Provider Readiness Assessment
New Mexico Interagency Behavioral Health Purchasing Collaborative

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Executive Summary

The New Mexico Interagency Behavioral Health Purchasing Collaborative (the Collaborative) is undertaking a significant transformation of its publicly funded behavioral health system. A key component of this transformation includes various strategies for developing the service and infrastructure capacity of its provider network. One aspect of the transformation will likely include increased and different level of accountability for services delivered by providers (e.g. greater emphasis on encounter reporting, fee for service reimbursement, etc.) The readiness assessment process described below was designed to establish a baseline for existing provider competencies and functions in all areas. The outcome of this process will assist providers to identify areas within their operations that may need development. In addition, this process will identify priority areas where additional training or technical assistance may be needed across the system as the transformation proceeds. The results of this assessment will contribute to the development of a long-term training and technical assistance plan to aid providers with making a successful transition in partnership with the Collaborative and ValueOptions.

The readiness assessment process focused on the 193 organizational providers that currently offer publicly funded behavioral health services. A total of 91 responses (47%) were received. This level of response was only slightly below the targeted rate of 50%, and the resulting data should be sufficient to indicate general competencies and areas in need of development in the public provider network.

Key Conclusions and Recommendations

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

- **Size and organization structure**—Providers participating in the assessment process were primarily non-profit (66%) and the largest group (47%) had medium sized budgets ranging from $1 – 5,000,000. It is important to note that nearly 70% of the smallest providers (less than $250,000 annual budget) are for-profit organizations.

- **Assessment scores**—75% is used as the threshold to indicate readiness to implement new requirements successfully with less intensive training or technical assistance. A score between 50 – 75% indicates providers can implement changes with some transition supports. Scores below 50% indicate significant deficits in basic provider competencies. Detailed scoring results by question, stratified by organization size, are available in Appendix A.
  - The New Mexico provider network appears to be relatively well-positioned to make changes as the behavioral health system is transformed, with nearly two-thirds of the providers scoring above 50%. Those providers scoring between 50 - 75% will need some supports to make the necessary changes.
  - One-third of the providers had scores under 50% and are poorly prepared to successfully respond to changes in payer requirements.
  - As expected, providers with larger annual budgets (over $5,000,000) had the highest scores in many areas. However, the providers with the smallest budgets scored higher than their larger peers in five of the eight domains. This result may be explained in part by the fact that these providers are for profit.
• **Specific network limitations**—Responses to specific questions highlight the following issues that should be addressed during transformation.

  o It appears that more than half of the providers do not have an information system that can be used to track and manage operations based on billing and productivity data. This score was calculated excluding the ValueOptions electronic interface that is available to providers for reporting and billing. The large gap in information system capacity in New Mexico is much greater than that found in other states. In Illinois, only 25 – 30% of the providers did not have an information system.

  o Significant numbers of providers have very limited cash reserves, which is not atypical, but does present challenges for implementing changes. Nearly half of the providers reported less than 60 days of cash and 28% reported less than 30 days of reserves.

  o A significant number of providers (26%) are specialty providers, offering a narrow range of services. Specialty providers often have greater difficulties in making adjustments to the mix of funded services. Specialty providers often have great difficulties in expanding into new service types since they may not have sufficient staff, or financial and infrastructure resources to make a service transition.

  o The network reported significant difficulties in clients accessing same-day psychiatric services, and further analysis is indicated in this area. These results may be mitigated by the individual practitioner network, which was not included in the assessment process, and by informal arrangements that providers have with other community resources. Providers were instructed to respond “no” to same day psychiatric coverage if there were no employed or contracted staff to fulfill this function.

• **Recommendations**—Because the assessment was not structured to measure ability to respond to a specific type of system change, the scope of recommendations is somewhat limited. Specific recommendations were made for general development of the New Mexico publicly funded provider network. In addition, recommendations for provider development activities were offered related to increased fee for service reimbursement, increased grant reporting requirements and the addition of new services since these changes have occurred frequently in other states.

  o The availability of provider management information systems is a serious deficit in New Mexico which should be acknowledged along with specific activities to encourage and support provider acquisition of needed software and hardware. Providers should be advised that their on-going viability may depend upon the available of management data in the future, and that it is their responsibility to acquire the necessary resources. An MIS resource list should be developed to identify a range of available products and costs. ValueOptions should support providers by offering dedicated assistance to achieve connectivity to the ValueOptions system where there are groups of providers electing to purchase a common software product.

  o The reported limitations in access to same day psychiatric services should be analyzed further, including an overlay of the individual practitioners who are a part of the ValueOptions network in New Mexico, but were excluded from this readiness process.

  o Provider training efforts need to be extensive in order to support those providers who are poorly or marginally prepared for change. The scope, amount and duration of this the training for many providers will need to be available over an extended period. Technical assistance that is tailored to specific providers may be needed to supplement group training activities.
Appendix B includes a list of training topics that have been extremely useful in development of providers in other states that are undergoing significant change.

- Engagement of non-participating providers—Approximately half of the targeted providers did not participate in the assessment process. These providers may be less prepared than the responding providers. Specific engagement strategies should be direct toward non-participating providers who serve geographically isolated areas, or who serve a large number of consumers.

- As specific changes are planned and implemented as a part of the system transformation efforts in New Mexico, the results of this assessment process should be used to develop provider training and transitional supports. TAC and Parker Dennison should be consulted for their experiences with and recommendations for provider readiness related to specific New Mexico system changes.
Section 1: Assessment Process

The provider assessment project is being funded primarily through a grant from the Robert Woods Johnson Foundation. The assessment was undertaken by consultants from the Technical Assistance Collaborative (TAC) and Parker Dennison and Associates, Ltd. (Parker Dennison) who have extensive experience in assisting provider organizations with responding to significant changes in public behavioral health purchaser requirements. The provider readiness assessment process used in New Mexico was based on Parker Dennison experience with over 400 providers in other states who were experiencing similar structural and reimbursement changes in publicly financed behavioral healthcare. A structured provider self-assessment process similar to the one used in New Mexico has been used or is being used in three other states—Illinois, Connecticut and Maine. The process, self-assessment tool and desired outcomes have been tailored to each state’s planned changes to its publicly funded behavioral health delivery system.

The readiness assessment process in New Mexico included the following major components:

1. A planning process that included the Collaborative and its statewide managed care entity, ValueOptions, to understand the range of possible changes that might be incorporated into upcoming system transformation efforts. Based upon this planning process, the provider readiness process for New Mexico was developed.

2. A self-assessment tool was developed that measures provider operational capabilities, procedures and financial resources that contribute to successful performance in an environment that includes changing payer requirements.

3. A letter was sent from the Collaborative to all targeted providers explaining the purpose and goals of the assessment process and inviting the providers to participate. The tool was made available on the Internet and by fax for providers who did not have Internet access. ValueOptions regional staff were available for questions, and contacted providers to encourage participation.

4. Training sessions were held in two locations for all available, targeted providers. The training offered didactic instruction regarding provider core competencies and successful practices in a rapidly changing environment. It also included information about the readiness assessment process, its purpose and benefits to the providers, and instructions regarding how to complete and return the tool.

5. A written report with summaries and analysis of the aggregate results from completed tools, along with recommendations to providers and to the Collaborative regarding indicated priorities and development strategies.

6. The final step will be to review the report with the Collaborative and ValueOptions to plan follow-up strategies and activities.

During the planning activities, it was clear that the readiness assessment should be used to measure overall provider competencies in all areas in order to gather data that can be used as the transformation process evolves. The underlying theme for the assessment was to measure the competencies that contribute to a provider’s ability to successfully weather and manage change based on new requirements from payers.
Training sessions were held in Las Cruces and Albuquerque in early February with completed tools due in early March. Providers were offered three choices regarding how to complete and submit the tool. Most providers chose to complete and submit an online version of the tool, but faxed and emailed copies of the completed tools were also accepted. To encourage candid provider responses that are useful for a provider development plan, only aggregated data and analysis will be made available to the Collaborative and ValueOptions, thereby ensuring confidentiality for providers.

**Assessment Tool**

Parker Dennison has assessed readiness of over 400 public sector behavioral health providers throughout the country and has found very common operational competencies that are essential to success in a fee for service reimbursement or other accountability-oriented environments. These operational competences (or domains) include:

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

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

- **Services** – clinical processes and services that are congruent with a recovery/resilience philosophy, consistently applied, increase the likelihood of compliance with Medicaid and local service rules, and are productivity oriented

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

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

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

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

Appendix A includes a copy of the self-assessment tool, with aggregated responses to each question stratified by the size of the responding agency.
Section 2: Analysis

The readiness assessment process targeted 193 organizational providers that currently offer behavioral health services that have been funded by Medicaid (managed and fee for service), Department of Health Behavioral Health Services Division (DOH), Children Youth and Families Department (CYFD) and Department of Corrections (DOC). Individual practitioners were not included in the assessment process. A response rate of 47% (91 responses) was achieved, which was only slightly below the targeted rate of 50%. The resulting data should be sufficient to indicate general competencies and areas in need of development in the public behavioral health provider network.

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

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

Network Profile

To fully understand the impact of provider readiness issues, it is helpful to understand the nature of the providers sampled in terms of size, organizational structure and funding. The organizations responding to the survey represent nearly one half of the New Mexico provider network. Key information collected from respondents indicates the network is:

- **Overwhelmingly non-profit** – 66% of the sample are non-profit, which is significant in that non-profit providers tend to reinvest more net proceeds into services and supports and often have smaller cash reserves. It is important to note that nearly 70% of the smallest providers (less than $250,000 annual budget) are for-profit organizations.

- **Medium budget size** – Nearly half (47%) of the sample had total annual budgets of $1 – 5 million, with another 24% in the $250,000 - $1 million range. The balance of the sample was evenly split between very small (less than $250,000) and large (over $5 million). The ranges for this question were set to reflect the New Mexico environment and providers in this state appear to be generally smaller than publicly funded behavioral health providers in other states. Organizations of at least $1 million tend to be able to sustain and absorb some business changes and be small enough to more easily make...
operational changes. Those agencies with smaller budgets (less than $1 million or 38% of the sample) may find it more challenging to absorb the costs of infrastructure changes due to major payer changes. A larger percentage of these agencies’ total budgets may be fixed administrative costs and they will be affected by staffing issues more immediately.

- **Moderate to high reliance on ValueOptions contracts** – 50% of the sample rely on at least half of their annual revenue coming from ValueOptions contracts comprised of Medicaid, DOH, CYFD or DOC funding. This results in a network that is highly sensitive to changes in ValueOptions funding levels and payment timeliness.

### Provider Readiness Results

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

<table>
<thead>
<tr>
<th>Readiness Score Range</th>
<th>Percentage of Providers</th>
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<tbody>
<tr>
<td>25% or below</td>
<td>7% of providers</td>
</tr>
<tr>
<td>26-50%</td>
<td>27% of providers</td>
</tr>
<tr>
<td>51-75%</td>
<td>49% of providers</td>
</tr>
<tr>
<td>Greater than 75%</td>
<td>17% of providers</td>
</tr>
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</table>

These results suggest to Parker Dennison that the New Mexico provider network is more advanced in their operational capabilities than what is typically found in a network at this stage of the system transformation. However, overall readiness is at a level that would indicate substantial risk to the behavioral health system. The lack of readiness may adversely affect access to services, if significant changes in payer requirements proceeded without additional provider technical assistance and training due to some providers discontinuing services or ceasing operations.

Using a 50% score as the threshold, these data suggest that fully a third of the provider network is poorly prepared to successfully respond to changes in payer requirements, including:

- changes in service requirements,
- increased reporting requirements,
- increased fee for service reimbursement: and/or
- new service authorization requirements.
These providers will likely require intensive training and in some cases ongoing mentoring to make the necessary operational changes. These providers as a group will likely require fairly intensive supports, and strong commitment on their part to make changes.

Conversely, nearly two thirds of providers scored above 50% and are may be more likely to be operationally ready. The availability of targeted training and technical assistance, and focused efforts on the part of the provider enhance the likelihood of these organizations to be successful to weather the transformation within a relatively short period of time. Individual provider circumstances may vary.

The graph below summarizes scores on each of the eight domains, stratified by agency size. These data show the greatest readiness in Services and Compliance, and that larger providers score higher than their smaller peers, as might be expected. However, it is interesting to note that the group of smallest providers (<$250,000) score higher than some of their larger peers in five of the eight domains, which is an anomaly that may be explained in part by the high percentage of the small providers who are for-profit. The lowest scoring domains are Governance/Leadership and Outreach, and responses to individual questions within those sections indicate that development is needed to support and increase consumer and family involvement in provider governance, policy development and operational initiatives.

![Provider Readiness Survey](image)

Based on experiences in other states, care should be taken with interpreting higher compliance scores resulting from the assessment tool. Compliance was the primary area where self-reported data consistently exceeded that from site visits scored by professionals. Overstatement of provider performance in this area is likely due to a combination of provider lack of understanding about the prescriptive nature of compliance requirements and
differences between policy and actual practice. Actual compliance performance is best measured by very structured internal provider audits and/or post-payment audits conducted by payers.

**Question Level Detail**

In addition to the summary level data, there are certain questions that highlight specific issues that are present in the New Mexico behavioral health system that should be considered as plans for system transformation proceed. The results from these questions are highlighted below along with their implications for system change.

- **Limited information system resources** – 31% of the sample reported not having an information system that was capable of generating a HIPAA compliant claim form, which generally indicates absence of an information system. It is also important to note that nearly one-third of the providers who indicated that they could generate HIPAA compliance claims, identified the ValueOptions EDI system as their information system. This data appears to indicate that those providers do not possess their own information system capable of tracking operational data for the purposes of provider management, and that more than 50% of the providers do not have their own information system. Though it clearly is not the responsibility of the state to provide each provider with an information system, the ability to track operational data within a provider greatly increases a provider's capacity to adapt to significant payer changes. Poor cash reserves can also contribute to agencies being limited in their ability to immediately procure and/or support information system development.

- **Limited liquid assets/cash** – 28% of the sample have less than 30 days of cash reserves. Nearly half have less than 60 days. While these results are not unique to New Mexico providers, they do represent a financial viability risk. Parker Dennison typically recommends that providers have 60 days of cash going into systems transitions to be positioned to absorb necessary staffing or operational changes, or any cash flow timing changes.

- **Specialty providers**—26% of the respondents report that they are specialty providers for a limited range of services. These providers typically have more difficulties in absorbing system changes especially if the payer changes impact the types of services they render. Specialty providers often have greater difficulties in expanding into new service types since they may not have sufficient staff or financial and infrastructure resources to make a service transition.

- **Limited access to psychiatric services**—Only 16% responded that same day access to psychiatric services was available in emergent/urgent situations, indicating a need for further analysis of geographic availability of psychiatric services and possible development of these services at the Collaborative and/or ValueOptions level. Overlay of the independent practitioner network may mitigate these results, though integration of the services from individual practitioners with comprehensive providers would still be of concern.

- **Limited community based services**—Only 37% of the sample currently offer more than half of their services in community or natural settings. This will pose challenges in introducing community support services which includes requirements that significant portions of the service be available outside of traditional office-based settings.

The five highest and lowest scoring questions for all providers are listed in the table below. The high ranking questions reflect strong staff training/credentialing and treatment planning processes. The low ranking
questions show highlight psychiatric coverage issues, specific MIS limitations and limited capacities to support consumers with involvement in provider governance and other activities.

<table>
<thead>
<tr>
<th>Questions With Highest Scores</th>
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<tbody>
<tr>
<td>91%</td>
<td>46. Does the organization have a consistent and reliable process to ensure that services are delivered by staff with credentials required by regulation and/or service definitions?</td>
</tr>
<tr>
<td>88%</td>
<td>58. Does the organization demonstrate culture responsiveness through promotion of inclusion, prohibiting discrimination, staff race/ethnicity reflective of program participants, requirement competency training for all, and availability of translators?</td>
</tr>
<tr>
<td>83%</td>
<td>17. At least 75% of the time, do consumers and parent/guardians (minors) participate in the treatment planning process as evidenced by participation in treatment planning conferences and their signature on the treatment plan?</td>
</tr>
<tr>
<td>83%</td>
<td>18. Do at least 75% of treatment plans directly reflect diagnosis, assessed functional needs, consumer preference, consumer strengths, and natural supports?</td>
</tr>
<tr>
<td>81%</td>
<td>41. Is there evidence that all current staff and new hires are trained on compliance requirements including confidentiality, fraud/abuse, and clinical record documentation requirements (for clinical staff)?</td>
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</table>

<table>
<thead>
<tr>
<th>Questions With Lowest Scores</th>
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<tbody>
<tr>
<td>16%</td>
<td>13. When indicated by client need (urgent/emergent), does the organization have the ability to provide same day face-to-face psychiatrist appointments?</td>
</tr>
<tr>
<td>26%</td>
<td>55. Does the organization offer financial assistance (reimbursement for travel and/or time) for consumer participation in governance and work groups?</td>
</tr>
<tr>
<td>30%</td>
<td>51. Is an automated schedule available and used for at least assessments, therapy/counseling, and psychiatric services?</td>
</tr>
<tr>
<td>33%</td>
<td>53. Are monthly no show rate reports produced within 15 days for the preceding month for each direct service staff and program?</td>
</tr>
<tr>
<td>36%</td>
<td>55. Are consumers who have been asked to participate in governance, quality or policy activities been offered assistance training and ongoing support to maximize their comfort and effectiveness consistent with the nature of their involvement?</td>
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</table>

**Future Use of Provider Readiness Review**

For providers who have participated in the provider readiness review process thus far, Parker Dennison does not recommend formal re-surveying using this tool. These providers can use the tool as an internal education aid, help set implementation and technical assistance priorities, and establish benchmarks in key operational areas.
We would recommend that those providers who have not participated in the readiness review process be encouraged to do so. Should a provider request technical or financial assistance, we would recommend that the tool be considered as one means to help assess likely areas in need of operational development.
Section 3: Recommendations

Recommendations for development of provider competencies fall into two groups. There are development activities that will benefit the competencies of the overall public behavioral health provider network. There are also specific development activities that will be needed depending on the nature of the planned change.

ValueOptions staff are recommended in several areas as a logical resource. Some of the activities may be within the scope of the existing contract and others may require negotiation between the state and ValueOptions regarding financial arrangements. The recommendations are intended to indicate the logical resource based on provider interface, regional structures, and coordination with existing and available data. Not all activities are or should necessarily be a part of the existing contractual arrangement.

General Development

- **Information systems**—One of the greatest challenges in the New Mexico provider network is that more than half of the providers do not have an information system that can assist with tracking and managing data for internal operational purposes. Client statistics, billing, scheduling, staff productivity, and no show rates are examples of the types of activities and management data that can be extremely important to adjusting operations as payer requirements change. The following activities may assist with increasing the number of providers with information systems:
  - **Education**—At every opportunity, advise the providers that it will be in their best interest to acquire and implement an information system.
  - **MIS resource list**—A list of potential information systems should be developed and made available. The list should focus on affordable solutions, include key functions, such as scheduling, billing and productivity data, along with estimated initial and on-going costs. The resource list should also identify whether the system is currently being used in New Mexico. This tool will assist providers with quantifying the expense and identifying potential vendors in their price range.
  - **Electronic connectivity to ValueOptions**—If a number of providers (4 – 6) select one information system, ValueOptions should develop the capacity to provide dedicated assistance to the MIS vendor or a contractor hired by the providers to develop necessary connectivity to ValueOptions to avoid duplicate data entry. While ValueOptions should be expected to provide specifications to any vendor to facilitate electronic communications, the assistance recommended here is directed toward assisting a group of providers achieve electronic communication through more proactive and time-consuming problem resolution from the ValueOptions side.
  - **Identification of user groups**—Where multiple providers select the same system, ValueOptions or the Collaborative should assist with the development of user groups for that system. Examples of MIS user groups currently exist in New Mexico, and can help with vendor problem resolution, implementation of new features, or cost sharing for customized reports or other tools that are specific to the state.
• **Psychiatric coverage**—Given the low reported access to same day psychiatric services by the organizational providers, ValueOptions should complete additional analysis of the geographic coverage of its combined organizational and individual provider networks to assure sufficient access. The analysis should also include any contractual arrangements that providers may have with other community providers to obtain same day access. Providers were instructed to respond “no” to same day psychiatric coverage if there were no employed or contracted staff who could fulfill this function. Depending on the results of this analysis, additional efforts may be needed to improve access to psychiatric services. This may include encouraging or requiring contractual arrangements between organizational providers and individual practitioners, and improving rural access through telemedicine or other subsidies.

• **Education and technical assistance supports**—Because one-third of the providers are poorly prepared for system change, educational and technical assistance efforts related to any change will need to be more extensive.
  - **Frequency**—Training will have to be easily available and repetitive to allow providers and their staff to absorb the information at their own pace. Regional train-the-trainer structures will need to be in place to assure sufficient training resources.
  - **Technical assistance**—As critical changes are implemented, resources should be identified to provide onsite technical assistance for providers. The technical assistance may be available through ValueOptions or Collaborative staff, or by advising providers that technical assistance in a particular area is recommended along with a list of local contractors who may be hired by the provider.

• **Engagement of non-participating providers**—ValueOptions staff should identify the providers who did not participate in the readiness assessment process along with whether these providers are significant to client access based on location and billing levels. As indicated, ValueOptions regional staff should work with non-participating providers to encourage use of the self-assessment tool for internal planning and development purposes.

• **Planning and development for participating providers**—Those providers who did participate should use the results of the tool to develop an internal work plan to improve competencies in identified areas.

• **Training**—Appendix B offers a list of training topics that have been extremely useful in development of provider networks in other states that are undergoing significant change. As training plans are developed for the coming months and years, efforts should be made to integrate the listed topics. For example, if training is to occur on a new service, the training should be expanded to include strategies to effectively supervise staff to achieve targeted/necessary productivity levels.

## Targeted Development

Some of the provider development activities that will be needed will depend on planned changes in the delivery system. Specific strategies will need to be implemented to support providers as a part of each significant change. TAC and Parker Dennison should be consulted for their experiences with and recommendations for provider readiness related to specific New Mexico system changes. Examples of system changes that have occurred frequently in other states and corresponding provider support and development activities are provided below.
• **Increased fee for service reimbursement**—Since approximately half of the provider network has less than 60 days of cash reserves, any increase in the amount of services subject to fee for service reimbursement could jeopardize providers who are accustomed to advances or grants. Since fee for service is paid after a service is delivered and a claim is submitted, the difference in cash flow to the provider can be 15 – 45 days later depending on when grants have paid, timeliness of claims submission, and timeliness of claims processing and payment. Activities that have been helpful in other states to assist with an increase in fee for service include the following:

  o **Cash flow transition plan**—Providers often need support in transitioning from grant payments to fee for service due to the difference in the timing of cash flows. Grant payments are typically advanced or received during the same month, and fee for service claims payment are typically received 15 – 45 days after delivery of service, depending on provider billing cycles and claims payment timeliness. The likely delay in payment from a grant structure to fee for service should be quantified based on all of the factors present in New Mexico, and specific strategies developed to support providers through the transition period. Strategies include periods of shadow claims submissions while grants are still paid, overlapping early months of grant payments with fee for service, and some type of front-end advance that is then recovered over several months following the conversion.

  o **Provider training and technical assistance**—Topics should include specific activities that will assist providers, particularly any who have not been paid on a fee for service/claims basis in the past. Suggested topics should include: billing forms and flows, timeliness requirements for each step in the process, productivity measurement and management, and accounts receivable management. The training should be prior to and immediately following the significant payer changes that create significant operational changes for the providers.

  o **Contingency plan**—The Collaborative and ValueOptions should develop mechanisms for early identification of at-risk risk providers along with intervention strategies to avoid disruptions in service. The plan should include criteria for any additional advances, payback requirements, and identification of alternative providers in critical or high risk areas.

  o **Timely payment**—Requirements for timely claims payment should be in place including plans and or penalties for failure to meet the requirements.

• **Reporting of grant funded services**—If payment will require full accounting for a specified amount of services in order to retain grant funds, many of the provider training and technical assistance topics listed under fee for service will apply. If providers have not been subject to these requirements before, providers will need to develop reporting flows and productivity management techniques that are very similar to fee for service in order to assure that grant funds are fully accounted for and can be retained.

• **New services**—If new services will be introduced, the implementation plan should include the following components to support providers in making the transition:

  o **Initial training**—Approximately 60 days prior to implementation, training sessions should be held to orient providers to the requirements for the new service, provide information regarding targeted consumers and how to best transition staff and consumers to the new service.

  o **Follow-up training**—Approximately 90 days following implementation of the new service, a follow-up training should occur to reinforce the concepts from the initial orientation, and to respond to implementation and operational issues that typically arise during the first few
months of a new service. This training should be specifically targeted at managers and supervisors who are responsible for direct service activities.

- **Development of training resources**—If national trainers will be used for early training activities for a new service, New Mexico experts should be identified for the new service to ensure that on-going local training resources are developed and available. The identified experts should participate in all initial and follow-up training to learn the training materials and to ensure they become extremely familiar with all provider questions.

- **Educational audits**—For the first 1 – 2 years following implementation, a team of auditors/trainer should be identified to visit providers and review how the new service is being performed and billed, and offer recommended changes. For a limited period, these audits would be educational only and not result in financial recoupments. This type of training/audit makes the service development activities specific to each provider, and begins to ensure that the service being provided is the one the state intended to purchase when the service and rate was developed.
Appendices
Appendix A—Provider Readiness Data
Governance and Leadership

**Governance and leadership that is equipped with experience, skills, and an orientation toward effective change management and which is aligned with a core value set consistent with best practices.**

1. Do current versions of organization’s mission/vision/values include an expressed commitment to best practices including recovery/resilience? *(should be expressly stated and not just implied)*
   - ALL: 53%
   - <$250k: 69%
   - $250k-$1mil: 64%
   - $1mil – $5mil: 53%
   - >$5mil: 23%

2. Does the board composition include of a primary consumer and/or family member, and at least one business oriented professional (CPA, attorney, senior manager)? *(must have both to answer yes)*
   - ALL: 48%
   - <$250k: 15%
   - $250k-$1mil: 50%
   - $1mil – $5mil: 53%
   - >$5mil: 23%

3. Have all members of the board participated in education regarding both fiduciary responsibilities (related to holding a governance position as a member of the board) and establishing/monitoring organizational performance indicators? *(To answer yes, the training must have been offered and all Board members must have participated.)*
   - ALL: 43%
   - <$250k: 8%
   - $250k-$1mil: 41%
   - $1mil – $5mil: 47%
   - >$5mil: 69%

4. Has the board received training regarding behavioral health environment/funding changes and the specific impact of those changes on the organization as well as on governance and leadership? *(The training must have been provided to answer yes.)*
   - ALL: 57%
   - <$250k: 54%
   - $250k-$1mil: 59%
   - $1mil – $5mil: 58%
   - >$5mil: 54%

5. Does the organization have a written plan (goals, tasks, resources, and timelines) to transition to new funding methods and related systems and report progress regularly (at least monthly) to senior management and the board?
   - ALL: 38%
   - <$250k: 31%
   - $250k-$1mil: 23%
   - $1mil – $5mil: 40%
   - >$5mil: 62%

6. Has the organization developed and communicated a process for managing change (including what to expect in the process, plan for ongoing communication, changes in procedures/responsibilities) to staff and consumers/families? *(There should be written evidence of this process and the communication.)*
   - ALL: 38%
   - <$250k: 23%
   - $250k-$1mil: 23%
   - $1mil – $5mil: 42%
   - >$5mil: 62%

7. Does organization have all of the following performance indicator information? *(Please check each area that is currently in place)*
   - Written indicators
   - Regular measurement against those indicators that is reported to leadership and board
   - Demonstrated impact on operations resulting from measuring and monitoring performance indicators
   - ALL: 49%
   - <$250k: 15%
   - $250k-$1mil: 50%
   - $1mil – $5mil: 42%
   - >$5mil: 100%

Total Governance and Leadership: 47% 31% 44% 48% 60%

Access and Intake

*A clinical/fiscally integrated ‘front door’ that ensures timely access for consumers/families while ensuring effective establishment of the clinical need and fiscal parameters.*

8. Is the average time from first call to initiation of assessment less than or equal to ten calendar days? *(should include all categories of clients—urgent, emergent, routine—and all levels of care)*
   - ALL: 78%
   - <$250k: 100%
   - $250k-$1mil: 77%
   - $1mil – $5mil: 74%
   - >$5mil: 69%

9. Is eligibility for Medicaid, Medicare and other third party benefits checked and documented in the record at first appointment and once a month thereafter? *(Both parts must be present for a “yes” answer.)*
   - ALL: 69%
   - <$250k: 77%
   - $250k-$1mil: 59%
   - $1mil – $5mil: 63%
   - >$5mil: 92%

10. Do front desk (reception or clerical support) staff review financial resources, screen for possible Medicaid eligibility and apply a sliding fee scale to individuals who present without Medicaid or other third party benefits? *(All parts must be present for a “yes” answer.)*
    - ALL: 49%
    - <$250k: 62%
    - $250k-$1mil: 36%
    - $1mil – $5mil: 47%
    - >$5mil: 62%

11. Are front desk staff able to determine the amount of any co-payment (from the record or the billing system) and expected to collect the co-payment at the time of service? *(Both parts must be present for a “yes” answer.)*
    - ALL: 47%
    - <$250k: 69%
    - $250k-$1mil: 36%
    - $1mil – $5mil: 44%
    - >$5mil: 46%

12. When indicated by client need (urgent/emergent), does the organization have the ability to provide same day face-to-face assessment appointments?
    - ALL: 83%
    - <$250k: 92%
    - $250k-$1mil: 68%
    - $1mil – $5mil: 86%
    - >$5mil: 92%

13. When indicated by client need (urgent/emergent), does the organization have the ability to provide same day face-to-face psychiatrist appointments?
    - ALL: 16%
    - <$250k: 8%
    - $250k-$1mil: 9%
    - $1mil – $5mil: 16%
    - >$5mil: 31%
<table>
<thead>
<tr>
<th>#</th>
<th>Dimension</th>
<th>ALL (%)</th>
<th>&lt;$250k (%)</th>
<th>$250k–1mil (%)</th>
<th>$1mil – 5mil (%)</th>
<th>&gt; $5mil (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>14.</td>
<td>Does the organization have a centralized scheduling process (manual or automated) where appointments are scheduled using a master schedule with ability to schedule urgent, next or missed appointments into any available slot?</td>
<td>64 69 64 67 54</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Total Access and Intake** 58% 68% 50% 57% 64%

### Services

*Services that are consistent with service definitions and best practices, and clinical systems that support and encourage compliance with associated rules/requirements.*

<table>
<thead>
<tr>
<th>#</th>
<th>Dimension</th>
<th>ALL (%)</th>
<th>&lt;$250k (%)</th>
<th>$250k–1mil (%)</th>
<th>$1mil – 5mil (%)</th>
<th>&gt; $5mil (%)</th>
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</thead>
<tbody>
<tr>
<td>15.</td>
<td>Have direct service clinical staff been trained in all of the following areas? <em>(Please check each area where training has been provided)</em>&lt;br&gt;__ Service definitions&lt;br&gt;__ Provider manual(s) or other clinically related rules (including documentation, billing)&lt;br&gt;__ Recovery/resiliency or other best practice approaches to services&lt;br&gt;__ Periodic training updates on changes/clarifications in the above</td>
<td>70 85 59 74 54</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16.</td>
<td>Does the assessment process include all of the following? <em>(Please check each area included in the assessment)</em>&lt;br&gt;__ Consistent form (adult and youth forms may be different)&lt;br&gt;__ Completed on a timely basis (within 45 days of admission)&lt;br&gt;__ Standardized functional assessments (e.g., LOCUS, CALOCUS, CAFAS, Multnomah, ASAM)&lt;br&gt;__ Diagnostic components (including all five axis per the most recent edition of DSM)</td>
<td>71 69 68 77 54</td>
<td></td>
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</tr>
<tr>
<td>17.</td>
<td>At least 75% of the time, do consumers and parent/guardians (minors) participate in the treatment planning process as evidenced by participation in treatment planning conferences and their signature on the treatment plan? <em>(Both parts must be present for a “yes” answer.)</em></td>
<td>83 69 82 84 92</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>18.</td>
<td>Do at least 75% of treatment plans directly reflect diagnosis, assessed functional needs, consumer preferences, consumer strengths, and natural supports? <em>(All parts must be present for a “yes” answer.)</em></td>
<td>83 85 77 84 85</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>19.</td>
<td>Are at least 75% of treatment plans reviewed and updated as needed or at least once every 90 days inclusive of consumer/family participation in the review process?</td>
<td>82 85 77 81 85</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>20.</td>
<td>Are core services (assessment, medication monitoring/education, and case management, etc) available at times appropriate to consumer needs and preferences, including evenings and weekends?</td>
<td>67 85 45 74 62</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21.</td>
<td>Are the majority (&gt;50%) of service units delivered in the community/natural setting (not office locations)? <em>(Will be important for the development of community support services)</em></td>
<td>37 15 41 40 46</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>22.</td>
<td>Excluding psychiatric services, is the time from referral to first routine service less than 10 days for Medicaid enrollees?</td>
<td>69 85 68 65 69</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>23.</td>
<td>Excluding psychiatric services, is the time from referral to first routine service less than 10 days for non-Medicaid consumers?</td>
<td>70 92 73 67 54</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>24.</td>
<td>Do clinical supervisors receive staff productivity reports at least monthly, use those reports in direct supervision of staff, and demonstrate a change in practice as a result of these efforts? <em>(All parts must be reflected for “yes” answer.)</em></td>
<td>61 69 55 63 62</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25.</td>
<td>Does the organization have a system to monitor and supervise line staff to ensure service delivery (type, frequency, duration), is consistent with the service definitions, and the treatment plan and can demonstrate a change in practice as a result of this system?</td>
<td>78 77 59 84 85</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Total Services** 70% 74% 64% 72% 68%

### Billing and Financial Management

*Stable and diversified financial position, timely and capable billing processes including electronic claims/billing submission capabilities, competitive cost and productivity levels, and useful/integrated financial reporting.*

<table>
<thead>
<tr>
<th>#</th>
<th>Dimension</th>
<th>ALL (%)</th>
<th>&lt;$250k (%)</th>
<th>$250k–1mil (%)</th>
<th>$1mil – 5mil (%)</th>
<th>&gt; $5mil (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>26.</td>
<td>Does the organization require service staff to submit billing/encounter information within 1-2 business days from the delivery of service and does data indicate at least a 75% compliance rate with this policy? <em>(Both parts must be present for a “yes” answer.)</em></td>
<td>47 54 36 53 31</td>
<td></td>
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</tr>
</tbody>
</table>
### Provider Readiness Assessment

**New Mexico BH Collaborative**

**May 12, 2006**

<table>
<thead>
<tr>
<th>#</th>
<th>Dimension</th>
<th>ALL (%)</th>
<th>&lt;$250k (%)</th>
<th>$250k–1mil (%)</th>
<th>$1mil – 5mil (%)</th>
<th>&gt; $5mil (%)</th>
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<tbody>
<tr>
<td>27</td>
<td>Does the organization track average time from date of service to claims submission, and is the average time less than or equal to 14 calendar days? (Both parts must be present for a “yes” answer.)</td>
<td>43</td>
<td>38</td>
<td>36</td>
<td>49</td>
<td>38</td>
</tr>
<tr>
<td>28</td>
<td>Does the organization consistently bill Medicare (for Medicare eligible services) prior to Medicaid when a consumer is dually eligible?</td>
<td>38</td>
<td>23</td>
<td>23</td>
<td>44</td>
<td>54</td>
</tr>
<tr>
<td>29</td>
<td>Does the organization submit claims to any payor at least twice per month?</td>
<td>67</td>
<td>69</td>
<td>55</td>
<td>72</td>
<td>62</td>
</tr>
<tr>
<td>30</td>
<td>Does the organization submit claims to any payor at least once per week?</td>
<td>47</td>
<td>38</td>
<td>36</td>
<td>51</td>
<td>54</td>
</tr>
<tr>
<td>31</td>
<td>Does the organization have at least 30 days of cash reserves (Days of cash reserves = Cash + Investments/[Average monthly expenses/30 days])?</td>
<td>72</td>
<td>77</td>
<td>68</td>
<td>74</td>
<td>69</td>
</tr>
<tr>
<td>32</td>
<td>Does the organization have at least 60 days of cash reserves?</td>
<td>48</td>
<td>54</td>
<td>55</td>
<td>49</td>
<td>31</td>
</tr>
<tr>
<td>33</td>
<td>Is there a process to reconcile amounts billed to paid/accepted claims within ten business days of receipt of reports/remittance advice and resubmit claims as indicated?</td>
<td>77</td>
<td>85</td>
<td>64</td>
<td>74</td>
<td>100</td>
</tr>
<tr>
<td>34</td>
<td>Has the organization calculated costs per unit (including delineation of direct and indirect cost components) for each service provided? (Based on units of service and not total program costs)</td>
<td>52</td>
<td>69</td>
<td>45</td>
<td>42</td>
<td>77</td>
</tr>
<tr>
<td>35</td>
<td>Have efforts been made during the past 12 months to reduce unit costs? (If unit costs have not been calculated, answer “no”. If current costs are at/below reimbursement levels, answer “yes.”)</td>
<td>51</td>
<td>46</td>
<td>50</td>
<td>42</td>
<td>85</td>
</tr>
<tr>
<td>36</td>
<td>Does agency have productivity targets or standards for a majority (more than half) of clinical direct service staff? (Productivity = billed or reimbursable time / paid or available time)</td>
<td>54</td>
<td>62</td>
<td>45</td>
<td>56</td>
<td>62</td>
</tr>
<tr>
<td>37</td>
<td>Do average productivity rates for all clinical staff equal or exceed 50%?</td>
<td>66</td>
<td>85</td>
<td>59</td>
<td>63</td>
<td>69</td>
</tr>
</tbody>
</table>

#### Total Billing and Financial Management

<table>
<thead>
<tr>
<th>Compliance</th>
<th>ALL (%)</th>
<th>&lt;$250k (%)</th>
<th>$250k–1mil (%)</th>
<th>$1mil – 5mil (%)</th>
<th>&gt; $5mil (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Structured and reliable processes to ensure compliance with requirements and rules of all payors and regulatory bodies.</td>
<td>56%</td>
<td>58%</td>
<td>50%</td>
<td>57%</td>
<td>65%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>#</th>
<th>Dimension</th>
<th>ALL (%)</th>
<th>&lt;$250k (%)</th>
<th>$250k–1mil (%)</th>
<th>$1mil – 5mil (%)</th>
<th>&gt; $5mil (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>40</td>
<td>Does the organization have a compliance plan that has been approved by leadership and the board of directors, and a staff person assigned who is responsible for monitoring and updating the compliance plan? (Both parts must be present for a “yes” answer. The compliance plan must be written.)</td>
<td>62</td>
<td>38</td>
<td>59</td>
<td>70</td>
<td>69</td>
</tr>
<tr>
<td>41</td>
<td>Is there evidence that all current staff and new hires are trained on compliance requirements including confidentiality, fraud/abuse, and clinical record documentation requirements (for clinical staff)?</td>
<td>81</td>
<td>77</td>
<td>77</td>
<td>84</td>
<td>85</td>
</tr>
<tr>
<td>42</td>
<td>Does the organization have a consistent and reliable process to ensure all delivered services are included on a treatment plan that covers the date of service? (There should be evidence of this process for a “yes” answer.)</td>
<td>74</td>
<td>77</td>
<td>64</td>
<td>77</td>
<td>77</td>
</tr>
<tr>
<td>43</td>
<td>Does the organization have a consistent and reliable process to monitor the accuracy, completeness and timeliness of clinical record documentation for each billed/encountered service including matching service documentation to units billed? (There should be evidence of this process for a “yes” answer.)</td>
<td>77</td>
<td>77</td>
<td>73</td>
<td>81</td>
<td>69</td>
</tr>
<tr>
<td>44</td>
<td>Does the organization have a consistent and reliable process to monitor whether services delivered demonstrate consistency with payor/regulatory body service definitions and programmatic requirements? (There should be evidence of this process for a “yes” answer.)</td>
<td>73</td>
<td>77</td>
<td>68</td>
<td>79</td>
<td>54</td>
</tr>
<tr>
<td>45</td>
<td>Does the organization have a written plan to monitor medical/clinical necessity &amp; can demonstrate documented practice impact? (There should be evidence of this process for a “yes” answer.)</td>
<td>53</td>
<td>38</td>
<td>50</td>
<td>58</td>
<td>54</td>
</tr>
<tr>
<td>#</td>
<td>Dimension</td>
<td>ALL (%)</td>
<td>&lt;$250k (%)</td>
<td>$250k–1mil (%)</td>
<td>$1mil–$5mil (%)</td>
<td>&gt;$5mil (%)</td>
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</tr>
<tr>
<td>46</td>
<td>Does the organization have a consistent and reliable process to ensure that services are delivered by staff with credentials required by regulation and/or service definitions? (There should be evidence of this process for a ‘yes’ answer.)</td>
<td>91</td>
<td>85</td>
<td>86</td>
<td>93</td>
<td>100</td>
</tr>
<tr>
<td></td>
<td><strong>Total Compliance</strong></td>
<td>73%</td>
<td>67%</td>
<td>68%</td>
<td>77%</td>
<td>73%</td>
</tr>
</tbody>
</table>

**Management Information**

*Information system capabilities that support staff communication, tracking of required elements, and timely/accurate reporting to measure/support change.*

<table>
<thead>
<tr>
<th>#</th>
<th>Question</th>
<th>ALL (%)</th>
<th>&lt;$250k (%)</th>
<th>$250k–1mil (%)</th>
<th>$1mil–$5mil (%)</th>
<th>&gt;$5mil (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>47</td>
<td>Does the organization have an information system that is capable of tracking client demographics and billing information?</td>
<td>74</td>
<td>62</td>
<td>73</td>
<td>72</td>
<td>100</td>
</tr>
<tr>
<td>48</td>
<td>Do each staff member have access to both a work station and e-mail?</td>
<td>79</td>
<td>92</td>
<td>91</td>
<td>74</td>
<td>62</td>
</tr>
<tr>
<td>49</td>
<td>Does the information system track treatment plan expiration dates to ensure that services are not being delivered under an expired treatment plan?</td>
<td>44</td>
<td>62</td>
<td>32</td>
<td>42</td>
<td>54</td>
</tr>
<tr>
<td>50</td>
<td>Does the information system include eligibility/payer source for each consumer?</td>
<td>80</td>
<td>77</td>
<td>73</td>
<td>81</td>
<td>92</td>
</tr>
<tr>
<td>51</td>
<td>Is an automated scheduler available and used for at least assessments, therapy/counseling, and psychiatric services? (All parts must be present for a ‘yes’ answer.)</td>
<td>30</td>
<td>38</td>
<td>23</td>
<td>30</td>
<td>31</td>
</tr>
<tr>
<td>52</td>
<td>Are monthly productivity reports produced within 15 days of the preceding month for each direct service staff and program?</td>
<td>42</td>
<td>62</td>
<td>32</td>
<td>42</td>
<td>38</td>
</tr>
<tr>
<td>53</td>
<td>Are monthly no show rate reports produced within 15 days for the preceding month for each direct service staff and program?</td>
<td>33</td>
<td>31</td>
<td>27</td>
<td>35</td>
<td>38</td>
</tr>
<tr>
<td>54</td>
<td>Are sufficient resources available for information system functions to ensure production of routine reports according to established deadlines, provide help desk functions within one business day, and produce 80% of ad hoc reporting within 14 business days of request? (All parts must be present for a ‘yes’ answer.)</td>
<td>50</td>
<td>54</td>
<td>55</td>
<td>47</td>
<td>54</td>
</tr>
</tbody>
</table>

**Total Management Information** 54% 60% 51% 53% 59%

**Outreach, Engagement, & Consumer Involvement**

*Active support of consumers/family involvement in agency operations, effective communication processes to active and potential consumers and the community, and cultural responsiveness.*

<table>
<thead>
<tr>
<th>#</th>
<th>Question</th>
<th>ALL (%)</th>
<th>&lt;$250k (%)</th>
<th>$250k–1mil (%)</th>
<th>$1mil–$5mil (%)</th>
<th>&gt;$5mil (%)</th>
</tr>
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<tbody>
<tr>
<td>55</td>
<td>Are consumers who have been asked to participate in governance, quality or policy activities been offered assistance, training, and ongoing support to maximize their comfort and effectiveness consistent with the nature of their involvement? (To answer yes, consumers must have been asked to participate, AND they must be able to report that they received assistance/ training/ on-going support.)</td>
<td>36</td>
<td>8</td>
<td>50</td>
<td>30</td>
<td>54</td>
</tr>
<tr>
<td>56</td>
<td>Does the organization offer financial assistance (reimbursement for travel and/or time) for consumer participation in governance and work groups?</td>
<td>26</td>
<td>0</td>
<td>23</td>
<td>28</td>
<td>46</td>
</tr>
<tr>
<td>57</td>
<td>Does the organization have a plan (goals, tasks, resources, timelines) to participate in community activities designed to educate referral sources, consumers, and families regarding availability of services and supports? (To answer yes, there must be written evidence of a plan.)</td>
<td>41</td>
<td>46</td>
<td>45</td>
<td>37</td>
<td>38</td>
</tr>
<tr>
<td>58</td>
<td>Does the organization demonstrate cultural responsiveness through promotion of inclusion, prohibiting discrimination, staff race/ethnicity reflective of program participants, requiring competency training for all, and availability of translators? (All parts must be present for a ‘yes’ answer.)</td>
<td>88</td>
<td>85</td>
<td>73</td>
<td>95</td>
<td>85</td>
</tr>
<tr>
<td>59</td>
<td>Does the organization have a process to focus outreach efforts to encourage active engagement for consumers/families in need (both enrolled and new clients)? (Process must be functioning to be counted as a ‘yes’.)</td>
<td>53</td>
<td>69</td>
<td>59</td>
<td>49</td>
<td>39</td>
</tr>
<tr>
<td>60</td>
<td>Does the organization have a process to collect information regarding consumer/family satisfaction and can demonstrate the information has been used to change practice or processes? (Both parts must be present for a ‘yes’ answer.)</td>
<td>63</td>
<td>38</td>
<td>55</td>
<td>67</td>
<td>85</td>
</tr>
</tbody>
</table>

**Total Outreach** 51% 41% 51% 51% 58%

**Grand Total** 59% 59% 54% 60% 63%
Appendix B–Provider Training Topics
Provider Training Topics

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

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

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

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

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

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

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

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

- Financial analysis
  - Financial modeling/impact analysis based on existing and targeted productivity
  - Cost of service determination by type and staff
  - Key financial indicators and benchmarks
Appendix C—Information Systems in Use
Information Systems in Use in New Mexico

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

Absolute
Anasazi
Claim MD
Compulink Psych Advantage
EZ Claim
LVBI billing
Mega West
MYSIS
Navinet
NDC Medisoft
Payer Path
ValueOptions EDI