Business Practices for the Future – Fee for Service
Regional Meeting Agenda

Course #2 Blue Team-Optimizing your Billing System to Improve Collections

Baltimore Substance Abuse Systems
Friday, November 12, 2010

AIM-Increase collections by xx%

Pre-work

1. Review the Billing Guide (complete page 7)-http://www.niatx.net/Action/promisingpractices.aspx
2. Complete page 7 of the Billing Guide and bring with you to the kickoff
3. Review the project form and instructions-http://www.niatx.net/content/contentpage.aspx?NID=43
4. Come prepared to discuss your collections rate and primary reason for denials (this can come from the information you used to complete the survey monkey back in October)

Time	Title	Presenter
8:30am – 8:45am	Registration/Breakfast	Vanessa
8:45am – 9:15am	Welcome and Simulation Exercise	Pauley/Jeanne/Chris
9:15am – 10am	Leadership Vision for this project Why NIATx? Why Now? Standing Laws & Policy State & Federal Allocation (Medicaid, Medicare) Third Party Billing Where to go to keep up to date on health care reform.	Vanessa
10am – 10:10am	Video of Pam Hyde/Kathleen Sebelius	
10:10 – 10:20am	Break	
10:20am – 11:05am	PI 101	Pauley
11:05am – 11:40am	Airplane Exercise	Pauley/Vanessa/Jeanne (?)
11:40am – 12:10pm	Resource Allocation -Who does what? -Dedicated Staff -Change Leader -Project Charters -Staffing	Vanessa/Pauley
12:10pm – 1pm	Lunch	
1pm – 2pm	Patient -Breakdown of bottle necks and barriers -Hand offs -Is the right decision maker doing the right steps? -Why do claims get denied?	Kim
2pm – 2:45pm	Finance 101: tracking your revenue	Kim
2:45pm – 2:55pm	Break	
2:55pm – 3:40pm	EDI HIPPA Paper Billing How to Buy/procurement	Kim
3:40pm – 4:25pm	Design/Change Project Charter	All
4:25pm – 4:35pm	Next Steps, Wrap-Up	Pauley/Vanessa

Welcome Exercise

While you are waiting for the workshop to begin,
As a group, please discuss the questions relating to the picture on your table

Reduce Waiting Times & No-shows • Increase Admissions & Continuation

NIATx Kickoff Meeting

November 12, 2010

Welcome!!

Goals and Vision for this Project?

- What do you want to accomplish with this project?
- How does this project fit into your vision and goals for your agency?

Vision for this Project

- Remain a successful agency in changing environment
- Be prepared for an expanding fee-for-service system
- Work on specific change processes within each agency to improve collection rate
- Apply NIATx principles to other aspects of your agency
- Turn problems into opportunities
- Embrace change!

Why NIATx?

- Proven track record
- Addiction focused
- Nationally recognized
- Provides training opportunity
- Expert technical assistance
- We have historically not focused on process improvement
- Concrete agency-level process improvement work
- Learned principles can be applied widely

Why Now?

- No time like the present
- Changing environment won't wait for us to get ready
- More FFS will be coming
- Opportunity to get ready is here
- The sooner you can improve your collection rate, the sooner you can sleep easier!!

Billing and Collecting Process

- Eligibility verification
- Authorization process
- Service documentation
- Bill creation and submission
- Explanation of Benefits (EOB) review
  - Paid
  - Denied
    - Correction
    - Appeal

ALL STEPS IN PROCESS CAN BE IMPROVED! YAY!!!!

Collection Rate

- A measure of revenue/collections vs. billings
- Target approximately 85-95%
- Rate is impacted by:
  - Payer mix
  - Coverage verification
  - Accurate tracking of authorized service units
  - Accuracy and timeliness of billing process
  - Success of resolving denials

Where Are We?

No. of Respondents	Bill Medicaid (%)	Billing ≥ 1 MCO	Claim Rejection Rate (%)	# of Contracts with Insurers/MCOs
7	100%	100.00%	Less than 20%: 66.7% Between 40-60%: 33.3%	None: 14.3% One-Two: 28.6% Two-Five: 14.3% ≥ Five: 42.9%

Standing Laws & Policy

- HealthChoice and Primary Adult Care (PAC)
- Five services are covered under the new self-referral protocol:
  1. Comprehensive Substance Abuse Assessment
  2. Individual Outpatient Therapy
  3. Group Outpatient Therapy
  4. Intensive Outpatient Therapy
  5. Methadone Maintenance

Rates

Service	Unit	Rate
Comprehensive SA Assessment (CSAA)	Per assessment	$142
Individual Outpatient Therapy	Per 15 minutes	$20
Group Outpatient Therapy	Per 60-90 minute session	$39
Intensive Outpatient Therapy	Per diem (minimum 2 hours per session and maximum 4 days/week)	$125
Methadone Maintenance	Per Week	$80

Assessment

- The CSAA is generally considered part of treatment and is not reimbursed separately.
- Comprehensive Substance Abuse Assessment will be covered under the following conditions:
  - Once per enrollee per program per 12-month period, unless there is more than a 30-day break in treatment;
  - Only if the enrollee is not already in SA treatment; and
  - If a patient returns to treatment after 30 days, the MCO/BHO will pay for another CSAA.

Assessment

- Additionally, MCOs will pay for CSAA separately when:
  - Provider does not offer level of care the enrollee requires and enrollee has to be referred to another provider;
  - Provider conducts CSAA, but enrollee doesn't return for treatment; and
  - Provider determines enrollee doesn't need treatment

Outpatient Services

- Self-referred individual or group therapy services must be provided in the community.
- For hospital rate regulated settings must get preauthorization for HealthChoice clients.
- MCO will pay for 30 self-referred sessions (any combination of individual, group, and family therapy) within 12-month period per client.
  - Providers must obtain preauthorization for more than 30 sessions within the 12-month period.

Outpatient Services

- To bill for family counseling, enrollee must be present for an appropriate length of time, but does not need to be present for the entire counseling session.
  - In some circumstances the counselor might spend part of the session with the family out of the presence of the enrollee.
  - Family therapy is billed under the individual enrollee's Medicaid number.
- All approval rules for HealthChoice apply for PAC, except that PAC only covers Level 1, individual, family, and group therapy in community-based settings.

Intensive Outpatient Services

- IOP is reimbursed only when care is delivered in a community-based setting.
- For hospital rate regulated settings must get preauthorization for HealthChoice clients.
- If the treatment plan is approved:
  - MCO will pay for services provided within first 30 calendar days of IOP.
  - At the end of week three (3), for care coordination purposes, the provider must notify the MCO of discharge plan or need for remaining treatment.
  - Additional days must be approved based on medical necessity.

Intensive Outpatient Services

- If determined that client **does not** meet ASAM LOC:
  - MCO will pay for all services delivered up until the point that they formally notify the provider of the denial.
  - If the client does not qualify for IOP, the MCO will work with the provider to determine the appropriate level of care.

Methadone Treatment

- HealthChoice covers methadone maintenance services provided in the community or in outpatient departments of hospitals.
- PAC only covers services provided in a community-based setting.
- If methadone treatment is approved:
  - MCO will pay for 26 weeks under the self-referral option.
  - Continued eligibility will be determined by medical necessity.
  - Additional approvals beyond the first 26 weeks will be at six-month intervals.

Where to Go for Updates on Healthcare Reform?

Maryland:
http://www.healthreform.maryland.gov/
Federal:
http://www.healthcare.gov/
State Associations of Addiction Services:
http://www.saasnet.org/PDF/Implementing_Healthcare_Reform-First_Steps.pdf
NIATx Health Care Reform Readiness Index:
http://www.niatx.net/hrri

NIATx
The Network for the Improvement of Addiction Treatment

PI 101: Using Rapid Cycle Improvement Methods

Pauley Johnson, PhD, NIATx Coach
Vanessa Kuhn, PhD, BSAS
Baltimore Learning Collaborative for Business Practice Improvement, Nov. 12, 2010

Reduce Waiting & No-Shows • Increase Admissions & Continuation

Objectives

- What is process improvement
- Why use process improvement
- Become familiar with rapid cycle methods

W. Edwards Deming

85 percent of the problems that organizations have in serving customers are caused by their processes

Changing Systems, Not People

- Deming – People cannot succeed in meeting a goal unless the system is designed to allow this to happen.
- "If the person succeeds, it is because the system is designed to generate success."
- Individuals need to be a part of changing systems that allow them to do their jobs better.

Process improvement is one way of making change. It uses an incremental improvement process that leads to gradual improvement over time.

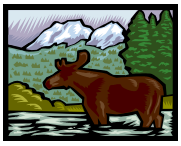
Some methodologies for process improvement that you may have heard of:

- TQM
- Six Sigma
- ISO 9000
- NIATx

NIATx Quality Improvement

The Moose is Loose (old way)

Plan change – Implement change (One Shot)



The Mice are Nibbling (new way)

Cyclic Improvement

NIATx Results

- Reduce Waiting Times: **51%** reduction *(37 agencies reporting)*
- Reduce No-Shows: **41%** reduction *(28 agencies reporting)*
- Increase Admissions: **56%** increase *(23 agencies reporting)*
- Increase Continuation: **39%** increase *(39 agencies reporting)*

Measuring and Changing Processes

- All processes have: inputs, steps to perform, and outcomes
- Data can be collected on each of these
- Changes can be developed and tested to improve them

NIATx Five Key Principles

Evidence-based predictors of change

- Understand & Involve the Customer
- Focus on Key Problems
- Select the Right Change Agent
- Seek Ideas from Outside the Field and Organization
- Do Rapid-Cycle Testing

1. Understand and Involve the Customer

- Most important of all the Principles
- What is it like to be a customer? Staff are customers, too!
- Flow charts, Org maps, Interviews, Walk-through, focus groups…

2. Focus on Key Problems

- 80-20 Rule: 80% of the problems with a process are caused by 20% of the elements of the process.
- ID bottlenecks (flowcharts and process maps)
- Talk with customers (payers) and staff
- Look at claims data

3. Select a Powerful Change Leader

Who has:

- influence, respect and authority across levels of the organization
- a direct line to the CEO
- empathy for the staff
- time available to lead change projects
- no fear of data
- challenges status quo

4. Seek Ideas Outside the Organization and Field

- Provides a new way to look at the problem
- Real creativity in problem solving comes from looking outside the familiar

5. Do Rapid-Cycle Testing

- Start by asking 3 questions
  - What are we trying to accomplish?
  - How will we know the change is an improvement?
  - What changes can we test that will result in an improvement?

Langley, Nolan, Nolan, Norman, & Provost. *The Improvement Guide,* San Francisco, Jossey-Bass Publishers, 1996

Rapid-Cycle Testing

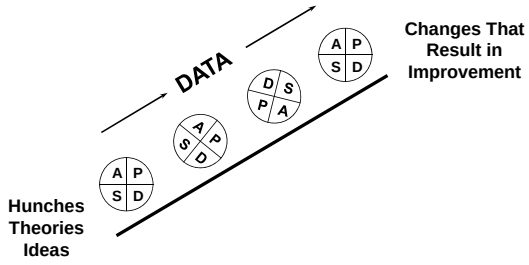
Rapid-Cycle changes

- Are quick; do-able in 2 weeks

PDSA cycles

- **P**lan the change
- **D**o the plan
- **S**tudy the results
- **A**ct on the new knowledge

Repeated Use of Cycle



Setting the Aim

- Be specific – baseline quantity and desired goal in numbers
  - E.G. Reduce # of claims rejected from 40% to 15%.
- Goal should be a stretch but attainable
- Aim is the "big picture"
- Change team will determine the changes to pilot to try to improve the aim

Planning a Change

- ONE change at a time!
- Keep it simple!
- COLLECT BASELINE DATA
- Clear and simple measures (can be collected weekly)
- Interim measure for fidelity
- Be Bold! This is an experiment, not a large scale permanent change.
- Have fun!

How will you know if a change is an improvement?

"I always wanted to be somebody, I should have been more specific." Lily Tomlin

- What will be the measure of improvement for your change cycle?
- Is it easy to collect the data?
- Who will collect it?
- How often will the team provide progress reports?

Was the Change Accomplished?

- Interim measures:
  - Increase in # of contacts with payers
  - Reduction in time to complete an invoice
  - Reduction in # of handoffs in a process

Did the Change Move the Aim?

- Final measures
  - % and actual value increases in collections
    - Overall
    - Due to reduction in claims denials for preauthorizations
    - Due to reduction in all claims denials for documentation errors
    - Due to increase in resubmissions

Implementing a Change

- Collect baseline data
- Clear action plans for team members with firm deadlines
  - agree to hold each other accountable
- Keep momentum, don't let change drag on
- Data collection and reporting at EACH weekly meeting

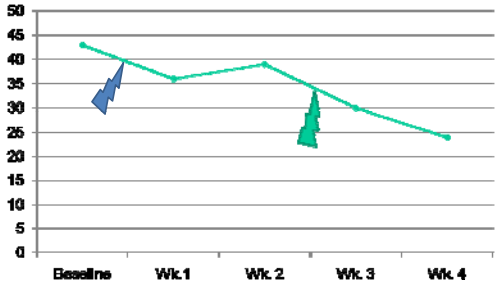
Study a Change

- Use data WEEKLY to determine if change is working
  - Aims and Interim data
- Get feedback from staff about problems implementing
- ASK QUESTIONS – Why is it not working? Why is it working?
- Develop hypotheses for how to make further improvements

Act on Cycle Outcomes

- Move quickly to action items for:
  - A modification of prior change
  - A new change
  - "Know when to hold 'em and when to fold 'em"
- Report cycle outcomes regularly to Executive Director, Board, other staff

% Claims Rejected – No Prior Authorization



EXERCISES IN DEVELOPING CHANGE CYCLES

For each of the following, suggest one change cycle and measures for the cycle:

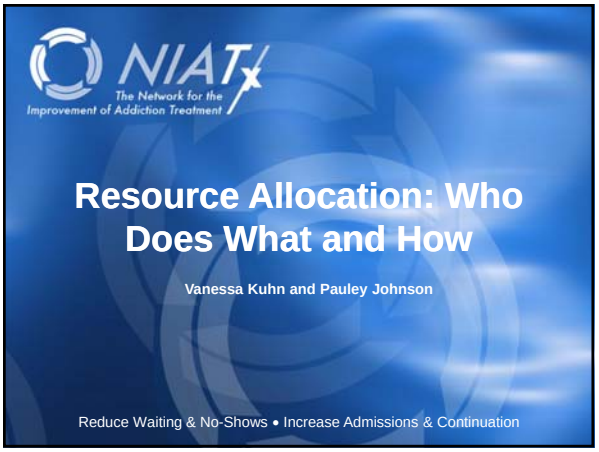
1. Prior authorization not consistently obtained
2. Too many handoffs in the billing process
3. Billing errors due to variations in requirements among MCOs

Specify possible interim and outcome measures for each of the following change cycles:

1. One person assigned to be contact/point person for payers.
2. Train staff in requirements for documenting services.
3. One person monitors claim denials and handles resubmits.

Every system is perfectly designed to achieve exactly the results it gets.

Paul Batalden



Objectives

- Understand the process of change
- Become familiar with Change Team issues
- Become familiar with key process roles and responsibilities (exec sponsor, change team leader, and change team members)
- Time Line and Project Charters

What Makes Change Happen?

- Resistance – inertia is norm
  - Personally efficient to continue doing things the same way
- Cost/Benefit – Is it worth the effort?
  - Where are we headed?
  - Is this really necessary?
  - What are the chances for success?
  - What will my role be?

Natural Planning Process

- Point A: Clear description of current reality
- Point B: Clear vision of what a successful outcome will look like
- Mind will naturally begin to fill gaps to get from A to B
- But will action naturally flow from this?

Motivating the Process of Change

- Create a sense of urgency for change
- Involve the "right" people
- Establish clear parameters of action
  - Accountability
  - Responsibility
  - Boundaries
- Group members trust each other to make it happen
- Mistakes and failures okay

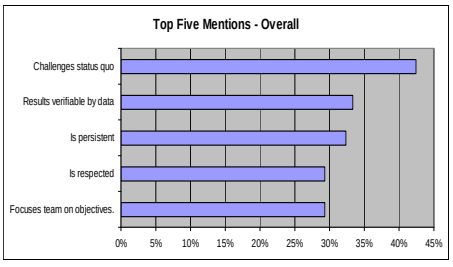
Executive Sponsor Role

- If we are successful, it will look like this (specifics are important here).
- It's okay to make mistakes!
- You can do it!
- I give you the power to do it!
- What have you done so far? (I care and am interested)
- Good job!

Exec Sponsor Activities

- Set aim and provide "vision"
- Support and encourage change leader
- Formally establish change team
  - Clarify team's level of responsibility and accountability
  - Model behavior – okay to make mistakes and to uncover problems
- Show interest and require reports
- Communicate team success to rest of org.

Change Leader Characteristics



Change Leader Responsibilities

- Serves as a catalyst to develop ideas
- Facilitates change team meetings and keeps team focused
- Consistent data collection
- Creative and engaging, inclusive with all members
- Keeps exec sponsor updated, reports on progress

Change Team Characteristics

- Is affected by potential changes
- Is close to the problem and the customer
- Represents a variety of perspectives
- Willing to suspend judgment/think broadly
- Willing to try new things

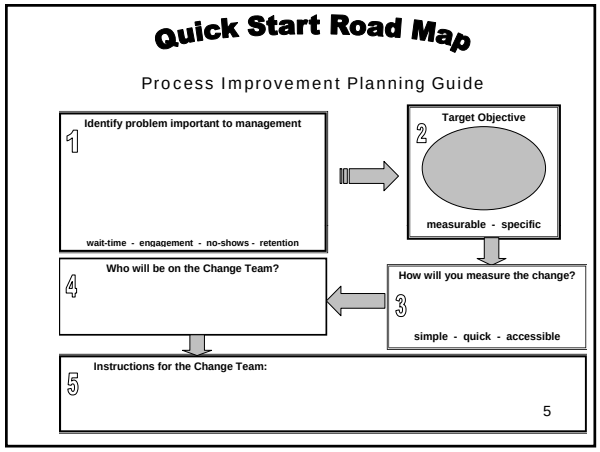
Planning a Service Improvement

Or, now that we have the theory, what do we actually do

Quick Start Road Map

- A graphic series of steps to make it easier to plan and implement a change
- Steps divided into leadership and change team responsibilities
- Assures that critical steps in the process will not be skipped

3



Role of the Executive Sponsor

- Senior leader in the organization
- Must see change/improvement as a priority
- Identifies the problem and articulates the vision
- Demonstrates commitment to the process (time, resources)
- Empowers the change leader

Quick Start Road Map

Leadership responsibilities:

1. Do a needs assessment and identify a problem important to management
   - Walk-Through
   - Focus Groups
   - Existing Data
2. Establish a target objective
   - Achievable
   - Specific
   - Measurable

Quick Start Road Map

Leadership responsibilities:

3. How will the change be measured?
   - Simple
   - Quick
   - Accessible
   - Who can record the data?
   - How frequently can it be gathered and summarized?

TIP: Data driven decisions are more objective and more readily accepted

TIP: Without data you have no way to gauge the success or effectiveness of a new practice

Quick Start Road Map

Leadership responsibilities:

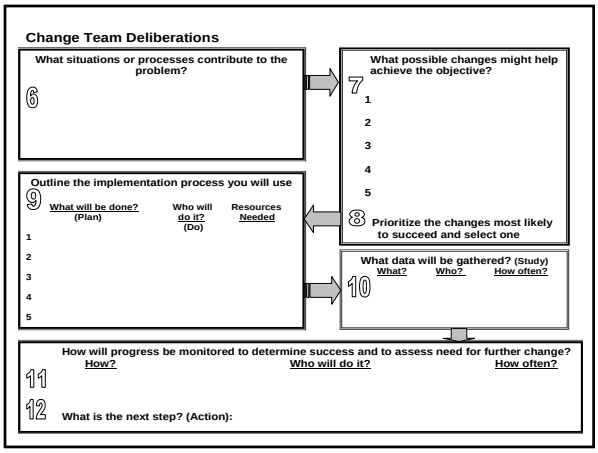
4. Who will be on the Change Team?
   - Change Leader
   - 3-5 Members
   - Work together until success is achieved
5. Instructions for the Team
   - Clear statement of problem with data
   - Priority for improvement
   - Clear objective
   - Promise of support and commitment

Selecting a Change Leader

- Person has sufficient power and respect to influence others at all levels of the organization.
- Person has the ability to: instill optimism, has big picture thinking, focused, goal oriented, a good sense of humor.

Change Leader Responsibilities

- Serves as a catalyst to develop ideas
- Successful communicator: facilitates change team meetings, consistent, concise (data), creative and engaging (incentives), skilled listener.
- Minimizes resistance to change
- Keeps the executive sponsor updated on change leader activities.



Quick Start Road Map

Change Team responsibilities:

6. Collaborate on what contributes to the maintenance of the problem
   - Agency processes
   - Unclear Interagency communication
   - Service design
   - Unclear expectations
   - Lack of knowledge or skill
   - Organizational policy
   - Others?

Frequent start-up issues

1. **Measuring** the impact of change
   - What measures to use
   - Documenting the change process
   - Recording data daily; reviewing data weekly
2. **Having the right people** in key roles
   - Executive Champion or Sponsor
   - Change Leader with time to do the job
   - Small enough Team to be effective
3. **Assuring key participants understand** the service improvement model and process
4. **Lack of customer involvement** in establishing a change objective

Communication: Key to Success

- Frequent meetings
- Consistent, concise (data)
- Creative, engaging (incentives)
- Truthful, authentic, real
- Authentic listening
- Continuous feedback to the organization

Other Keys to successful change and spread

- Align with the vision and values of the target audience (staff, client, community)
- Adopt a results orientation model of improvement
- Use skits, stories, analogies and metaphors
- "Engage, engage, engage, retain, retain, retain"

Every system is perfectly designed to achieve exactly the results it gets.

Paul Batalden

Overview

Topics to be addressed:

- Understanding and Documenting the Patient Flow
- Understanding and Documenting the Revenue Cycle
- Creating a Maximizing Reimbursement Environment

Patient Flow and the Patient Experience

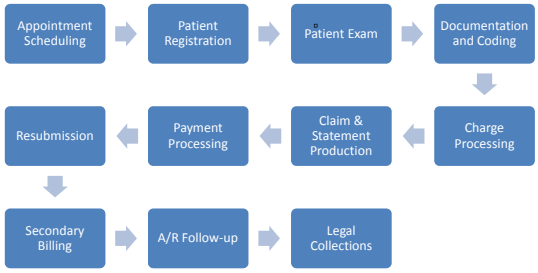
Patient Flow

It all begins when the patient needs services from the Behavioral Health Center

The Patient Experience

- What is it like to be your patient?
  - Perform a detailed walkthrough and document your patients' experience
  - Evaluate your findings and improve on the process
  - Tie in the ultimate patient experience with the ultimate revenue cycle

The Revenue Cycle



Appointment Scheduling: Goals

What should be the goals those of the Clinical Department and Patient Services?

- Schedule the appointment within time desired by patient
- Informed patient of the sliding fee process
- Inform patient to bring insurance card and co-payment

Appointment Scheduling Process

- Pre-registration
- Begin the revenue cycle
- Verification of insurance
- Authorization and certification of insurance
- Sliding fees policy

Patient Registration: Goals

- Insure Pre-authorization received
- Insure verification of insurance and PCP validated
- Sliding fee application completely filled out
- For all appropriate patients, collect co-pay and verify demographic information

Patient Registration Process

- **Revenue Cycle (For Appointments)**
- Verification of insurance
- Authorization and certifications
- Registration gathering demographics
- Initial review of financial requirements
- Co-pay collection for all appropriate patients

Patient Visit: Goals

- Reasonable/timely access
- Complete clinical service
- Informative to patient
- Appropriate documentation for patient care and for correct billing to third party

Patient Visit

- Patient identifies concern/problem
- Treatment provided
- Service documentation initially recorded

Documentation and Coding Process

Where it can go wrong!

- Clinician documenting service
- Service coding

Documentation & Coding Process

- Clinician documents services
- Services coded by clinician and/or coders: CPT codes (procedures), ICD-9 (diagnosis)

Documentation & Coding: Goals

- Documentation complete and signed by provider
- Codes accurately reflect patient service(s)
- Coding reviewed to insure it reflects documentation

Ensuring Proper Coding – High-Level Overview

- Collect data on provider visits (E&M Codes)
  - By individual Provider
  - In the aggregate for the health center
- Prepare graphs to show frequency of codes used
  - Show increasing intensity of visit from left to right
- Overlay Health Center providers and aggregate data on national averages
  - Include payor-source specific graphs

Charge Processing

Data Entry and coders enter data into Practice Management System

- Fee entered automatically or manually
- Claims Manager software scrubs entries for correctness
- Problems sent to department work file for processing
- Reconciliation performed to insure all entries received and entered into practice management system

Charge Processing: Goals

- Accuracy of service and charge
- Appropriate edits to scrub data
- Charges entered timely for prompt payment

Claim & Statement Production

- Claims edited to insure completeness and correctness
- Claims sent regularly to carriers for processing
- Claims flow electronic and paper
- Billing statements sent to patients for self-pay balances

Claim & Statement: Goals

- Get accurate claims out daily
- Increase % of electronic claims
- Keep average cost per claim better than benchmark
- Get statements out to patients for self-pay balances every Monday within the current billing cycle (30 days)

Payment Processing

- electronically or manually post remittances from payers and patients
  - Payments
  - Denials or rejections
  - Adjustments
- Refunds
- Reconciliation of charges, payments and adjustments

Payment Processing

- All payments and denials processed within 24 hours of receipt
- Process all refunds in a timely manner

Resubmission, Appeals, & Secondary Claims

- Invalid registration
- Medical documentation required
- Correct coding /charge corrections
- Missing referral/pre-authorizations
- Secondary claims and patient statement produced

Resubmission & Appeals: Goals

- All invoices requiring an appeal processed are completed within one week of receiving rejection
- Process all responses from clinical departments within one day of receiving information
- All secondary claims submitted within a week of receiving primary payment

A/R Follow-up

Follow-up on...

- Payment arrangements (budget plans)
- Red flag rules
- http://www.nachc.com/client/documents/FTC_Red_Flag_ITPP_IB_4_8_09%5b1%5d.pdf
- Improve claim edits as an outcome
- Bad debt transfer

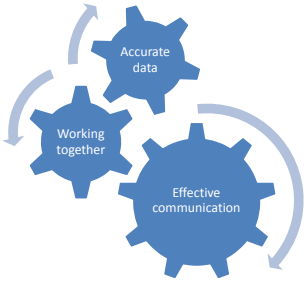
A/R Follow-up: Goals

- Process all denials requiring departmental involvement within one week of receipt of reject
- Follow-up on all outstanding requests with clinical departments within one week of initial request
- Follow-up on all “no response” invoices within 45 days of submission of claim

Legal Collections

- Actions if any to be determined by Executive Staff & Board

A successful Revenue Cycle depends on…



Common Reasons Claims are Denied

- The Patient is not enrolled
- The service/procedure is not covered
- No pre-certification/authorization is on file
- Demographic mistakes on the claim
- Claim not timely filed

Strategies to avoid denials

- Select Implementation Tasks:
  - Incorporate standards and policies that guide personnel.
  - Establish analysis for denials
  - Coordinate training of clinical staff and billing personnel.
  - Develop a standard feedback mechanism for professional employees.
  - Institute regular chart/billing reviews to assess compliance and to identify issues requiring further education.
- Measure performance at the front desk
  - Select standard measurements for accuracy of data collection
  - Establish minimum thresholds for staff to meet

Billing and Revenue Strategies

Billing and revenue strategies are intended to improve the billing and collections process in the Health Center and encourage the effective use of staff who perform these functions.

Common goals and objectives achieved through billing and revenue strategies:

- Increased patient revenue.
- Improved collections rates.
- Reduced medical coding errors.
- Cost savings of doing it right the first time.

Steps for the Board and Executive Management to Ensure the Health Center has a Maximizing Revenue Culture

- Establishing a culture of Revenue Maximization with Board, staff, patients, and community
- Setting the health center up for success – operationally
- Regular reports and monitoring
- Intervening when necessary

ACTION CAMPAIGN
FINANCIAL STRENGTH IN A CHANGING WORLD
An initiative of NIATx

Let's Imagine you Work for General Mills

This is the product you need to sell

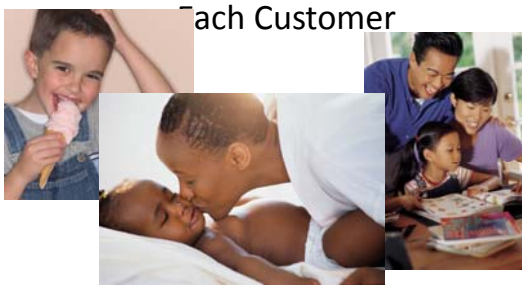
Who Is Your Customer?

- The kid that will eat it?
- The dad that bought it?
- The mom whose job paid for it?

Three Types of Customers

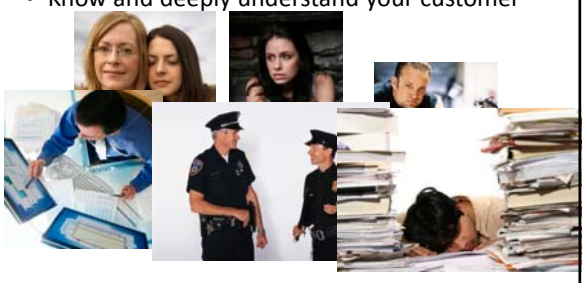
- End user of the product or service
- The purchaser of the product or service
- The payer

What Do You Need to Know about Each Customer



NIATx First Principle

- Know and deeply understand your customer



Who Is Your Customer?

- The client
- The family
- The state
- Referral Sources
- Let's add managed care companies and insurers

You have a lot of customers to understand!

What do You Need to Know About Each Customer?

The End User

What Do You Need to Know About Each Customer?

The Purchaser

What Do You Need to Know About Each Customer?

The Payer

What does this have to do with third party reimbursement?

Everything!

Knowing and understanding the purchaser and the payer needs is *almost* as important to running your business as knowing the end user of your services' needs

Where do I begin?

Let's do a walk through

Walk Through Results

Were you asked about insurance?

What information does your agency collect about insurance at first contact?

What was the response to the patient that asked if you took their insurance?

Is there anything you want to change?

Where Do I Begin

Billing for treatment is a very systematic process

Following the procedure is key to success

A Billing Process Map

NIATx Five Principles

- Understand your customer
- Focus on key problems
- Choose a powerful change leader
- Get ideas from outside the organization
- Rapid cycle changes

An Exercise

Divide into groups of five

Roles: State authority
MCO
Provider Executive Director
Provider Clinician
Patient

Roles

- State Authority: Your budget is about to be cut again! You get calls from people who can't get services and last week you were informed of a young man who died of an overdose while on a waiting list. You want treatment agencies to start billing for services and you don't understand what all the angst is about

Roles

- MCO: You have a budget to manage to. You are supposed to keep costs low so that your company doesn't lose contracts because prices go up too high, but you also don't want consumer complaints because that will make you lose contracts too. These behavioral health contracts are the worst. There doesn't seem to be any standard of care and the providers can't articulate what they are doing.

Roles

- Provider Executive Director: You know if your agency is going to be around in five years that you have to do a better job with collections. You are frustrated with the complexities of the systems and you are frustrated that your staff just don't seem to get that they don't have a job if you don't get paid.

Roles

- Provider Clinician: You are not paid enough to deal with all of this bureaucratic BS. Your client is obviously sick and they are authorizing out-patient counseling only in increments of four sessions at a time. Surely you are spending as much time dealing with the insurer as you are with the client.

Roles

- Patient: You have called three treatment centers. They all have a waiting list and of course the only one that takes your insurance has the longest waiting list. Your family is getting tenser by the day, your boss is getting less and less patient with you and if you don't get treatment, you are going to jail for your DUI. You thought having insurance was supposed to mean you had health care.

Aim

Meet the need of the people who are not getting treatment even though they have insurance

What is one thing that you could try?