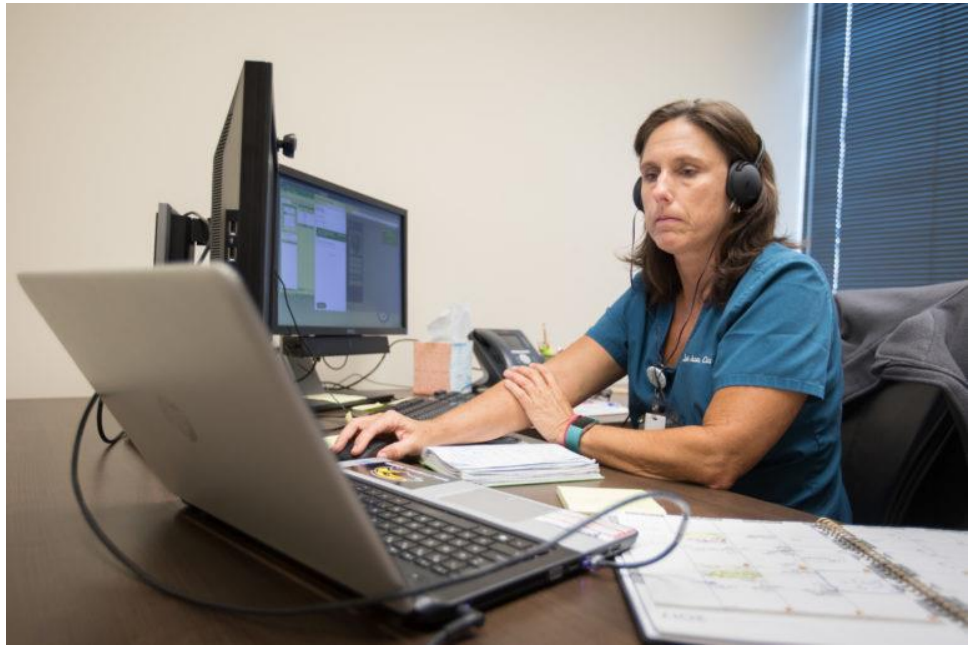
What team members need to work remotely from their supervisor.

- Communication
- Direction
- Support
- Feedback
- Setting Priorities



Frequently Asked Questions form team members

- How will I see clients
- Are we still doing Centralized Scheduling
- What training do I have available
- How can I contact you if I need you?
- How will we meet as a team and will I still have supervision?
- How will we handle a crisis or emergency
- Do I still have to get my note done in session?
- Do I still need to meet my direct service hours?
- How will I do my groups?
- Tips for keeping clients engaged in telehealth
- What is the agency doing to support HIPAA and compliance



Supporting Staff in a tele health environment
(this includes managers)

- Supervision Logs
- Productivity Data
- Late Service Activity Log (SAL) report
- UM/UR
- Case Load Reports
- Deficient Data Reports

Formal Remote Agenda Supervision Session Activities

1. **Overview: Value Setting/ Reinforcement/Solution Focused**
2. **Housekeeping**
3. **Administrative Functions**
4. **Clinical Functions**
5. **Case Studies/Clinical Supervision**

Need for Supervision Plan

- Supervision Plan provides the focus of what types of supervision need to be provided, frequency and tools to provide Solution/Action Planning to address specific performance changes
- Supervision Plan provides a fair/ equitable work environment for staff by providing appropriate levels of coaching/ mentoring of staff

Individual Supervision Logs

- Individual Supervision logs review both clinical and business goals of the agency
- Sets Plan of Corrections

Individual Supervision Log – Clinical

Staff Member:	**Supervisor:**	**Program/Dept:**

Topics Discussed: (Check all that apply)

☐ Assessments ☐ Treatment Plans ☐ Direct Service Standards ☐ Utilization Management ☐ DNKA Rates	☐ Cultural Competency ☐ Clinical Outcomes/DLA20 ☐ Payor Mix ☐ Ethics/Professional Standards ☐ PTO/Tardiness	☐ Caseload ☐ Employee Satisfaction ☐ Progress Notes ☐ Consumer Satisfaction	☐ Professional Development ☐ Other:

1. Topic(s) Summary (Provide a brief summary of the issues/needs in the topic(s) indicated above):

here

2. Accomplishments/Strengths/Progress Since Last Supervision Session:

3. Support Plan (Complete if change needs identified require employee action beyond this supervision session):

a. Specific Change/Performance Requirements Needed:

Increase direct service to 2 additional hours per day, schedule 34-38 client hours

b. Performance Improvement Indicators Required:

c. Date Action Plan To Be Completed:	**d. Progress Review Date:**

▶ **Clinical Supervision Comments/Instruction** (complete this section only if supervision is provided):

▶ **Competencies:** ☐ No data reviewed ☐ Docmentation reviewed/see QMHP Review ☐ Clinical Case Supervision

♦ **Employee/Contract Provider Comments:**

Employee/Contract Provider Signature **Date**	**Supervisor Signature** **Date**

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Driving Transformational Change!

SPQM

Group Supervision Log – Clinical

Supervisor:	**Program:**	**Date:**	**Time:**

Employees Attending:

Topics Discussed: (Check all that apply)

☐ Assessments ☐ Treatment Plans ☐ Referral Capacity ☐ Utilization Management ☐ DNKA Rates	☐ Direct Service Standards ☐ Cultural Competency ☐ Progress Notes ☐ Employee Satisfaction ☐ Ethics/Professional Standards	☐ Caseload ☐ Payer Mix ☐ PTO/Tardiness ☐ Consumer Satisfaction ☐ Professional Development	☐ Cooperation/Participation ☐ Other:

1. Topic(s) Summary (Provide a brief summary of the issues/needs in the topic(s) indicated above):

2. Accomplishments/Strengths/Progress Since Last Supervision Session:

3. Action Plan (Complete if change needs identified require employee action beyond this supervision session):

a. Specific Change/Performance Requirements Needed:

b. Performance Improvement Indicators Required:

c. Date Action Plan To Be Completed:	**d. Progress Review Date:**

► **Group Clinical Supervision Comments/Instruction** (complete this section only if supervision is provided):

Employee/Contract Provider Comments to be submitted in writing to Supervisor within 24 hrs after supervision.

Employee/Contract Provider Signature/Date

Supervisor Signature/Date	

Group Supervision Logs

- Group Supervision logs review both clinical and business goals of the agency
- Sets Plan of Corrections
- Used to communicate team goals and needs

Day-To-Day Manager Activities

1. **Continuous Awareness of service delivery environment**
2. **Empowering Staff to Solve Needs Before they Become a Crisis**
3. **Train/Educate Staff**
4. **Coordination of Activities**
5. **Timely Decision-Making**

Focus on “We Can Do This” Management Teams

1. Assess competency levels of staff…
2. Hire for attitude… train for focused skills…
3. Define one work area where you need assistance in completing your work…
4. Delegate responsibility and authority and do not pull either back even if you have to bite your tongue and leave the building…
5. Celebrate the victories…
6. Move beyond operations to vision for the organization

Pro Tips for Supervising Remotely

- Establish specific times and days supervision will occur
- Send an agenda at least 48 hours in advance
- Review metrics needed for supervision
- Management skills training with teambuilding and using data in management and performance goals.
- Use a structure supervision log
- Gain feedback and understating of needed areas of performance an support needed
- Help the team member establish specific work areas free of distractions and that meets the agencies privacy and confidentiality expectations

Same Day Access

Presented by:

Joy Fruth, MSW
Lead Process Change Consultant,
MTM Services

MTMSERVICES

What is Same Day Access?

- Components of the Traditional SDA model:

  1. BHO offers blocks of time when a client can walk-in *unscheduled* and have an assessment.

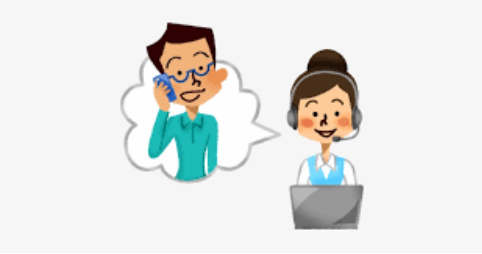
  2. When the client walks-in, a clinician completes an assessment and at least one goal of the treatment plan based on the client's presenting problem.

  3. Client leaves with a return appointment for Treatment (target: <8 days) and a psych eval appointment (target: <5 days), if warranted.

- An engagement strategy whereby organizations offer an ***assessment*** on the same day it is requested by the consumer, without a scheduling delay or waitlist, eliminating consumer no-shows for assessment.
- Meets CCBHC access timelines for clients screened as emergency/urgent and ***exceeds*** CCBHC access expectation for routine consumers.

Traditional Same Day Access

- *Unscheduled* access to clinical assessment either same day or next day from client's request



Screening Call:
- Rule out crisis
- Confirm service need matches services provided
- Insurance?
- Invite client in and give the Same Day Access hours

Target: 3-4 minutes

Credit: dribble.com Guna D (artist)

Client Walks In to the Community BH Center for a Clinical Assessment

Traditional Same Day Access

Client Walks In to the Community BH Center

Photo Source: Amerymedicalcenter.org

Photo Source: Pinterest

Photo Source: tampabaytherapist.com

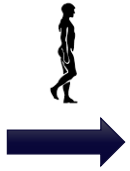


Photo Source: NBC

Waiting Room:
- Initial Screening (confirm)
- Administrative Forms
- Business/Financial Forms
- Health Questionnaires
- Basic ROIs

Target: 30-60 minutes

Therapist Office:
- Diagnostic Assessment
- At least one individualized Treatment Plan goal

Target: 60 minutes

Reception:
- Schedule next appointments
- Target <8 days to return for treatment.

Target: 1-5 minutes

What is Same Day Access?

- Components of the Traditional SDA model:

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3. Client leaves with a return appointment for Treatment (target: <8 days) and a psych eval appointment (target: <5 days), if warranted.

Common Misapplications of Same Day Access

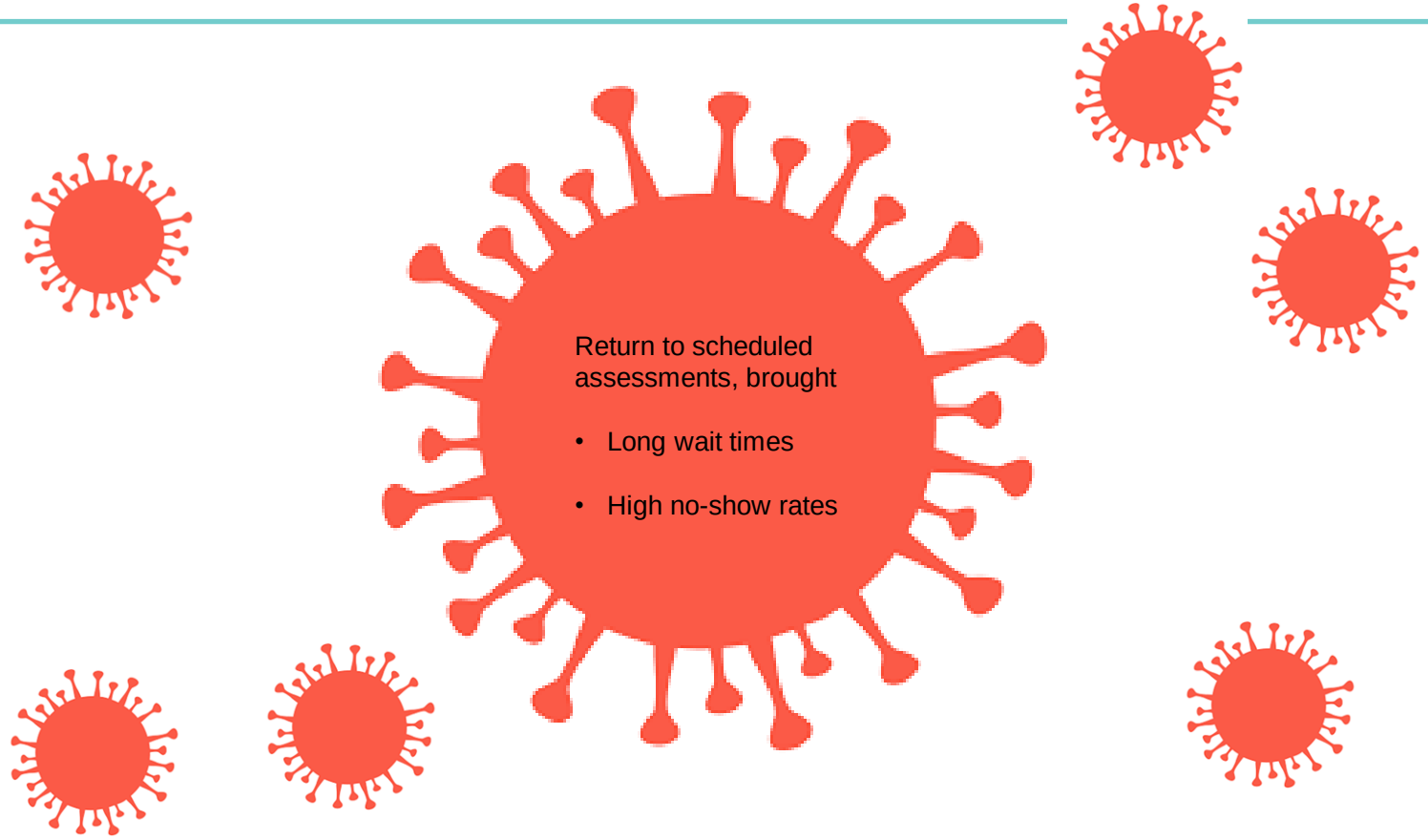
- Offering walk-in access for *paperwork* and then scheduling an assessment appointment once paperwork is complete.
- Offering walk-in access for *assessment* once per week or once per month while most assessments continue to be scheduled.
- These models do not shorten consumer's wait OR eliminate no- shows for the provider, resulting in lost clinician productivity.
- Telling all the clients to come in at 8:00 am and then handing out stacked appointment slots for later in the day.
- This may shorten the wait *days* for the consumer, but commonly results in a day lost for the consumer and can still result in no-shows for the provider.

Common Misapplications of Same Day Access

- Using Same Day Access for assessment, but then scheduling clients weeks/months out for the second appointment.
- The intent behind SDA is to move a client quickly to *treatment*.
- Assessments are not treatment.
- You will lose the client if you make them wait.

Traditional Same Day Access

- Around since the 1980s.
- Considered a best practice.
- Always worked well, until…

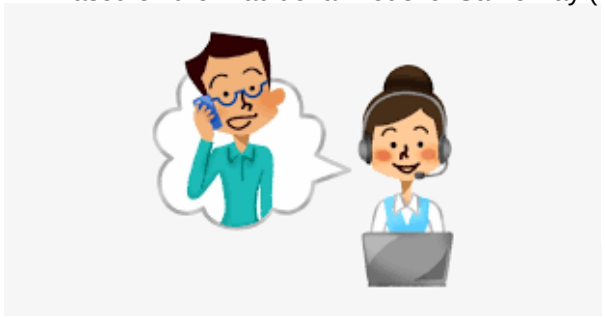


Virtual Same Day Access

Virtual Same Day Access

Virtual Same Day Access

- Based on the Traditional Model of Same Day (walk-in) Access, but entirely *virtual*.



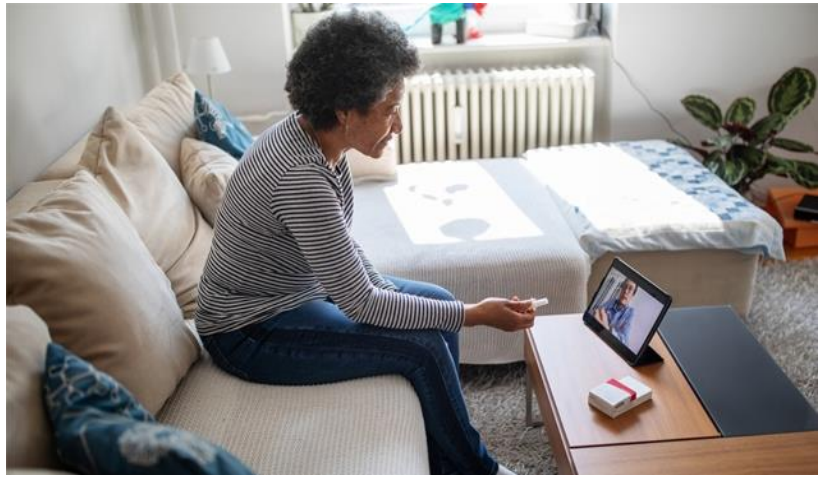
Screening Call:

- Rule out crisis
- Confirm service need matches services provided
- Insurance?
- Confirm client's available technology and give login hours and login details (no password/account required)

  Target: 5-6 minutes

Client *Logs In* to the BH Virtual Waiting Room

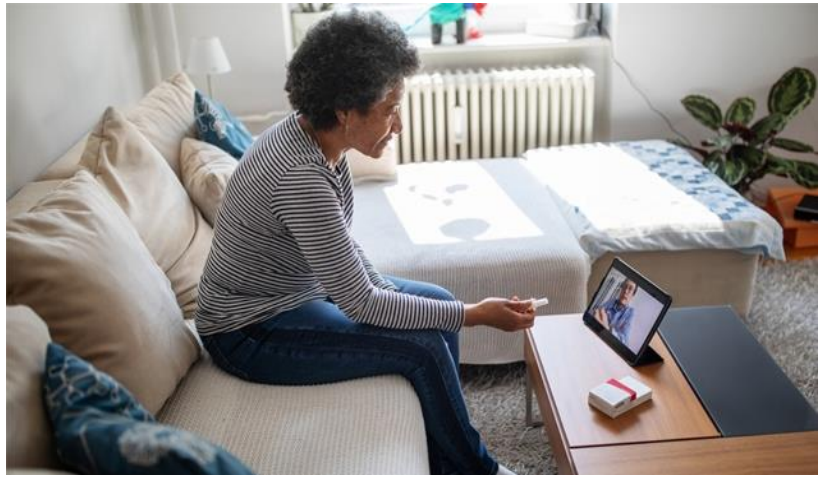
WHAT IS *VIRTUAL* SAME DAY ACCESS?



Credit: Healthcarefinancenews.com

- Enter the virtual waiting room
- Greeted by administrative support staff
- Complete consents and release forms digitally
- Return to the virtual waiting room until the clinician is ready.

WHAT IS *VIRTUAL* SAME DAY ACCESS?



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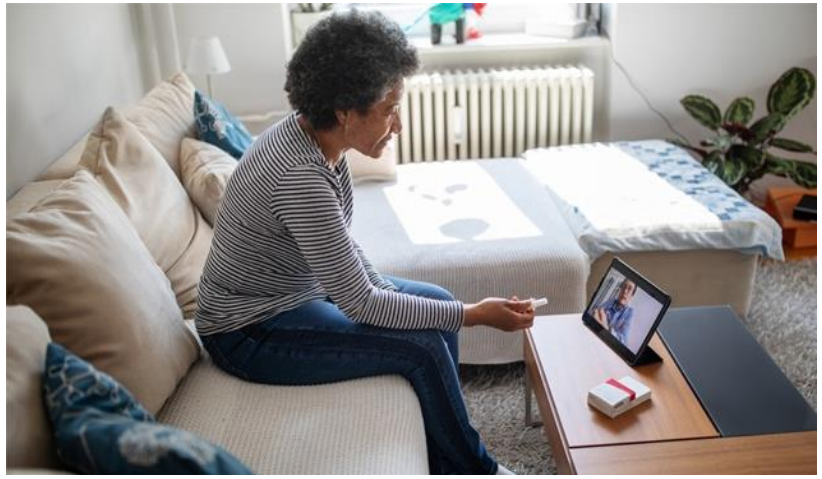


Credit: Healthcarefinancenews.com

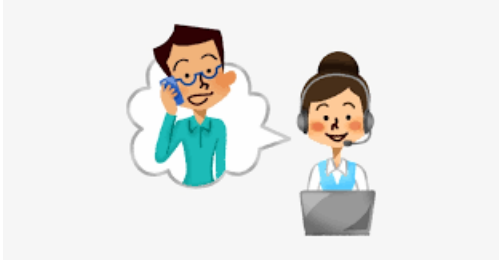
WHAT IS *VIRTUAL* SAME DAY ACCESS?

With Clinician

- Complete Assessment
- One Treatment Plan goal
- Leave with a scheduled appointment to return within 5-8 days.

Credit: Healthcarefinancenews.com

What if client can’t connect virtually?



Screening Call:
- Rule out crisis
- Confirm service need matches services provided
- Insurance?
- What if client has no telehealth capability? Invite client in and give the Same Day Access hours.

Target: 3-4 minutes

Invite them to walk-in but be seen virtually.

Traditional Same Day Access (*with Virtual Assessment*)

Client Walks In to the Community BH Center

Photo Source: Amerymedicalcenter.org

Photo Source: Pinterest

Photo Source: NBC

Waiting Room:
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Why Same Day Access?

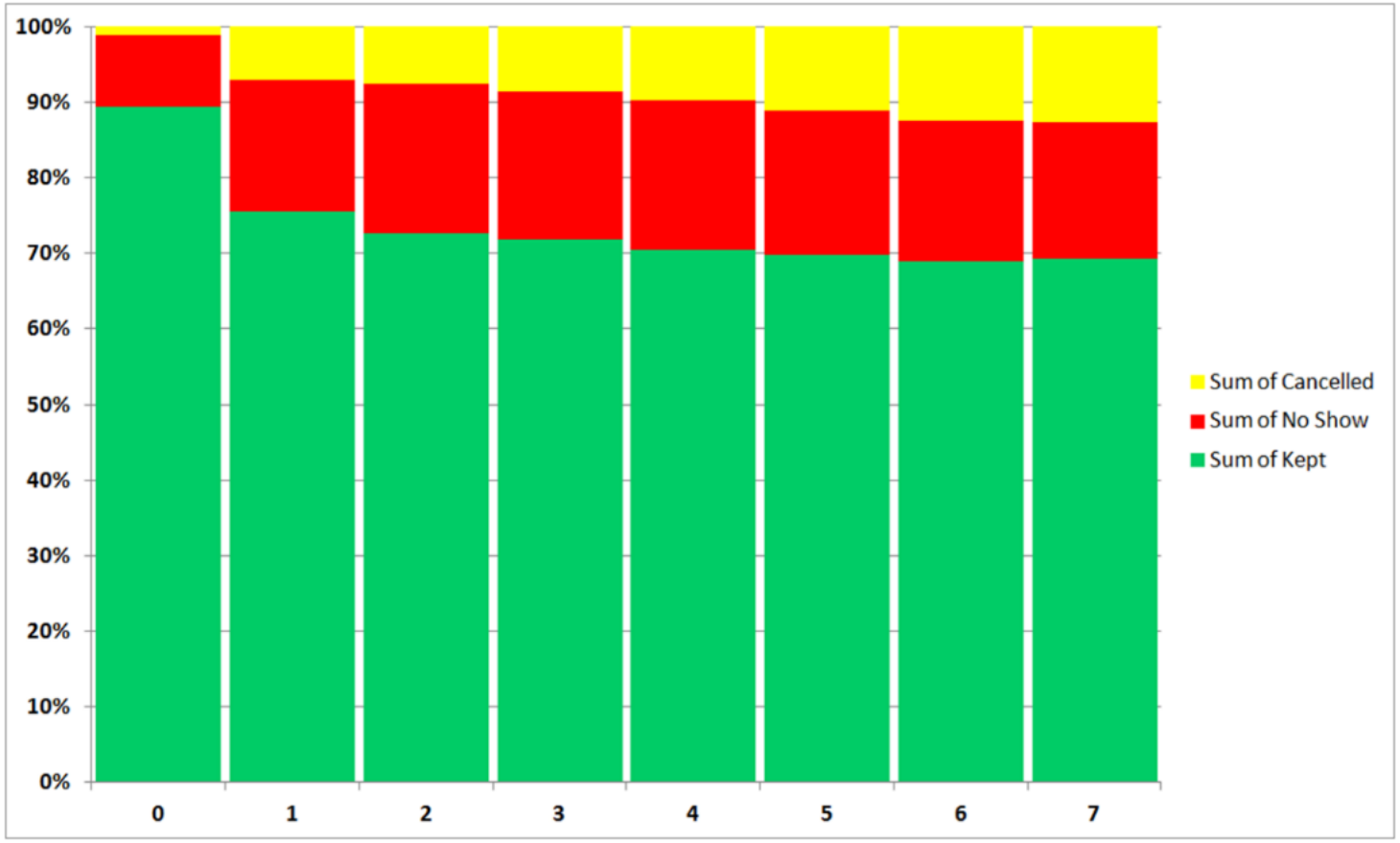
BECAUSE IT WORKS.

Best Possible Client Access

BECAUSE IT WORKS.

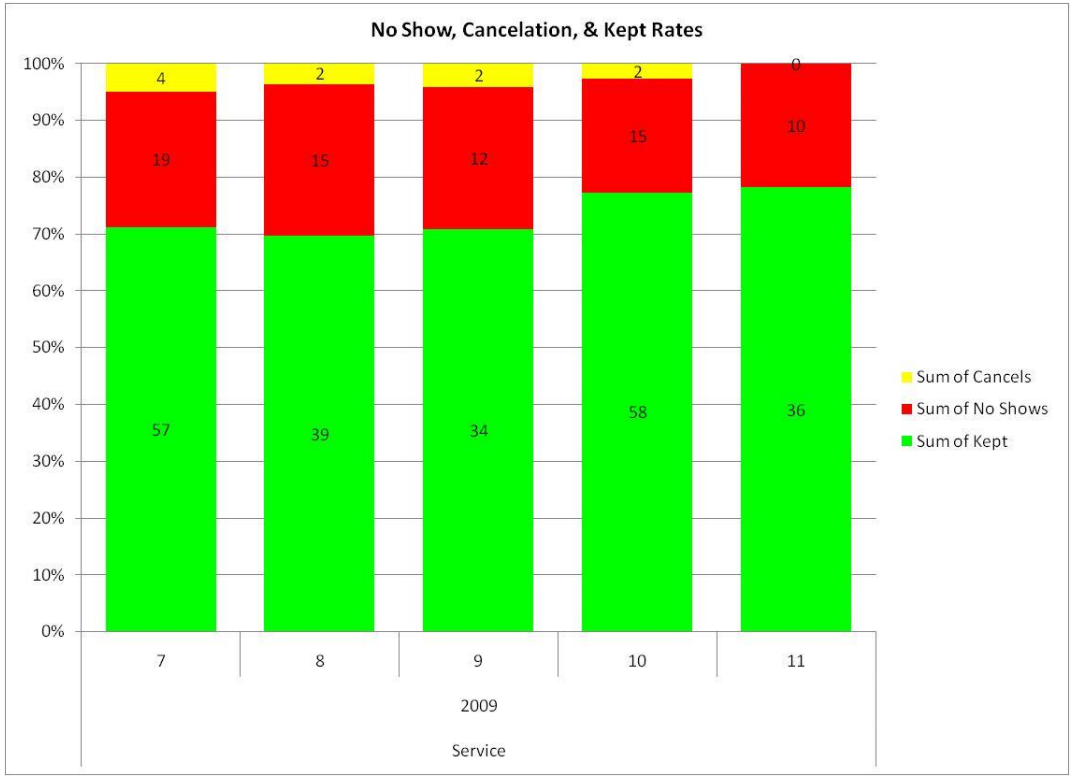
Increases Customer Engagement

Wait Days *Create* No Shows



Data taken from 22,000 assessment events.
National Council Access Grant.

As long as clients are seen for treatment within 8 days of the intake, engagement benefits gained through SDA extend to the initial service appointment.



BECAUSE IT WORKS.

Increases Customer Engagement

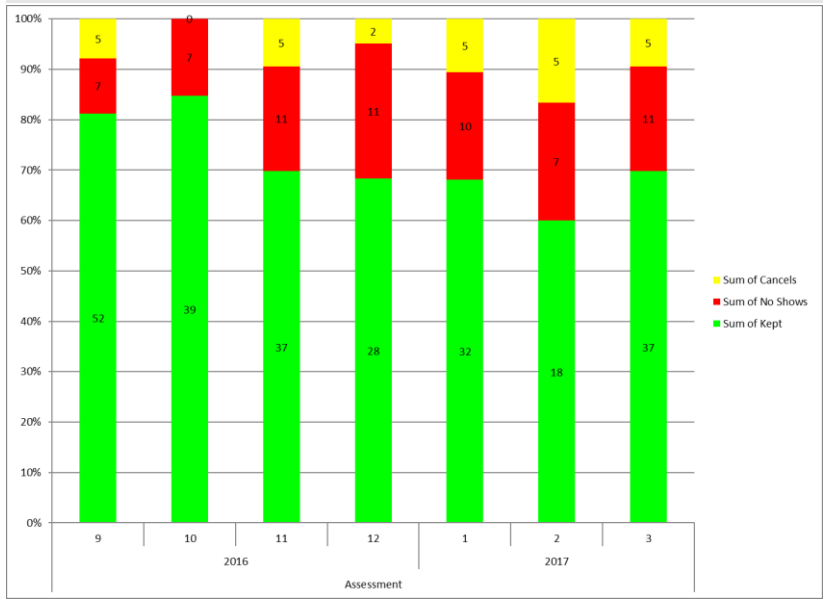
BECAUSE IT WORKS.

Eliminates No-Shows and Increases Clinician Productivity

Same Day Access Saves Clinician Time

Scheduled Model:
All eligible clients are scheduled, setting aside time for each, whether they show or not. Then, only 60-80% of clients show up and 20-40% of clinician time is lost.

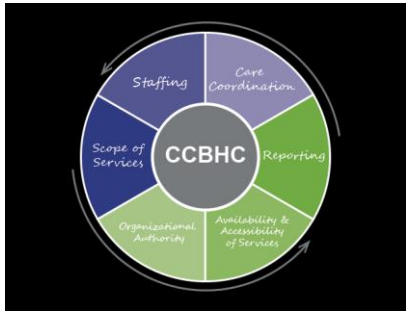
Same Day Access Model:
We only devote enough clinician hours for the number of assessments that are statistically completed. This frees up time that was previously lost to no-shows. This is closer to **100% productive**.



BECAUSE IT WORKS.

Eliminates No-Shows and Increases Clinician Productivity

BECAUSE IT WORKS.



Required for CCBHCs

CCBHC Criteria for Access*

- New Consumers are screened for risk and acuity at initial contact.
  - If emergent, immediate action to complete initial eval (can be telephonic, in-person is preferred)
  - If urgent, initial eval within one business day
  - If routine, initial eval within 10 business days

*subject to more stringent state, federal or applicable accreditation standards

Same Day Access Consultation Results

Access Comparison Worksheet				
	Total Staff Time (Hrs)	Total Client Time without Wait-time (Hrs)	Cost for Process	Total Wait Time (Days)
Old Process Averages:	5.12	3.47	($379.73)	48.49
New Process Averages:	3.92	2.99	($295.80)	26.31
Savings:	1.20	0.48	$83.94	22.18
Change %:	23%	14%	22%	46%

Avg. Number of Intakes Per Month	33,286.85
Intake Volume Change %:	12%
Monthly Savings:	$2,409,687.41
Annual Savings:	$28,916,248.88
Average Savings Per Center:	$112,954.10

256 Organizations included in this sample, from 26 states

These change numbers are averages, as teams have different starting points. For example, the average wait time change percentage is 46%, while the highest wait time change percentage recorded is 91%.

Change measurements are taken approximately nine to twleve months after the baseline is established.
Often, teams continue their work beyond this measurement.

Same Day Access Consultation Results

Highlights:

- Average *Reduction* in Wait Days = 46%
- Average *Increase* in Intake Volume = 12%
- Average Savings per Center = **$112,954**
- Average Return on Investment = 8 to 1

Using the Value of Care Equation to Improve Quality – *Why We Measure*

Scott Lloyd, President of MTM Services

Senior National Council Consultant & Chief SPQM Data Consultant

MTMSERVICES

Experience –

Improving Quality in the Face of Healthcare Reform

"Working to help organizations deliver the highest quality care possible, while improving the quality of life for those delivering the care!"

- MTM Services has delivered consultation to over 1,000 providers (MH/SA/DD/Residential) in 47 states, Washington, DC, and 2 foreign countries since 1995.

- **MTM Services' Access Redesign Experience** *(Excluding individual clients)*:
  - 5 National Council Funded Access Redesign grants with 200 organizations across 25 states
  - 10 Statewide efforts with 216 organizations
  - Over 9,000 individualized flow charts created

- Leading CCBHC Set up and/or TA efforts in 5 states

Experience –

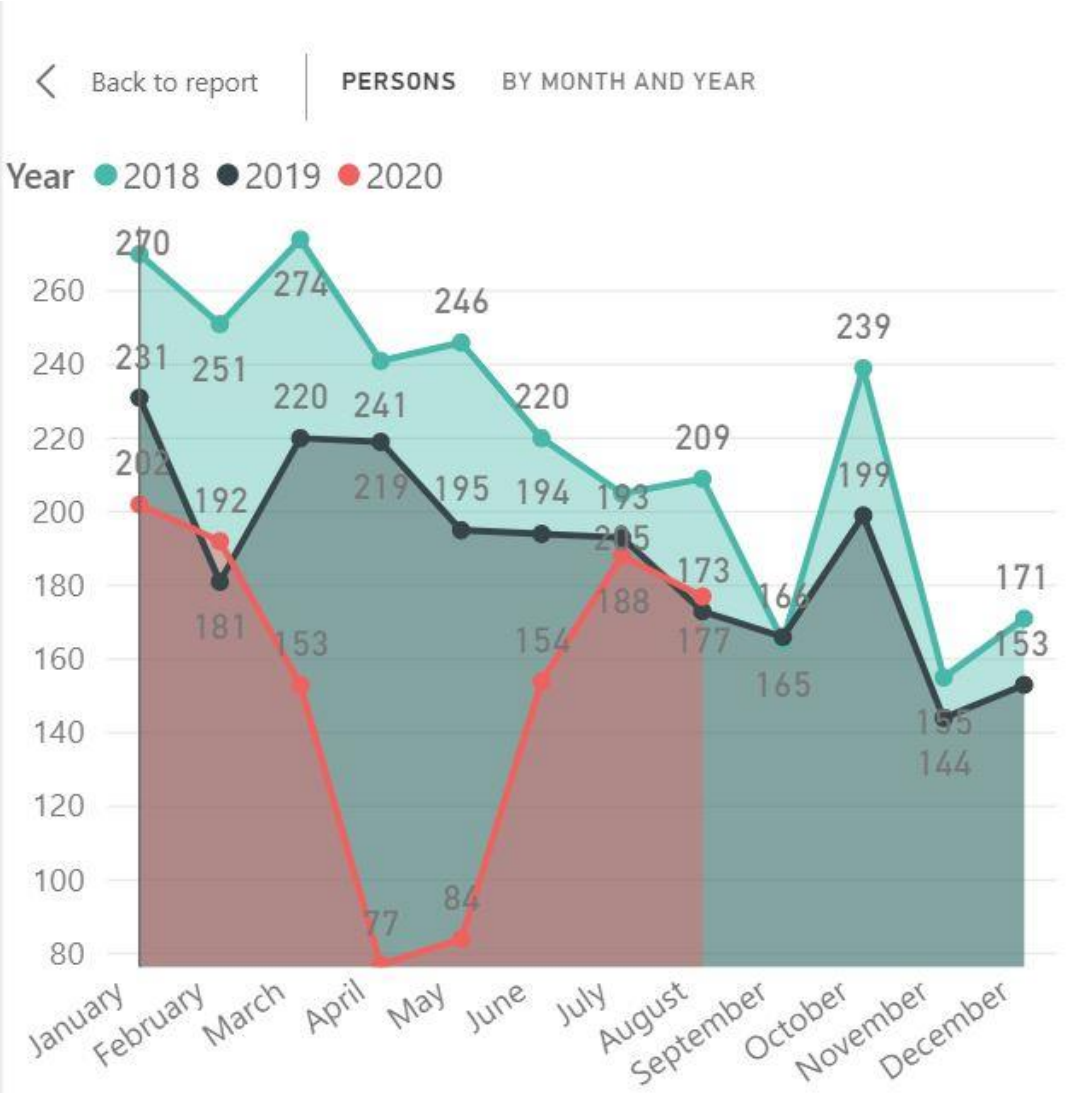
Improving Quality in the Face of Healthcare Reform

Resetting our Reality…How do we do with Making Changes?!

Most Significant COVID Impacts –

1. Access/Intake services dropped by 80% on average in March and April of 2020 but started to return by August of 2020, and most teams were back to 100% levels by the end of 2020.
2. Emergency services dropped by 50% on average in March and April of 2020 and did not return until return for most teams until 2021, and some teams have not seen numbers return to normal.
3. No Show Rates dropped to virtually 0% for March through June and has now increased to pre-COVID levels or worse due to lack of availability.
4. Residential and Group services basically stopped in March and April and have returned in very different ways depending on the state.
5. The systems we used to bring people in for access, especially the forms processes that have not worked for years was highlighted the virtual environment as teams went to virtual access systems.
6. Demand for Mental Health services has increased this year, with states seeing 80-100% increases in demand from June through September of 2021.
7. Significant Workforce Challenges in 2021.

Resetting our Reality…How do we do with Making Changes?!



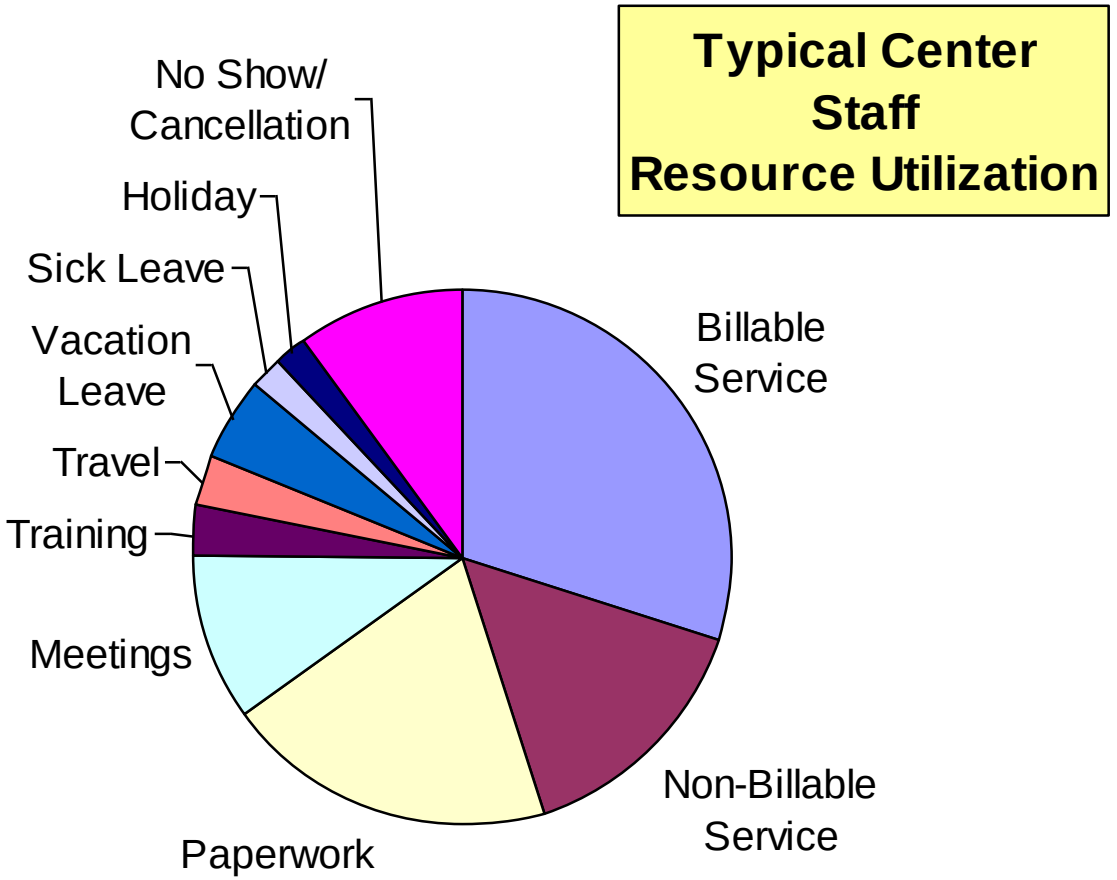
Month	2018	2019	2020
January	270	231	202
February	251	181	192
March	274	220	153
April	241	219	77
May	246	195	84
June	220	194	154
July	205	193	188
August	209	173	177
September	165	166	
October	239	199	
November	155	144	
December	171	153	

Resetting our Reality…

Change ***- (Verb) -*** Alter, vary, modify. To make or become different. **Change** implies making either an essential difference often amounting to a loss of ***original identity*** or a ***substitution of one thing for another***.

Making the Value of Care Equation Work –

How did we get to here?!



Substitute Process is Key!

All Mate

Making the Value of Care Equation Work –
How did we get to here?!

System Noise –

Anything that keeps staff from being able to do the job they want to do:

Helping consumers in need!

More Importantly, what do you do about it!?

Resetting our Reality…

As We Move to CCBHCs / Higher Funding Environments

Hiring more low producing staff without fixing the issues that cause your current staff to struggle is NOT a sound strategy…

Resetting our Reality…

The #1 Reason that Change Efforts Fail -

Teams come into the change process looking to alter what they are doing now instead of looking at what it will take to actually make a substantive change….

Partial Implementation or Cherry Picking the Change…

The best way to overcome this is to tie to a solid change reason with a solid change target…

Bedrock Change Principle….

The “Value” of Care Equation

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

Cost of Services provided based on current service delivery processes by CPT/HCPCS code and staff type.

Outcomes Achieved (i.e., how do we demonstrate that people are getting “better” such as with the DLA-20 Activities of Daily Living).

Value is Determined based on can you achieve the same or better outcomes with a change of services delivered or change in service process costs which makes the outcomes under the new clinical model a better value for the payer.

The “Value” of Care Equation

The 2 Main *Measurable* Components Encompass A Lot!

- **Quality**
  - **Access to care/Wait times**
  - **Engagement/Show rates**
  - **Adherence to treatment**
  - **An appropriate length of stay**
  - ***Outcomes measured with a validated outcomes tool***
  - **Staff’s job satisfaction**
  - **Staff turnover rates**
- **Cost**
  - **Seems easy to measure, but most teams are using a flawed methodology**
  - **Is not a popular topic with clinical staff so is often not addressed**
  - **Because flawed methodologies are used, costing number often do not make sense to staff then they so discuss it**
  - **If you focus on the cost of care, you are often seen as the enemy of Quality**

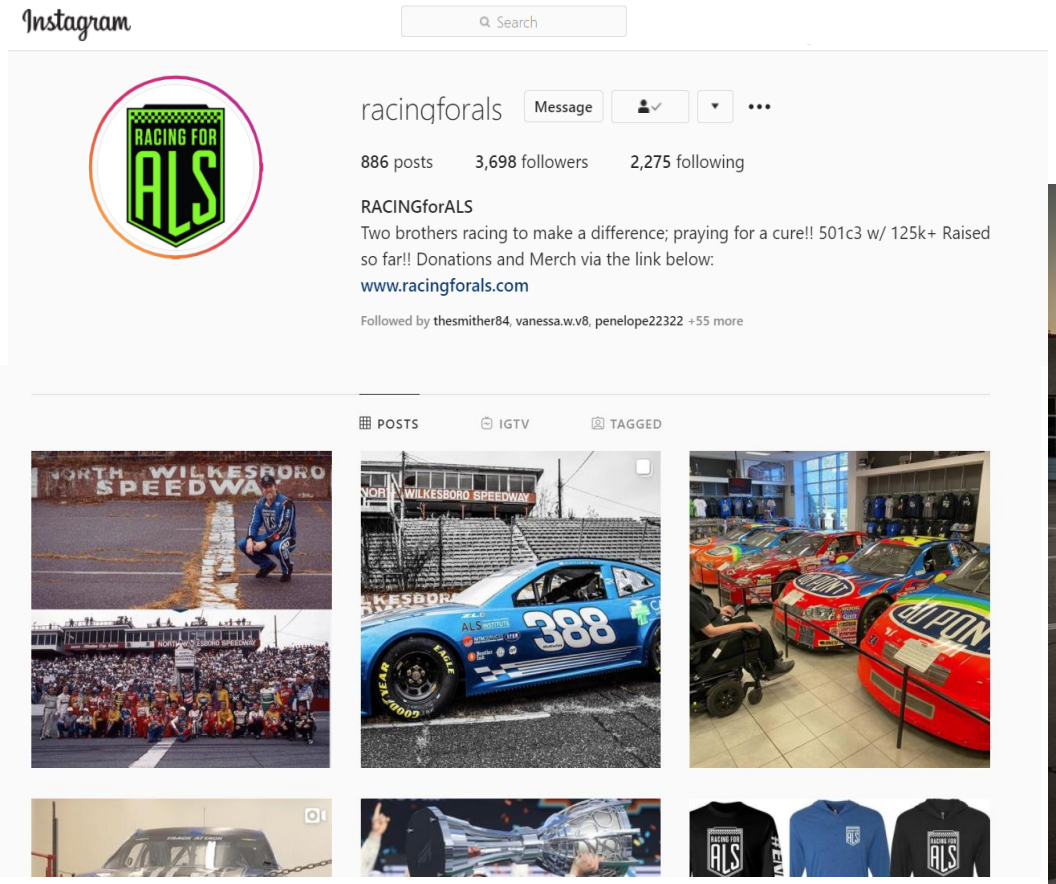
Resetting our Reality…System Noise Impacts

Key Question –

Does Data Lead Your Team To Make a Change or to Make Excuses!?

Using Data to Make Change Happen!

How Does/ Does Your Team Use Data?!



Over $150,000 raised for ALS Research - @RacingForALS

Anecdotal Data -

Which Car Would You Choose?

Photo Credit: Scott Lloyd Photography

Resetting our Reality…How do we do with Making Changes?!

In the absence of sound data, staff will assume/ believe the worst….

1. *Set up a solid communication channel for all staff*
2. *Select a solid data system so that everyone can draw their data from that singular source*
3. *Establish clear timelines for when/how you will communicate*
4. *Select a solid outcome measurement tool if possible, and if not then limit the number of measures*

Give them DATA, DATA, DATA, DATA, DATA!

Resetting our Reality…System Noise Impacts

Productivity is not a measure of how hard our staff is working….

It is a measure of how well our systems are supporting our staff!

Resetting our Reality…System Noise Impacts

Had a team that wanted to hire 2 more Doctors…

www.mtmservices.org

Hours per Day	Work Days PY
8	260
BH Standard	**No Show %**
50.0%	30%

Available Hours Per Year	2,080		
Annual Leave / PTO	256	32.00	Days Pe
Personal / Holidays / Sick	0	0.00	
Charting/Paperwork	248	31.00	
Training/Staffings	48	6.00	
Scheduling	96	12.00	
Other Non-Billable Activity	392	49.00	
Non-Billable Hours:	1,040	130.00	Non-Billa
Billable Hours:	1,040	130.00	Billable

Salary	FB%	Salary + FB	Base Cost PH	Overhe
$200,834.00	30%	$261,084.20	$251.04	44

Staff FTE %:	Yearly BH Production	Quarterly BH Production	Mon BH Proc
100.0%	1,040	260	86
			Hou

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Hours per Day	Work Days PY
8	260
BH Standard	**No Show %**
23.1%	30%

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Basic Cost Based Productivity Calculator

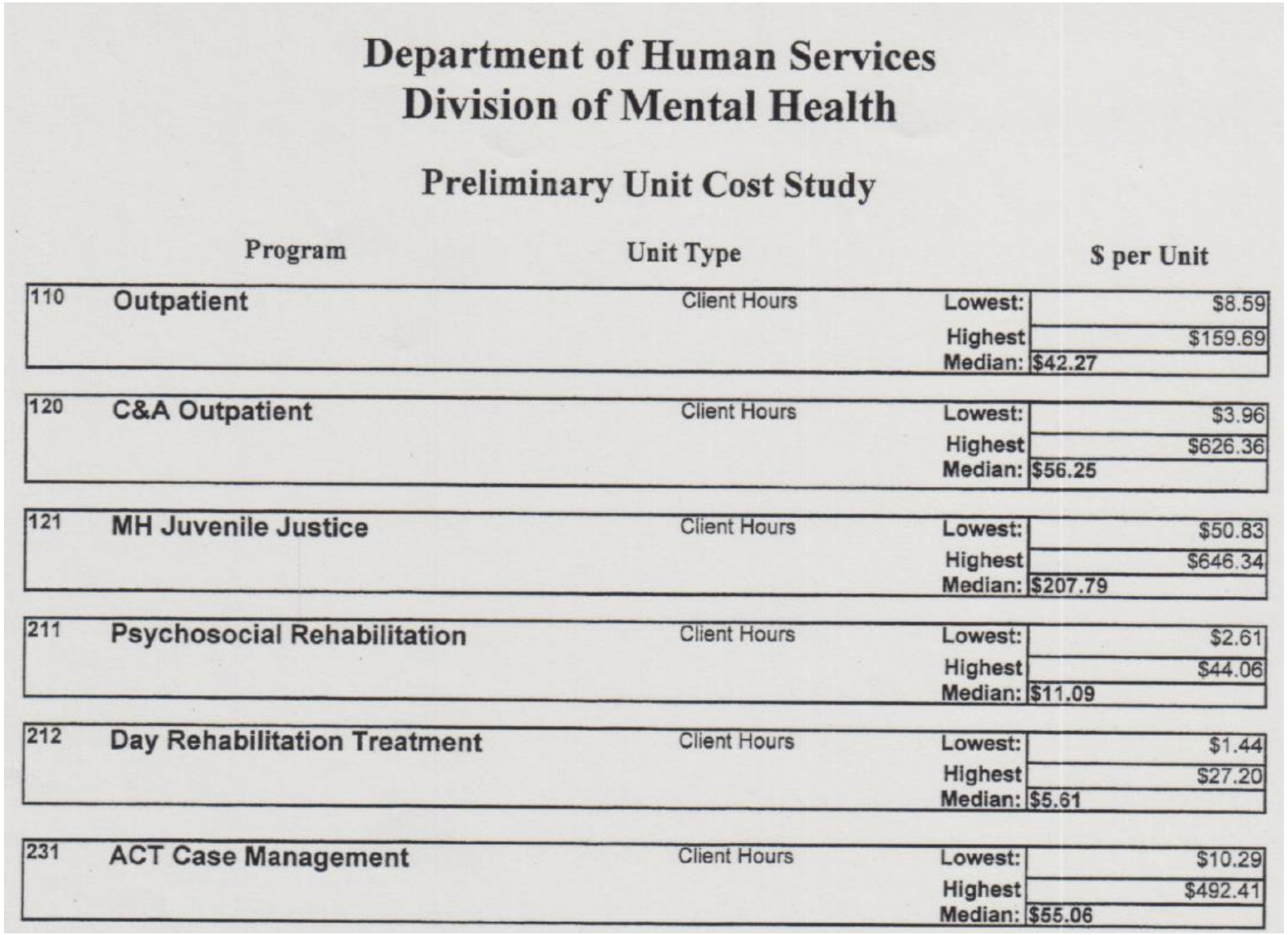
Change Only The Blue Cells

Available Hours Per Year	2,080		
Annual Leave / PTO	256	32.00	Days Per Year
Personal / Holidays / Sick	0	0.00	
Charting/Paperwork	248	31.00	
Training/Staffings	48	6.00	
Scheduling	96	12.00	
Other Non-Billable Activity	952	118.94	

Non-Billable Hours:	1,600	199.94	Non-Billable Days	9.23	Non-Billable Months
Billable Hours:	480	60.06	Billable Days	2.77	Billable Months

Salary	FB%	Salary + FB	Base Cost PH	Overhead %	Cost Per Hour	Avg. Revenue	Margin
$200,834.00	30%	$261,084.20	$543.38	44%	$782.47	$150.00	($632.47)

Staff FTE %:	Yearly BH Production	Quarterly BH Production	Monthly BH Production	Daily BH Production		No Show Percentage Driven Scheduling Rate	
				All Days	Minus PTO	All Days	Minus PTO
100.0%	480	120.12	40.0	1.8	2.1	2.6	3.0
			Hours Weekly	9.2	10.5	13.2	15.1



Department of Human Services
Division of Mental Health

Preliminary Unit Cost Study

	Program	Unit Type		$ per Unit
110	Outpatient	Client Hours	Lowest:	$8.59
			Highest	$159.69
			Median:	$42.27
120	C&A Outpatient	Client Hours	Lowest:	$3.96
			Highest	$626.36
			Median:	$56.25
121	MH Juvenile Justice	Client Hours	Lowest:	$50.83
			Highest	$646.34
			Median:	$207.79
211	Psychosocial Rehabilitation	Client Hours	Lowest:	$2.61
			Highest	$44.06
			Median:	$11.09
212	Day Rehabilitation Treatment	Client Hours	Lowest:	$1.44
			Highest	$27.20
			Median:	$5.61
231	ACT Case Management	Client Hours	Lowest:	$10.29
			Highest	$492.41
			Median:	$55.06

Do You Actually Know your Costs?

Top Costing Failure Points -

- Dividing costs by 2080 hours
- Not including all of your costs
- Using overhead percentages instead of actual costs
- Looking at expected revenue instead of actual revenue
- Including monies outside of *At Risk Funding*

Do You Actually Know your Costs?

Costing Methodology Review:

Actually Understanding your Costs!

Let's Do the Math!

$40,000 / 2080 Hours = **$19.23** An Hour

$30 = **$10.77**

Per Hour — Margin Per Hour??

$30 x 1200 Hours = **$36,000**

Do You Actually Know your Costs?

Our Costing Methodology Defined –

Total Cost for Service Delivery

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

Total Revenue for Service Delivery

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

- Divided By -

Total Billable Direct Service Hours Delivered **

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

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

Do You Actually Know your Costs?

Breaking down cost versus revenue by modified code –

Crucial for CCBHC rate setting versus the CMS Tool that gives a system wide cost.

CCBHC Cost Report				
MEDICAID ID:				
NPI:				
REPORTING PERIOD:	From:		To:	
RATE PERIOD:	From:		To:	
WORKSHEET:	CC PPS-1 Rate			

PART 1 - DETERMINATION OF TOTAL ALLOWABLE COST APPLICABLE TO THE CCBHC		
	Description	Amount 1
1.	Total direct cost of CCBHC services (Trial Balance, column 9, line 29)	$0
2.	Indirect cost applicable to CCBHC services (Indirect Cost Allocation, line 16)	$0
3.	Total allowable CCBHC costs (sum of lines 1-2)	$0

PART 2 - DETERMINATION OF CC PPS-1 RATE		
	Description	Amount 1
4.	Total allowable CCBHC costs (line 3)	$0
5.	Total CCBHC visits* (Daily Visits, column 1, line 4)	0
6.	Unadjusted PPS rate (line 4 divided by line 5)	$0
7.	Medicare Economic Index (MEI) adjustment from midpoint of the cost period to the midpoint of the rate period	0.000%
8.	CC PPS-1 rate (line 6 adjusted by factor from line 7)	$0

* Total should reflect the total count of CCBHC visits provided and not be restricted to Medicaid visits

OMB #0398-1148 CMS-10398 (#43)

End of Worksheet

Breaking down cost versus revenue by modified code –

Crucial for CCBHC rate setting versus the CMS Tool that gives a system wide cost.

MTMSERVICES.ORG Driving Transformational Change! SPQM

Cost Per Hour Ranges

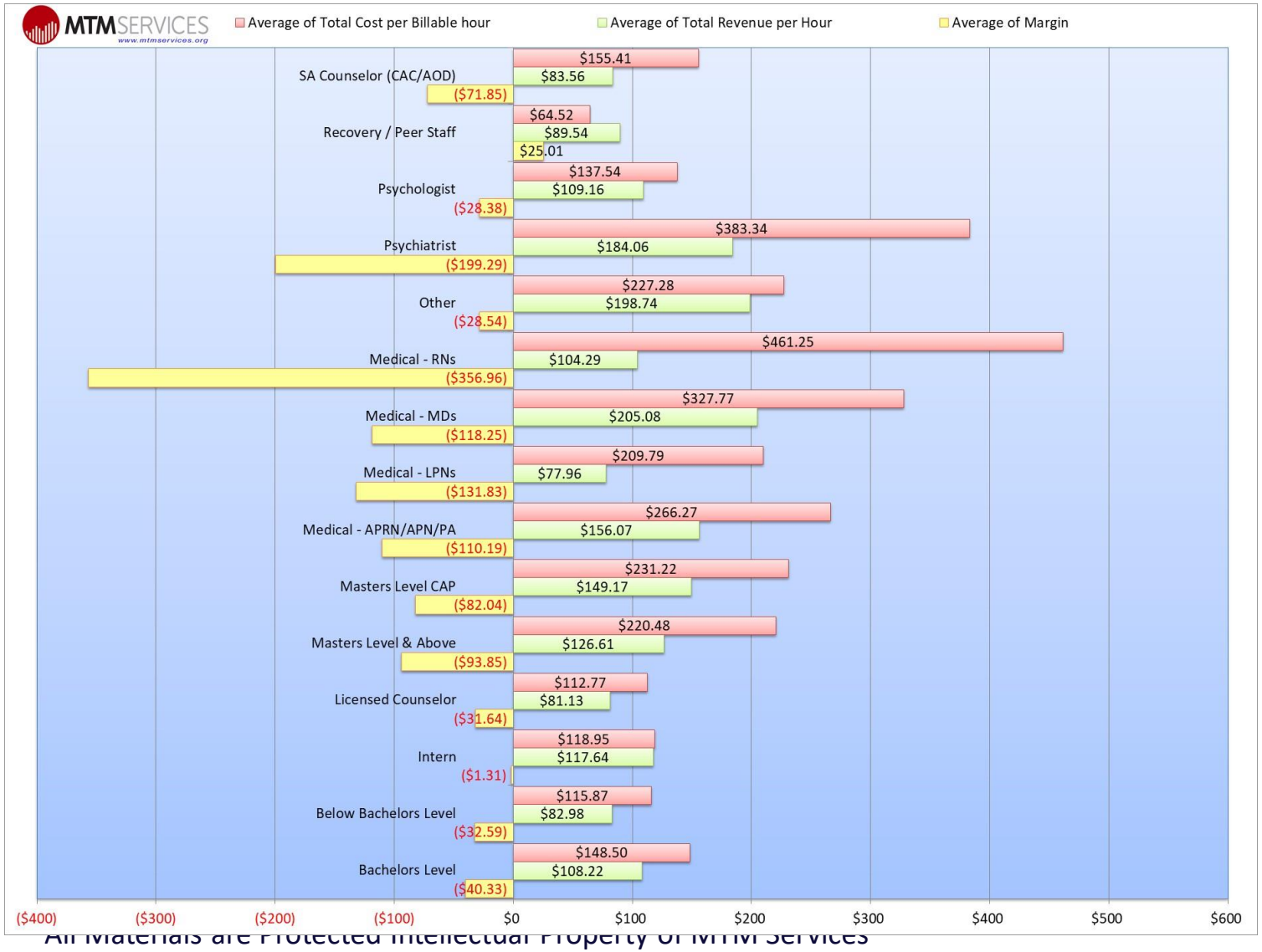
Salary	FB%	Salary + FB	Overhead %	Total Pay
$32,000.00	32%	$42,240.00	44%	$60,825.60

Hours per Day	Work Days PY	Days of PTO
8	260	31

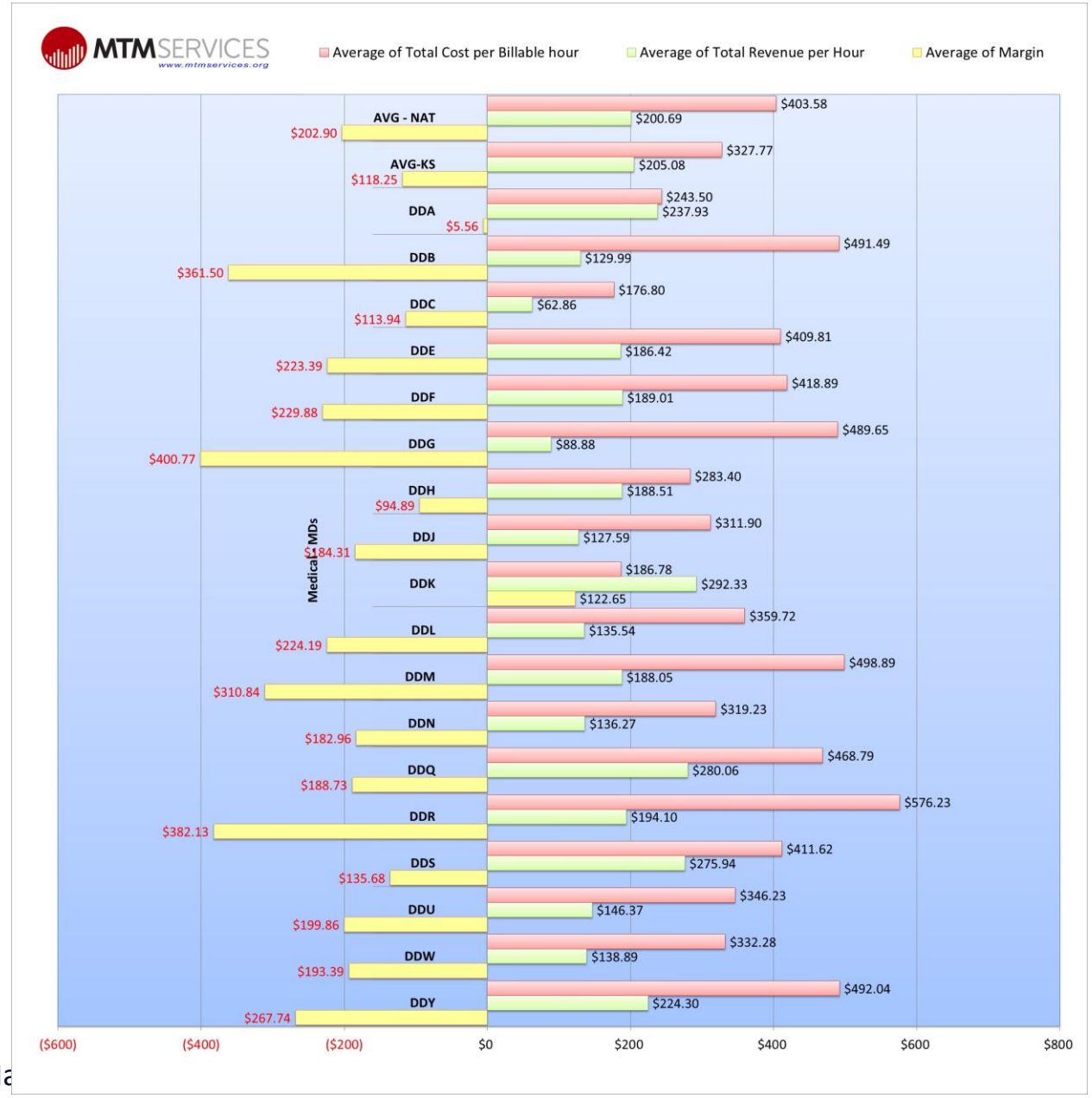
Direct Service Hours	DS%	Cost Per Hour	Revenue	Margin
100	4.8%	$608.26	$87	($521.26)
200	9.6%	$304.13	$87	($217.13)
300	14.4%	$202.75	$87	($115.75)
400	19.2%	$152.06	$87	($65.06)
500	24.0%	$121.65	$87	($34.65)
600	28.8%	$101.38	$87	($14.38)
700	33.7%	$86.89	$87	$0.11
800	38.5%	$76.03	$87	$10.97
900	43.3%	$67.58	$87	$19.42
1000	48.1%	$60.83	$87	$26.17
1100	52.9%	$55.30	$87	$31.70
1200	57.7%	$50.69	$87	$36.31

Avg. Reimbursement
$87

Incorrect Examples					
All Hours	2080	100.0%	$29.24	$87	$57.76
AH Minus PTO	1832	88.1%	$33.20	$87	$53.80



ACMHCK – Establishing a Solid Costing Reality



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Margin Comparisons by Center / National

Breaking down cost versus revenue by modified code –

Crucial for CCBHC rate setting versus the CMS Tool that gives a system wide cost.

Row Labels	Sum of Total Hours Per Code	Average of Average Cost per Code	Average of NET Revenue per Code Per Hour	Average of Total Margin Per Code	Sum of Total Gain/Loss Per Code
99213	**75,915.26**	**$298.26**	**$133.66**	**($164.60)**	**($12,828,035.22)**
NR	45,493.40	$317.20	$142.05	($175.15)	($7,932,654.01)
(blank)	7,320.21	$286.08	$124.77	($161.31)	($1,418,101.78)
U1	6,008.86	$311.44	$163.80	($147.64)	($808,860.74)
ECC	2,799.29	$373.26	$150.69	($222.57)	($511,106.41)
U1 U6	2,287.86	$314.30	$110.38	($203.92)	($466,543.38)
U2	2,087.81	$203.20	$114.49	($88.71)	($194,798.60)
FQHC	1,882.50	$367.83	$346.75	($21.07)	($39,668.52)
0	1,654.83	$157.25	$64.46	($92.79)	($201,598.35)
Non-ECC	1,409.57	$340.35	$97.96	($242.39)	($450,658.06)
U1	1,263.75	$177.77	$43.39	($134.38)	($169,827.83)
Insurance	1,214.21	$356.89	$168.87	($188.02)	($228,292.25)
U2 U6	973.11	$198.07	$78.94	($119.14)	($115,931.95)
	438.00	$325.42	$157.15	($168.27)	($73,702.55)
Private Insurance	302.94	$336.09	$142.70	($193.39)	($58,584.74)
Medicaid	291.84	$335.83	$99.35	($236.49)	($68,696.87)

Why Change Efforts Fail…

Successful Change Examples …

- **Data Mapping/Documentation Redesign –** Teams on average cut 62% of the questions that they were asking before the process, while also improving the quality of care.

Row Labels	Count of Form Field	%		
(blank)		0%		**Original Elements**
Delete	1028	63%		1960
dd		0%		
Initial Contact	11	1%		**Final Elements**
Registration	113	7%		596
Evaluation	388	24%		
ACS Intake	52	3%		**Entry Count Reduction**
SUD Intake	32	2%		**69.59%**
Grand Total	**1624**			

- **MSDP Statewide Forms** – Reduced 9,735 Forms down to 33 Forms in 9 months!

Why Change Efforts Fail…

Successful Change Examples …

- **Same Day Access *(SDA)* and Just in Time *(JIT)* –** Reduces Time to Care
  - SDA reduces no shows from 40% to 0%, JIT from 40% down to below 10%
  - SDA reduces time through the system from 31 days on average to 7
    JIT from 48 days down to 3
  - SDA and JIT have 97-98% Customer Approval Ratings
  - SDA has an 8 to 1 return on investment in the first year, JIT is a 5 to 1 ROI in 6 months
  - Both have very high clinical diversion rates from ER/ED services
  - Both attain better outcomes thanks to higher engagement
  - Both can be done in virtual environments

Access Comparison Worksheet				
	Total Staff Time (Hrs)	Total Client Time without Wait-time (Hrs)	Cost for Process	Total Wait-time (Days)
Old Process Averages:	4.83	2.76	($355.13)	52.37
New Process Averages:	2.91	2.08	($221.61)	24.78
Savings:	1.93	0.68	$133.52	27.59
Change %:	40%	25%	38%	53%
		Avg. Number of Intakes Per Month	1,663.00	
		Intake Volume Change %:	7%	
		Monthly Savings:	$222,050.92	
		Annual Savings:	$2,664,611.04	
		Average Savings Per Center:	$222,050.92	

Why Change Efforts Fail…

Successful Change Examples …

- **Use of Data and KPIs –** Reduces Staff Turnover
  - We often see 7 figures worth of revenue that teams are expecting to bill but are not.
  - We often see teams with multiple FTEs worth of Unrealized Capacity.
  - The current turnover rate nationally is 40%.
    - Turnover costs an agency capacity/revenue, retraining and ramp up time each year – And more importantly it breaks up standing clinical relationships.
    - Turnover losses for an agency with 100 clinical staff is over $500,000 a year!

Unrealized Service Capacity in Hours and Lost Revenue by Staff

		Values	
Staff Name	**Position**	**Sum of Unrealized Capacity (Hours)**	**Sum of Unrealized Revenue ($)**
[redacted]	Masters Level & Above	-44.67	($4,727.86)
	Below Bachelors Level	-816.34	($85,263.54)
	Bachelors Level	-512.26	($39,900.02)
	Bachelors Level	-29.73	($3,074.62)
	Intern	0	$0.00
	Intern	0	$0.00
	Licensed Counselor	-17.11	($2,155.62)
	Below Bachelors Level	56.15	$11,464.44
	Below Bachelors Level	-61.3	($9,120.43)
	Intern	85.49	$11,392.38
Grand Total		**-40327.04**	**($4,671,894.52)**

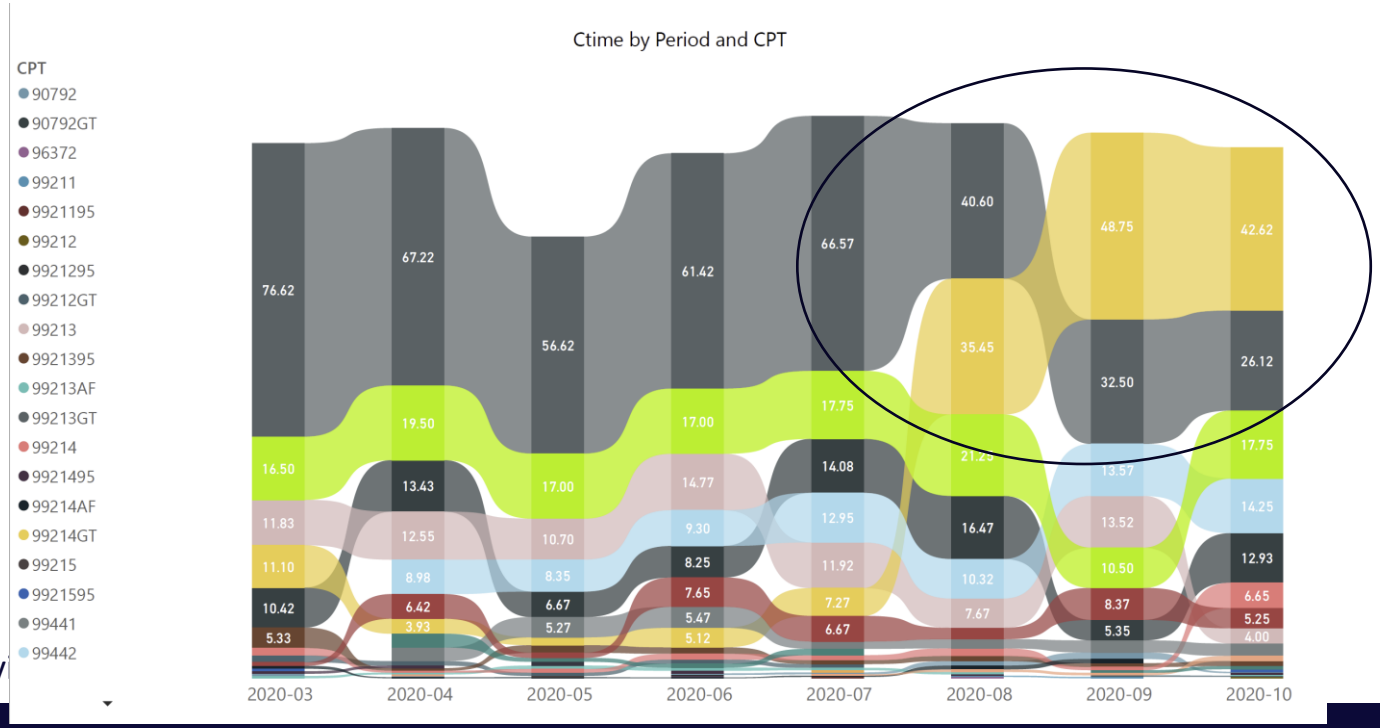
Why Change Efforts Fail…

Successful Change Examples …

- **Back Office Management and EM Coding Consultation –** Reduces Billing Errors & Paybacks
  - We often see teams writing off 7 figures in billings that were simply not processed correctly. Normally simple things like taking to long to turn in their billings, utilizing the wrong codes, etc.

  - EM coders are often under-coding and/or over-coding, leading to either a loss of revenue, an audit risk or both!

Billings Increase 10-15% on average as you increase your billing to a higher intensity code starting at 99211 up to 99215



Why Change Efforts Fail…

Successful Change Examples …

- **The Change Numbers From Previous Efforts Should be a Slam Dunk –** Teams get excited by the possibilities, but then get quickly distracted from their original goals and start to compromise.

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Resetting our Reality…

A Successful Change Should Benefit You, Your Consumers and Your Staff!

Changes Should…

- Reduce Repetition / Extraneous Data Capture
- Reduce Time to Care
- Reduce Documentation Time
- Reduce Staff Turnover
- Reduce Billing Errors
- Reduce Miscommunications
- Reduce Management's Time in Decision Making by Building Leadership
- Reduce Costs

All of these changes will converge to Increase the Quality of Care and your Staff's Job Satisfaction.

Resetting our Reality…

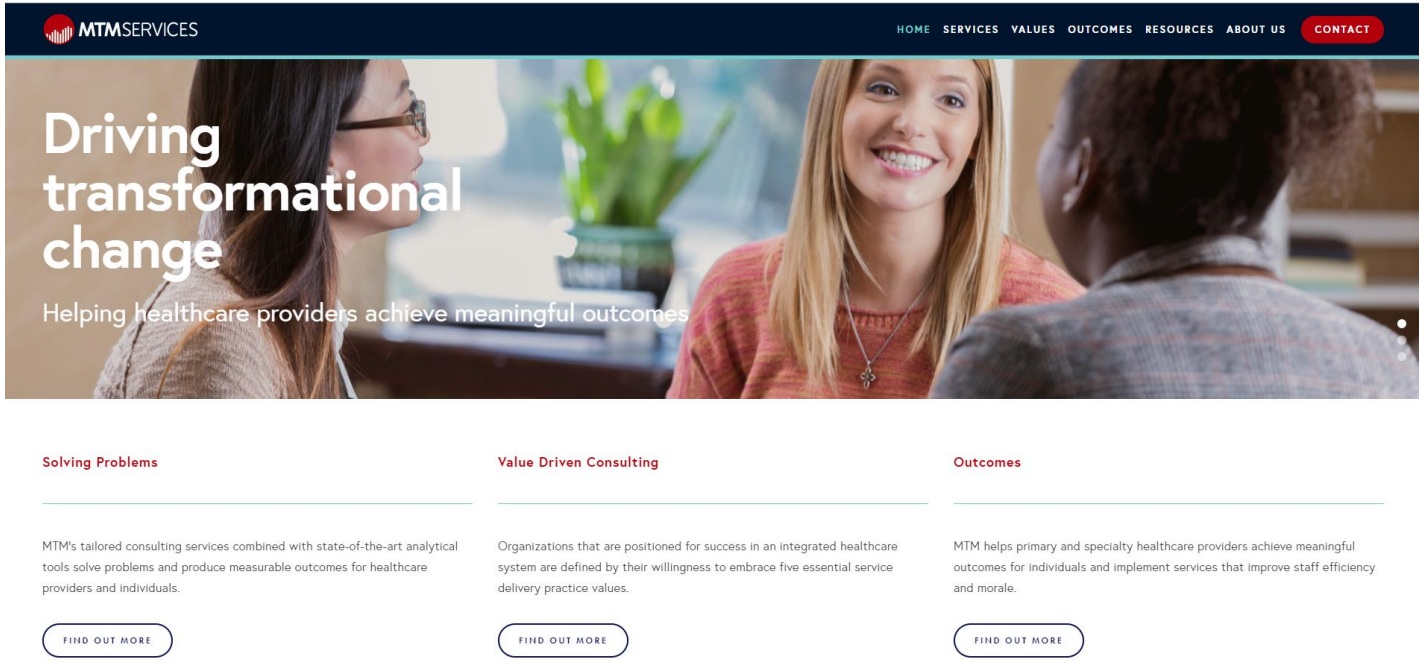
The easiest way to know if you have made a successful change is when the care you are delivering meets with the expectations of what you would want for yourself and/or your loved ones!

Thank You

Scott.Lloyd@mtmservices.org

See our outcomes, resources and more…

www.mtmservices.org



Questions

What Questions do you Have?