Submitted to Community Support Steering Committee (from August 6, 2009 meeting)

Community Support
Lessons Learned

- ☐ Recovery Focused, Community Centered
  - o The initial reform movement was driven by a philosophy of recovery and a focus on rehabilitation and best practice and provided the catalyst to an attempt to positively change the system.
  - o This transition resulted in bringing more services to consumers in the community thus supporting them in developing and maintaining natural supports.
  - o Because of the person-focus foundation, CS has helped many consumers achieve their goals and maintain community tenure.

- ☐ Limited consumer advocacy in the behavioral health population
  - o Because of limited consumer advocacy within behavioral health, providers serve a dual role of service delivery and consumer advocacy.
  - o Because of limited public awareness and advocates for system change, changes to the system occur without fully taking into account all dimensions of the impact (e.g., on families, natural support systems, and community resources).

- ☐ Accurate budget forecasting
  - o Budget forecasting proved formidable, with two specific variables impacting higher than expected utilization; 1) "No wrong door policy" for consumers seeking service resulted in higher than expected demand – consumers finally had open access. 2) "Any willing and qualified provider" resulted in too many new providers entering the system and in retrospect making it difficult to oversight the service.
  - o When financial and other system indicators are not clearly established prior to initiating a program/service, the results cannot be anticipated/planned for and solutions to identified problems cannot be made quickly or effectively. Responses to financial and system concerns should be carefully evaluated and the financial, clinical, and community impact should be weighed out thoughtfully (e.g., Drastic and immediate cuts to support services results in significant increase in crisis services, hospitalizations, and incarcerations. These more intensive services are less clinically effective and more costly).
  - o Service design or re-design should be accompanied by rigorous cost analysis so that providers know ahead of time if they can afford to provide the service(s). When cost modeling is required it must be done with very clear assumptions and then those assumptions must be tested as was done with the LME cost model but not done with service cost modeling. Many original service definitions were cost modeled, however as requirements changed (e.g., QP percentage increase, a 16% CS rate cut, utilization cuts, etc…) a thorough review of the rates did not occur. This approach can encourage providers to "dilute" service delivery.

- ☐ Outcome focused
  - o System and services should be founded on effective identification of clinical outcomes to be tracked and measured rather than financial impact alone.

- Clinical outcomes were not established and mechanisms for measuring and tracking outcomes were not in place prior to service implementation and therefore the system could not determine whether or not services were effective. Clinical outcomes (e.g., hospitalizations, sobriety, housing, incarcerations) should be tracked and trended to demonstrate the effectiveness of the services. Clinical, not just financial (paid claims, expenditures) and process (training expectations, service orders completed), outcomes should be accurately and frequently reported to stake holders.
- Outcome data should be accurate and easily accessed by stakeholders.

- ☐ Effective treatment plan development, utilization management, and authorization approval
  - Transition from CBS to CS occurred before the utilization management entities (VO and some LME's) were fully operational and ready to receive volume of authorizations. Blanket authorization approval resulted in significant over expenditure. Consideration should be given to piloting significant changes to provide opportunity to effectively address any challenges that may occur.
  - During the transition to CS, response and approval for requests for services were extremely slow and resulted in consumers going without services.
  - Because an effective tracking system was not in place in the beginning of reform, authorization requests were lost in the system which resulted in consumers going without necessary services as well as re-work for the providers and the utilization entity.
  - Initial communication from VO was poor (e.g., erroneous fax numbers, no clear chain of command, unclear of whom to contact for resolution of issues) which created bottlenecks, lack of follow-thru, and misinformation.
  - Authorizations for services should be based on clinical pathways, outcomes, and progress rather than time, units, etc…
  - Because of lack of uniformity in forms and practices between utilization entities, providers have difficulty with building successful IT systems, effectively responding to diverse business processes, and, as a result, incur excessive administrative costs. Example: Some LMEs authorize services by staff type yet VO does not, multiple authorization request forms and processes, etc… Identical forms and processes will allow providers to be more effective and efficient in requests for authorizations, thus providing greater opportunity for quality services.
  - Current practice of using the same authorization number for concurrent authorization challenges provider IT systems to effectively track and bill for services.
  - Frequent changes to the PCP results in confusion and re-work for providers and frequently does not provide any extra value for the consumer.

- ☐ Clear and consistent communication and information to stakeholders
  - Current service definitions are not presented in a uniform manner. Some definitions have clear and specific guidelines around outcomes, requirements, staffing patterns, etc. while others appear vague and lack specific guidance around

the various components. The 2009 service definitions improved on this challenge, but continued effort in consistency and uniformity is needed. A uniform template would force consistent communication of expectations around utilization review, staffing and program requirements, and entrance criteria.
  - Service definitions have conflicting language about staff roles (QP, AP, and PP).
  - There are several instances of inconsistent information between state implementation bulletins and state rules. This impacts provider's ability to successfully address possible compliance issues.
  - Poor communication about services and changes to stakeholders outside of behavioral health services (e.g., schools, DSS, Dept of Corrections, etc…) resulted in conflicts and misunderstanding between team members. Communication with all of the community stakeholders is necessary to successfully transitions to system changes.
  - Monthly implementation bulletin made information flow easier to follow than frequent bulletins submitted in the same month.

- ☐ Capacity
  - When significant changes occur in the system, the human resource capacity (e.g., available staff, available providers, etc…) in various communities should be fully weighed out prior to implementation.
  - The plan to professionalize the workforce did not take into account available and practicing qualified staff (e.g., qps, substance abuse professionals, etc...) and resulted in consumers not receiving necessary services.
  - When services are eliminated, as was done in several LMEs in an attempt to address financial challenges, the capacity of alternative, available, and active service providers should be evaluated (e.g., limited sources in rural areas – ACTT, MCM, IIH).

- ☐ Placement in the appropriate level of care based on medical necessity
  - With 2006 reform, consumers that may not be eligible for services were admitted because no clinical assessment was completed when crosswalk was implemented.
  - Initial expectation of diagnostic assessment was costly to providers and involved duplication of work and services.
  - There is a need for a balance between totally unmanaged access and overly restrictive access that does not allow sufficient time or reimbursement for determining appropriate levels of care. Current assessment expectations (e.g., initial assessment prior to any plan development) do not allow for flexibility to bring consumer into services as quickly as necessary to stabilize.

- ☐ Caseload and services
  - Current capitation of caseload does not allow for flexibility based on clinical acuity or service delivery barriers and is a barrier to the implementation of many evidence-based practice models.
  - For individuals in residential services, two hours a month of case management activities does not allow adequate time for effective case management and discharge to lower level of care planning.

  - Most effective method to support individuals in accessing necessary services is a small amount of unmanaged services to engage individuals in treatment quickly. Current process severely limits agencies intake time slots which delays consumers receiving necessary supports.

- Providers
  - Many responsible organizations, driven by mission, adapted to changes to provide quality services and were driven by focus on consumer outcomes.
  - No clear and objective criteria for being a provider were initially developed. Efforts to improve the quality of the provider pool by attempting to eliminate ineffective providers through multiple audits resulted in costly measures for all providers (e.g., increasing staff and service delivery requirements, increasing the auditing activities – FEM, endorsement, post-payment reviews). Such activities take away from the available funding for service delivery.
  - Comprehensive providers have been found to be most effective in service delivery and adjusting to changes.
  - Providers were not involved in the initial service design and therefore issues with implementation were not anticipated and addressed. Providers should be active participants in the system development process. Improvements in work teams including DMHDDSAS, DMA, and providers have been noted (e.g., service definition work group, community support steering committee).

- Training is vital to service delivery.
  - Clear expectations around training requirements and content create a stronger work force.
  - On-going changes of training requirements and inconsistent training expectations results in confusion and unproductive time.
  - Auditing process of training expectations is not consistent across LME's and auditing teams.

- Crosswalk process in 2006
  - Initial transition did not involve clear guidelines based on clinical necessity for individuals crosswalking from CBS.
  - Some consumers began receiving a service that they were subsequently required to be discharged from due to not meeting medical necessity (e.g., consumers with DD and MH diagnosis crosswalked to CS but required and were transitioned to TCM).
  - Although crosswalk decreased number of consumers who went without services, many consumers had to change level of care and/or primary service after establishing clinical plans and relationships.
  - If no crosswalk for 2009/2010 transition, UM entity should be fully prepared to receive and respond to authorization requests in a timely manner.