New Mexico Provider Assessment Project—Phase II

Training Session

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Rusty Dennison
Susan Parker
Parker Dennison & Associates, Ltd.

E-mail
Susan:  susanppda@aol.com
Rusty:  rustydpda@aol.com

www.ParkerDennison.com
Purpose

- Support process for facilitating provider development in New Mexico through technical assistance provided by ValueOptions
- Review recommended approach for completing assessment site visits, development of work plan and follow-up visits
- Review site visit tools with VO staff for consistent application and use of tools
  - Assessment
  - Work plan
  - Visit summary
What to Expect From Providers

Providers are conditioned to react to specific payer requirements and are often resistive to changes to improve overall effectiveness that are not expressly ‘required’.

- Long experience with announced changes that do not occur—no need to waste time and resources until payer changes are finalized
- Concerned about supporting the costs for changes
- Concerned that payer will move in a direction that is inconsistent with changes, causing the change effort to be wasted
Provider Response to Change

Encourage providers that practices reflected in the assessment are consistent with needs of Collaborative and VO

- Tools reflect input from all Collaborative stakeholders and VO staff
- Good clinical/business practices designed to improve provider viability
- Preparation for future implementation of CCSS and core service agency roles
Approach to Assessment Site Visits

- Develop VO schedule and staff assignments
  - Begin with most interested providers
  - Consider two staff for selected providers

- Develop VO database to accumulate responses across network
  - Assign staff to input assessment results
  - Establish timeline for entering data—tool must be complete at close of visit

- Develop VO responsibilities for completion/review of workplans and visit summaries
Approach to Assessment Site Visits

- Develop provider communication tools
  - Cover memo with purpose/plan and provider responsibilities
  - Explain relationship/changes from prior tool
- Provider responsibilities
  - Review and complete draft tool prior to visit—fax to VO in advance of visit
  - Schedule onsite meeting with VO and key provider staff to review draft response
  - Assemble evidence of performance to be available at the meeting
Approach to Assessment Site Visit

- One day onsite
  - Approximately 5 hours to jointly review and agree on responses to assessment tool
    - Walk through each question and ask what evidence caused provider to answer yes
    - Describe any VO experiences/examples that are inconsistent with response
    - Chart reviews to validate key areas—primarily assessment(s), treatment plan, progress notes
Approach to Assessment Site Visit

- Approximately 2 hours to develop work plan priority areas and tasks
  - If time allows, facilitate provider identification of priorities with VO providing feedback
  - Verbal concurrence on priorities during visit
  - Work plan document completed by VO staff following visit and submitted to provider for review

- Follow-up TA visits to check progress/ provide assistance
  - Documented by Visit Summaries
Approach to Assessment Site Visit

- Develop interface with Collaborative
  - Reporting
  - Role of state staff
  - Action plans from aggregate results data
  - Feed into development/quality improvement processes as applicable
Overview of Tools

- **Assessment Tool**—gather data on provider’s current operations
  - Update from one year ago and available to VO (last assessment was anonymous)
  - Tool updated to reflect current NM environment and plans
  - Build customized work plans to improve provider readiness from current position

- **Work Plan**—sets key priorities (3 - 5) for next 6 months, benchmarks, and resources

- **Visit Summary**—documents follow-up visits and monitors work plan progress
Assessment Tool

- **General guidelines**
  - Establish boundaries of confidentiality—not shared with other providers/competitors but will be available to Collaborative members on need to know basis
  - Avoid equivocating—if something is not fully functional or achieving the essence, it’s ‘no’
  - Multiple part questions—all must be ‘yes’
  - Look at evidence wherever possible—i.e. read mission statement, ask when training occurred and how many participated, ask for examples, MIS reports, etc
  - May want to be forgiving on “softer” questions, but more rigid on key measures
Demographics

- 1—Demographic: self explanatory
- 2—Ownership: ’Other’ could be tribe, consider structure of parent organization as it describes resources available
- 3—Budget: Include parent organization for available resources
- 4—# Served: Estimate, if necessary
- 5—MIS: VO interface only does not count-- trying to measure provider capacity and ability to generate data, reports from provider system
Governance and Leadership

- 1 & 2—Establishes a values base consistent with purchasers’ priorities
- 3—Encourages board composition that can facilitate both consumer focus and business system accountability
- 4—Articulates a best practice of a Board providing meaningful oversight and accountability
- 5—Provides opportunity for informed Board
  - Opportunity for VO to offer Board education about changes, etc
Governance and Leadership

- 6, 7—Encourages development of a structured plan for implementation & change management
- 8—Articulates a best practice expectation of accountability and managing by data
  - Focus on impact/outcomes of these efforts—lots of organizations say they have them but they’re not used to change practice
Access and Intake

- 9—Encourages a coherent, integrated intake function
  - Important measure of access to care
  - Use to highlight potential problems with intake process flow—if substantially longer than standard, have provide describe process flow
  - Does agency maintain waiting lists?, If I call today, what is the first routine appointment available
Access and Intake

- 10, 11—Evidence of these indicators include copies of standard forms to gather the info and completed forms sampled from records
- 12—Related to sliding fee schedule and copay collections
  - Ask for aggregate self pay collection amounts from most recent year
- 13, 14—How staffed/covered? By whom? How frequently does this happen in practice?
Access and Intake

- 15—How is translation handled? How many bi-lingual staff at Intake? Number of consumers with non-English primary language
- 16—Scheduling is a central tool for productivity and clinical management
- 17—Essential intake related processes related to CSA and CCSS. Must see examples of written documents to meet each item
Services

- 18—Training should be part of new employee orientation as well as existing employees
- 19—Important to establish medical necessity and foundation of service plans—review in charts
- 20, 21, 22—Focused on consumer/family involvement in service planning and compliance aspects
  - Should look for evidence of these in chart review—providers frequently believe they do more than actual
Services

- 23—Look for evening, weekend hours, staff schedules and if reviewing charts, actual service notes time of service
- 24—If possible, ask provider to do billing run for time period by place of service. Should be ongoing key indicator that is monitored
- 25, 26—Has the provider look at data for this? How do they manage case loads to ensure?
Services

- 27, 28—Addresses the direct supervision aspect of productivity and compliance management. Focus on practice change outcome/impact

- 29—Must have some form of documentation of psychiatric involvement in clinical ops, not just admin
Services

- 30—Necessary for 24/7 coverage for CCSS. How covered (live, message, dedicated line)? Volume? Linkage to CCSS follow up and treatment plan revision?

- 31—Need not be MIS (though that is optimal). Focus on does this info get tracked and used at the clinical line level to manage scheduling, supervision, compliance monitoring.
Billing and Financial Management

- 32—Data integrity lost as time passes, productivity higher/time required to document reduced with “real time” documentation.
  - Develop structures to support field staff—single page summaries for all daily activities, data entry of written notes, coordinate with team meetings 3 times per week
  - Use schedule to track timeliness
  - Ask to see report/summary of performance, check charts for date of service compared to signature date
Billing and Financial Management

- 33—Provider controlled portion of timely payment/cash flow mgt
  - Billing system should be able to produce report for sample period. Performance is often substantially below standards
  - Billing often delayed due to late billing submissions—need to correct underlying practice in #32
  - If existing performance is 20 days and it can be reduced to 10 days, it can be a rapid improvement in cash reserves

- 34, 35—Does rapid billing experience exist in organization? Review billing cycle for every payer (Medicare, commercial) and determine reasons for delays/materiality of improvements on cash flow.
Billing and Financial Management

- 36, 37—Capacity to invest in infrastructure, move to fee for service
  - Formula on tool, calculate with provider staff
  - Do not include line of credit in cash, should be for emergencies only
  - Non-profit does not equal no money
  - How quickly are A/P paid—ever delayed beyond 30 days?
  - Billing timeliness can improve cash reserves
- 38—basic A/R management to assure payment of amounts billed
  - Who is responsible? If walked into office now, what VO remittance would she/he be working? Ever backlogged?
Billing and Financial Management

- 39—Know which services are profitable, breakeven, losses?
  - Unit costs decrease with increased productivity
  - Number of staff without productivity targets increases unit costs
  - Any efforts to reduce costs for services with losses, decrease volume of services with losses.
  - Intake example—often break even at best, but must minimize costs
Billing and Financial Management

- **40**—Has the cost of any of the proposed changes been financially projected?
  - Not required and may be early for CSA, but good business practice
  - Ask to see the models, review key variables—are they accurate/reasonable?

- **41**—Ask about the nature/impact of cost cutting efforts
  - Eliminate vacancies/support staff or comprehensive examination of structures/costs
Billing and Financial Management

- 42, 43—Productivity is critical management issue for providers, requires constant attention
  - Formula in tool is based on paid time for consistency/ease of measure, but available time is preferred method (paid time less paid time off)
  - Do not deduct time for travel, meeting, training—those can be covered in non-productive allowance (100% - productivity standard)
  - Ask to see sample reports? Easy to use? How do supervisors use reports?
  - 50% is minimum based on paid time, 65% of available time is achievable for many services for mature organizations
Billing and Financial Management

- Payer mix—portion of revenues from each payer
- Service mix—what are predominant services? Is mix best for organization, consumers, or staff preference?
- Cost per type of staff
- Productivity—may have different rates by type of staff based on costs—i.e. MDs
- Revenue mix—providers with diversification have more less risk from single payer, more experience with payer changes
Compliance

- 45—Especially important if agency bills more than $5m Medicaid (DRA). May be part of QI process/plan. Key elements:
  - Educate, monitor, report, correct
- 46—Education on all elements should be present. Look for written curriculum/P & Ps
- 47-51—Core of functional internal monitoring program. Should be part of QI/UR process, have good sample size, dedicated staff resources, data examples, and impact on practice
Management Information

- 52—Must have own MIS to generate internal management reports for productivity, etc.
  - Inexpensive ($1000) billing system is critical
- 53—Cultural competency monitoring data
- 54—Affects productivity, communication effectiveness
  - Explore who does not have access, sharing arrangements
Management Information

- 55—Substantial compliance issue
  - Can be within MIS (preferred), or separate database.
  - Explore how data is captured and entered into the system
  - Who is responsible for producing reports, on what timeline, for using reports? See copy
- 56—Should include multiple payer sources
Management Information

- 57—Assure scheduler actually used for all staff/services/sites
  - Any appointment books used?
  - What are scheduling requirements—appts/day blocks of time for MDs
  - Can use manual centralized scheduler (still would be “No” on this section of tool)

- 58—Ask to see reports
  - User friendly, require any math by user?
  - Comparative to standards, other staff
  - How are reports used
Management Information

- 59—No shows can be contributing factor for poor productivity
  - What is engagement activity after no show?
- 60—Ask for examples of measure, any reports, performance history
- 61—If CEO or Clinical Director asked for a report today, when will it be done
Outreach, Engagement & Consumer Involvement

- 62—Number of consumers/family members on BOD?
- 63—Describe how new BOD members are oriented? Any specific activities for consumers/families?
- 64—May be restricted to consumers/family members to manage costs, should be more than food, mileage is most common
- 65—Business development plan
- 66—Cultural competency
- 67—Request examples of outreach to new clients, treatment resistive clients
- 68—When was last survey? What were results? How used?
Assessment Tool

- Score jointly with provider at the end of each section and in total
  - Be sure provider agrees with changes from draft scores

- Explain how scores will be used
  - At individual provider level and in aggregate
Key Measures
General Provider Performance

- Overall score at/above 75%
- Governance—#4 - 6
- Access—#9, 10 and 16
- Services—#19 - 22
- Billing—# 32, 33, 36, 42
- Compliance—#47, 48
- MIS—#52, 54, 55, 56, 58
- Outreach—#62, 64, 68
Key Measures

CCSS

- General performance measures, plus:
  - Services--#24, 28
  - Billing--#32, 42 (re-emphasize with CSWs)
  - Compliance--#49
  - MIS--#52 (CSW assignments)
Key Measures
Core Service Agency

- General performance measures plus:
  - Demographics--#5 (presence of MIS)
    - Some capacity to track provider-identified fields
  - Governance--#5-6
  - Services--#21-22 (coordination role)
  - Billing--#35-36 cash reserves
    - Demonstrate leadership capacity, ability to support infrastructure needs
  - MIS--#52 (CSW tracking), #61
  - Outreach--#61
Work Plan Development

- Identify 3 – 5 priorities for improvement in next 90 – 180 days
  - Request provider priorities, shape from VO perspective/experience
  - Does not need to include task from each area
- Identify work tasks (indicators) for each priority
  - Break into very small tasks to improve achievability
  - Productivity example—calculation method, report baseline levels, set standards ST/LT, routine reporting, supervision activities
Work Plan Development

- **Set targets**
  - Dates, performance levels, trends, etc.

- **Discussion and recommendations**
  - Use as needed, often explains the importance of area and impact on provider, assistance available from VO

- **Overall**
  - Designed to be completed in 1 – 2 hours
  - Provider should incorporate into internal work plan with staff assignments
  - VO follow-up to measure completion of tasks according to targets
Visit Summaries

- Designed to document follow-up visits
- Goals/Issues—set priorities for visit at outset
- Interventions—review specific activities completed
- Next steps---identify specific responsibilities for provider/VO
- Designed to be completed in 1 hour
Short Term Next Steps

- Develop VO plan with major milestones
- Complete “pilot” visits with most cooperative providers
- Conference call with VO team and PDA for group discussion of lessons learned, review of work plans
- Complete assessment site visits
- Possible onsite meeting to review results, plan follow-up visits, activities
Additional Background
Governance & Leadership

- Mission and values align with the change
- Board composition inclusive of business, consumer, and service-oriented members
- Board educated regarding their functions, nature of change, & possible implications
- Expectation of Board actively drives the expectation for change, sets goals/outcomes for the change process, and monitors progress but does not engage in operations
Governance & Leadership

- Board and Leadership see selves as Change Agents who actively plan, lead and facilitate change as opposed to resisting or ‘turfing’.
- Active Decision Makers (with incomplete information)
- Accountability Culture: promotes and models at all levels of the organization. Problem solvers not blamers.
- Data Oriented: Demands and uses data to quantify and focus issues as well as to inform active decision making.
Access & Intake

Key Goals:

- Clients (and potential clients) are quickly seen, assessed, and moved into services.
- Clients, potential clients, and referral sources see responsive system.
- All information necessary for billing is collected and verified.
Access & Intake: How

- Timely/responsive telephone triage, information, referral
  - rapidly and competently determines what clients need and matches them to the most appropriate service
- Timely, competent and balanced financial resource/eligibility screening and verification
  - Determines/facilitates client eligibility and funding resources
- Timely access to face to face assessments
  - new clients seen for assessment within five business days
- Availability of urgent/emergent assessment and intervention services
  - same day face to face assessments and same day psychiatrist appointments
- Integration of authorization process with intake and access (if applicable)
Services

Goals

- All staff can implement the services in alignment with the treatment plan AND with fidelity and billing rules
- Systems are in place to ensure medical necessity for services
- Philosophy is integrated into service
- Staff are able to be successful at meeting consumer needs AND meeting productivity targets
Services: How To

- Training re: new services/rules is process not event
- Training about recovery and impact on service delivery and process is essential
- Linear relationship between functional assessment, diagnosis, service plan, services, interventions, notes
- Enhanced role of consumer/family in service planning, interventions, and services with use of natural supports
- Majority of service units delivered in natural environment
- Productivity (billed time/available time)
- Supervision structure changes emphasis to treatment plan
Compliance

- Goals:
  - Internal processes and structures to ensure that all payor requirements are met
  - Allows for “clean” billing
  - Minimizes risk of paybacks
  - Enhances payor satisfaction
Compliance How Tos

- Structured, effective, and ongoing monitoring systems in the following areas:
  - Medical Necessity: ensures clients have the level of medical necessity as required by payers
  - Benefits: types, duration, and exhaustion of benefits
  - Eligibility for benefits from various payers
  - Community-based productivity creep: ensures service duration or frequency is not overstated by clinicians in billing documents
  - Documenting supervision: ensures there is documentation of a supervision plan and that clinical supervision is occurring
  - Service Definitions: monitors that actual services being delivered are consistent with services as defined by payers
  - Documentation: monitors the accuracy, completeness, timeliness, and presence of supportive clinical documentation for all billed charges. Includes tracking of treatment plans dates/content and notes.

- Regularly communicates results of compliance monitoring efforts to senior management and the Board of Directors.
Outreach

- Two aspects
  - Outreach to involve consumers in agency operations
  - Outreach to consumers and community as business development and community service
Billing & Financial Management

- **Eligibility verification**
  - Upon intake/admission and monthly

- **Billing flow**
  - Controls to capture all services
  - Monitored timelines for submission/data entry of service data
  - Integrated service note and charge ticket
  - Prompt and frequent billing (FFS)
  - Monitor billing cycle timelines by service/program, supervisor, staff person (service delivery to time sheet to claim submission)
Billing & Financial Management

- Scheduling
  - First step to achieving productivity
  - Schedule for required productivity plus no show
  - Clinical supervisor’s role
  - Used as internal control for capturing all service tickets and service notes
Billing & Financial Management

- Managing capacity for bed/per diem services
  - Compare actual census to staffing levels
    - May indicate need to increase enrollment for some services to offset lower attendance
  - Efficient intake processes for new admissions
    - Limit lost revenues from empty beds
  - Match services to client need
    - Within licensing requirements
Billing & Financial Management

- Productivity for outpatient/community services
  - “Billable” time divided by available time
    - Mix of FFS and grant funded activities need to have defined billable/productive activities
    - Available time = paid hours less paid time off, approximately 1,700 – 1,800 hours
    - Meeting, travel, documentation time not included
  - Define requirements by day and week
Billing & Financial Management

- **Productivity**
  - **Standards**
    - 50 – 60% for community based services
    - 60 – 70% for office based services
    - 70 – 75% for physician services
  - Standards must reflect levels needed to maintain costs that can be support by funding/fees
    - Will productivity standards cause cost of services to be less than/equal to rates?
    - Total program/service costs divided by total units—what productivity standard is required to attain needed units?
Billing & Financial Management

- Productivity reporting
  - User friendly—graphs, simple
  - Regular and timely
  - Express as percentage of available time (not target)
Billing & Financial Management

- Productivity barriers
  - Lack of management support
  - Poor data or data integrity questions
  - Unfriendly or untimely productivity reports
  - Poor or inconsistent supervision
  - Documentation
  - Inflated caseloads
Billing & Financial Management

- Billing audits
  - Can be completed by support staff to ensure presence of note/required elements prior to billing
- Coordination of benefits—Medicaid/state payer of last resort
- Minimum 60-90 days cash reserves
  - Cash = 2 - 3 months of expenses
Billing & Financial Management

- On-going, timely monitoring of performance
  - Timely billing for FFS provides better data
  - Achieving budget
  - Earning grant dollars
  - Periodic adjustments as needed
    - Time needed for operational changes

- A/R management
  - Reconciliation of amounts billed to receipts
  - Use results to adjust procedures

- Diversification of revenue/funding
Management Information

- Providers must have basic internal MIS capabilities
  - Good MIS decreases admin costs in managing operations
  - Needs minimum billing and client tracking components
  - Clinical module can be next/last phase
- Staff access
  - Workstations (except all residential staff)
  - Reports
Management Information

- Track key indicators
  - Service plan expiration
  - Absence/presence of notes
  - Productivity
  - No shows
- Facilitate timely processes, e.g. scheduling
- Reporting—timely and user friendly
  - Graphs, comparative, small number of fields/numbers