Enhanced Access: Lessons Learned & Advice for CCBHCs

August 9, 2017
Today’s Faculty

Moderator: Rebecca Farley David
• VP, Policy and Advocacy at National Council
• CCBHC Policy Pro
• 10+ years in health system policy & financing

Presenter: Scott Lloyd
• President of MTM Services, Chief Data Consultant for SPQM, and Senior National Council Consultant
• Lead consultant for more than 700 Same Day Access and Just in Time Medical Scheduling Implementations in 42 states, Washington, DC and 2 foreign countries
Webinar Login Directions

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• **Enter your unique Audio PIN** so we can mute/unmute your line when necessary.
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Learning objectives

• Recognize the enhanced access requirements tied to CCBHC status/certification.
• Recognize the performance measures related to timely access to services.
• Understand the financial implications of no-shows under the PPS payment model, the impact on CCBHCs’ quality reporting requirements, and the opportunity for improved outcomes when enhanced access models are implemented.
• Compare lessons learned from other organizations that have successfully implemented enhanced access initiatives.
Why focus on enhanced access?

Because it’s better for clients
- Improves client experience of care
- Increases engagement with care
- Allows us to serve more people!

Because it’s required
- Standards of timeliness in CCBHC certification criteria
- Quality reporting requirements

Because it affects the bottom line
- Actual vs. anticipated visits
- No-shows have a greater impact on total yearly revenue under PPS vs. FFS
CCBHC Certification Requirements

General access criteria

CCBHCs must offer access to services “during times that ensure accessibility and meet the needs of the consumer population to be served, including some nights and weekend hours,” as well as 24/7 crisis care (including mobile crisis response teams)
Poll question

Do you currently offer:

• Evening and weekend hours
• Weekend hours only
• Evening hours only
• Neither, but we are planning to implement
• Neither, no plans to implement
Standards of timely access

- If a **crisis need** is identified, care must be provided **immediately or within 3 hours** at the latest.
- If an **urgent need** is identified, clinical services must be provided **within 1 business day**.
- If **routine needs** are identified, services must be provided **within 10 business days**.
- Subject to more stringent state standards, **all new consumers** must receive a person-centered diagnostic and treatment planning evaluation **within 60 days** of their first request for services.
CCBHC Quality Metrics

Directly related to access

• Number/percent of new clients with initial evaluation provided **within 10 business days**, & mean number of days until initial evaluation (CCBHC)

• Follow-up after emergency department (2 separate measures for mental health and for alcohol/other dependence, State)
  – 30-Day Follow-Up: An outpatient visit, intensive outpatient encounter or partial hospitalization, with any practitioner, **within 30 days** after the ED visit
  – 7-Day Follow-Up: An outpatient visit, intensive outpatient encounter or partial hospitalization, with any practitioner, **within 7 days** after the ED visit

Detailed technical specifications for each quality measure are available at [https://www.samhsa.gov/section-223/quality-measures](https://www.samhsa.gov/section-223/quality-measures), along with FAQs and the slides and recordings from SAMHSA’s quality webinar series.
CCBHC Quality Metrics

Directly related to access, cont.

• Follow-up after hospitalization for mental illness (2 separate measures for adult and for child/adolescent, State)
  – 30-Day Follow-Up: An outpatient visit, intensive outpatient encounter or partial hospitalization, with any practitioner, within 30 days after the ED visit
  – 7-Day Follow-Up: An outpatient visit, intensive outpatient encounter or partial hospitalization, with any practitioner, within 7 days after the ED visit

• Initiation and engagement of alcohol/drug dependence treatment (State)
  – Initiation: Initiation of AOD treatment within 14 days of diagnosis
  – Engagement: Two or more additional services within 30 days of the initiation visit

Detailed technical specifications for each quality measure are available at https://www.samhsa.gov/section-223/quality-measures, along with FAQs and the slides and recordings from SAMHSA’s quality webinar series.
CCBHC Quality Metrics

Indirectly related to access

• Patient and family experience of care surveys (State)
• Any quality metric involving following through on a planned course of treatment or monitoring improvement of symptoms/functioning (hint: all of them!)

Remember: quicker access means more value to the consumer in distress and increases probability of visits into the future!

Innovation Alert
Evaluate your intake and initial evaluation processes to see where they can be streamlined. How much & what client data are you collecting upon intake? Do you need to do an exhaustive psychosocial report, or can you do functional assessments & screens?
Financial implications of no-shows under PPS

**FFS:**
Clinic loses reimbursement for the service that would have been rendered (e.g. 45-minutes cognitive behavioral therapy)

**PPS:**
Clinic loses reimbursement for a portion of all services, activities and indirects over the course of the year
## Consequences of no-shows: an example

<table>
<thead>
<tr>
<th>Payment model</th>
<th>Loss to clinic as a result of no-show</th>
<th>End-of year difference between anticipated &amp; actual visits</th>
<th>Total loss to clinic as a result of no-shows</th>
</tr>
</thead>
<tbody>
<tr>
<td>FFS</td>
<td>$125 for 45-min therapy with psychologist</td>
<td>-1,000</td>
<td>$125,000</td>
</tr>
<tr>
<td>PPS</td>
<td>$305 for any encounter</td>
<td>-1,000</td>
<td>$305,000</td>
</tr>
</tbody>
</table>

Under FFS, clinic receives other reimbursement for services like case management → payment for those services is still available if client shows up for other appointments.

Under PPS, clinic does NOT receive other reimbursement for nonbillable activities like case management* → no-shows for any service hurt the bottom line for all services and activities.

*May vary by state; each state determines which activities are nonbillable.
Our recommendations:

- Follow up after any hospitalization or emergency department encounter: **3 days**
- Initiation of services for all new consumers or after a new diagnosis: **same-day**

**Innovation Alert**
Work with hospital partners to establish a notification system when your patients are discharged.

**CCBHC Advantage**
Assertive outreach for recently-discharged clients, care coordination with hospitals and electronic tools that support these functions can be built into your PPS rate!
For all patients/services, how long is the average wait time from intake/referral to first appointment?

- Same-day
- Within 1-3 days
- 4-10 days
- 11-30 days
- 31-60 days
- 61 days or more
- Don’t know
Poll question

For all services and clients, what is your current no-show rate?

• 0-5%
• 5-10%
• 10-20%
• 20%+
• Don’t know
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As Rebecca Reported on Access....

- Number/percent of new clients with initial evaluation provided **within 10 business days**, & mean number of days until initial evaluation (CCBHC)

- Follow-up after emergency department (2 separate measures for mental health and for alcohol/other dependence, State)
  - 30-Day Follow-Up: An outpatient visit, intensive outpatient encounter or partial hospitalization, with any practitioner, **within 30 days** after the ED visit
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- **Presenter’s Opinion** - These should be the worst case requirements.
The importance of the qualifying Threshold Visit.

- **Why is the Threshold Visit Important?** - Certain states are not counting certain crisis events like calling a crisis hotline, a service with an ER liaison, etc. as a threshold event (If the cost report is correct, then it shouldn’t be a loss. Care Coordination it not paid unless there is another triggering event.).

- **What is a Threshold Visit?** - Each state defines what this visit is (8 different ways), so make sure you know what your state’s guidelines are!

- Why teams can’t do a full assessment instead?
Client’s Definition of Access

1. Client Calls for Help
2. Assessment Appointment
3. Treatment Planning Appointment
4. Client Arrives for an Open Session
**A 1 State Example - 212 Access Flows**

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>Avg. Wait Time per Client</td>
<td>42.89</td>
<td>3-10</td>
</tr>
<tr>
<td>Avg. Client Time per Client</td>
<td>2.82</td>
<td>1.5</td>
</tr>
<tr>
<td>Avg. Staff Time per Client</td>
<td>4.77</td>
<td>1.75</td>
</tr>
</tbody>
</table>

*What Do our Actions Say to our Consumers?*
How did We Get to Here?

System Noise –
Anything that keeps staff from being able to do the job they want to do: Helping consumers in need!
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What Your Staff is Fighting -

Areas of System Noise –
1. Documentation
2. No Shows
3. Non-Billable Activities
4. Scheduling
5. Meetings

Photo Credit: Scott Lloyd Photography
System Noise Directly ties to these 2 of our learning objectives –

- Understand the financial implications of no shows under the PPS payment model, the impact on CCBHCs’ quality reporting requirements, and the opportunity for improved outcomes when enhanced access models are implemented.

- Understand need to revise staff productivity expectations to take into account how the new PPS rate methodology covers costs on average as opposed to cost of the specific service currently rendered.
• The impact of No Shows for a CCBHC –
  – Loss of a daily rate and/or monthly rate if that contact was the only one for the month.
  – Loss of additional time/money/resources is other staff deliver support that doesn’t qualify for reimbursement.
  – Direct impact on staff’s direct service production, which directly impacts their cost for care.
• The impact of low productivity on the cost per service for a CCBHC –

- A CCBHC has the advantage of being able to have an average cost per person if multiple services are delivered for that consumer against their PPS rate.
- If the Rate Setting was done correctly, then it should be enough to offset your costs for the services you are delivering.
- However, staff who have low direct service production will have a higher cost per hour delivered just like any other costing methodology, and that higher cost will increase the average cost per consumer per day/month.
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www.mtmservices.org

### Hours per Day
- **8**

### BH Standard
- **57.7%**

#### No Show %
- **30%**

### Available Hours Per Year
- **2,080**
  - Annual Leave / PTO: **256**
  - Personal / Holidays / Sick: **0**
  - Charting/Paperwork: **248**
  - Training/Staffings: **48**
  - Scheduling: **96**
  - Other Non-Billable Activity: **232**

#### Days Per Year

<table>
<thead>
<tr>
<th>Activity</th>
<th>Days per Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Leave / PTO</td>
<td>32.00</td>
</tr>
<tr>
<td>Personal / Holidays / Sick</td>
<td>0.00</td>
</tr>
<tr>
<td>Charting/Paperwork</td>
<td>31.00</td>
</tr>
<tr>
<td>Training/Staffings</td>
<td>6.00</td>
</tr>
<tr>
<td>Scheduling</td>
<td>12.00</td>
</tr>
<tr>
<td>Other Non-Billable Activity</td>
<td>28.98</td>
</tr>
</tbody>
</table>

### Non-Billable Hours: 880
- **Billable Hours: 1,200**
- **Non-Billable Days: 5.08**
- **Billable Days: 6.92**

### Cost Per Hour

<table>
<thead>
<tr>
<th>Salary</th>
<th>FB%</th>
<th>Salary + FB</th>
<th>Base Cost PH</th>
<th>Overhead %</th>
<th>Cost Per Hour</th>
<th>Avg. Revenue</th>
<th>Margin</th>
</tr>
</thead>
<tbody>
<tr>
<td>$34,000.00</td>
<td>30%</td>
<td>$44,200.00</td>
<td>$36.83</td>
<td>44%</td>
<td>$53.03</td>
<td>$62.00</td>
<td>$8.97</td>
</tr>
</tbody>
</table>

### Staff FTE %:
- **100.0%**

### Yearly BH Production
- **1,200**

### Quarterly BH Production
- **300.04**

### Monthly BH Production
- **100.0**

### Daily BH Production

<table>
<thead>
<tr>
<th>All Days</th>
<th>Minus PTO</th>
</tr>
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<tbody>
<tr>
<td>4.6</td>
<td>5.3</td>
</tr>
</tbody>
</table>

### No Show Percentage Driven Scheduling Rate

<table>
<thead>
<tr>
<th>All Days</th>
<th>Minus PTO</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.6</td>
<td>7.5</td>
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</table>

### Hours Weekly

<table>
<thead>
<tr>
<th>Hours Weekly</th>
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<tbody>
<tr>
<td>23.1</td>
</tr>
<tr>
<td>26.3</td>
</tr>
<tr>
<td>33.0</td>
</tr>
<tr>
<td>37.6</td>
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</table>
Eradicate your No Shows instead of working around them.
Eradicating your No Shows instead of working around them.

**Same Day Access Defined:** Same Day Access is the process of establishing the appropriate staffing and systems needed to offer a full Diagnostic Assessment on the same day it is requested to all consumers, without a scheduling delay or waitlist. This process greatly improves consumer satisfaction and engagement, while also eradicating no shows in the assessment process! MTM has moved more than 600 teams through this process and knows how to tailor it to the specific needs of each organization!

**Just in Time Prescriber Scheduling Defined:** This process allows teams to move a consumer from their diagnostic assessment to a psychiatric evaluation within 3 to 5 days, greatly increasing engagement and reducing no shows and cancellations.

This move improves that consumer's experience and the staff member's quality of life by removing obstacles like non-billable med call-ins that generate high levels of frustration.
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Eradicate your No Shows instead of working around them.

• When are the best times for Same Day Access?

• Are After Hour Appointment times right for you?

1. What are the most convenient times for you to attend Spectrum appointments?
   - 7am-9am
   - 9am-11am
   - 11am-1pm
   - 1pm-3pm
   - 3pm-5pm
   - after 5pm
   - any

2. What are the most convenient days for you to attend Spectrum appointments?
   - Monday
   - Tuesday
   - Wednesday
   - Thursday
   - Friday
   - Saturday
   - any

Or -

<table>
<thead>
<tr>
<th></th>
<th>7am-9am</th>
<th>9am-11am</th>
<th>11am-1pm</th>
<th>1pm-3pm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monday</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Tuesday</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wednesday</td>
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Putting It All Together

Clinical

Operational

Financial

Quality/Data

Actionable Strategies
Clinical Considerations

• Appropriate staffing is a must for SDA and JIT, not only your clinical staffing but your support staff as well.

• Build a quality assessment that captures the appropriate information to be billable, but leave out the other extraneous information that teams often capture but do not really need.

• Be ready for higher engagement levels and a higher return rate, which generates better outcomes and billing opportunities, but also creates a need to handle higher capacity.

• You need to build a back up plan for your clinical staffing model.
Operational Considerations

• Your documentation systems must be able to perform at a level that will allow you to attain the proper throughput times.

• Your scheduling systems need to support the practice of centralized scheduling.

• You have to have a client navigator to make this system work at its optimal levels.

• You need the appropriate facilities to welcome your consumers and meet the needs.
Financial Considerations

• For teams that implement this correctly, this is a financial win.

  – Same Day Access - Produces an average reduction of costs to perform intakes of $135,000 based upon our documented results.

  – JIT generates more revenue by taking time spent on free call ins and converting that to face to face billable time. Example - Teams in our GA project documented additional revenue increases up to 36% over their previous systems.
Quality/Data Considerations

• Do you have a way to track your available appointments versus the appointments utilized?
• Do you have a way to track your staff’s production?
• Do you have a way to track your Kept vs. No Show / Cancellation rates?
Questions
Get Help!

Peer Learning Network Participants

• Listserv Inquiries
  – ccbhc_cop@nationalcouncilcommunities.org

• CCBHC Resource Page
  – https://www.nationalcouncildocs.net/ccbhc-learning-community
Certified Community Behavioral Health Center Peer Learning Network and Master Class Community of Practice Home Page

Welcome to the National Council’s CCBHC Launch Pad! This site website provides a centralized virtual location for CCBHC Peer Learning Network and Master Class Community of Practice participants to access training and technical assistance resources. Please note that *denotes resources that are available exclusively to Master Class Community of Practice participants.

Upcoming Events

Living (and Thriving) Under PPS: What You Need to Know for the Year Ahead Register Now

Enhanced Access with Scott Lloyd from MTM Register Now

Change Management with David Lloyd from MTM Register Now

Past Webinars

Staffing for Success by Leveraging PPS with Dr. Yrima Little examined the opportunities and
Get Help!

Master Class Community of Practice Participants

CCBHC Resource Page
  – https://www.nationalcouncildocs.net/ccbhc-learning-community

Sign-Up for Faculty Office Hours

Attend an Affinity Group Call

Request Individualized Coaching
  ➢ Sign up here
Webinars

August 23 at 2pm EDT
Change Management

Sept. 6 at 2pm EDT
Best Practices in Care Transitions for CCBHCs (reg. link coming soon)

CCBHC Resource Page
https://www.nationalcounildocs.net/ccbhc-learning-community
Still have Questions?

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