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NATCON22

APRIL 11-13, 2022

NATIONAL HARBOR, WASHINGTON, DC METRO AREA

NATIONAL COUNCIL *for* Mental Wellbeing

NatCon22.org

#NatCon22

MTMSERVICES.ORG *Driving Transformational Change!*

SPQM

CCBHC Readiness – What Does It Take!?

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&

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Nothing to disclose except that we like to help teams make positive and substantive changes!

We have 45 minutes to cover a lot of very important topics…..
Each topic could fill an hour/day long training….

The Data/Information Presented is tied to our work since the first phase of CCBHC but is focused mainly on the multiple statewide readiness assessments that we have performed over the last few funding cycles.

Readiness Needs

1. The systems /Accurate data to support your mission – Our primary focus as a team for the last 2 years has been helping teams measure their readiness in the following areas -
    1. IT
    2. Back Office - The ability to collect on the services you deliver
    3. Access to Care – Getting people in better than the standard
    4. Awareness of your true costs
2. Leadership ready to walk the walk!
3. A State that is onboard with you – Not always in your control, so the things to do to help them see the vision of the CCBHC system – National Council support…

CCBHC NOFO Office Hours

- Join the National Council's CCBHC Success Center team to discuss this year's grant announcements
- Get answers to your questions
- Understand how this year's requirements differ from prior years'
- Hear tips and advice for a successful application
- No appointment needed!

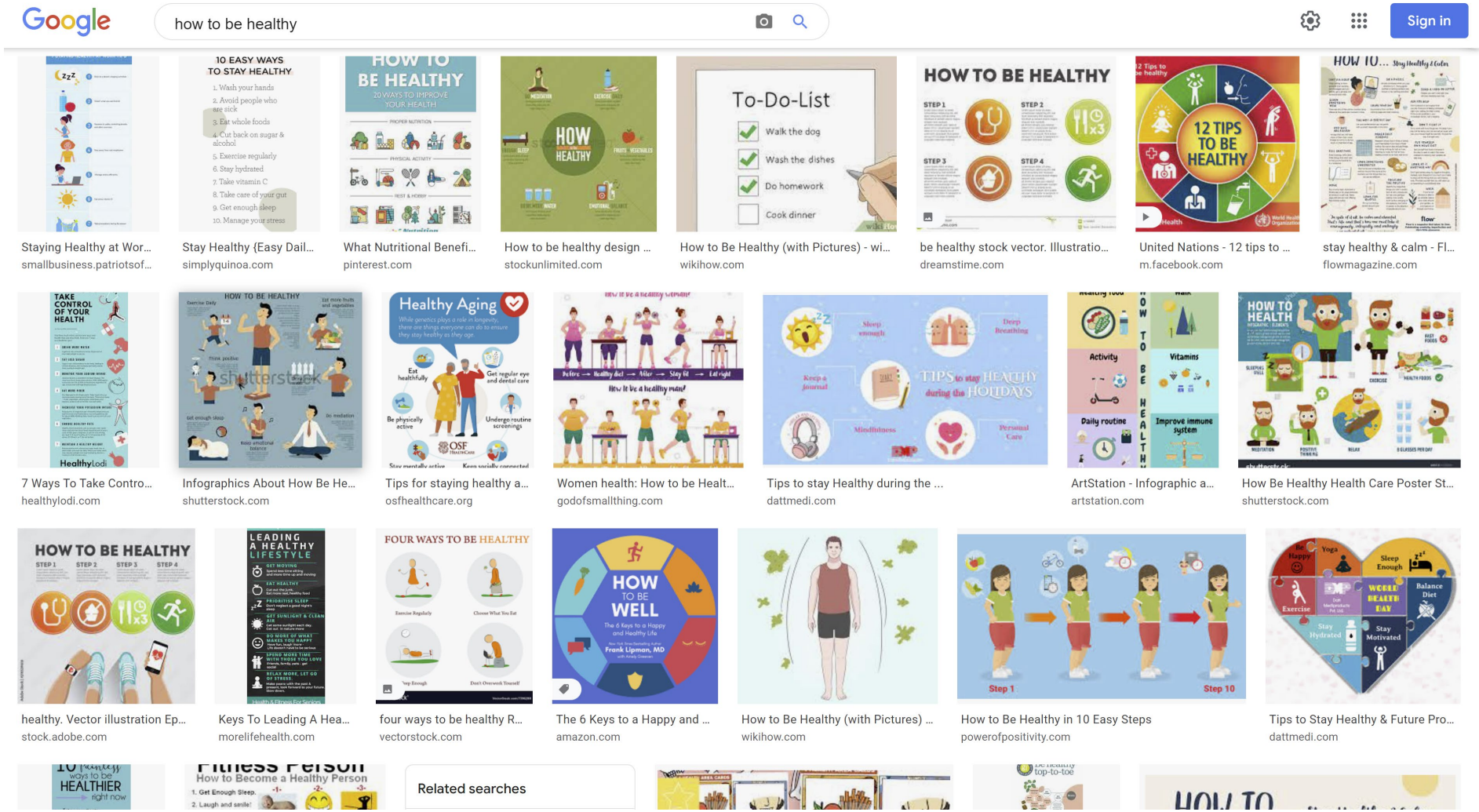
Where: CCBHC Lounge

When: Tuesday, April 11

7:30-8:30 a.m. | 3:15-4:30 p.m.

Most Teams Already Know What To Do…

Why do some organizations achieve success while others continue to struggle?



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More of the same, or will you be ready!?

Scott Lloyd

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More of the Same?

As We Move to CCBHCs / Higher Funding Environments

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

What has your team gotten used to?

More of the Same?

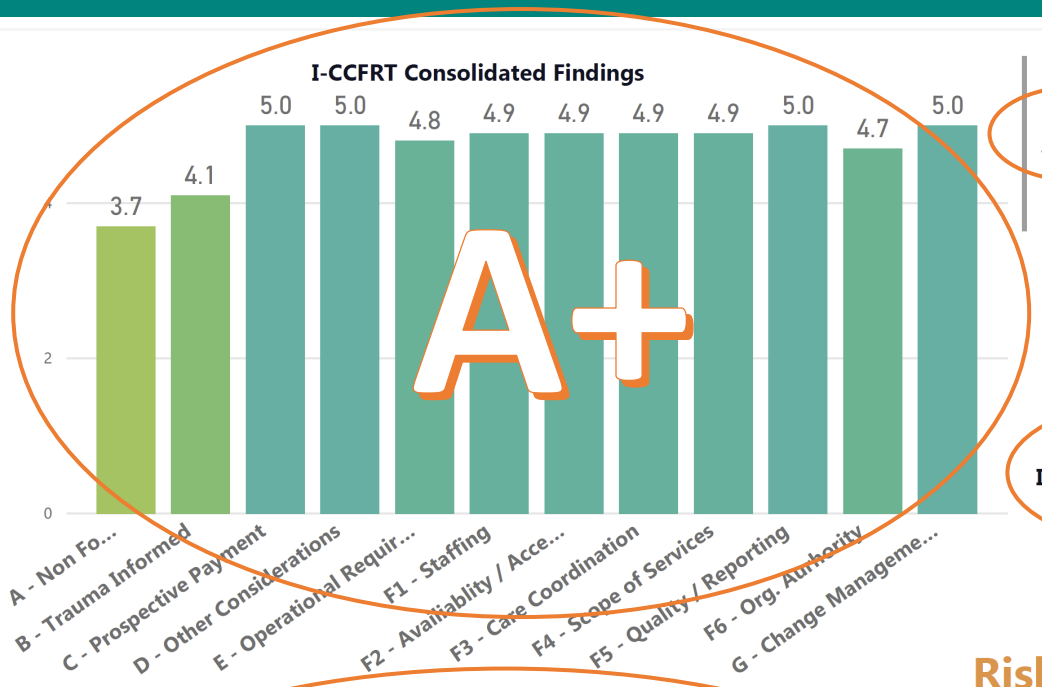
CCBHCs can be an incredible way to improve your organization, but they are not a *Magic Fix-all*!

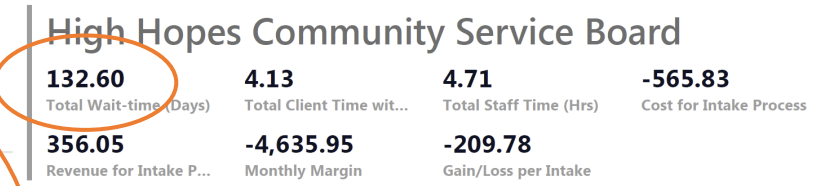
1. A significant number of agencies nationwide are dealing with significant systems issues tied to insufficient access to care, under powered data capture & EHRs/EMRs, and financial collections processes that do not actually meet their needs.
2. Why!? - Systems are set up based upon previous broken models.
3. Staff struggle to attain their production targets as they struggle with broken systems.

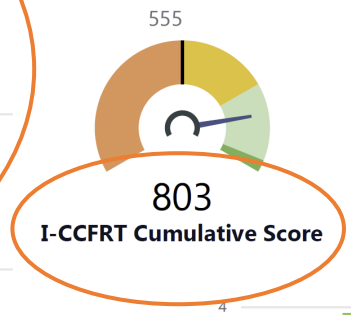
Mental Resets

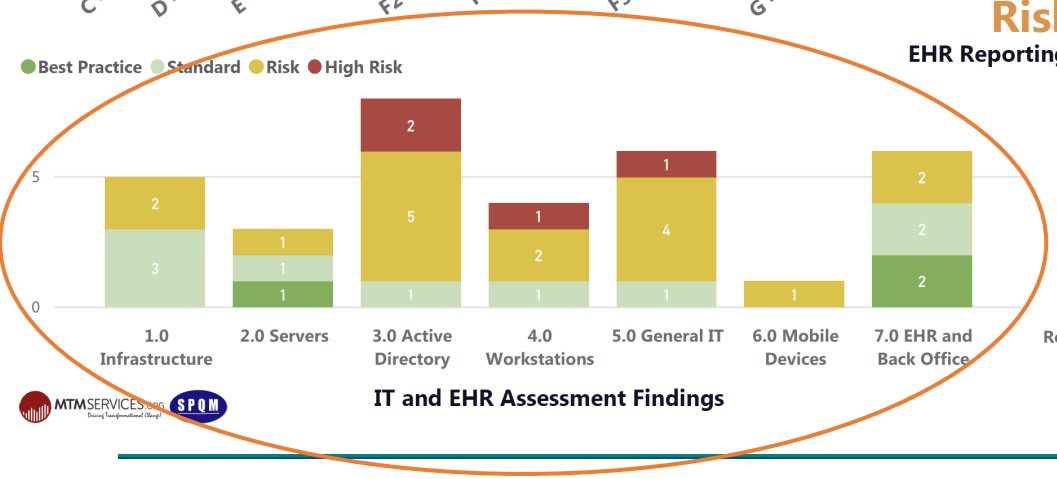
- ***Productivity*** is not a measure of how hard staff are working, it is a measure of how well our systems are working to support our staff!
- **System Noise** is anything that keeps staff from doing the job they want/need to be doing, which is helping their consumers in need!
  (Paperwork, Meetings, Wait Times, No Show Rates, etc.)
- ***Most Teams are not as ready as they think they are…Talking about change is not the same as taking action…***

Readiness is About Having The Data To Know For Sure…

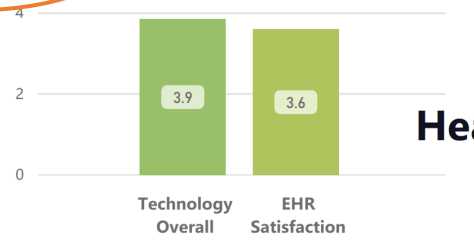




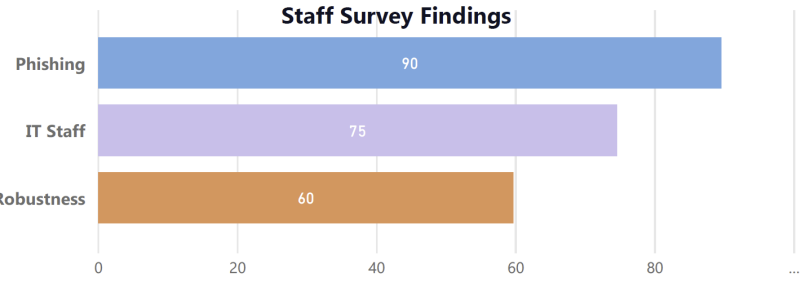




Risk
EHR Reporting Finding



HealChart
EHR



Anecdotal/Self Assessment
vs.
Real Data

The Data To Know For Sure…IT

IT and EHR Assessment Methodology

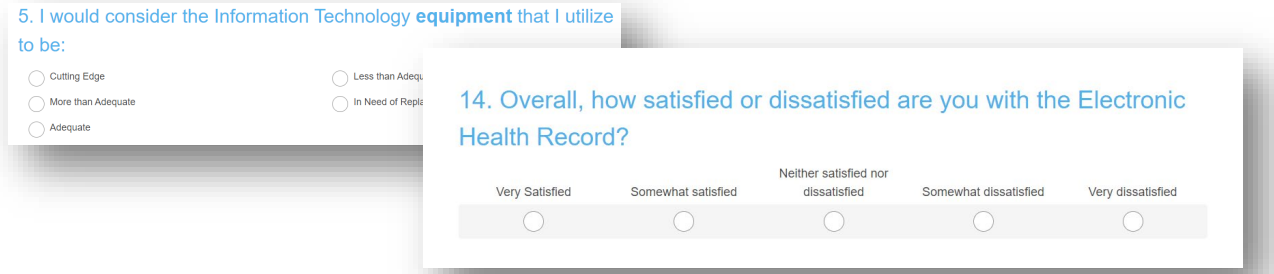
Targeted Department Review

- Information Technology
- EHR Support Team
- Quality / Process Improvement
- Health Information Management
- Corporate Compliance
- Billing Team

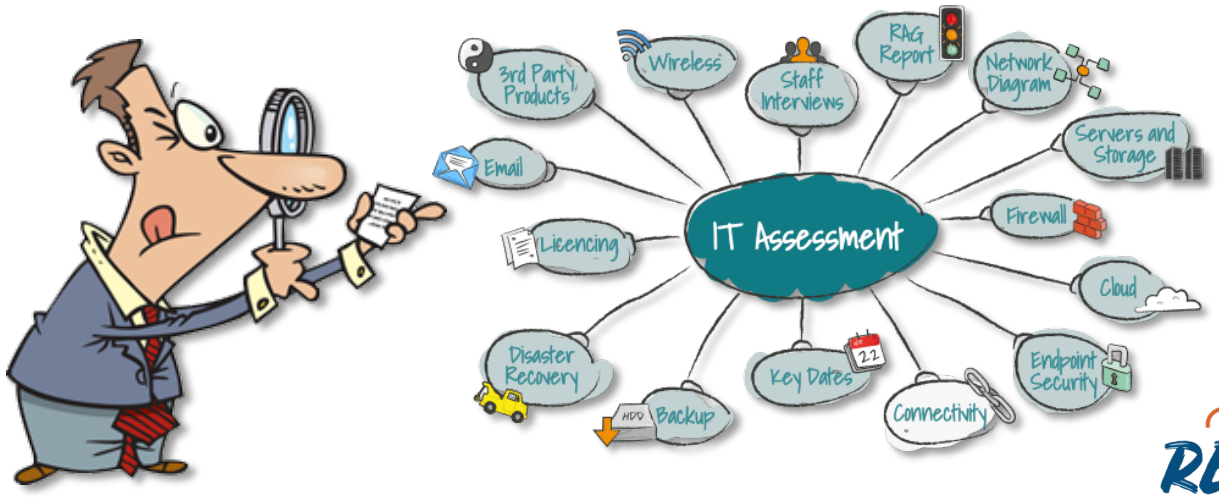
Revenue Unit Review

- ** RUs assessed

Staff Survey – *** Participants



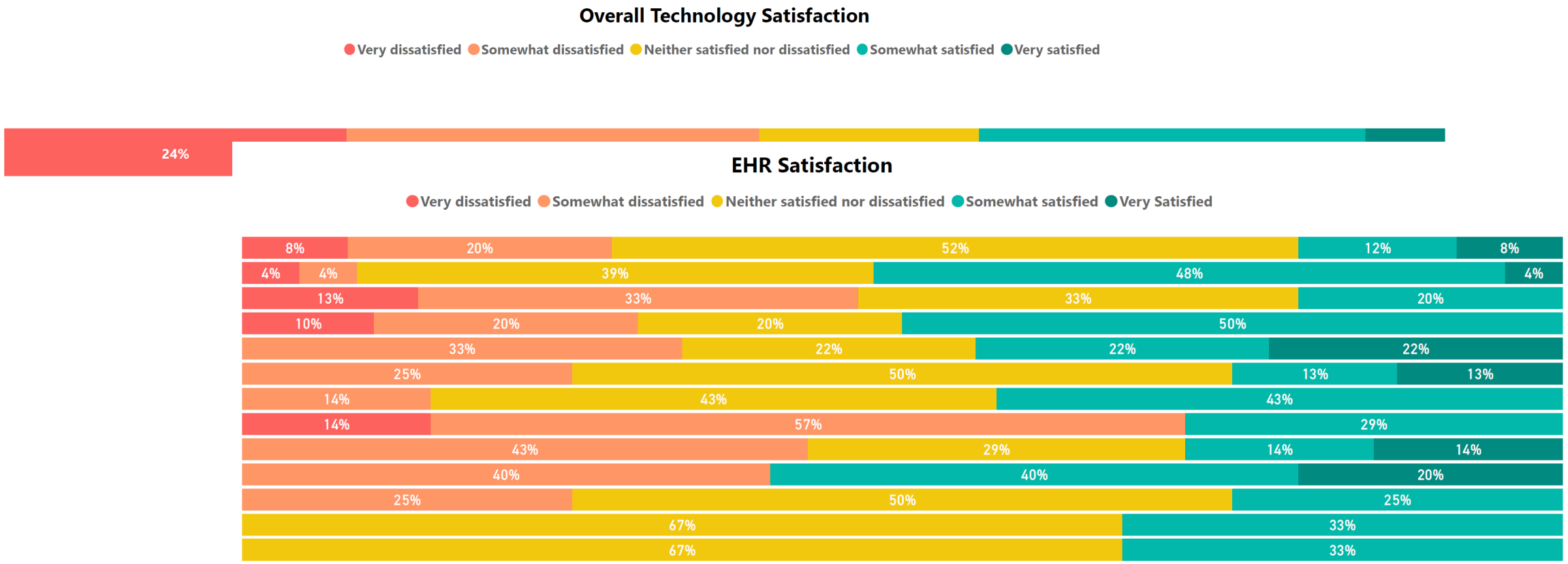
Assessment



EHR and Systems

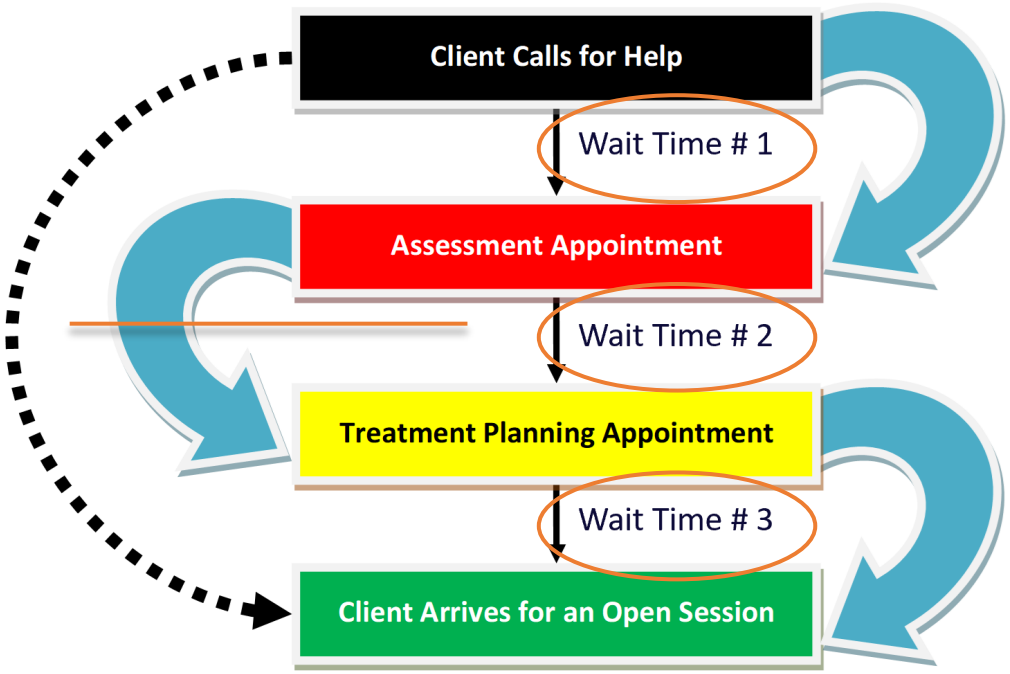
IT Assessments Performed by Charlie Grantham and his team.

The Data To Know For Sure…IT



IT Assessments Performed by Charlie Grantham and his team.

The Data To Know For Sure…Access



1. **Access to care –**
   - Same Day Access versus Scheduling – 90% vs 75%
   - Client's Definition of Access vs. the Organization's
   - Wait time accurately drives the show rate
   - CCBHC requires assessment within 7 days –
     - The benefits of surpassing that target
   - Requires a holistic change approach to be successful

2. ***What to Do About it!?***
   - Implement Same Day Access!
     - Documentation Redesign
     - No Show/Late Cancelation Engagement and Management
     - Centralized Scheduling
     - Episode of Care/Level of Care Design

GAP Analysis and SDA work is Performed by Joy Fruth and her team.

The Data To Know For Sure…Access

Billable Hours Per Year	1,200
Operational Weeks Per Year	52
Average Session Length	60

PN Time Per Session (min.)	Total: Mins	Hours PD	Hours PW	Hours PY	# of Staff	Total Hours	Avg. $	Recapture %	Total $
5	6,000	0.43	2	100.00	100	10,000	$76.00	50%	$380,000.00
7.5	9,000	0.65	3	150.00	100	15,000	$76.00	50%	$570,000.00
10	12,000	0.87	4	200.00	100				
12.5	15,000	1.09	5	250.00	100				
15	18,000	1.30	7	300.00	100				

Access Comparison Worksheet

	Total Staff Time (Hrs)	Total Client Time without Wait-time (Hrs)	Cost for Process	Total Wait Time (Days)
Old Process Averages:	5.14	3.48	($383.14)	48.38
New Process Averages:	3.92	2.99	($297.78)	26.34
Savings:	1.21	0.49	$85.35	22.04
Change %:	24%	14%	22%	46%

Avg. Number of Intakes Per Month	33,685.44
Intake Volume Change %:	12%
Monthly Savings:	$2,509,707.04
Annual Savings:	$30,116,484.51
Average Savings Per Center:	$115,832.63

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260 Organizations included in this sample, from 26 states

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

Change measurements are taken after the first cycle, typically nine to twleve months after the baseline is established. Often, teams continue their work beyond this measurement. Due to the transformative nature of these changes, some organizations require more than one cycle to fully implement the new processes.

GAP Analysis and SDA work is Performed by Joy Fruth and her team.

The Data To Know For Sure…Back Office

Back Office Administrative Readiness Tool (BART)

- The Back Office Administrative Readiness Tool (BART) provides an opportunity for the management team to review key service process support and administrative functions
- Assessments are completed by each reporting unit that is included
- Review the important service processes and administrative functions proven to support
  - Appropriate billing and collections
  - Administrative efficiencies
  - Integrated care service delivery
  - Value Based Readiness
- The BART is a self-assessment tool that help to assess and evaluate the CBHO's/CCBHC's current state in performance of the above back office and clinical service delivery functions.
- Each section and question of the CBHO's Back Office Readiness Assessment is based on a five-point scale as outlined below:

5	4	3	2	1
Not a Challenge	Small Concern	Moderate Concern	Quite a bit of Concern	Serious Challenge

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MTM Services' Back Office Administrative Readiness Tool (BART)

This Back Office Administrative Readiness Tool (BART) provides an opportunity for the management team of the CBHO to review several important service process support and administrative function areas that have been proven essential to support appropriate billing and collections in an enhance managed care funding environment needed in an integrated care service delivery model under healthcare reform.

The MTM Services Team has identified core assessment focus areas based on the typical identified challenges within CBHOs as a result of providing service process measurement and change management support for over 700 CBHOs nationally. Additionally, the assessment focus areas support your team's readiness awareness to support the seven core "Values" needed to successfully participate in an integrated and reformed healthcare system that are outlined below:

1. Be Accessible (Fast Access to all Needed Services)
2. Be Efficient (Provide High quality Services at Lowest Possible Cost)
3. Ability to focus on mergers and acquisition in an Integrated Healthcare environment – Establishing a business case that supports valued partner status
4. Electronic Health Record capacity to connect with other providers in the BH/IDD arena and quickly with physical health providers MCOs.
5. Focus on Episodic Care Needs and Treat to Target Models
6. Ability/Willingness to participate in Bundled/Case Rate Shared Risk Payment Models
7. Produce Outcomes!
8. Engaged Clients using Natural Support Networks
9. Help Clients Self Manage Their Health, Wellness and Recovery
10. Reduce Need for Emergent/ High-Cost Services

Healthcare reform is creating a tremendous amount of disruption in nearly all aspects of healthcare. A U.S. Congressional Budget Office analysis indicates that 16 million individuals will enroll in insurance in 2014, either through the Medicaid expansion or through the health insurance exchanges or Marketplaces. This tremendous growth in newly insured individuals will put overwhelming pressure on health care providers to provide high-quality services, customized to the individual, while maintaining financial and operational practices that are in compliance with insurance billing requirements. According to Dale Jarvis, of Dale Jarvis and Associates, in order to rise above this chaos and thrive in it, CBHOs need to be seen as *Behavioral Health CBHOs of Excellence (BH-COE)*, CBHOs or programs within an CBHO "that excel at addressing the whole health of one or more identified populations and is viewed by the community as a preferred place of care." [http://mentalhealthcarereform.org/what-is-a-behavioral-health-CBHO-of-excellence-and-why-should-i-care/]

While a focus on clinical quality improvement is a must, CBHOs will need to enhance their back-office functions to support the services it provides. The key back-office functions that will be needed are:

- Credentialing staff on provider panels
- Internal referrals to appropriately credentialed staff
- Obtaining pre-certifications, authorizations and re-authorizations as needed prior to service continuation
- Support enrollment needs of clients
- Clinical focus to meet the managed care best practices (i.e., MI focused brief therapy "treat to target" models, shift in paying for volume to paying for value/quality/outcomes, etc.)

1

Back Office Assessments performed by Michael Flora and his team.

The Data To Know For Sure…Back Office

Assessment Process

Scott's Take-Away – I'm always shocked by how much the numbers change after Michael meets with the teams to review each area of the vBart.

Back Office Assessments performed by Michael Flora and his team.

The Data To Know For Sure…Costing

Why Productivity Matters, Even in a CCBHC!!

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Cost Per Hour Ranges

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

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

Avg. Reimbursement
$87

	Direct Service Hours	DS%	Cost Per Hour	Revenue	Margin
	100	4.8%	$608.26	$87	($521.26)
	200	9.6%	$304.13	$87	($217.13)
	300	14.4%	$202.75	$87	($115.75)
	400	19.2%	$152.06	$87	($65.06)
	500	24.0%	$121.65	$87	($34.65)
	600	28.8%	$101.38	$87	($14.38)
	700	33.7%	$86.89	$87	$0.11
	800	38.5%	$76.03	$87	$10.97
	900	43.3%	$67.58	$87	$19.42
	1000	48.1%	$60.83	$87	$26.17
	1100	52.9%	$55.30	$87	$31.70
	1200	57.7%	$50.69	$87	$36.31
	Incorrect Examples				
All Hours	2080	100.0%	$29.24	$87	$57.76
AH Minus PTO	1832	88.1%	$33.20	$87	$53.80

Why you have to addressing System Noise…Not just move it around!

The Data To Know For Sure…Costing

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

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

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

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

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

End of Worksheet

The CMS Costing Tool was Designed to Estimate Costs

The Data To Know For Sure…Costing

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PPS1 Rate	PPS2 Rate
$0.00	$0.00

PPS Rate Calculator

Avg Cost Per Hour	CMS Avg Cost Per Event	Projected Expense Increase % (P.E.I.%)
$258.20	$121.83	27%

Code	Modifier	Code Descriptions	Avg Time Per Code (Hours)	Avg Time Per Code (min)	Avg. Events Per Hour
90791		Admission Intake	0.95	57.20888889	1.05
90785		Interactive Complexity			
90792		Psychiatric Evaluation	0.76	45.60235294	1.32
90832		Individual Therapy	0.48	28.92854573	2.07
90834		Individual Therapy	0.76	45.79885092	1.31
90837		Individual Therapy	0.96	57.31127695	1.05
90839		Crisis Therapy	1.38	82.7	0.73
90840		Crisis + 90840			
90847		Family Therapy	0.81	48.61046512	1.23
90853		Group Therapy			
90899		PASRR Screen	2.50	150	0.40
96101		Psychological Testing			
96130		ychological Testing Evaluation - 1 H	1.92	115.4571429	0.52
96131		ical Testing Evaluation - Each Additi	1.55	92.76	0.65
96136		ogical Test Administration/Scoring -	2.57	154.15	0.39
96137	NR	est Administration/Scoring - Each A	0.79	47.64	1.26
99211	TD	E & M Est. Patient	0.21	12.81654135	4.68
99211		E & M Est. Patient			
99212		E & M Est. Patient	0.18	11.03225806	5.44
99213		E & M Est. Patient	0.23	13.52917706	4.43

	Scenario 1	Outpatient Services	
PPS1 Actual Cost	$345.65	PPS2 Actual Cost	
CMS Average Cost	$243.67	CMS Average Cost	
Actual Cost with P.E.I.%	$438.97	Actual Cost with P.E.I.%	
PPS1 Rate	$0.00	PPS2 Rate	$0.00
Margin (Gain/Loss)	($438.97)	Margin (Gain/Loss)	

PPS1 Total Hours	PPS1 Total Events	PPS2 Total Hours	PPS2 Total Ev
0.71	2	0.00	0

Hours Per Day	Events Per Day	Hours Per Month	Events Per Mo
0.48	1		
0.23	1		

We Focus on Real Costs.

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The Data To Know For Sure…Costing

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PPS Rate Calculator

PPS1 Rate	PPS2 Rate	Projected Expense Increase % (PEI%)
$154.73	$0.00	27%

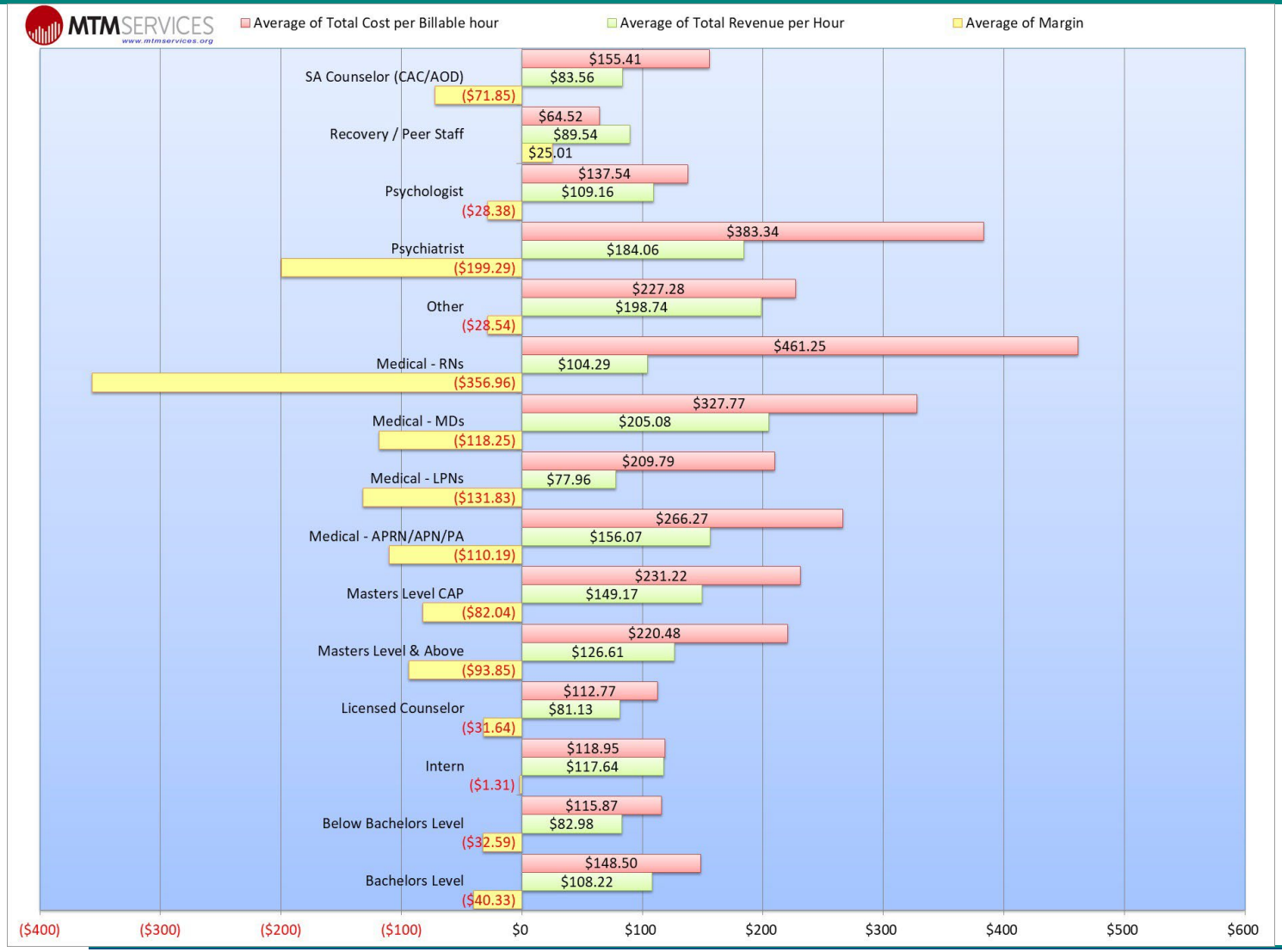
Avg Cost Per Hour	CMS Avg Cost Per Event	CMS Avg Cost Per Event w/ PEI%
$258.20	$121.83	$154.73

Total Codes with a Positive Margin	31
Total Codes with a Negative Margin	25
Total Gain/Loss at current Event Counts	$1,067,602.15

	ode Information		Single Service versus PPS1 w/ P.E.I%		Average Time and Eve	
Code	Modifier	Code Descriptions	Total EVENTS Per Code	Margin per Event	Total Gain/Loss at current Event Counts	Avg Time Per Code (Hours)	Avg Time Per Code (min)
90791		Admission Intake	810.00	$9.49	$7,685.69	0.95	57.20888889
90785		Interactive Complexity	0.00				
90792		Psychiatric Evaluation	255.00	($69.52)	($17,726.46)	0.76	45.60235294
90832		Individual Therapy	2,001.00	$17.87	$35,767.60	0.48	28.92854573
90834		Individual Therapy	3,307.00	$18.31	$60,566.48	0.76	45.79885092
90837		Individual Therapy	3,618.00	$17.60	$63,688.26	0.96	57.31127695
90839		Crisis Therapy	144.00	($219.86)	($31,660.29)	1.38	82.7
90840		Crisis + 90840	0.00				
90847		Family Therapy	172.00	$17.11	$2,943.69	0.81	48.61046512
90853		Group Therapy	0.00				

We Focus on Real Costs.

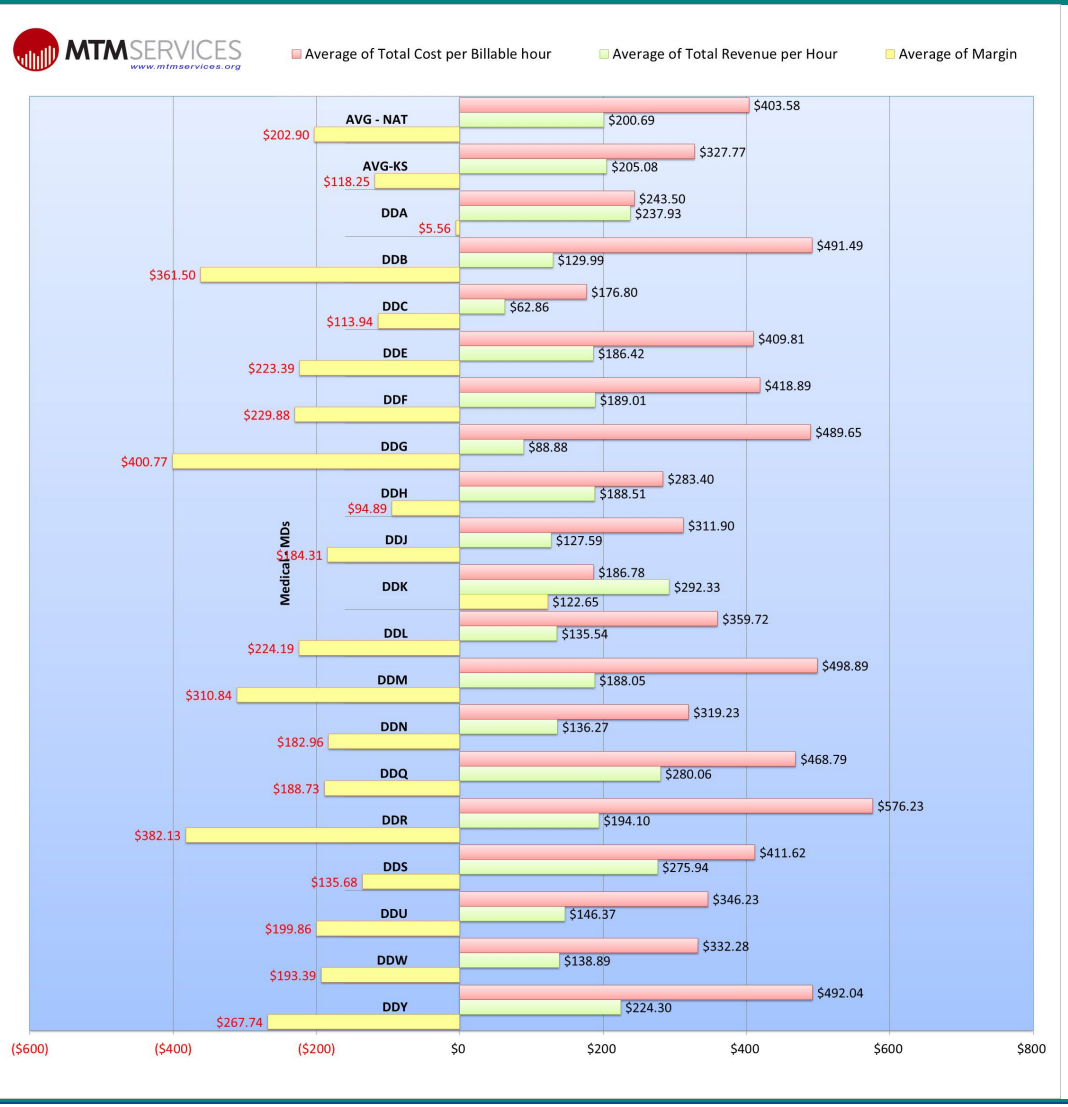
The Data To Know For Sure…Costing



We Focus on Real Costs.

ACMHCK – Establishing a Solid Costing Reality

The Data To Know For Sure…Costing



We Focus on Real Costs.

Margin Comparisons by Center / National

The Data To Know For Sure…Costing

We Focus on Real Costs.

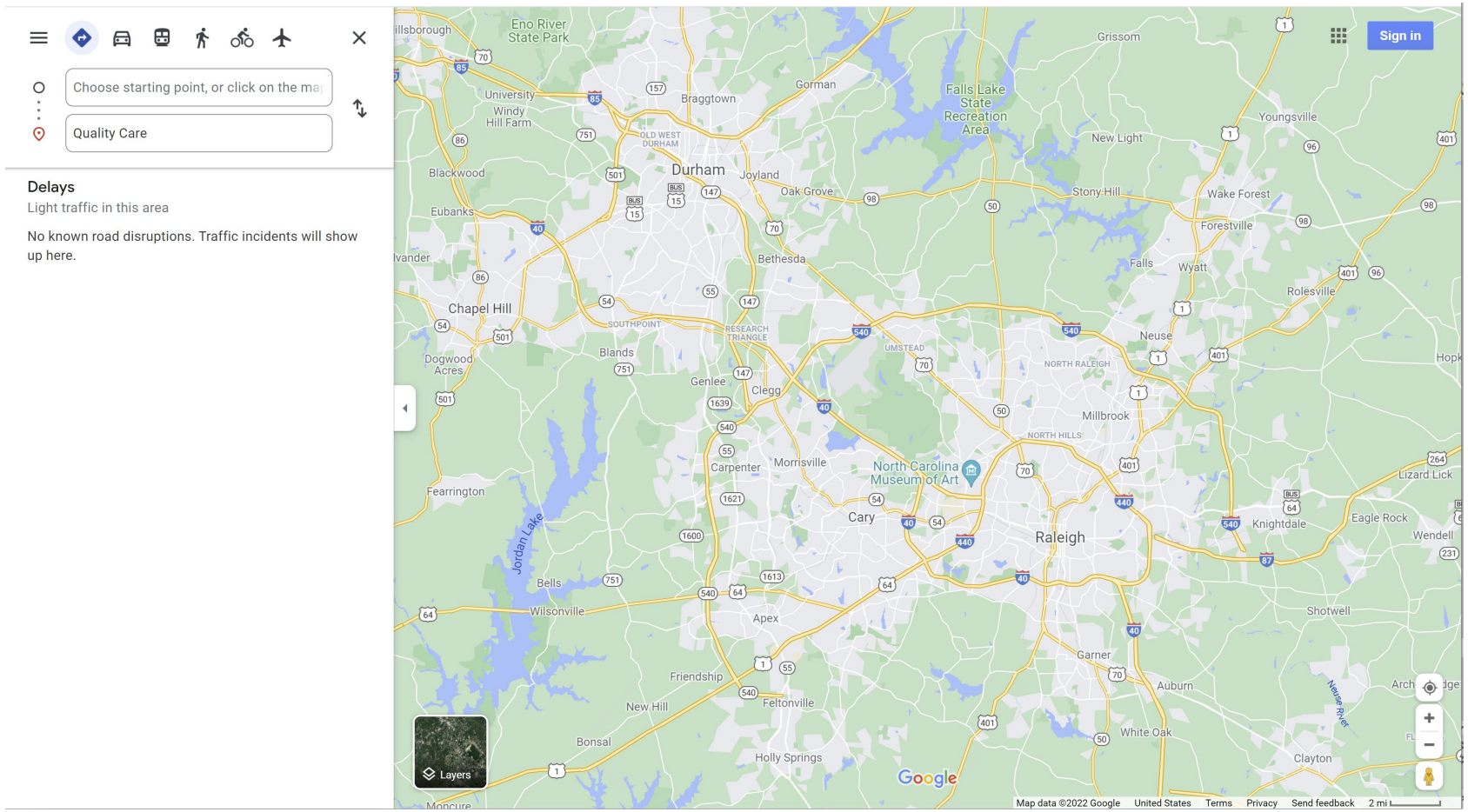
Breaking down cost versus revenue by modified code –

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

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

The Data To Know For Sure…Summary

Data is Not About ***Gotcha!!*** You Need to Know Your Starting Point!!



The data is about giving an opportunity for system improvement!

The Data To Know For Sure…Summary

The #1 Reason that Change Efforts Fail -

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

This Results in Partial Implementation or Cherry Picking the Change…

CCBHC Implementation: Lessons Learned

Valerie Westhead, MD, FASAM
Medical Consultant, MTM Services
CMO, Aspire Health Partners

Nothing to disclose

Don’t Reinvent the Wheel

- **National Council CCBHC Success Center**
  - On Demand Webinars
  - Mentorship Program
- **Learning Collaboratives**
  - CCBHC Grantees within your state
- **State Trade Organizations**
  - Forum for implementation within your state
  - Work with other medical trade organizations
  - Working with state government and agencies to make changes that support successful implementation and Sustainability

Role of the Medical Director

- **Medical Directors are essential members of the team**
  - Boundary Spanner
    - Service Provider
    - Administrator
    - Leader – Member of Management Team, Engaging with CEO and the Board
    - Collaborate with Community Partners Including Hospital Systems, EDs, PCPs, and CJS
  - Duties and Responsibilities
    - Collaborate with clinical leadership to develop a robust, Team Based SOC
    - Effective and Efficient Utilization of EBPs
    - Protocol and Measurement Driven care
    - Compliant with professional standards and funder expectations
    - Skills assessment and training for medical providers in the management of Co-occurring Conditions and the role of SDOH
- **Adequate Administrative Time and Sufficient Authority**
  - Management Medical Components of Care
  - Ensure Integration with Primary Care

Role of Care Coordination

- **On Demand Webinar on Care Coordination**
- **Building Client Skill Set and Resilience - Addressing Population Health**
  - Needs assessment – Shared Decision Making – Client Prep – Connect – Follow up
  - Establishing partnerships with Community Resources (BH/PC/SDOH)
  - Data Collection – QIPS – Improved Care Pathways
- **Building a Tiered System based on LOC Needs**
  - MH and SUD Management
  - Primary Care conditions
  - SDOH
- **Sustainability Planning**
  - Nursing Services
  - Intervention and Outreach Services

Care Coordination Agreements

- **Identify Community Partners with the shared goal of Integrating Clients Care**
  - Healthcare Providers and Systems
  - SDOH –Housing, Transportation, Education and Vocational, Food Insecurity
- **Strengthen Existing Partnerships and Build New Ones**
- **Create Mutually Beneficial Commitment to Work as Partners and put it in writing**
- **Update and modify as needs change**

Primary Care Integration

- **Primary Care Screening – Required CCBHC Activity**
- **Working with FQHCs and Provider Networks**
  - Establishing Care Coordination Agreements and DCOs
  - Collaborative Care Management (CoCM)
  - Hospital Systems
  - Public Health Departments
- **Onsite Primary Care Clinic/FQHC Look Alike/Health Home**
  - Autonomous Nurse Practitioners
  - Sustainability

Community Based Crisis Intervention

- **Single Point of Access**
  - Nurse Navigation
  - Peers Embedded in EDS
- **SAMHSA Crisis Service Toolkit**
  - Air Traffic Control Model
  - Regional Call Center
  - MRT
    - Collaboration with CJS and First Responders
    - Peers and clinicians with medical back up
  - CRC, Crisis Stabilization Services and Locus 4/5 SRT
  - Sustainability … state initiatives.

SUD/Co-occurring Services and ROSC

- **Medical Management of SUD Conditions**
  - Rescue – Narcan
  - Detoxification
  - “MAT” – Methadone, Buprenorphine, Naltrexone – oral or LAI
  - Post Acute Withdrawal
  - Co-occurring conditions
- **Spectrum of Services**
  - Residential vs. Community Based
  - Harm Reduction – Public Health and engagement
  - Maintenance – chronic medical condition

NOMS

- **Data to Drive Quality Improvement**
  - Relevance
  - SAMHSA looking into making changes
- **Workflow**
  - Additional Data Collection – Medical Elements
  - Monitoring – Collection Frequency
- **Documentation**
  - Duplication
  - EHR Resources
  - Data Capture and monitoring

Questions