

Rethinking the Behavioral Health Organization

Ronald L. Ravneberg

R1

A Re-engineering
Source Book

The Health Systems Consulting Re-engineering Series

- R1 – A Re-engineering Source Book
- R2 – An Information Systems Source Book
- R3 – A Strategic Information Assessment Guide
- R4 – A Sample Information System Request for Proposals

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Health Systems Consulting is a component of TURN,
a management and consulting joint venture chartered to
help behavioral health organizations reach their goals
through performance and process improvement.

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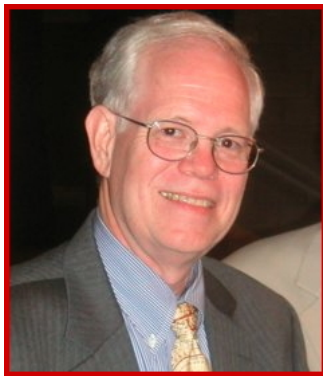
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He has an extensive consulting background, both as an independent consultant and as a representative of the National Institute of Mental Health (NIMH), where in addition to his health systems consulting he developed instructional courses and advised on media presentations. He has served as faculty for the NIMH Staff College in the areas of management information systems and medical records.

Mr. Ravneberg's experience includes work with behavioral health organizations in over 35 states, providing consultation in organizational re-engineering, selection and implementation of information systems, consumer outcomes, and management use of data. He has also worked closely with major developers of behavioral health information systems, advising on software operation and documentation, industry needs and requirements, and production of marketing plans. He has also been a regular contributor to *ONE Magazine: The Integration of Healthcare & Technology*.

In 1993 he founded Health Systems Consulting, a national management consulting company to serve the behavioral health industry. HSC provides a full range of decision support consulting to mental health and retardation organizations, psychiatric facilities, state mental health and retardation program directors and other health and behavioral health organizations. Mr. Ravneberg is also a founding partner of TURN, a management and consulting joint venture chartered to help behavioral health organizations reach their goals through performance and process improvement.

The volumes of *Rethinking the Behavioral Health Organization* bring together his 30+ years of hand-on experience to help today's behavioral health organizations identify and resolve issues related to organizational processes and decision making.

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1

A Re-engineering Parable

Several years ago I was traveling on a major airline to visit a client's organization that was experiencing funding cuts and reductions in staffing. It was a night flight and we were flying through the clouds and fog that are typical of winter journeys. There was little to watch out the window so I was thinking about ways to explain to people besieged by regulation and change that they should look beyond the immediate crisis and try to work toward creating an organization that can survive and thrive in the long-term.

You know ... the standard alligator and swamp dilemma.

As we were approaching the airport, the plane encountered an unanticipated wind shear, began to shudder, and then basically stopped flying. It was as if someone had cut a cord that was holding us in the air.

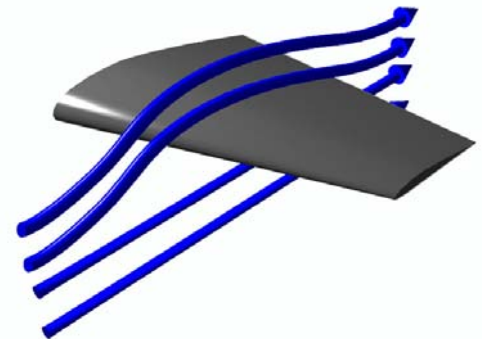
The pilot did exactly what he was supposed to do and exactly the opposite of what "common sense" would dictate. Even though we were already falling, he nosed the plane further downward and throttled the engines to maximum power. The plane immediately accelerated, leveled itself, and resumed flying as before.

The whole episode lasted only a few seconds, and we probably lost little more than a hundred feet of altitude. The flight continued normally, and several minutes later we were safely parked at the gate.

I realized I had just observed an interesting example of understanding challenges and responding to them appropriately. At a time when the most intuitive action seemed to be to keep the plane's nose up, the pilot pointed the nose down and "stepped on the gas." Any pilot will tell you that it's the only course of action that will get a plane out of a stall.

I now had a story to tell my clients about dealing with their crisis. They got the point, stopped letting the "intuitive" drive their decision making, reorganized for success and are thriving today.

A colleague recently commented to me that as a rule, behavioral health organizations are reluctant to spend money on organizational and administrative improvements; they seem



to think that any resources not directed toward direct service are wasted. It doesn't matter that an organization might not know if its services are appropriate, effective, or delivered at a cost greater than their reimbursement. It only matters that "billable hours" are maximized.

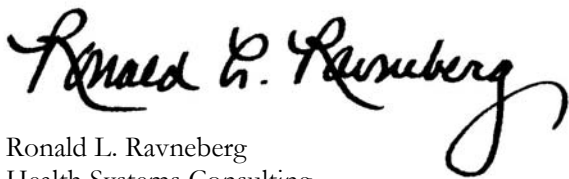
In such an environment, an additional requirement like re-engineering is often seen as just another imposed initiative on top of the "real" work. More rules and regulations. More things that need to be checked off a list. More, more, more. Do it now!

Maybe not. Maybe now's when you should stop trying to solve immediate problems immediately, step away from traditional and intuitive reactions, take a deep breath, and look closely to see how everything can fit together in a simpler model that better addresses what you're trying to accomplish as an organization. Then build that model.

Other organizations will think you're heading for oblivion because you're not attempting multiple solutions for multiple problems and trying to solve them all at once.

Just tell them that there are times, even when the plane is falling, when it is appropriate to point the nose toward the ground and step on the gas.

They won't understand ... but you will.



Ronald L. Ravneberg
Health Systems Consulting

2

The HSC Re-engineering Series

I have served you better, if upon departing, you can follow the path rather than follow the guide.

Unknown

The HSC Re-engineering Series was created to provide executives and managers of behavioral health organizations with a detailed reference that can help them take a fresh look at their organizations.

So what is the HSC Re-engineering Series really about?

It is about Clinically-Based Re-engineering — the process of making changes to your organization that will facilitate consumer treatment and recovery. The HSC Re-engineering Series does not concentrate on the “clinical specifics” of re-engineering; rather, it focuses on methods designed to get decision-makers to understand clinically-based re-engineering. Once that’s accomplished, it outlines processes to help them mobilize their organizations to implement a consumer-centered approach.

Is the HSC Re-engineering Series about the Clinical Process? No. But it is about how the clinical process is at the heart of what behavioral health organizations do. The clinical process is the reason they exist, and it’s the process around which they can (and should) structure everything else they do.

Is the HSC Re-engineering Series about Information Systems? No again. The flow of information is central to the successful operation of a behavioral health organization. For that reason, much of the content of the HSC Re-engineering Series is about information and information systems. However, the series is not a technical “bits and bytes” look at information systems, but instead presents a high level view of the role of information in decision making, how information flows through a system (and the organization), how to determine what information is important, and how to select an information system that will meet the organization’s needs.

Finally, is the HSC Re-engineering Series a “Cookbook” with step-by-step instructions? No again. Although it contains a number of specific techniques and examples, the HSC Re-engineering Series isn’t designed to simply be a list of re-engineering instructions; it’s intended to be an overview of principles, goals, obstacles and techniques that, taken collectively and internalized, can equip the reader with the primary tools required to undertake a clinically-based re-engineering project.

The underlying theme of the HSC Re-engineering Series is that the best approach to coping with the complexities of operating a behavioral health organization in today's highly-regulated environment has four parts: (1) *resist* the temptation to create short-term solutions for immediate problems; (2) *return* to the basic reason the organization exists — to provide care to people in need; (3) *rethink* the entire organization to see how everything you're trying to accomplish can fit together in a simpler model; and (4) *re-engineer* the organization using that model.

An organization re-engineered around the information necessary for consumer-centered decision making will meet most outside regulatory and accreditation requirements.

Volumes in the HSC Re-engineering Series include:

- *R1 – Rethinking the Behavioral Health Organization: A Re-engineering Source Book* is the first volume in the HSC Re-engineering Series and is organized to help the reader: (1) understand the principles underlying a clinically-based re-engineering project; (2) assess his or her own organization's need for such a re-engineering project; (3) learn some helpful techniques for clinically-based re-engineering; and (4) structure teams to facilitate and ensure the success of the project.
- *R2 – Rethinking the Behavioral Health Organization: An Information Systems Source Book* is the second volume in the HSC Re-engineering Series and is organized to help the reader: (1) understand the background and evolution of behavioral health information systems and the role of computers; (2) understand what to expect from a comprehensive behavioral health information system; (3) learn how to evaluate system vendors and select an appropriate system; and (4) gain insight into the process of implementing systems and staffing for their successful operation.
- *R3 – Rethinking the Behavioral Health Organization: A Strategic Information Assessment Guide* is the third volume in the HSC Re-engineering Series and is organized to help the reader understand what a strategic information assessment is, and how it fits into organizational re-engineering and system improvement efforts.
- *R4 – Rethinking the Behavioral Health Organization: A Sample Information System Request for Proposals* is the fourth volume in the HSC Re-engineering Series, and is organized to correspond to the sections of a typical behavioral health information system Request for Proposals (RFP).

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Organization of the Current Volume

R1 - Rethinking the Behavioral Health Organization: A Re-engineering Source Book is the first volume in the HSC Re-engineering Series and is divided into several chapters to help the reader: (1) understand the principles underlying a clinically-based re-engineering project; (2) assess his or her own organization's need for such a re-engineering project; (3) learn some helpful techniques for clinically-based re-engineering; and (4) structure teams to facilitate and ensure the success of the project.

Specifically, the chapters are as follows:

- **Survivor Organizations: Plain Talk for Executives** — This chapter focuses on the executive as primary change agent within the behavioral health organization, and includes a review of how the behavioral health industry has evolved, the changing role of the executive, and some of the characterizes of survivor organizations.
- **Setting the Stage** — This chapter links all operations to the organization's mission and vision. The goal is twofold: (1) to get the reader to understand that the consumer is the reason the organization exists; and (2) to demonstrate that organizing around the consumer's care and recovery is not inconsistent with good operations, and is, in fact, the optimal approach for long-term organizational success.
- **Components of Clinical Re-engineering** — This chapter reinforces the clinical process as the core of the re-engineering process, and begins with a discussion of the clinical partnership required for success in a consumer-centered organization. The all-encompassing scope of clinical re-engineering is further defined. The chapter then identifies six major system components of a consumer-centered system and their consistent themes — the use of performance/quality measures; feedback mechanisms; and consumer and family involvement.
- **Symptoms of the Need to Re-engineer** — This chapter identifies a series of symptoms exhibited by organizations in need of re-engineering and places a re-engineering effort in the context of the issues experienced by administrators and other decision-makers.

- **Gearing Up for Re-engineering** — How extensive should a re-engineering effort be? This chapter encourages looking to the organization as a whole, and avoiding the reactionary process of fixing “symptoms.” Subsequent sections discuss information flow, taking the information lead, and the relationship between re-engineering and information flow. In addition, the reader is encouraged to consider both the costs of re-engineering and (possibly more important) the costs of not re-engineering.
- **Re-engineering Project Essentials** — Organizational re-engineering is a major undertaking, and the people involved in the project can use all the help they can get. This chapter addresses a series of issues that can facilitate a re-engineering project, maximize the opportunities for success, and minimize organizational culture shock.
- **Re-engineering Teams** — Re-engineering draws upon the skills of a variety of staff. This chapter outlines a structure of re-engineering teams to address varied parts of a re-engineering project. Principles for team operation and individual tasks for each team are defined.
- **Helpful Re-engineering Tools** — This chapter describes useful techniques to help the reader: (1) clarify the critical aspects of an issue before trying to resolve it; (2) facilitate the setting of results-based organizational objectives; and (3) analyze performance problems that can impede the re-engineering effort.
- **Re-engineering Recommendations** — The purpose of recommendations is to provide clear, persuasive cases that others can feel confident in adopting. The appendix provides details and a format for demonstrating: (1) the need for the proposed changes; (2) the appropriateness of the changes to the needs they address; (3) the effectiveness of the change in resolving the problems; and (4) the validity of the costs and resources needed to accomplish the change.
- **Life Signs: Measuring How You’re Doing** — In order to make appropriate organizational management decisions for the future, you must have a clear picture of where you stand at any given point in time. This chapter discusses a selection of easy to compute, intuitive measures that allow quick assessments of the health of the organization — a few critical “life signs” that give a measure of how you’re doing.
- **Appendix A: A Few Thoughts About Productivity** — The term “productivity” is a slippery one at best; it means different things to different people. This appendix: (1) describes what constitutes a productivity measure; (2) provides a series of examples of how different definitions of productivity could be used; and (3) demonstrates how a wide variety in productivity calculations can be made from the same data.
- **Appendix B: Case Studies in Clinical Re-engineering** — This appendix presents a series of “real-world” examples where behavioral health organizations have undertaken consumer-centered re-engineering projects.

- Appendix C: The Ohio Outcomes Initiative — This appendix provides background information about the Ohio Mental Health Consumer Outcomes Initiative and Values-Based Decision-Making to create a frame of reference for understanding the other materials in the manual. The appendix concludes with a description of the flow of outcomes information through the organization, followed with a description of the roles and responsibilities of the wide range of participants in a well-engineered outcomes-based clinical process.

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Survivor Organizations: Plain Talk for Executives

Lead, follow, or get out of the way.

Thomas Paine (1737–1809)

At the recent meeting of one statewide association of behavioral health agencies it was announced with a certain amount of satisfaction that the state's behavioral health organizations would be flat-funded for the next fiscal year. No increases whatsoever. And everyone was elated.

Happy at no new funding? Hello?

Well, when you consider that the state in question was one of only 12 states to receive either the same or increased funding for behavioral health, the reason for the joy becomes a bit clearer. Unfortunately, however, it also meant that three-quarters of the states experienced a real decrease in program funding. Does one state's good fortune mean that it's out of the financial woods? Is anybody out of the woods? Probably no more than the man who jumped off the Empire State Building was out of the woods when he was heard to say as he passed by the fifth floor, "So far, so good."

There are still more tough times to come, but things will eventually get better. Behavioral health isn't going away, but all of the current players won't survive. There will be casualties in the funding struggles, but there will also be survivors.

These books are designed to help your organization make the changes necessary to be one of the survivors.

Who's Going to Make Change Happen?

You are. Not your staff. Not your board. You.

I know you're busy. We're all busy. But you are the executive, aren't you? So be executive and direct. There's nobody else to do the job and it won't get done unless you take charge and set the pace.

On my first day of work in behavioral health over thirty years ago, I noted a poster hanging over a fellow employee's desk. It simply stated, "Not to decide is to decide." Today the message is as relevant as ever. If you don't decide how you're going to handle a situa-

tion, the situation will decide for you. Ignoring or learning to live with the problems isn't good enough.

Remember the story in news recently about the rock climber who got his hand trapped under a boulder and had to amputate it in order to survive? Not pretty ... but real. He knew that such a drastic action was the only way he could live to tell his tale. He also knew that there was nobody else who could make the decision for him. So he just did it.

The Changing Role of the Executive Director

Several years ago I listened to a presentation by one Executive Director in which he described how the behavioral health industry had changed for his and similar organizations during the three decades he'd been involved. First he posed the question, "How did we get where we are?" He then described the process as follows:

- First you simply said you wanted to help people and they gave you money.
- Later they asked for outcomes, then they gave you money.
- Later they asked for outcomes and costs, then they gave you money.
- Later they asked for outcomes and costs and consumer feedback, then they gave you money.
- Finally they have asked for outcomes and costs and consumer feedback and organizational efficiency relative to other providers. But even with all that, it doesn't necessarily mean that they will give you any money!

Not a bad description of what has been an organizational roller coaster ride.

Over that same period the role of the executive in behavioral health organizations has also evolved. Not surprisingly, behavioral health executives have been shaped by the way their organizations have been funded.

The Community Service Years

At the outset of the community behavioral health movement, many behavioral health centers were flush with funds provided by Federal staffing and operations grants. It seemed that all one needed to do was form a board of directors, apply for a staffing grant from the National Institute of Mental Health, hire a staff, and start serving consumers.

In those early days, there were some psychologists and other behavioral health professionals at the helms of organizations, but there were also board secretaries and other individuals with little prior training or experience who served in the role of executive.

The main criteria for the job were a dedication to community service and a willingness to take on the pressures of the behavioral health mission.

The Clinical Years

By the early part of the 1980s, behavioral health centers had established themselves as viable organizations. Behavioral health had become a profession; it was no longer looked upon as simply a community service.

Accreditation and certification were the bywords of the day. Many of those organizations that had previously been served effectively by individuals who brought only a strong dedication and a willingness to work hard found themselves needing stronger clinical direction.

Federal grants were disappearing and the remaining public funds were being directed toward consumers with more serious impairments as state psychiatric hospitals emptied in a wave of deinstitutionalization. Fees for services were still available (and abundant by today's standards), but there was less money for activities not directly related to treatment.

Innovative treatment programming offered the organization the best way to capture additional funding. The more and varied the programs, the more funding there was available. It followed that if organizations were to become much more complex clinically, then the executives of those organizations would have to have more clinical experience in order to lead.

So, as members of the community service wave of executives retired or moved on, they were often replaced by former clinical program managers and other "superclinicians." "After all," the thinking went, "he/she is a good clinical manager; he/she would probably also be a good executive.

The Business Years

Just when you thought it was safe to go back into the Executive Suite ... another shift.

During the "clinical" years payers reimbursed organizations for what they did. With few exceptions, that all stopped with the introduction of managed care, case rates and other attempts at slowing runaway inflation of medical costs. The tables had turned. Now the behavioral health organization was faced with payers who wanted to define what constituted care. Whereas before the payers paid what the organizations did, now in order to get paid the organization had to do what the payer would reimburse.

That meant that the cost of running an organization and the income stream for that organization were severed. Just because an organization had expenses and did "good" things for consumers didn't mean that anyone would pay dollar one.

Finding the best path through the competing needs of the organization and the payer was a business problem, so as members of the clinical wave of executives retired or moved on, they were often replaced by former business managers and other "MBA types."

Whither the Future?

Which brings us to today.

Time for another shift. There is great dissatisfaction and disillusionment with behavioral health organizations forced by external funding sources to do everything for a buck. Whatever happened to community service? What about clinical need?

It seems we've tried most of the characteristics it takes to be a successful executive (i.e., talent and interest, clinical training, business acumen). In earlier times, the demands of the job were such that one could often be a successful leader while possessing only that characteristic relevant to the times (i.e., public servant, clinician, businessperson).

But that's no longer the case. Not that those characteristics are no longer necessary. They are! It's just that having one or two characteristics isn't enough anymore. Today there is only one combination of characteristics that will reliably equip an executive to deal with the pressures of operating a behavioral health organization, and that is to have them all.

How Good Do We Have to Be?

In the land of the blind, the one-eyed man is king.

Desiderius Gerhard Erasmus (1465–1536)

Don't waste your time worrying about the overall state of the economy and large-scale funding for behavioral health, because you probably can't do anything about either. Work on what you can change — making your organization a survivor. Remember that it isn't the mountains ahead that wear you out, it's the grain of sand in your shoe. Build a survivor organization, and you'll be able to handle the tough times.

Consider the following anecdote:

Two campers were hiking in the forest when all of a sudden a bear jumped out of a bush and started chasing them. Both campers started running for their lives. But soon one of them stopped and started to put on his running shoes.

Looking back over his shoulder, his partner yelled, "What are you doing? Those shoes won't help you outrun a bear!"

His friend replied, "I don't have to outrun the bear, I only have to outrun you!"

In other words, he understood that although the bear might eat somebody, it wouldn't eat everybody.

A similar situation exists in behavioral health. Do you have to have the "best" organization in order to stay in business? Maybe not, but you do have to be pretty good, and you certainly have to be better than your competitors.

A “Real” Organization, or One In Name Only?

Samuel Johnson, that 18th century man of letters and author of the first great dictionary of the English language, defined the word “essay” as, “a loose sally of the mind; an irregular indigested piece; not a regular and orderly composition.” While such looseness may be acceptable when composing an essay, it leaves much to be desired when creating and managing an organization.

To run with the dictionary theme for a bit, let’s look at a couple of words.

- Organization — Something made up of elements with varied functions that contribute to the whole and to collective functions; a structure through which individuals cooperate systematically to conduct business.
- Organize — To put together into an orderly, functional, structured whole.

The one thing common to both definitions is the concept of structure. In other words, it takes more to create a “real” organization than a board of directors, staff members and a tax designation from the Internal Revenue Service.

To put it bluntly, “real” organizations are organized. Not just in some places, but from top to bottom, and including all of the following:

Mission — *The definition of the job*

Policies — *Accepted ways of approaching the job*

Procedures — *What staff are told about how to do the job*

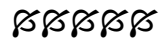
Operations — *How the organization is set up to support the job*

Then What?

Being a “real” organization doesn’t mean you can relax as soon as your own shop is in order. Rather, “real” organizations recognize that they are part of a larger industry comprised of other organizations like themselves. And then they act.

Find other organizations like yours and establish informal associations to talk about common problems. Help those who wish they were where you already are, and seek help from those who are where you want to be. Work with each other and share tools and techniques you find helpful; your peers will probably like them too. And they may give you something useful in return.

Finally, be proactive and take the lead in determining where the industry is going. Take advantage of existing groups to lobby for change. Become an active member of your local state behavioral health association. Get involved in the major initiatives that are changing the environment in which we work. Other people have been telling you what you need to be doing for years, but it usually hasn’t been because they were smarter than you were; it’s been because they were part of the decision-making groups and you weren’t.



Alfonso X (1221-1284), otherwise called “Alfonso the Wise” is to have made the comment, “Had I been present at the creation, I would have given some useful hints for the better ordering of the universe.”

Well, Alfonso wasn't present so couldn't contribute. You, on the other hand, are present today and have the opportunity to bring about change. You just have to do it.

Ronald Reagan said it pretty well ...

If not us, who? And if not now, when?

5

Setting the Stage

Value is the predecessor of structure.

Robert M. Pirsig

You've got to accentuate the positive

Eliminate the negative

Latch on to the affirmative

Don't mess with Mister In-Between

Johnny Mercer

Behavioral Health Re-engineering

Organizational processes in most behavioral health organizations often result from a large number of arbitrary decisions, made by a variety of people, over an extended period of time, in response to multiple situations, using then-available technology. In this document, you will learn ways to review and evaluate those prior decisions to determine what changes need to be made to re-engineer your organization to achieve outcomes for consumer recovery.

It's important in this context to understand what the term "re-engineering" means and what it does not mean. First, re-engineering does not mean that you have to scrap everything you do and start over. Re-engineering is not intended to:

- indict either the current processes or those who produced them;
- second-guess well-made decisions of the past that no longer stand up under the changed priorities of the present; or
- criticize the organization and how it has evolved.

Re-engineering does mean that you should revisit the key decisions that shaped your current organizational processes in the light of today's needs and the pressing need for effective decision making and consumer recovery. Re-engineering is intended to:

- understand and place in context both the strengths and weaknesses of the current system;
- trace the many working relationships that run through the organization;

- evaluate what the organization has become;
- map the current organizational information and decision flows, not with an eye to replicating them, but in order to better build new ones; and
- create more effective and efficient systems and processes that can facilitate consumer care and recovery, and carry the organization into the future.

The Behavioral Health Marketplace

The behavioral health world is changing, and not always for the better. Today new management and financial challenges confront behavioral health organizations, not the least of which are reduced funding, increased regulation and more competition. The behavioral health program manager must give continuing attention to program costs, service income and financial self-sufficiency. The challenges are compounded in many instances by the problematic structure of many Federal programs that support care.

The catch phrase these days for behavioral health programs is to “run them like businesses.” This does not mean that profits are more important than people are. However, it does mean that behavioral health organizations cannot be casual about their approach to management. Behavioral health managers are beginning to use information to assist them in decision making, and to help them gain better control of how their organizations are running.

Managers cannot manage if they are uncertain of the behavioral health organization’s “product,” how well the product is delivered, how effective the product is, how much the product sells for, or how well the organization does in collecting revenues for that product. Like every other care provider, behavioral health organizations need effective tools to help in assisting consumers, managing programs, and gathering revenue.

Toward that end, processes are being implemented to manage time and event information for everyone from managers to clerks; they are tallying encounters and describing the services delivered, the outcomes achieved and the costs incurred by those encounters. These data are grist for the mill of decision making.

But are the processes the right ones, given the mission at hand?

The Behavioral Health Mission

Most behavioral health organizations function within mission statements that define the consumer and care-oriented nature of their work. Those missions, in turn, have significant implications for any re-engineering efforts designed to enhance consumer care and recovery or improve the use of information in decision-making. The rapidly changing behavioral health environment further exacerbates the challenges faced by behavioral health organizations. To help ensure survival in an uncertain future, the behavioral health

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organization's primary task is to develop effective consumer-centered decision-making techniques and to use those techniques to facilitate consumer care and recovery.

Let's look at a typical behavioral health mission statement. The Ohio Department of Mental Health (ODMH) has adopted the following to guide its work:¹

Vision

Ohio will be a community of mentally healthy people who lead fulfilling and productive lives. It will be a caring community with strong compassion for and a determination to respond effectively and respectfully to the needs of all citizens with mental illness and behavioral disorders.

Mission

The mission of the Ohio Department of Mental Health is to establish mental health and recovery from mental illness as a cornerstone to health in Ohio, assuring access to quality mental health services for Ohioans at all levels of needs and life stages.

Values

Ohio's mental health system is committed to these values:

- *Respect — We treat all people with respect and dignity. We support individual choice and build on the strengths of individuals, families and communities.*
- *Integrity — We are honest and ethical in all our dealings. We keep our promises and are accountable for our actions.*
- *Dedication — We are committed to helping every Ohioan with mental health needs. Our goal is to exceed the expectations of those we serve.*
- *Quality — We strive to provide the highest quality services to the people of Ohio. We embrace and respect individual and community differences and provide clinically competent services and interventions in a manner that is acceptable to consumers and families and that help them to achieve the outcomes they desire.*
- *Teamwork — We promote partnerships that reach across system and organizational boundaries.*

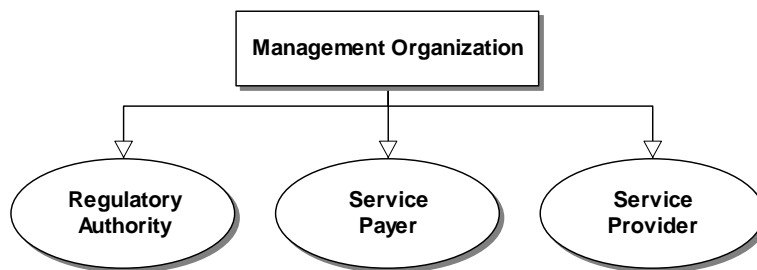
The above mission reinforces the statement made earlier that organizations like ODMH, behavioral health boards and individual providers exist to provide care to people in need and to facilitate consumer recovery. The mission is an important one, and a variety of funding sources ranging from the citizens of the state to private insurance carriers and corporations are willing to pay for such care. Because both people's lives and money are involved, tracking the services provided by a behavioral health organization is a critical task.

¹ While the ODMH mission statements may differ in details from the specific mission statements of other behavioral health organizations, it is fair to say that the ODMH statements are representative of the others.

Behavioral Health's Multiple Roles

Possibly the single most important factor understanding and managing the modern behavioral health organization is the recognition that it frequently does not function as a single organization. Rather, it provides the functions of at least four distinct entities, each of which has its own management needs and key performance indicators. The comprehensive behavioral health organization is, at a minimum: (1) a regulatory authority responsible for the delivery of behavioral health services (whether or not it delivers those services itself); (2) a payer to other care providers; (3) a provider of services; and (4) a management organization that must manage its various components and make strategic decisions concerning their operations.

The Behavioral Health Organization's Multiple Organizational Roles



The Role of Regulatory Authority

Frequently behavioral health organizations are responsible for overseeing, measuring and monitoring the delivery of services that are outside their direct control. The focus of the regulatory authority role is on ensuring that appropriate services are received by appropriate consumers. To measure its performance as a regulatory authority, the organization will be making decisions in response to questions such as:

Are the "right" consumers receiving behavioral health care?

Are the services delivered in line with perceived need?

Are consumers receiving consistent, quality care?

Are the appropriate services available when needed?

Are service costs consistent across providers? Should they be?

The Role of Service Payer

Behavioral health organizations are often managers of Medicaid and other funds that help defray the cost of the behavioral health care delivery system. In its role as payer, the organization's focus should be on achieving the greatest possible impact for the funds it has available and ensuring that appropriate services are reimbursed according to negotiated contracts. To measure its performance as a payer, the organization will be making decisions in response to questions such as:

Are we paying our providers correctly and on-time?

Are we paying an appropriate amount for services?

Can we purchase comparable services cheaper from other sources?

Do our payment and contracting procedures facilitate the best possible use of resources for the delivery of consumer services?

The need is greater than the resources available. Do our payment and contracting procedures facilitate the lowest possible rate of reimbursement for the delivery of consumer services?

The Role of Service Provider

Behavioral health organizations are also major providers of direct inpatient and outpatient services. Decision making in the provider environment is typically focused on areas such as:

*Intake, Termination & Transfer
Service Recording
Clinical Reporting
Consumer Scheduling*

*Clinical Records Management
Managed Care
Utilization Review
Quality Assurance*

To measure its performance as a service provider, the organization will be making decisions in response to questions such as:

Are we providing the best possible care for our consumers, given the resources available?

Are we operating our organizations as efficiently as we can?

Are the services being delivered in line with our contracts with payers?

Are we getting paid correctly and on-time?

Are we getting paid an adequate amount for services?

Can we justify a higher rate for the services we provide?

The need is greater than the resources available. Do our payment and contracting procedures facilitate the highest possible rates of reimbursement for the delivery of consumer care?

The Role of Management Organization

In addition to its roles as regulatory authority, service payer and service provider, the behavioral health organization is also charged with its own management, per se. As such it not only monitors the operations of the other functional areas, but it provides them with certain centralized services. The management organization is also responsible for helping to shape internal policy, and implementing the decisions made by its board of directors, management team and external regulatory bodies. Decision making in the management organization focuses on areas such as:

<i>Administration</i>	<i>Credentialing</i>
<i>General Ledger</i>	<i>Payroll</i>
<i>Cost Accounting</i>	<i>Accounts Payable</i>
<i>Budgeting & Forecasting</i>	<i>Fixed Assets</i>
<i>Billing/Accounts Receivable</i>	<i>Cash Management</i>
<i>Collections</i>	<i>Materials Management</i>
<i>Contracts Management</i>	<i>Community Relations</i>
<i>Human Resources</i>	<i>Operational Data from Other Roles</i>

To measure its performance as a management organization, the organization will be making decisions in response to questions such as:

Are we operating according to our mission statement?

Are we improving the overall quality of the care we provide?

Does the delivery of behavioral health care conform to national norms and standards?

Are our actions consistent with the wishes of the board of directors, management team and external regulatory bodies?

Are we appropriate guardians of the public trust?

Making Everything Work Together

For the behavioral health organization to be successful overall, it must recognize that it performs multiple roles and must be successful in each. The process will not be a simple one. In many cases, the needs of various organizational roles overlap. However, upon closer examination, it can be seen that the type of information and the level of detail required are different for each organizational role.

As an example, the table on the following page provides a brief comparison of some of the information requirements of the service payer and service provider functional areas with respect to service tracking and reimbursement. Both functional areas have to respond to the following issues:

<i>Enrollment Verification</i>
<i>Authorizations & Limitations</i>
<i>Claims Processing</i>
<i>Contract Management & Reimbursement</i>
<i>Clinical Information</i>
<i>Cost Analysis</i>

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However, how they respond to the issues is quite different. The organization as a payer is able to address only those contracts it administers. The organization as a provider, however, not only has to respond to its own payer contracts, but also has to be prepared to address similar contracts from other funders. As a result, the type of information and the level of detail required is significantly greater for the provider.

Therein lies the challenge. A decision making model will have to provide effective tools and performance indicators for use within each separate functional area. Additionally, the model will have to integrate the multiple roles into a single approach that facilitates organization-wide strategic management decisions. No individual component of the organization can succeed at the expense of another. All must be successful if the behavioral health organization is to prosper in an uncertain environment.

A Comparison of Information Requirements

	Service Payer Requirements	Service Provider Requirements
Enrollment Verification	<p>Access to Benefit Plan Enrollment</p> <p>Medicaid Eligibility Determination</p> <p>Non-Medicaid Eligibility Determination</p>	<p>Access to Benefit Plan Enrollment</p> <p>Medicaid Eligibility Determination</p> <p>Non-Medicaid Eligibility Determination</p> <p>Other Payer Contracts Not Related to the Above</p> <p>Enrollment Verification Prior to Scheduling and Service Delivery</p>
Authorizations & Limitations	<p>Access to Authorization Status</p> <p>Service Authorizations & Referrals (Future?)</p> <p>Benefit Limitations (Future?)</p>	<p>Access to Authorization Status</p> <p>Service Authorizations & Referrals (Future?)</p> <p>Benefit Limitations (Future?)</p> <p>Other Payer Contracts Not Related to the Above</p> <p>Service Authorization & Limitation Verification Prior to Scheduling and Service Delivery</p> <p>Fitting it <u>All</u> Together in One Place</p> <p>Utilization Monitoring & Excess Usage Warnings (<u>Provider At Risk</u>)</p>
Claims Processing	<p>Claims Processing</p> <p><u>Standard</u> Claim Formats</p> <p>HCFA-1500, UB-92</p> <p><u>All</u> Claims Submitted Electronically</p>	<p>Claims Submission</p> <p><u>Flexible</u> Claim Formats</p> <p>HCFA-1500, UB-92, Others</p> <p><u>Some</u> Claims Submitted Electronically</p>

	Service Payer Requirements	Service Provider Requirements
Contract Management & Reimbursement	<p>Defined Contract Management <i>Providers submit a basic claim. Payer has contract management for payer's contracts only.</i></p> <p><i>Contract Management Parameters Indemnity, Capitated, Prior Authorization</i></p> <p><i>Profiling Credentialing, Service Category Restrictions</i></p>	<p>Flexible Contract Management <i>Need to Prepare a Variety of Claims</i></p> <p><i>Contract Management Parameters Indemnity, Capitated, Prior Authorization</i></p> <p><i>Profiling Credentialing, Service Category Restrictions</i></p> <p><i>Copays Percentage, Amount, Both</i></p> <p><i>Payment Application Open Item, Balance Forward</i></p> <p><i>Revenue Management Adjustments to Revenue, Financial Management</i></p>
Clinical Information	<p>Minimum Clinical Information Required to Process Claim <i>Medical Necessity</i> <i>Outcomes</i></p>	<p>Maximum Clinical Information Required to Provide Care <i>Medical Necessity</i> <i>Outcomes</i> <i>Medical Records</i> <i>Treatment Plans</i> <i>Audit Trails</i></p>
Cost Analysis	<p>Minimal Need for Cost Analysis <i>Simple: Cost = Payments</i></p>	<p>Full Cost Analysis to Minimize Risk <i>Capture of <u>All</u> Costs</i> <i>Time Recording</i> <i>Payroll Distribution</i> <i>Payables Distribution</i> <i>Tracking of Bad Debt</i></p> <p><i>Unit Costs</i> <i>Minimize Risk</i></p>

Implications for Process Re-engineering

It is a riddle wrapped in a mystery in an enigma, but there is a key ...

Winston Churchill

Given that the rate of change in the behavioral health industry is now possibly greater than the rate at which you can analyze the change (much less respond to it), what is the best approach you should take as you prepare your organization for an uncertain future?

- Tradition? — Simply continue to do things the way you've always done them?
- Intuition? — Just think about the problems as they occur and then simply do what "seems right" at the time?

– or –

- Action! — Actually take a look at what's happening and re-engineer the organization along clinical quality lines.

Sure, it's a trick question and the correct answer is obvious. If it's so obvious, however, why do so many behavioral health organizations keep trying to handle change with traditional or intuitive models?

In his comment above, Winston Churchill noted that, "there is a key." In the case at hand, that key is clinical re-engineering.

Any decision-making process should be designed to support the mission of its parent organization. To support effectively, the process should possess several important characteristics:

- Strategically-Focused — Mission statements are, by their very nature, strategic statements fundamental to long-term decision making and operations. Any supporting information structure should provide information that supports decision-making at the strategic level, and not simply limit itself to operational data.
- Organization-Wide Implementation — To address the requirements inherent in its mission statements, the process should encompass all components of its organization, including clinical, administrative, fiscal and operational.
- Consumer-Centered — The consumer is the reason behavioral health organizations exist, and any re-engineered process should place the consumer (and not the organization) at its focus.

In each of the above items the organization, per se, is secondary; it's the organization's consumers that are primary focus. Therefore, it is appropriate that plans for continued development and evolution of any re-engineering project should also proceed along consumer-centered lines.

Re-engineering Projects

Despite the potential benefits to be gained from process re-engineering, how to undertake a successful re-engineering project may still be an unanswered question for many behavioral health organizations. There are also other concerns; re-engineering projects can cause organizational distress by exposing conflicts in the organization (e.g., staff territoriality, overlapping responsibilities, management problems, personality clashes).

Therefore, re-engineering should be approached positively. By itself, the information contains no imperatives, effects no control, makes no decisions — it only reflects what is going on in the care delivery system. A re-engineering project can (and should) act as a barometer for what is happening within the organization. Because the clinical process touches each part of the organization, a re-engineering of the clinical process will also.

Such an in-depth review of the clinical process is appropriate because the role of information within behavioral health organizations is changing as we enter the 21st century. In the entitlement world of the past twenty years, one simply did what was “right” for the consumer, billed for whatever one did, and used an information system solely to record and report services. Under today’s more highly structured care management models, the individual consumer’s needs and benefits are much more a part of the care delivery process (e.g., consumer recovery, specialized service contracting, restrictive credentialing requirements, benefits enrollment and verification, prior authorizations, clinical necessity). As a result, the proactive use of consumer-centered information has become the method whereby one does business.

In many ways, the use information for decision making has moved from being a passive process at the end of the care delivery chain to being an active component at the front.

That’s why you re-engineer.

6

Components of Clinical Re-engineering

The cosmos is all that is, or ever was, or ever will be.

Carl Sagan

While clinical re-engineering might not be as sweeping as Carl Sagan's definition of the cosmos, at times it feels pretty close. Often the first question asked about clinical re-engineering is, "who and what is involved?" In consumer-centered behavioral health organizations it's probably easier to ask, "who and what isn't?"

Consumer-centered clinical re-engineering has the potential of touching virtually everyone involved with a behavioral health organization. Why? Because the primary business of behavioral health organizations is the delivery of care and almost everybody involved with the organization is involved with care delivery.

This chapter presents a lot of information about both the components of clinical re-engineering and consistent themes that occur through the process; but be careful not to lose sight of the forest for the trees. As you review the information in this chapter, try not to focus on the details; instead, continually reprocess the information in the context of:

- consumer-centered focus;
- active involvement of staff;
- staff and consumer self-management through feedback; and
- movement toward outcome management and away from process management.

If you do so, you will gain a better understanding of how the varied components of clinical re-engineering can relate to your organization.

Consumer-Centered Management

The materials in this manual describe a process of re-engineering organizational processes that places the clinical process at the center of the re-engineering efforts. The model is based upon several assumptions about re-engineered processes:

- Quality-Driven — Quality is the foundation of clinical re-engineering. Clinical quality has three major components:
 1. Consumer Care & Recovery — Clinical quality must be consumer-centered and focused upon consumer care and recovery.
 2. Professional Standards — Clinical quality must be consistent with your standards as clinical professionals.
 3. Community Responsiveness — Clinical quality must be consistent with the values of the larger community such that the community will respond positively and support your efforts.

Quality is like a three-legged stool; all three legs must be present or the stool will not stand. Organizational quality doesn't just occur; you have to make it happen.

- Consumer-Centered — Re-engineering should focus primarily on the consumer (and not the organization).
- Strategically-Focused — Re-engineering should provide information that supports decision-making at the strategic level.
- Organization-Wide Implementation — Re-engineering should encompass all components of its organization, including clinical, administrative, fiscal and operational.

Partners in the Clinical Process

Nexus: 1. A connection, tie, or link between individuals or a group, members of a series, etc. 2. The group or series connected.

Behavioral health organizations exist for one purpose — to provide care to people in need. The clinical process, however, extends far beyond the simple consumer-clinician relationship. In fact it involves almost everyone who works closely with the consumer, both inside and outside the behavioral health organization, including:

<i>Consumers</i>	<i>Clinicians</i>	<i>Supervisors</i>
<i>Support Staff</i>	<i>Administrators/Managers</i>	<i>QI/Compliance Staff</i>
<i>Support Staff (MIS)</i>	<i>Consumer Family Members</i>	<i>Community Support Groups</i>

The nexus of the clinical process is a working partnership of the above groups, where a care management plan that reflects the diversity, strengths, abilities and needs of the consumer is negotiated, implemented, and evaluated.

Each of the above parties has an important role to play in the clinical process. Those roles, in turn, only produce real results that enhance consumer recovery when: (1) each party respects the rights, abilities and uniqueness of the others; (2) there is sufficient time to allow it to be an iterative process; (3) everyone is working in concert with each other; and (4) all of the parties are supported by appropriate organizational policies, procedures and materials.

Outcomes & Behavioral Health

You can't tell which way the train went by looking at the tracks.

Frederick L. Newman

As stated before, behavioral health organizations exist to provide care to people in need. Consequently, each service delivered becomes an important measure for looking at a behavioral health organization. That fact remains true whether one's perspective is clinical, administrative, fiscal or operational.

That basic service unit can be broken down into an 11-part question, as follows:²

1. *Who*
2. *received how much of*
3. *what service*
4. *from whom,*
5. *when,*
6. *where,*
7. *within what program,*
8. *reimbursable by what source of funds,*
9. *for what amount,*
10. *at what cost,*
11. *and with what effect?*

Traditional behavioral health management models have been structured around the first 10 items. Reports can tell you everything you might want to know about how many people were seen, services were delivered, or dollars were spent. But such quantitative measures are about the provider, and tell us little or nothing about the consumer. In Newman's language, they're "tracks."

Outcomes information, on the other hand, focuses on how the consumer fared, and not simply on what the provider did. As a result, understanding item 11 of the 11-part question demonstrates the value of the services provided from the consumer's perspective.

Consumer outcomes provide important information for the management of consumer care, the improvement of the service delivery system, and accountability for public resources.

- Management of Consumer Care — Consumer outcomes data provide information for both clinical and administrative care management.
- Quality Improvement — Aggregated consumer outcomes provide data for the ongoing quality improvement processes of agencies, boards and state behavioral health authorities and for developing and monitoring best practices.

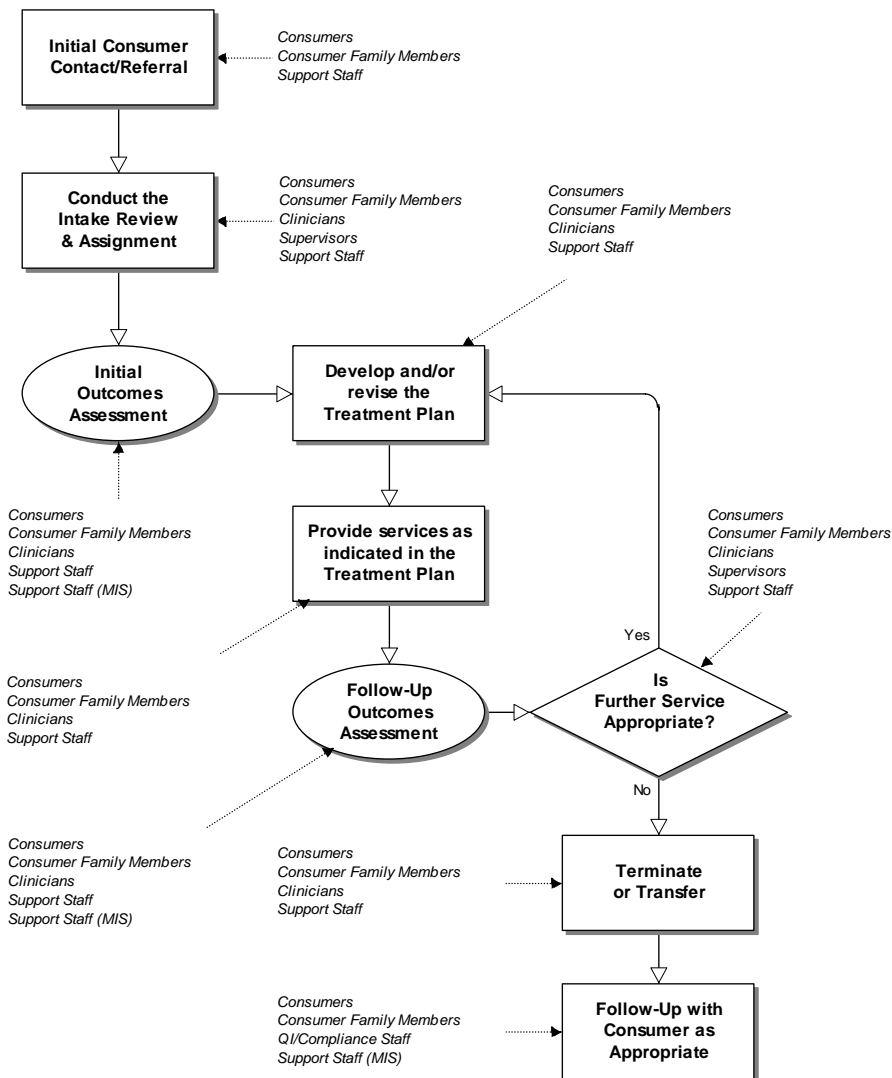
² Obviously, there are more pieces of information required to run a behavioral health organization, but if one can track the above 11 items for all key activities, and tie them back to additional details about the total resources available, the recipients of the services, the providers, and other important factors, one would be able to report most of what is required to operate and support a behavioral health organization.

- **Public Accountability** — The results obtained concerning consumer outcomes demonstrate the public behavioral health system’s accountability for tax dollars to the general public and to the state and federal governments.

Outcomes data can be of use to consumers and their family members, behavioral health professionals, provider organizations, behavioral health boards, state authorities, and the general public.

The diagram below provides an abbreviated view of an outcomes-based clinical process and identifies some of the parties that are involved in each step.

The Realm of Clinical Re-engineering



The diagram is actually much more comprehensive than it appears at first glance. For example, “Support Staff” (who are present in each process in the diagram) include a wide range of people and roles, including:

- people who answer telephones, direct calls, schedule appointments, and greet people in the reception area;
- financial services staff who monitor benefits, send out bills, maintain accounts, and assist with consumer questions related to the complexities of billing and accounts receivable;
- clinical records people who work to ensure that clinical records are complete, organized, and available;
- human resources personnel who process consumer applications for internal job openings and help with the myriad of payroll and benefit issues that arise;
- kitchen staff who prepare and serve meals;
- maintenance staff who clear the snow from the sidewalks in the winter; and
- almost everyone else who is related to the behavioral health organization and has direct or indirect contact with consumers and their families.

If you think carefully about each step in the clinical process, you will begin to get an idea of the degree to which a consumer-centered clinical process permeates the entire organization. It accomplishes little to have a few isolated pockets of consumer-centrism if the rest of the organization pays little heed to anything beyond its own immediate needs and wants. Therefore, when you consider the clinical process in a re-engineering effort, think in a fashion that encompasses the entire organization.

Re-engineering Scope

*No man is an island, entire of itself;
every man is a piece of the continent, a part of the main.*

John Donne

In a consumer-centered system, everyone works in the context of appropriate consumer-centered policies and procedures, has the tools and technologies required for the job, and has been trained in the effective use of resources. But it doesn't end there; applying policies, procedures, tools and training that are applied in isolated programs isn't enough.

In an orchestra, not only does each participant need sheet music appropriate to his or her instrument, but everyone's sheet music must be for the same song. In other words, the entire process must be “orchestrated” to work together across the group.

It's no different in behavioral health; consumer-centered processes need to be organization-wide, procedures need to be consistent, common tools and technologies need to be available, and the rules need to be known by all.

All of the following must not only be present, but must be consistent throughout the organization if clinical re-engineering is to be effective:

Mission — *The definition of the job*

Policies — *Accepted ways of approaching the job*

Procedures — *What staff are told about how to do the job*

Operations — *How the organization is set up to support the job*

Components of a Consumer-Centered System³

There are six major system components that need to be in place for ongoing management of a consumer-centered system. Each of them needs to be incorporated in any clinical re-engineering project.

1. Program Design — Program design is the process of relating care to program goals for consumers. Key aspects of program design include:
 - identification of consumer-centered program goals and services;
 - relating program goals to care planning and coordination;
 - assurance of dependable and useful measures of consumer behaviors and care goals (i.e., consumer outcomes);
 - relating internal program management measures to external reporting and monitoring; and
 - training of staff and consumers to be able to both maximize the utility of program design decisions, and to contribute to their continued evolution.
2. Clinical Process Design — Clinical process design describes the concerns and decisions of consumers and staff during consumer entry, care planning and delivery, and termination from a care program. Key components of clinical process design include:
 - identification of key information needs related to the admission or entry process (Who is the consumer? What are the initial outcomes? Is the consumer in the right place?);
 - identification of key information needs related to care planning (What are the issues? What events are to happen?);

³ Adapted from Frederick L. Newman and James E. Sorensen in *Integrated Clinical and Fiscal Management in Mental Health* (1985).

- identification of key information needs related to the review process (Is care provision occurring as planned? What are the interim outcomes? What changes are needed?);
 - identification of key information needs related to the termination and follow-up processes (Were goals met? What are the final outcomes? Is follow-up required?); and
 - training of staff and consumers in the use of the above information to help achieve the goals of consumer recovery.
3. Visible Evidence — Visible evidence includes clinical records and other processes that foster and support dependable clinical communication. Key components of visible evidence include:
- development of clinical record systems that are proactive facilitators of consumer care, instead of being reactive administrative paper repositories;
 - identification of factors that influence clinical data validity, reliability and dependability;
 - continued refinement of consumer outcomes information and reports for use in initial assessment and recovery planning, progress monitoring over time, and subsequent treatment decisions;
 - use of consumer outcomes and clinical records information as a supervisory aid, and to look at patterns of service use and service benefits among different groups of consumers; and
 - training of staff and consumers in the use of the above information to help improve the quality and effectiveness of treatment.
4. Fiscal Management — Formulates cost-finding procedures to relate costs and clinical efforts. Key components of the financial system include:
- development of techniques for estimating costs of service for each consumer in ongoing management;
 - setting of rates and fees to be charged and billed;
 - creation of models for planning resource allocation (budgeting) to match the goals of programs and care;
 - definition of processes that can interrelate the cost and effectiveness of care; and
 - training of staff and consumers in the use of financial information to help them manage their respective roles in the clinical process.

5. Management Structures — Describes the supporting roles of staff in relationship to the care delivery process. Key components of management support include:
 - identification for all staff of the questions and issues they address in support of those who perform the clinical process; and
 - training of staff and consumers in their roles with respect to the clinical process.
6. Information Technology — Provides the linkages among consumers, staff, and managers in providing and managing care delivery. Key components of management support include:
 - identification and linkage of data sources for measuring key performance indicators as required for assessing the achievement of organizational goals;
 - preparation of timely individualized reports for use by consumers, families, clinicians, and supervisors in decision-making related to the clinical process;
 - preparation of timely aggregate reports for use by supervisors, QI/compliance staff, and administrators/managers in programmatic decision-making related to the clinical process; and
 - training of staff and consumers in how to interpret and use outcomes and other data as the foundation for decision-making.

Behavioral health organizations generally deal with most or all of the above major system components in some form. As pointed out above, however, dealing with the components individually isn't enough. The value added by a comprehensive clinical re-engineering project is the integration of all six components into a single, consumer-centered approach that enhances the opportunity for consumer recovery.

Recurring Re-engineering Themes

There are three recurring themes embedded in the above re-engineering components — (1) the use of performance/quality measures; (2) feedback mechanisms; and (3) consumer and family involvement.

Performance/Quality Measures

Performance/quality measures are at the heart of a consumer-centered organization. If you set goals, you need to be able to evaluate progress toward those goals. If you consider clinical re-engineering and establishment of a consumer-centered organization, you need performance/quality measures to measure all of the following areas mentioned earlier:

Mission — *The definition of the job*

Policies — *Accepted ways of approaching the job*

Procedures — *What staff are told about how to do the job*

Operations — *How the organization is set up to support the job*

The range of performance/quality measures required to monitor and manage a consumer-centered organization fall into at least five domains.⁴

1. Outcome Measures — Representative system measures include:
 - Consumer outcomes
 - Consumer satisfaction, access to care, and follow-up
2. External Environment — Issues that relate to the quality of the operation of the organization with respect to externally imposed requirements. Representative system measures include:
 - National, state, county and local requirements
 - Local behavioral health and substance abuse board requirements
 - HIPAA compliance
 - Public image
 - Payer requirements
 - Legislative requirements
 - Strategic business planning
 - External/national accreditation requirements (e.g., JCAHO)

⁴ Adapted from David Lloyd of MTM Services in a presentation entitled *Integrated Performance Measurement Systems* made January 24, 2001, at the first HIPAA Roadmap Conference (Boston, Massachusetts).

3. Provider Measures — Issues that relate to the efficiency of individual clinical staff. Representative system measures include:
 - Billable service hours & productivity
 - Utilization management standards compliance
 - New referral standards
 - Documentation submission
 - No-show and cancellation rates
 - Peer review
 - Progress toward goals
 - Best practice standards compliance
 - Cost effectiveness indicators
4. Financial/Auditing Measures — Issues that relate to the efficiency of business operations. Representative system measures include:
 - ethics and corporate compliance plan
 - Collected vs. budgeted amounts
 - Late service tracking documents
 - Claims denials
 - Unauthorized services
 - Paybacks
 - Cash flow performance over time
5. System Measures — Issues that relate to the quality of the operation of the care delivery system, per se. Representative system measures include:
 - Care environment
 - Professional and consumer ethics
 - Consumer care
 - Consumer rights
 - Information management
 - Cultural competency
 - Human resources
 - Access to care
 - Employee satisfaction
 - Administrative and support performance indicators

Feedback Mechanisms

The second recurring theme is the need for feedback mechanisms. Once the methods of measuring movement are in place, feedback mechanisms are essential to improve quality in a consumer-centered organization. Without feedback, any organization and the people who comprise it can drift away from the mission at hand.

The two most critical types of feedback in a consumer-centered organization are supervision and training.

The impact of clinical supervision on client outcomes is considered by many to be the acid test of the efficacy of supervision.

Ellis & Ladany (1977)

- **Supervision** — Supervision is the process of overseeing, directing and managing the clinical process. Supervision serves three key roles, internal and external to the organization; it can be: (1) provider-focused and used to enhance the professional functioning of the person delivering care; (2) consumer-focused and used to monitor the quality of care being delivered; and (3) profession-focused and used as a competency tool for assessing appropriate professional skills and abilities for the care delivery profession.
- **Outcomes-Based Supervision** — The behavioral health profession has traditionally looked at outcomes from the verbal reports of clinicians, rather than through the use of standard measures. A comprehensive set of standard outcomes measures provides an opportunity to enhance the supervision process. Availability of ongoing outcomes information from consumers, family members and providers makes outcomes-based supervision a real option.

Points in the clinical process⁵ where outcomes-based supervision can occur include the following:

- **Intake Review & Assignment** — Outcomes-based supervision can be used to help providers identify consumer goals, match clinicians with consumers based upon experience or presenting problem areas, and determine appropriate types and intensities of care.
- **Treatment Planning** — Outcomes-based supervision can be used to help providers refine the focus of treatment through review of self-assessments and goals determined by the consumer and family members. Supervision can also be a tool in the identification of consumer strengths and in the setting of expected outcomes and time periods for treatment.

⁵ Refer to the diagram presented earlier in this chapter.

- Periodic Review & Outcome Assessments — Outcomes-based supervision can be used to help providers identify consumer treatment plateaus, shifts of consumer focus caused by internal and external factors, and indicators of consumer deterioration or success in treatment.
- Termination & Transfer — Outcomes-based supervision can be used to help providers evaluate when consumers are ready to end care and plan for potential future needs and follow-up.

Education that fails to enhance behavior is for naught.

Albert Einstein (Attributed)

- Training — People cannot be expected to behave in particular ways if they've never been provided with the tools and techniques required to support the desired behaviors. Therefore, the role of training in a consumer-centered organization is to help people understand the underlying concepts of consumer recovery and outcomes-based decision-making, and to provide them with the tools and techniques they need to put those concepts into action.

To be most effective, a well-structured organizational training program uses a six “C” approach:

1. Consumer-Centered — The training program is consumer-centered; it focuses on the roles of staff and consumers in relationship to achieving consumers' goals.
2. Coaching — The training program uses a coaching method; it informs rather than directs. Training is more effective when it helps people “follow the path” instead of “following the guide.”
3. Comprehensive — The training program is comprehensive; it encompasses all aspects of the clinical process, including those that aren't part of the direct consumer-clinician interaction.
4. Consistent — The training program is consistent; all components convey the same message. The use of information in decision-making, and consumer recovery are key training themes.
5. Complete — The training program is complete; each training module covers all the information required to understand the topic. The program design doesn't assume that people already understand the topic, or that they will remember everything covered in the sessions. Training is supported with manuals, videos, written procedures and other aids.
6. Continual — Finally, the training program is continual. Recollections change, staff come and go, and details tend to fade over time. The training is available on a timely basis for both new people and for former attendees who simply need “refresher” sessions.

Consumer and Family Involvement

The third recurring theme is the high level of consumer and family involvement in the clinical process. Consumers and their families are the reason behavioral health organizations exist, and their integration into all levels of the consumer-centered organization is an important part of the pursuit of consumer recovery.

Increased consumer input and family roles are two of the greatest challenge to “traditional” treatment models. While consumers and families have had roles to play in the past, the a consumer-centered, recovery-focused approach assumes a much more intensive participation than has generally been the case.

Levels of Consumer Participation in the Clinical Process — One way to view the degree of change that occurs in consumer and family involvement is through a six “T” model. The closer your clinical process comes to meeting the criteria of the sixth level, the more successful your organization is likely to be in promoting consumer recovery.

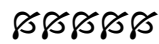
1. Information — Consumers and family members are informed of major treatment decisions made by others.
2. Input — Consumers and family members have limited input into major decisions regarding treatment.
3. Influence — Consumers and family members have enough influence over providers to help shape major treatment decisions.
4. Involvement — Consumers and family members are involved with some major treatment decisions.
5. Inclusion — Consumers and family members are included in the decision-making process for most significant treatment decisions.
6. Integration — Consumers and family members are fully integrated as partners in all aspects of the clinical process, from admission through termination.

Points in the clinical process⁶ where consumer and family integration occur include the following:

- Intake Review & Assignment — During the early contacts with the behavioral health organization, consumers and family members complete initial outcomes assessments and other materials that are used to help identify presenting problem areas, consumer strengths and initial baseline status.
- Treatment Planning — Following a review of the initial outcomes assessment and other materials, the caseworker and the consumer (and family members, as appropriate) collaborate to develop the recovery plan, including goals for treatment, intended services and treatment timeframes.

⁶ Refer to the diagram presented earlier in this chapter.

- Periodic Review & Outcome Assessments — Progress reviews and outcomes assessments occur throughout the clinical process and consumers and family members are key players in the process. Following a review of updated outcomes and progress to date, the caseworker and the consumer (and family members, as appropriate) decide whether continued care is appropriate. If so, they collaborate on revisions of the recovery plan, care goals, and treatment timeframes.
- Termination & Transfer — When the caseworker and the consumer (and family members, as appropriate) decide that continued care is no longer appropriate, they jointly determine the point and conditions of termination, subsequent referral, and any follow-up plan.



That's a lot of material, and there's a lot of organizational work that needs to be done in order to feel assured it will all be addressed— the kind of coordinated work that doesn't happen by accident.

And just how does one do all that?

Read on; that's what the rest of *R1 - Rethinking the Behavioral Health Organization: A Re-engineering Source Book* is all about.

7

Symptoms of the Need to Re-engineer

The first myth of management is that it exists.

Robert Heller

Nobody really knows what is going on anywhere within your organization.

Unknown

Behavioral health organizations in need of re-engineering frequently show a series of symptoms that signal their situations. Most of those symptoms result from a lack of organization-wide attention when responding to issues that present themselves.

Why Re-engineer? — Chaos to Order

Why re-engineer in the first place?

What's wrong with what we're doing now?

Why should we consider re-engineering our organization?

That depends. Organizations operate somewhere between chaos and order. Just exactly where your organization functions will determine whether you need to take a close look at how you do what you do and whether you have a consumer-centered organization.

How do you know if your organization is a candidate for re-engineering? There's no simple answer, but there are symptoms that frequently occur in organizations that are in need of retooling.

chaos
chaos
order
order
order

Seven Sinister Symptoms of a Seriously Slipping System

Naturally, no single list could possibly encompass the range of symptoms that “seriously slipping systems” exhibit. However, some of the most frequently encountered symptoms include:

1. Layering of External Demands & Fragmentation of Function
2. Lack of Access to Quality Information
3. “Tribal” Orientation
4. Management by Crisis
5. Never Time to Do Things Right (But Always Time to Do Them Over)
6. We’ve Learned to Make Do ...
7. Staff Burnout & Turnover

Layering of External Demands & Fragmentation of Function

With organizational functions, the whole is much greater than the parts. Re-engineered processes that support effective consumer-centered decision-making are more than simple collections of separate and independent functions; they are a system. However, the procedures in many behavioral health organizations lack the characteristics one would expect to find in a system that was thought through in comprehensive fashion prior to its definition.

In no small part, the fragmentation is due to external demands. Increasing political pressures, decreasing funding, staffing limitations and other factors continually keep organizations in a state of flux. External factors are forcing organizations into managing, coordinating, responding to and/or participating in a number of separate initiatives and issues, including:

Consumer Recovery
Consumer Outcomes
Corporate Compliance
Certification Standards

Quality Improvement
Emerging Best Practices
HIPAA

While you may not know what each of the above items entails, somebody in your organization probably does. In and of themselves, each of the above items (and the many that aren’t listed) is important, and each requires (or produces) large amounts of information in order to be effective.

Unfortunately, in many organizations, the response has been to simply “layer” the demands of one initiative top of the requirements of all the others; there has been no coordinated plan for linking the demands of such independent initiatives into a single consumer-centered way of doing business. More specifically, they haven’t taken the time to:

- analyze the organization’s key challenges;
- define the key performance indicators to manage those challenges;

SYMPTOMS OF THE NEED TO RE-ENGINEER

- minimize duplication of data collection and reporting;
- create policies and procedures to facilitate the timely capture and availability of the important information; and
- ensure that people know how to use information to make effective clinical and management decisions that lead to consumer recovery.

Lack of Access to Quality Information

Another common symptom that shows up in organizations is the tendency to operate without quality information for decision-making. While the lack of quality information can take many forms, you can feel fairly sure your organization is afflicted if you hear comments like the following:

- “I just can’t keep up with all the information requests.”
- “Those routine reports take forever to prepare.”
- “I don’t trust the information.”
- “I get all these reports and I still can’t tell what’s going on.”
- “Don’t tell them *that*; they’ll just use it against us.”

Being unable to get to information has the same effect as not having the information exist in the first place. In thinking about the typical organization’s lack of quality of information, one is reminded of the old story ...

*First person to a friend in a restaurant, “The food here is terrible!”
The friend’s response, “Yes, and such small portions!”*

In other words, not only aren’t the various information sources operating together optimally, but most people can’t easily get to the information that is there.

Thomas Jefferson, in his Report of the Commissioners for the University of Virginia, stated that the primary role of education is to “give to every citizen the information he needs for the transaction of his own business.” If one accepts a parallel between the roles of education and organizational processes (a reasonable parallel in our opinion), then many behavioral health organizations are operating in failure mode, and must face the challenge of ensuring that their decision-makers have access to what they need to do their jobs.

“Tribal” Orientation

When functions are fragmented and quality information is unavailable, organizations lose focus. Individual programs “look after their own” and begin to concentrate less on how they are similar to the rest of the organization and more on how they are unique. They become independent “tribes” with their own histories, goals and rituals — factors that create barriers to consumer-centered re-engineering solutions.

In many organizations, programs operate autonomously without systematic review of how their own initiatives relate to the overall mission. Programs develop redundant in-

formation requirements and formulate symptom-oriented “solutions” for issues that arise. It’s not unusual to encounter departments within a single organization generating forms, reports and procedures and using them independently of other programs. As a result, program staff often lack the overall information and supports they need and create coping mechanisms to get by. In addition, valuable mission-critical procedures that already exist run the risk of being ignored.

Often the primary focus is on departmental, internal mechanics, information, and details, and not enough on the broader vision of how those mechanics, that information, and those details link to the organization’s mission, consumer recovery and the needs of the wider organization.

Management by Crisis

Another symptom of a need to re-engineer is apparent when people spend so much time putting out “brush fires” that they don’t have the time to stop and ask where all the fires are coming from. Organizations are in a crisis management mode when they:

- never seem to have the time, resources or insight to anticipate organizational stressors;
- spend more time fixing problems than planning for new opportunities; and
- feel they are continually on the “critical path” and have no slack time or resources available.

Never Time to Do Things Right (But Always Time to Do Them Over)

Another key symptom appears in the guise of statements that begin with words similar to, “We don’t have time to...” The following examples are typical of those frequently encountered:

- “It’s something I could fix *if I had the time* to do it.” [So instead, the problem recurs, consuming much more time and resources than any fix.]
- “I just *don’t have the time* to re-engineer the system.” [So instead, I continue to maintain my manual work-arounds, which are of limited value to me and no value whatsoever to others who may need the same information.]
- “We *haven’t had time* for training.” [So instead, we continue to try to figure out each unique situation as it presents itself.]

In short, people end up spending significant amounts of their time involved in repetitive and duplicative activities — all the time insisting that they “don’t have time” to do the real job at hand. The negative impact of such duplication of effort cannot be overstated.

We've Learned to Make Do ...

*I'm fixing a hole where the rain gets in and stops my mind from wandering. ...
I'm filling the cracks that ran through the door and kept my mind from wandering. ...
And it really doesn't matter if I'm wrong, I'm right. ...*

The Beatles

Much of what passes as basic, core methodologies in behavioral health organizations is actually a series of coping behaviors by a lot of hard working, well-meaning people. In order to do their jobs as well as they can, staff have developed their own procedures throughout the organization. Why?

Policies and procedures that aren't consumer-centered can appear disjointed and irrelevant to the people who are working with the consumers. Consequently, many of the people who have to make consumer-based decisions end up doing so without a great deal of support in the form of consumer-centered procedures, training or direction.

There is an interesting characteristic of people who work without proper support; when confronted with issues for which they don't see obvious answers, they tend to create "solutions" based upon what seems to work for their particular situation, rather than what the overall organization requires. Often, such "solutions" involve elaborate and time-consuming work-arounds and manual manipulation. Staff spend a large amount of time maintaining their own local "solutions" that, while working to a degree, are consuming inordinate amounts of time and resources.

The end result is that staff end up doing everything that the organization requires first, and then do what they think really needs to be done for the consumer. To make things worse, the extra work they do usually works only for their specific situations and does nothing to further the success of the organization; in some cases the work-arounds may actually conflict with the correct procedures.

In an organization that fails to organize around consumer-centered lines, there may be little recognition of the need for planning, training and professionalism in the implementation of consumer-centered procedures. Instead, there is a tacit assumption that issues are relatively minor (or obvious) and comprehensive training isn't required.

The result of such a training deficit was stated succinctly by one behavioral health center employee describing why she developed her own methods for solving problems instead of relying upon the organization's established system ...

"We've learned to make do with the parts of the system we've figured out."

Unfortunately, to a certain degree many behavioral health organizations are caught in similar situations.

Staff Burnout & Excessive Turnover

Staff burnout and excessive turnover are probably the most destructive and costly symptoms of all. At a minimum, staff changes are disruptive and expensive to the organization. On a more personal level they can be damaging to people's feelings about themselves and can create barriers to achieving consumer recovery.

Organizations that have staff who are giving up and bailing out should look closely at what can be done to minimize the factors that are wearing people down. The root causes of staff burnout and excessive turnover may not be under organizational control, but it's incumbent upon the organization to identify those causes and do what it can to alleviate them.

So Where Are We?

Unfortunately, if you've done your job and taken an honest look at your organization and have found that one or more of the above symptoms fits your situation, you may be starting to feel a bit uncomfortable. Well, take heart and read on; there's hope ahead. It may take a lot of work, but it will be worth the effort.

8

Gearing Up for Re-engineering

Engineer: 1. *To plan and direct skillfully; superintend; guide.*

Behavioral health organizations that are characterized by the types of symptoms described in the previous chapter are faced with significant challenges. However, there is also great opportunity for positive change if re-engineering efforts are targeted toward problems instead of symptoms. While maintaining a focus on the consumers whom they ultimately exist to serve, behavioral health organizations should review the flow of information throughout their organizations, and take the lead in using information effectively for clinical decision-making. In other words — re-engineer a consumer-centered solution.

Crisis: Danger or Opportunity?

Our task is to help replace their despair with opportunity.

Lyndon B. Johnson

Given the commonly-occurring symptoms identified in the previous chapter, there can be little doubt that many behavioral health organizations are experiencing some form of organizational crisis. A great deal of time and resources are being invested in multiple interventions to address perceived issues, but those interventions aren't providing the organization with the results that a consumer-centered approach requires. In fact, in many cases the layers of interventions may actually impede quality care.



The Chinese recognize that a crisis has two components — one of *danger* and another of *opportunity*. They even reflect that distinction in their ideogram for the word, which is made up of the two separate ideograms for danger and opportunity.

It would be easy to focus on the danger component of the current situation and just react to the problems (e.g., “we have *this* problem” or “we have *that* problem.”) More difficult in the short term (and more rewarding in the long term), however, would be to focus on the opportunity component and develop a proactive plan for re-engineering internal processes to better address the consumer-centered decision-making needs of the organization as a whole.

Fixes for Symptoms or Problems?

*For every human problem, there is a neat, plain solution
— and it is always wrong.*

H.L. Menken

After even a cursory examination of all the issues facing behavioral health organizations, one is tempted to formulate solutions to the large number of specific issues identified. Even if such a response were feasible, it would still be inappropriate, because most of the items identified aren't problems, per se, but merely symptoms of other, more deeply rooted problems.

So should one handle each symptom with a quick fix (that's really not a fix), or step back and address the problem that created the symptoms in the first place? We believe that the latter approach is the only viable one.

Therefore, we do not recommend "fixing" each problem identified. Rather, the real re-engineering task is to: (1) review the role of information in the organization; (2) determine the information required to make effective and appropriate clinical decisions that lead to consumer recovery; and (3) revise the decision-making processes to provide the answers needed.

Re-engineering isn't an easy task; it will take a lot of time and effort. If you do it thoroughly, you may even make some people uncomfortable. But the stakes are high, and thoroughness is appropriate.

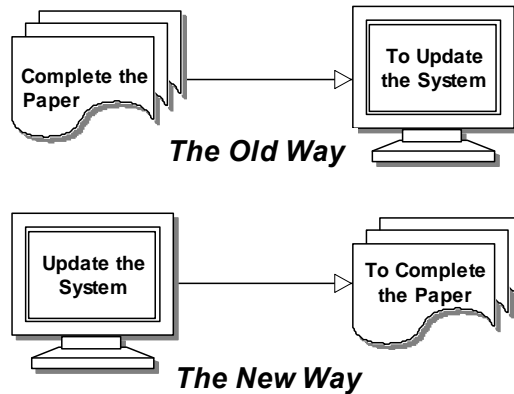
Re-engineering the Flow of Information

As part of your re-engineering effort, you will need to rethink the way information flows through your systems, whether computerized or not. Currently many people think of information systems as being peripheral to their "real" work. In other words, they first do the work they think is important and then record the information in the system. One of the problems inherent in such an approach is that because there is often too much "real" work to get done on a day-to-day basis, frequently the system doesn't get updated at all.

In the past, systems were often employed simply to record the way you did business. In a future where the individual consumer's needs and benefits are much more a part of the care delivery process, your organization's systems must become the way you do business. If you wish to have available the information necessary to implement a consumer-centered system, you cannot think of information systems as being secondary to other tasks.

So how does all this translate into action? One way is to make sure staff no longer fill out paper that will be used to update the system later. Frame your procedures so that staff can update the system directly. If you need the information on paper later, let the system print it.

Rethinking the Flow of Information



Such a transition will undoubtedly involve the implementation of emerging technologies such as remote e-mail, hand-held information entry devices, voice recognition, scanning, and other forms of communications. A review of these new business and decision-making tools should also be part of any re-engineering process.

If you restructure the flow along these lines, you will find that your system will no longer be an obstacle; it will become a companion on the road to consumer recovery.

Evaluating the Costs of Re-engineering

*The first 90% of the task takes 90% of the time and resources.
The last 10% of the task takes the other 90%.*

90:90 Rule of Project Schedules

Re-engineering is expensive, and like other tasks a re-engineering project will probably consume more resources and take longer than expected.

There are different kinds of costs involved in mounting organizational changes such as a clinically-based reorganization. The highest costs are those related to the time and energy contributed by the people who will be involved in the re-engineering process. Costs will also be seen throughout the organization as people become trained and begin using the various systems in the new ways.

Organizations will see offsets to these costs in the reduction of similar resource costs currently being incurred. And it is fair to assume that current costs are far higher than the re-engineered resource costs will be.

Consider:

- How many people are currently performing duplicate tasks?
- How much mainline production work are clinical staff forced to do that should be done by others?
- How often is the after-the-fact cleanup of data the rule, rather than just the exception?
- What is the cost of potentially reimbursable time that is lost?
- What is the cost of widespread, high levels of inefficiency?
- What is the cost of frustration among professionals who feel bound up in poor reporting and administrative systems when they should be doing other work?

The hard question to be considered here is not so much, “What are the costs of proceeding with the re-engineering project?” The better question is, “What are the costs if you don’t?”

9

Re-engineering Project Essentials

When implementing any new project, there is frequently a tendency to just “lay it on” the staff once the development work is done and the decisions are made. As you might expect, as often as not the result is a failure of the new process. Is this the fault of the process? Of course not! Even the best re-engineered system is bound to fail if people neither believe in it nor use it.

Quite often, the biggest problem with the implementation process is that people don’t give it enough thought. The implementation process is as complex as the development process and, in the short time span, more important.

Prerequisites

Projects don’t get done just because you want them to. The very first thing you must determine is whether you are capable of undertaking a re-engineering project. What does it mean to be capable? At a minimum, you must have the following three things:

1. Time — *You must have the time available for the project.*
2. Interest — *You must have an interest in getting the job done.*
3. Talent — *You must have the talent to do the re-engineering work.*

If you don’t have all of the above inside your organization, you must get it before you begin the job. If you can’t find the missing factor(s) inside your organization, then you’re not equipped to do the job yourself. Get some outside help!

Essentials for Project Success

... chance favors only the mind that is prepared.

Louis Pasteur

There are three major factors that must be present if the re-engineering project is to succeed:

1. Administrative Mandate — The first, and most important factor is the presence of an active administrative mandate to do the re-engineering project. This does not simply imply “permission” to do the project. Rather, what is required is

an unequivocal message from senior executive staff that the re-engineering project represents the will of the organization and is seen as a critical component of its ongoing development. As other staff members are expected to participate and support the process, so should executive staff. Executive staff must be committed if the project is to succeed.

2. Project “Champions” — The project should designate key individuals who can function as a “champions” for the process. The “champions” are the individuals most closely identified with the project and the ones to whom other staff can turn for quick answers about the process. The “champions” should be knowledgeable in the components of the organization, and should also function as the ongoing technical consultants to the various Functional Teams (discussed later).
3. Assertive Management Staff — Once decisions are in place, your organization will require management staff who understand the decisions that have been made regarding the ways the results of the re-engineering project should be implemented. Those staff should be empowered to be active and assertive participants who can “ride herd” on the rest of the organization to keep the project operating efficiently on a day-to-day basis.

Stop Chasing Regulations

One man's red tape is another man's system.

Dwight Waldo

Rules and regulations — they’re all around, and it seems at times that they control everything you do. How could anyone possibly re-engineer around consumer-centered principles in the midst of all the regulations?

It’s a good question. What would be the best strategy for re-engineering a successful system that would be of internal clinical value and yet satisfy multiple batches of external regulations?

Interestingly enough, the best first attempt at dealing with regulations might be to ignore them completely (at least at first). Consider the following:

- The primary goal of behavioral health organizations is to provide care to people in need and to facilitate consumer recovery. Behavioral health organizations generally work very hard to organize the clinical process to make sure that the clinical care provided is high quality, medically necessary and effective.
- Because both people’s lives and money are involved, behavioral health organizations must be accountable to regulatory bodies for the care they provide.
- For the most part, staff within those regulatory bodies are well-intentioned professionals trying to do their jobs to the best of their abilities.

- The jobs of regulatory bodies are focused on accountability of the clinical care provided. The one thing most behavioral health regulations have in common is that they are attempting to make sure the clinical care provided is high quality, medically necessary and effective.

In other words, if you take a proactive view, the primary interest of both the behavioral health organization and the regulatory bodies is the same.

Given that fact, there is an important point here that should be stressed. If you begin by re-engineering a system around the clinical process in such a way that it provides the information necessary for consumer-centered decision making, you will find that the resultant process will probably meet most (if not all) outside regulatory and accreditation requirements.

Naturally, it would be nice to be able to assume that once your consumer-centered system was operational you would have addressed all the regulations. That would be unrealistic; there will always be unmet regulations, some of which will seem to have little obvious relationship with the work you do.

So, what should you do? Then, and only then, set up special procedures designed to address the regulations, per se. If those procedures don't fit comfortably within the clinical process, make sure your staff know that you are aware that the procedures are "add-ons" and that there's nothing that can be done to avoid them.

The whole point is to not start off responding to every regulation that is thrown at you. If you do, you'll never catch up; you'll just keep chasing the regulations and will have to change your internal processes every time the regulations change.

And they do change, don't they?

Tactics for Project Implementation⁷

As the art of employing available means to accomplish an end, tactics must match the eccentricities of a situation. The following suggestions provide some information about development projects that may help you adopt a stance that fits the style of your organization.

The tactics outlined presume that the organization's climate for a re-engineering project is favorable. Dealing with an unfavorable climate is another problem entirely and is not attempted here. That is the domain of an organizational or management consultant and one that would be taken on by an ethical consultant only under certain conditions. Organizations, like individuals, rarely benefit from therapy unless they are experiencing considerable pain and are motivated to undertake a process of change.

⁷ Adapted from Chapman, R.L. *The Design of Management Information Systems for Mental Health Organizations: A Primer* (1976).

Tactic #1:**Find an Impetus**

An individual, even a manager, experiences enormous difficulty in launching a project single-handedly. The clever entrepreneur channels forces at hand in a particular direction.

Two hypotheses about organizational change may provoke thought: one, that most important decisions are made in a time of crisis; the other, that the major impetus for change comes from outside the organization. The main opportunities may lie in finding a pressing problem for which a consumer-centered re-engineering project may be an answer.

Consider a re-engineering project launched in the aftermath of the crisis of preparing for either HIPAA or a JCAHO certification review — lack of necessary information for planning purposes proved intolerable for the key staff. Drastic revisions in legislation, or administrative regulations, or funding agencies can cause organizational consternation, as can changes in leadership or organizational structure. Many threats to an organization's viability can be exploited in focusing attention upon a re-engineering project. Timing is of the essence in presenting a potential solution to a disconcerting situation.

Tactic #2:**Prepare a Realistic Plan**

Disciples of the “decision-in-the-time-of-crisis” school do their homework in advance and play a waiting game. Plans are brought out at an auspicious time, adapted to the circumstances, and introduced.

The plan should be explicit about:

- how the end result of the project will help solve the current crisis;
- what resources will be required (personnel and other costs); and
- providing a schedule of how the project will proceed.

The re-engineering process is phased into stages, with decision points at the end of each stage; lesser detail will be needed for latter steps but the initial phases should be outlined carefully.

The schedule must be realistic; it must take into account all the steps in the re-engineering process (and provide for some slippage due to unforeseen circumstances) but neither should it be drawn out. Uncertainties understandably make people reluctant to make commitments, but commitments are the legal tender for dealing with management. The schedule should also be phased to fit the organization's funding cycle if authorization for successive steps is not to be an impediment to a continuity of effort.

Then, the schedule should be met. The motivation to take those actions needed to produce the stated product on time, and within the allowable resources, must be present if credibility in the effort is to be achieved.

Tactic #3:

Get Management's Commitment

Management must, of course, authorize the resources required if the re-engineering project is to proceed. The more clearly and fully the process is explained, the better management understands the implications of the project, the more likely its support can be maintained.

Authorization must be beyond providing the necessary resources for starting the re-engineering project — it must include a commitment to support the results of the project and facilitate their implementation. Acceptance of the results that lead to organizational changes is important, because when change does occur, it will tend to occur from the top down, not from the bottom up.

The more realistic a view top management takes of the costs and consequences of a re-engineering project, the more likely their continued enthusiasm is needed for achieving an effectively operating system. The prognosis for a meaningful re-engineering project is poor without the strength of this kind of management endorsement.

Tactic #4:

Gain Staff Participation

The organization's staff must participate in the re-engineering process. Not only is this essential for the results to be acceptable to the people who must work with it, but personnel at all levels also have useful contributions to make.

One mechanism for achieving staff participation is through the Re-engineering Steering Committee and Functional Teams (described later in this document). Members should be selected on the basis of their interest in the project and their experience in the organization so that knowledge of the full range of the organization's activities is represented and so that the re-engineering teams constitute an adequate communication link with the entire organization.

The first task for the re-engineering teams is to familiarize themselves with the organization, its personnel, its activities, its structure, its workload, and its resources. With this background, the teams can proceed to work through the re-engineering process. Because the re-engineering teams' function is to perform organizational re-engineering, each member must deal with the total organization rather than restrict himself or herself to a special aspect of the system.

Communication is at a premium both within the re-engineering teams and between the teams and the remainder of the organization. The complexity and level of detail demand that the implications of each recommendation be explored again and again for full understanding. Thorough documentation is a must in accumulating and integrating the decisions reached. In addition to obtaining information from different staff and consumers, and checking on the acceptability of specific recommendations, the re-engineering teams should issue regular bulletins to organization personnel explaining its progress and, in general, allaying incipient anxieties by keeping people informed.

Tactic #5:**Stick to the Re-engineering Role**

In the course of the project, the re-engineering teams will uncover conflicts and organizational problems of many sorts. Because of their motivation to help the organization improve its performance, members may be tempted to do a little unofficial conflict resolution and organizational repair on their own. These impulses should be resisted. The re-engineering teams should rely on the organizational hierarchy and operating mechanisms to solve problems. The re-engineering role is that of gathering information and summarizing it in a fashion that will permit the staff to identify problems. Unless the re-engineering teams restrict themselves to this function, they may focus organization tensions upon themselves and thus jeopardize the function they were assigned to serve.

Tactic #6:**Tap Outside Expertise**

Although talented and dedicated staff can do much of the re-engineering work, there are always inherent risks in a “do-it-yourself” project. The re-engineering teams may benefit from outside expertise at various stages in their deliberations: in orienting the group to its task; in design reviews; and as special problems arise. Qualified experts can be found among the ranks of consultants, of university staffs, and even of other behavioral health organizations that have undertaken similar endeavors.

In seeking assistance, the re-engineering teams should permit the expert latitude in exploring a domain of issues; often answers are sought for a specific question when the difficulty lies with an inadequate formulation of the problem — the issue may actually be elsewhere. The consultant offers qualifications in addition to his expertise; as an outsider he can view the situation with greater objectivity and can make representations both to management and staff that a re-engineering team member could do only at some peril to his continued acceptance by the organization.

Tactic #7:**Conduct Project Reviews**

Both the preliminary and detailed re-engineering phases culminate with project reviews. At each stage, the re-engineering teams should anticipate a number of iterations. First, the groups should go over their conclusions and recommendations several times; in such a detailed process, anomalies emerge only gradually. Then, the re-engineering decisions should be reviewed with key managers, both individually and in combination. The proposals should also be reviewed with the remainder of the staff, again both individually and in combination.

The reviews should concentrate on explanation of issues and upon meeting clinical, informational and operational needs. Design revisions to accommodate points that are raised should be avoided. By this time, the re-engineering teams acting as a whole will be best qualified to make decisions once all reactions have been obtained. Of course, defen-

siveness should be shunned or else valuable criticisms will be lost and staff resistance will rise. It may be necessary to cycle through review sessions several times, winding up with top management for final approval.

The need for complete documentation and adequate communication cannot be overemphasized. Several documents with differing degrees of detail are required. Review sessions need supporting material that gets across salient structure and such specifics as workflow, consumer expectations and input document contents. The re-engineering teams themselves require detailed documentation, not necessarily structured for easy communication.

The Re-engineering “Danger Zone”

If a ... project is not worth doing at all, it is not worth doing well.

Gordon's First Law

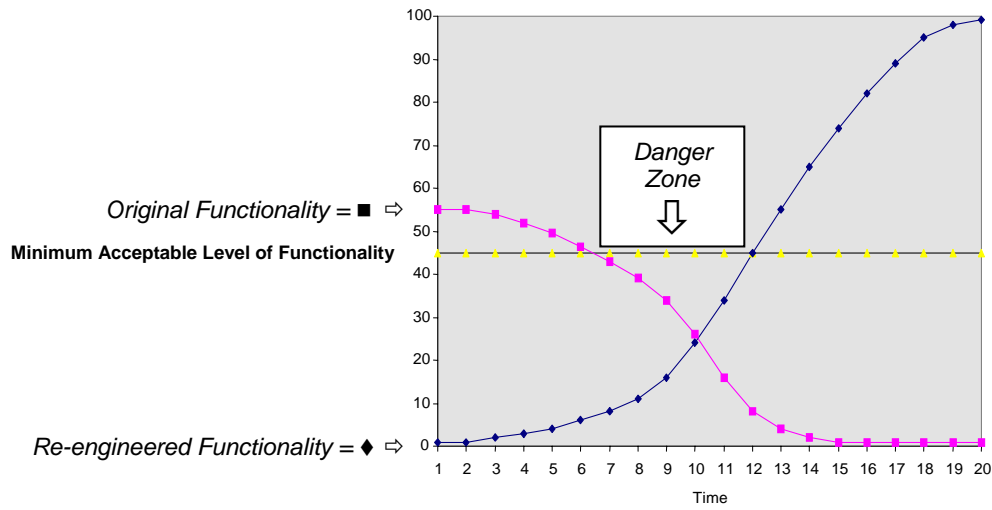
People need to know where a project is heading if they are to invest the resources required to make it successful. The trick, then, is to figure out the best way to keep people enthusiastic about the ultimate goals of the re-engineering project such that their enthusiasm will carry them through the periods when things get difficult.

You should not expect that the development of consumer-centered clinical re-engineering will be either quick or easy. On the contrary, such a project will probably tax both the patience and the commitment of your organization.

Why is this so? The current operational structure in your organization, irrespective of whether it is addressing your real needs, is at least a known quantity. People have learned to cope with its limitations. In other words, your organization is operating at or above some minimal level of functioning (even though it may not feel like it is).

As you begin the move to a re-engineered model of decision making, however, much of the time and energy that used to go into the old process will be transferred to the new. Then as procedures and processes begin to shift to the re-engineered approach, use of the old way of doing business will begin to drop off until it falls below what was once considered to be minimum functionality. The re-engineered model, while headed for a higher functionality than the old methods, won't have reached the original minimum functionality. Therefore, it will seem like you haven't really gained anything; in fact, there's a chance some staff will feel that you're worse off than before you started.

The triangular area below the horizontal line in the following graph represents the “danger zone” where frustrations of all involved will peak. The old methods won't be doing what they used to do and the re-engineered model won't yet be doing much of anything. It is the point where it is most important to press on and avoid the temptation to “go back to the way we used to do it.”



Frequently Asked Questions

The following questions are representative of ones you might ask or be expected to answer once you undertake a re-engineering project. The list is not all-inclusive, and in some cases, the information provided is duplicative of other materials located elsewhere in this manual. However, some of the answers may provide just that little piece of information you need for your project.

How does one weigh the relative merits of clinical vs. administrative needs when re-engineering?

You may be surprised to find out that consumer-centered processes designed to meet clinical needs often end up meeting administrative needs as a by-product.

To understand this statement, first consider what accountability really means. Being accountable for what you do is being able to show another person or organization what you've done, and both why and how well you've done it. Because these concerns are also shared by the clinician, it follows that any re-engineered process designed to allow the clinician and consumer easy and unimpeded access to the right information will readily meet most (if not all) reasonable administrative and accountability demands. On the other hand, a process perceived to be primarily oriented toward administrative needs is unlikely to be adopted by clinicians as their own.

What is a good first step in getting a re-engineered system going?

Probably the most constructive thing you can do is to conduct a survey of staff and consumers to determine their positive and negative feelings about the existing system. This should be done before re-engineering work begins.

When the information comes back, make a list of the comments and address every item on it in some form. You don't have to solve every item, but at least address each one. Remember that you can't be all things to all people.

What is a good way to determine what information is needed for a re-engineered process?

When re-engineering a process, the design task proceeds in reverse. You start with the desired effects and work back to the specific processes, information and forms required.

The first step is to set up a matrix similar to the following:

		Data Items Required (Unknown)			
		#1 ...	#2 ...	#3 ...	#4 ...
Desired Effect (Known)	Desired Effect #1 ...	✓		✓	✓
	Desired Effect #2 ...		✓	✓	
	Desired Effect #3 ...	✓		✓	✓

Label the rows with the desired effects you seek. Then create a column for each data item needed for each desired effect. (You may need a lot of columns!) By checking off the data items required for the desired effects, you will get an idea of the total number and nature of data items that need to be collected. You will also see where there are information overlaps among the desired effects. For example, in the example above, all three desired effects need the third data item (e.g., consumer address).

Once you have identified all the data items you will need, set up a second matrix similar to the one below:

		Forms Required (Unknown)			
		Form A	Form B	Form C	Form D
Data Items Required (Known)	Data Item #1 ...	✓		✓	
	Data Item #2 ...	✓			✓
	Data Item #3 ...	✓		✓	
	Data Item #4 ...				

Label the rows with the data items identified in the first matrix. Then create a column for each form you currently use. Check off the forms on which each data item occurs. When you are finished, you can use the results of the second matrix to determine the appropriate combination of forms required to accomplish the desired end products. You may also find a surprise or two. For example, in the limited example above, Form B apparently contains no data items identified as necessary to achieve the desired effects listed in the first matrix. Why do you keep Form B? Similarly, Data Item #4 isn't captured on any current forms, even though it is necessary to achieve two desired effects in the first matrix. Do you need to add Data Item #4 to an existing form?

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When conducting an analysis of this type, consider all forms and information together; don't simply consider the individual items to be justified or discarded. In this way you will be more likely to avoid biases caused by past habits (e.g., asking what data should be on the Intake Summary, instead of waiting to see if the process indicates that you even need an Intake Summary).

What about importing somebody else's re-engineered solution?

Other people's tools work only in other people's yards.

Jane Bryant Quinn

There is no question about the potential value of taking advantage of the re-engineering work done by others — it can save great amounts of time, money and other resources. It can also result in an ill-fitting and cumbersome system that does not fit your needs. Failures of imported processes and systems often result from differences between the organization where the process was created and the organization that later adopts and implements the process. However, there is another area that is not so obvious, that causes far more systems to come up short of expectations.

When systems are imported, there is a tendency to make “a few changes to improve the system's fit into our organization.” Unless these changes are made carefully, the system may fail.

If the original system was well-designed in the first place, “minor” changes made by an outsider could destroy the integrity of the system. Therefore, a good rule of thumb is:

Import a system “plus” modifications for your organization.

Do not import a system “with” modifications for your organization.

Why is this true? A Gestalt point of view would say that the whole is greater than the sum of the parts. So it is with systems. A well-engineered system is more than just a bunch of unrelated processes that can be altered at will.

Therefore, avoid shortcuts which “make it easier” unless you are sure that the imported system will still function as it should once the “shortcuts” are taken.

What is the proper balance between using in-house staff and outside resources in a re-engineering project?

Use of in-house resources is desirable both when re-engineering an existing process and when creating a new process from the ground up.

- In the first instance, in-house staff often are the only ones with enough knowledge of the problem and the structure of the existing process to make constructive suggestions for corrections.
- In the second instance, in-house creation of a totally new process provides complete control of the re-engineering process, thus avoiding much trial and error.

However, outside consultants can be helpful in several ways:

- They have experience that can help you avoid common mistakes that consume both time and energy.
- They task-orient for those of us who aren't task-oriented.
- They can organize vague areas so they make sense.
- They provide "window dressing" even when not used for design work. Remember that no man is a prophet in his own land; it is often handy to have an outside "expert" available to endorse your re-engineered process.

How elaborate a re-engineering project should you undertake?

In most situations, an investment of 20% of the resources required to accomplish the whole job will accomplish 80% of the job.

Vilfredo Pareto's 20:80 Rule

It should be food for thought that a huge organization like the Kentucky Fried Chicken chain has used for its motto:

KISS
Keep It Short and Simple.

Whatever you choose to do, don't overdo it. Don't try to build a system that will anticipate any clinical issue that might ever be thought up. If you're implementing a re-engineered process, it should be because there was some "sickness" in the old system. Then, when the sickness is gone, stop the cure. Don't create a process that imposes permanent solutions to temporary problems.

Any final thoughts?

OK, here goes ...

- Staff attitude will be the major obstacle to implementation. Don't be alarmed if the initial reaction to proposed changes in clinical processes is negative. This is quite normal.
- In order to get your system across to staff, identify the "natural leaders" and get them on your side. Start small. Don't try to light a log with a match. Get some kindling.
- Use a reward-oriented approach when implementing change. Don't just drop a bomb on people. Remember that your staff are human, too!
- If something in the system doesn't work at first, assume that the process is wrong, not just the person who is trying to make it work.
- Work with your staff so that they will help you build a consumer-centered process that gets used "because it works," not just "because it's a rule."
- "Face validity" is extremely important. Does the re-engineered process really look like it will do what it's supposed to do? If people think, "This can't possibly work" they will invest little effort to make it succeed.
- Finally, imposition invites opposition, so call the re-engineering process an *experiment*, no matter how permanent it is.

10

Re-engineering Teams

The work of re-engineering, as James Madison said of creating the Constitution, is not “the offspring of a single brain. It ought to be regarded as the work of many heads and many hands.”

Likewise, any re-engineering project should draw upon the knowledge and experience of a variety of people related to the organization, including consumers and family members. The process should be under the control of a Re-engineering Steering Committee, which directs the Re-engineering effort with the help of a series of Functional Teams that specialize in specific areas.

Overview of the Teams

One of the great advantages of teams is that they can provide the breadth of perspective required to encompass the varied functional and organizational aspects of providing high quality clinical care.

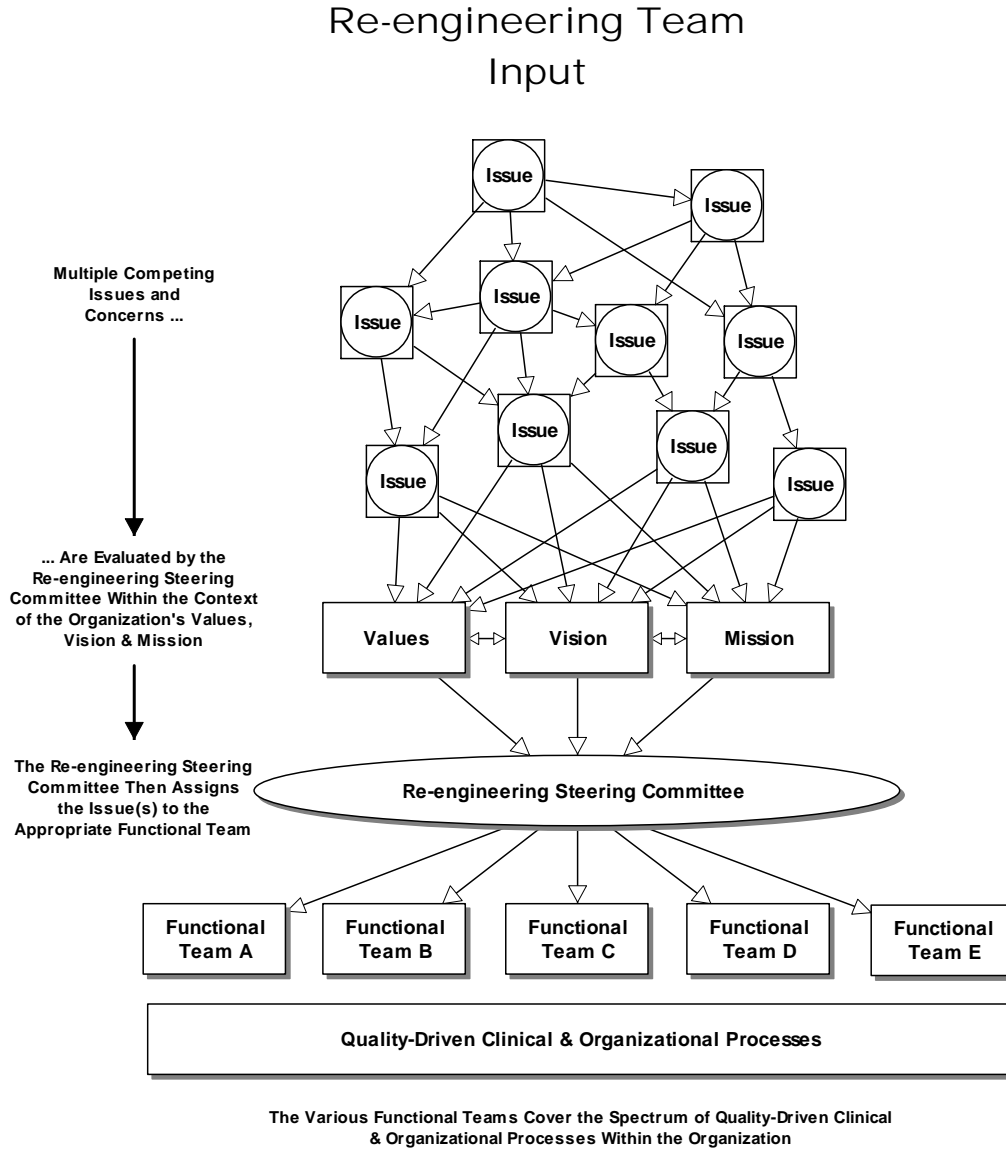
Working in conjunction with each other, multiple teams can better address the several supporting functions that make up the clinical process. The functions are not the same in every organization, but there is a core of functions that will be seen at every one. In addition, the teams are equipped to deal with those organizational processes that are necessary for the organization to perform, but that may be only indirectly related to the clinical process.

It's important to remember that any change in one functional process can affect other disciplines and functions. Therefore, all changes should be examined from a variety of perspectives, and final decisions need to take the impact on all functional processes into account.

One of the great temptations in a re-engineering effort is to work on individual issues independently and to try to make each individual process the “best that it can be.” Such “sub-optimization” should be avoided. Optimizing each component independently doesn't necessarily result in an optimized system solution. For example, if an automobile company asked each of his subassembly manufacturers (e.g., body, engine, transmission, instrumentation, fuel systems, interior coachwork, tires) to work independently to make the “best” component it could, how well do you think the vehicle would fit together on the assembly line?

How the Teams Operate

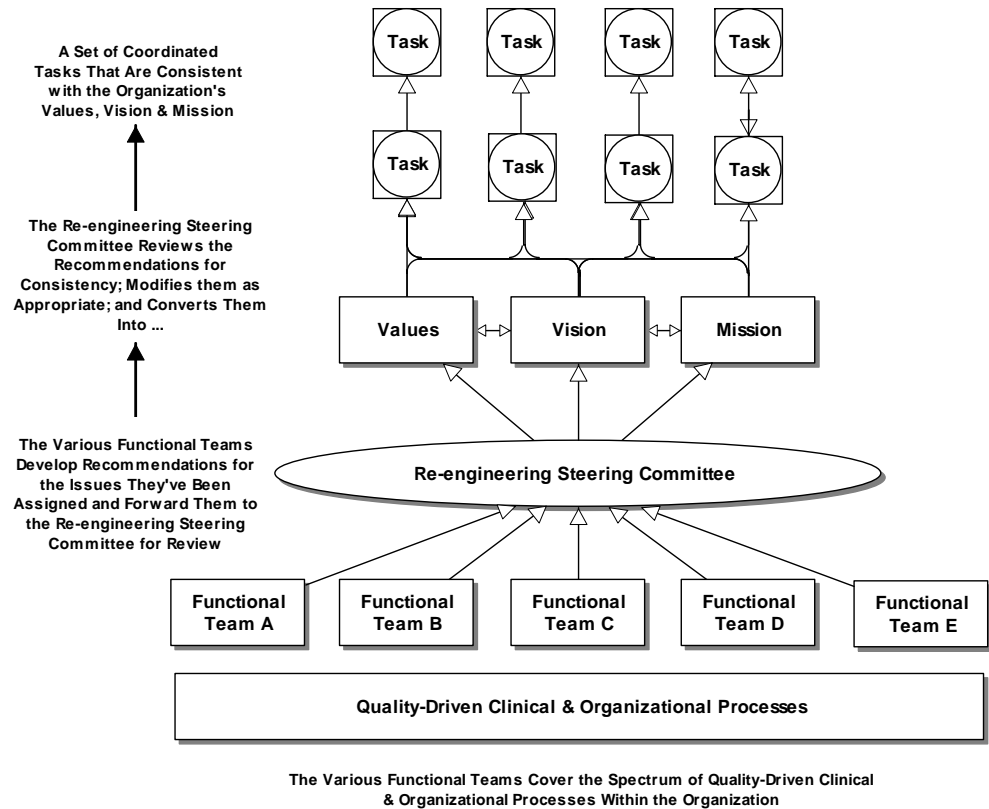
The input diagram below provides an overview of how the Re-engineering Steering Committee acts as a “values–vision–mission” filter to organize the multiple issues facing the organization and direct them to the appropriate Re-engineering Functional Team(s) for problem-solving and policy and procedures recommendations.



The output diagram below shows how the Re-engineering Steering Committee reviews and evaluates the recommendations from the Re-engineering Functional Teams and con-

verts them into a defined set of coordinated tasks that are consistent with the organization's values, vision and mission.

Re-engineering Team Output



It's important to remember that the Re-engineering Steering Committee and the Functional Teams are the guardians of the clinical process. Without them, the clinical process gets dragged hither, thither and yon by external issues and demands.

Re-engineering Steering Committee

The Re-engineering Steering Committee is chartered to guide and monitor the re-engineering project. The charter extends beyond the immediate project and extends to cover ongoing organizational development and evolution over time.

Role of the Re-engineering Steering Committee

The Re-engineering Steering Committee:

- Is designed to oversee the entire quality improvement process and ensure optimally beneficial change for the organization.
- Mirrors clinical and supporting organizational functions.
- Is charged with bringing order to the process of decision-making by setting priorities.⁸
- Identifies the need for, forms, and oversees all functional teams.
- Protects the functional teams from losing focus.
- As needed, constitutes and oversees ad hoc teams to advise on particular areas of knowledge or expertise.
- Remains focused on values, vision, and mission.
 - Identifies the organization's real values (espoused and those in practice), vision, and mission.
 - Sets priorities on values and identifies those in practice that should be discouraged and those that should be encouraged.
 - Validates the vision against values. Does the vision reflect the highest priority values?
 - Validates the mission against values and vision. Is the mission the optimal one for accomplishing the vision? Does it reflect the highest priority values?
- Evaluates all issues and concerns.
 - Reviews them relative to values, vision, and mission.

⁸ Priorities must be more than just numbers. After all, anyone can put a list of items in some ascending or descending order. Priorities require commitment. What can you accomplish and in what order? If you're not going to get around to doing something, don't prioritize it. Focus on the things you really plan to complete.

- Accepts or rejects them based upon their consistency with the highest priority values, the degree to which the vision is jeopardized or furthered, and the relevance to the mission.
- Assigns accepted issues and concerns to the appropriate functional team with a statement of what successful handling should be and the expected time frame for resolution.
 - Sets priorities for the functional teams to which more than one issue is assigned.
 - Monitors the capacity of the functional teams and guards against overloading to make sure progress is maintained.
 - Successful resolutions would include a decision to leave as is or a plan for implementing change with an analysis of the impact on the entire organization
 - There may be times when more than one functional team may be needed to address the issue or concern. If this happens frequently, the teams may not be constituted appropriately.
 - If multiple teams are assigned, the issue should be subdivided so that each team can work independently, or a coordinator responsible for that issue should be assigned.
- Tracks resolution of issues and concerns.
- Evaluates all recommendations made by the Functional Teams.
 - Is the sole decision-making authority
 - Reviews recommendations relative to values, vision, mission, impact on the entire organization, and appropriateness to the issue or concern being resolved.
 - Accepting the recommendation includes setting a timetable for implementation and garnering the resources to accomplish the task.
 - Rejecting the recommendation includes a decision to pursue the issue further or to table the issue for later review.

Guidelines for the Re-engineering Steering Committee

The optimal Re-engineering Steering Committee operates according to the following guidelines:

Small, High-Level, Multi-Disciplinary Committee	<i>The Re-engineering Steering Committee is small, composed of individuals who are high enough in the organization to make binding decisions, and representative of the diversity of programs, disciplines, consumers, and communities that make up the organization's environment. While it is important to have the ongoing input of senior executive staff (e.g., CEO), the Re-engineering Steering Committee is more likely to include such staff as ex-officio members who can be called upon as required, rather than as normal members whose input to the group could be confused with executive decisions.</i>
Mission-Centered	<i>All of the actions of the Re-engineering Steering Committee are designed to further the organization's mission.</i>
Respect for Consumers & Colleagues	<i>The members of the Re-engineering Steering Committee behave with consideration and respect for the personal dignity, autonomy, and privacy of both the consumer and the members' professional colleagues.</i>
Consumer & Recovery Focused	<i>In the decisions of the Re-engineering Steering Committee, the organization's <u>consumers</u> and <u>communities</u> are the primary focus; the organization as a <u>program</u> is secondary. Therefore, the focus of the Re-engineering Steering Committee is consumer and recovery based, not organizational-based. In other words, the first question is, "what does the consumer need for recovery," and <u>not</u> "what does the organization need?" Emphasis is placed upon finding the best way to do something, not simply focusing upon how it is done today.</i>
Quality Improvement Focus	<i>The Re-engineering Steering Committee focuses on all three components of Quality Improvement (i.e., consumer recovery, professional standards, community responsiveness) throughout all of its activities, and is responsible for ensuring that Quality Improvement is a key component of the work of each of the project's Functional Teams.</i>
Standards Review Orientation	<i>The Re-engineering Steering Committee continually considers the standards that have impact upon its work. Each Functional Team recommendation is reviewed in the context of the professional and regulatory standards that are imposed upon the organization (e.g., HIPAA, corporate compliance, certification, licensure).</i>
Sensitive to Cultural Change	<i>Every organization has a unique culture, and any change process will affect that culture, for better or for worse. The Re-engineering Steering Committee remains sensitive to the tension that exists between the current and proposed cultures.</i>

RE-ENGINEERING TEAMS

Global Policy & Procedure Development	<i>The Re-engineering Steering Committee is responsible for establishing policies and procedures related to the organization as a whole (e.g., completion and timeliness of information gathering, use of clinical information for decision making).</i>
Administrative Mandate	<i>The Re-engineering Steering Committee is responsible for communicating and reinforcing the administrative mandate for the project.</i>
Setting Expectations	<i>A major objective of the Re-engineering Steering Committee is to set the organization's expectations regarding the re-engineering process. There should be no doubt among staff regarding the importance and global nature of the project.</i>
Setting Priorities	<i>A major objective of the Re-engineering Steering Committee is to prioritize the issues to be incorporated into the Re-engineering effort, including the items assigned to the various Functional Teams.</i>
Regular, Scheduled Meetings & Minutes	<i>The Re-engineering Steering Committee maintains a regular schedule of meetings, with accompanying expectations of achievement of goals. To reinforce the importance of the task and prevent loss of momentum, the Re-engineering Steering Committee meetings are at set times (chosen by the Committee), with the time slot blocked for the foreseeable future. Minutes are taken at all Re-engineering Steering Committee meetings.</i>
Formal Re-engineering Plan	<i>In an effort to keep the project on schedule and avoid being diverted by tangential issues, the Re-engineering Steering Committee manages the project through use of a formal Re-engineering Plan.</i>
Periodic Plan Review	<i>The Re-engineering Steering Committee periodically reviews progress on the Re-engineering Plan and releases updated copies.</i>

Re-engineering Functional Teams

No single group can do all the tasks required to re-engineer an organization. Therefore, the Re-engineering Steering Committee relies upon multiple Functional Teams that are focused upon specific functional areas of the organization. Although the focus of the re-engineering effort is on consumer-centered areas of the organization, decisions will need to be made related to all parts of the organization.

Role of the Re-engineering Functional Teams

Members of each Functional Team should reflect the disciplines and special knowledge necessary to evaluate ideas from all perspectives.

The Functional Team:

- Accepts assignments from the Steering Committee.
- Sends any major issues or concerns that are uncovered in the process of investigation to the Steering Committee for review and possible assignment.
- Analyzes issues and concerns to determine possible resolutions.
- Determines the impact of possible resolutions on the entire organization.
- Identifies optimal resolutions based upon the resources required to implement them and the beneficial and/or detrimental impacts on all affected organizational areas.
- Develops an implementation plan.
- Formulates recommendations for the Steering Committee. If the recommendation is accepted, the Functional Team oversees the implementation; if the recommendation is rejected for further study, the Functional Team revises the recommendation based upon Steering Committee input.
- As needed, constitutes and oversees teams focused on particular issues or tasks to expedite progress.

Typical Functional Teams for a re-engineering project might include:⁹

- Clinical Decision Making & Documentation
- Service Delivery & Clinical Operations
- Program Development, Outcomes & Utilization Review
- Consumer Financial Eligibility & Authorizations
- Consumer Financial Services
- Contracts Management
- Human Resources
- Financial Services
- Non-Clinical Operations
- Executive Information

⁹ Whether you like it or not, your Functional Teams won't be able to do everything you'd like them to do. Not that they won't be willing; rather, they simply won't be able to control enough of the environment. There are always other parties (e.g., state and/or county behavioral health authorities) who may have competing requirements and agenda. When Functional Team recommendations clash with what's "possible," the resulting conflict creates a need to involve the greater community. Don't just give up; approach the other parties and offer your recommendations as alternatives that might meet their needs. You might be surprised at how often "rigid" external bodies will accommodate your ideas.

Guidelines for the Re-engineering Functional Teams

Each Functional Team operates according to the following guidelines:

Multi-Disciplinary Membership	<i>The Functional Team is a small, multi-disciplinary group of people who are knowledgeable about the Functional Team's area(s) of responsibility. Membership extends beyond the "obvious" people (e.g., clinicians on clinically-oriented teams), and includes the variety of staff, consumers and community representatives who interact with the Functional Team's area(s) of responsibility. To help maintain project continuity, the Functional Team contains at least one member of the Re-engineering Steering Committee.</i>
Mission-Centered	<i>All of the actions of the Functional Team are designed to further the organization's mission.</i>
Respect for Consumers & Colleagues	<i>The members of the Functional Team, behave with consideration and respect for the personal dignity, autonomy, and privacy of both the consumer and the members' professional colleagues.</i>
Consumer & Recovery Focused	<i>The Functional Team's context for decision making is upon the consumer and his or her needs for recovery. Types of questions to ask include: What decisions need to be made? What information is needed by whom, when, and in what form? How do we capture the information? Who collects it? What Policies & Procedures will be required or affected?</i>
Quality Improvement Focus	<i>Each Functional Team focuses on all three components of Quality Improvement (i.e., consumer recovery, professional standards, community responsiveness) in all of its activities. Each decision and recommendation is considered in the light of its role in the general improvement of quality throughout the organization.</i>
Standards Review Orientation	<i>Each Functional Team continually considers the standards that have impact upon its work. Each recommendation is reviewed in the context of the professional and regulatory standards imposed upon the organization (e.g., HIPAA, corporate compliance, certification, licensure).</i>
Sensitive to Cultural Change	<i>Every organization has a unique culture, and any change process will affect that culture, for better or for worse. The Functional Teams remain sensitive to the tension that exists between the current and proposed cultures.</i>
High-Priority	<i>Functional Team tasks are a high priority for the organization. Participation in a Functional Team is not perceived as work to be done <u>in addition</u> to the normal job. Rather, such participation is seen as one of the <u>most important parts</u> of the job.</i>
Topic-Specific	<i>Each Functional Team is topic-specific. The Functional Team concentrates on its areas or responsibility and avoids overlapping into other Functional Teams' areas. Where overlaps occur, the affected Functional Teams jointly determine how the overlap will be handled.</i>

RE-ENGINEERING TEAMS

Task-Oriented	<i>Each Functional Team is task-oriented. Functional Team meetings are not designed to be either “blue sky” or “gripe” sessions that merely rehash the complaint du jour.</i>
Regular, Scheduled Meetings & Minutes	<i>Each Functional Team maintains a regular schedule of meetings, with accompanying expectations of achievement of goals. To reinforce the importance of the task and prevent loss of momentum, Functional Team meetings are at set times (chosen by the Team), with the time slot blocked for the foreseeable future. Minutes are taken at all Functional Team meetings with a copy forwarded to the Re-engineering Steering Committee.</i>
Program Variations	<i>Each Functional Team is aware of inherent differences among clinical programs, but <u>is not ruled</u> by those differences. Problems are identified as common to all organizational programs first, and then varied to accommodate program differences.</i>
System Champion(s)	<i>Each Functional Team has at least one member who can function as a “champion.” Such a person (or persons) is knowledgeable in the technical aspects of the area(s) being reviewed by the Team, and serves as the ongoing technical consultant(s) to the Team. The role is critical, and if a given Functional Team’s “champion” is no longer able to serve, a new “champion” is assigned.</i>
Technologies, Documentation & Training	<i>Each Functional Team identifies the technologies, documentation and training requirements for successfully implementing its recommendations.</i>
Monitoring & Management	<i>Each Functional Team identifies those processes required to monitor and manage its recommendations. Specific measures, audit procedures, types of reporting required, and other indicators are addressed.</i>
Policy & Procedure Development	<i>Finally, each Functional Team develops policies and procedures that outline the processes and methodologies to be used by staff in support of the Team’s recommendations. Those policies and procedures are reviewed by the Re-engineering Steering Committee for consistency with the work performed by other Functional Teams.</i>

Clinical Decision Making & Documentation Team

Defining clinical decision-making and documentation requirements in a consumer-centered system involves more than just deciding what information will be captured. It also involves the way in which the information will be incorporated into care planning, and the role the consumer will play in the generation and review of the information.

In addition to the issues identified in the general guidelines for Functional Teams, the Clinical Decision Making & Documentation Team addresses (at a minimum) the following areas:

Admission, Assessment & Other Clinical Information	<i>Much of the information about consumers is captured during the admission process. The Functional Team reviews the information needs for admission, assessment and subsequent clinical processes, and develops procedures to ensure that the information is captured accurately, in a timely fashion, and in such a way that it can be used by clinical staff for making consumer-based decisions.</i>
Treatment Planning	<i>The Functional Team defines its treatment and discharge planning needs and reviews the organization's treatment planning models to determine the most appropriate ways to use information, including consumer outcomes data.</i>
Clinical Records	<i>The Functional Team reviews those legal, regulatory and ethical issues relating to the development and maintenance of an automated clinical record. Recommendations are then made regarding the most appropriate method to support the effort. Specific issues to be covered include topics such as HIPAA, the type and amount of user access, structure of the notes and timeliness of data entry.</i>
Clinical Access & Confidentiality	<i>The Functional Team recommends procedures for ensuring access to clinical information by appropriate staff. The Functional Team also identifies appropriate safeguards for ensuring the maintenance of confidentiality of consumer information.</i>

Service Delivery & Clinical Operations Team

Identifying and optimizing care delivery processes and clinical operations is a critical component of any consumer-centered quality review. All phases of the clinical processes, including assessment, treatment planning, service availability and accessibility, practice methods and best practices should be considered.

In addition to the issues identified in the general guidelines for Functional Teams, the Service Delivery & Clinical Operations Team addresses (at a minimum) the following areas:

Assessment	<i>The Functional Team defines the organization's assessment models to determine the most appropriate ways to integrate the assessment process into the delivery of clinical care.</i>
Treatment Planning	<i>The Functional Team defines the organization's treatment and discharge planning models to determine the most appropriate ways to integrate treatment planning and care delivery.</i>
Service Availability	<i>The Functional Team reviews the types of services provided by the organization to ensure that appropriate services are available to consumers.</i>
Service Accessibility	<i>The Functional Team reviews the schedule of services provided by the organization to ensure that appropriate services are accessible by consumers in a timely fashion that is consistent with their treatment plans.</i>
Clinical Practice Models	<i>The Functional Team reviews the clinical practices methods and models of various professional groups (e.g., psychiatrists, physicians, psychologists, social workers, therapists) and assists those groups in the identification of barriers to effective clinical practice.</i>
Best Practices	<i>The Functional Team reviews existing best practices to assess how they can be incorporated into the organization's care delivery models to ensure: (1) consumers can use best practices to guide their actions during their recovery, identify the services and/or supports they need, and assist them in receiving appropriate services and/or support when they need it; (2) clinicians can use best practices to validate that they are providing the services that will result in the best outcomes. Additionally, these best practices can assist clinicians in providing consistent services and supports to consumers in recovery; and (3) community supports can use best practices to determine the resource commitment that is needed to facilitate consumers' recovery in a timely manner.</i>

Program Development, Outcomes & Utilization Review Team

The creation of appropriate programmatic treatment alternatives for consumers is critical to the clinical success of the organization. What types of programming are most appropriate? Which alternatives are most cost-effective?

Consumer outcomes involves not only the identification of methods for handling outcomes and utilization review information, but also those issues relating to how the consumer is involved with the process. How is the information shared with consumers? What are the links to treatment and care planning? How can outcomes measurement techniques be kept as non-intrusive as possible with respect to the clinical process?

Are programs being used effectively and are outcomes consistent with expectations?

These are only a few of the questions that should be considered.

In addition to the issues identified in the general guidelines for Functional Teams, the Outcomes & Utilization Review Team addresses (at a minimum) the following areas:

Program Development	<i>The Functional Team identifies appropriate models for clinical program development. Specific data requirements for supporting those models are identified (including indicators of quality in all three areas of consumer recovery, professional standards, and community responsiveness). Additionally, the Functional Team defines appropriate links to Treatment Outcomes and Utilization Review.</i>
Treatment Outcome Models & Requirements	<i>The Functional Team identifies appropriate models for measuring and reporting consumer treatment outcomes. Specific data requirements for supporting those models are identified (including indicators of quality in all three areas of consumer recovery, professional standards, and community responsiveness). Additionally, the Functional Team defines appropriate links to Program Development and Utilization Review.</i>
Utilization Review	<i>The Functional Team identifies approaches, staffing requirements and information needs for creating and supporting a true utilization review process. Additionally, the Functional Team defines appropriate links to Program Development and Treatment Outcomes.</i>

Consumer Financial Eligibility & Authorizations Team

The role of the Consumer Financial Eligibility & Authorizations Team is to see that the organization has established and formalized procedures for ensuring that all services provided to consumers are as fully reimbursable as possible. In a consumer-centered system, people responsible for consumer financial eligibility and authorizations also need to be sensitive to issues with consumers, their life situations, and needs. They need to be trained and supported in those areas, to avoid the all-too-common trap of staff who are “unmindful” of consumer needs. This also applies to sensitivity to community issues regarding the need to manage resources to meet consumer needs.

In addition to the issues identified in the general guidelines for Functional Teams, the Consumer Financial Eligibility & Authorizations Team addresses (at a minimum) the following areas:

Consumer Contact Point Operations	<i>The Functional Team establishes procedures for the operations of initial consumer contact points (e.g., waiting room, telephone contact). The Team identifies the degree to which centralized scheduling will benefit the organization, the tasks to be performed by front desk personnel, the nature of consumer telephone contact, and what data are required for those functions.</i>
Capture of Initial Financial Information	<i>The Functional Team defines those procedures and system definition requirements for ensuring that all appropriate financial liability information is captured for consumers without creating barriers to consumer recovery. The Functional Team establishes the process whereby timely and reliable information is captured and maintained (i.e., who collects the information, how it is monitored, who updates it).</i>
Benefits Verification	<i>Benefits verification takes at least two forms: (1) initial recording of an individual consumer's benefits; and (2) the ability to review upon demand the remaining benefits a consumer has before specific reimbursement eligibility ceases. The Functional Team identifies the information requirements of each, including who has need for access to the information.</i>
Initial Service Authorizations	<i>Some services require prior authorizations in order for reimbursement to occur. The Functional Team identifies procedures for capturing such authorizations at the time the consumer initially presents to the organization.</i>
Ongoing Service Authorizations	<i>Service authorizations can change during the course of a consumer's treatment and different processes may be required for maintaining ongoing authorizations than were appropriate for obtaining initial authorizations. The Functional Team identifies procedures for capturing such authorizations.</i>

Service
Authorization
Monitoring

The Functional Team identifies the process whereby the status of service authorizations will be monitored so that subsequent authorizations can be obtained as appropriate. The Team identifies staffing and system functions required.

Reporting
Requirements

The Functional Team identifies any reporting requirements to external organizations needing information beyond bills for individual services. Once identified, the Team determines what information is needed to satisfy the requirements, the processes for gathering that information, the resources required to obtain the information, and the format and frequency of reporting.

Consumer Financial Services Team

The Consumer Financial Services Team is responsible for identifying and formulating solutions for dealing with those issues related to the consumer's (or the consumer's third party payers') financial liability for services provided by the organization. As was the case with the Consumer Financial Eligibility & Authorizations Team, people responsible for consumer financial services need to be sensitive to issues with consumers, their life situations, and needs. Everything from how bills are formatted to how consumer questions are handled on the telephone should be included in the review. Such consideration also needs to address community concerns to facilitate the smooth response to financial liabilities.

In addition to the issues identified in the general guidelines for Functional Teams, the Consumer Financial Services Team addresses (at a minimum) the following areas:

Financial Counseling	<i>Consumers should have as complete an understanding as possible regarding their financial responsibilities. The Functional Team defines those procedures and system definition requirements related to the consumer financial counseling role.</i>
Consumer Accounting	<i>The Functional Team defines those procedures and system definition requirements specific to the consumer accounting function. The Functional Team identifies "consumer-friendly" procedures for responding to queries about financial responsibilities.</i>
Billing & Accounts Receivable	<i>The Functional Team defines those procedures appropriate to the accurate and timely production of service billings, and the subsequent application of payments and tracking of accounts receivable.</i>

Contracts Management Team

Reimbursement for the organization's services is controlled for the most part by external funding such as contracts or grants. The Contracts Management Team is chartered with the responsibility of ensuring that such agreements are appropriately defined within the organization's infrastructure. Helping the consumer understand how his or her services are reimbursed can also be critical to the recovery process, and as is the case with all other Functional Teams, consumer and community input and feedback should be considered carefully.

In addition to the issues identified in the general guidelines for Functional Teams, the Contracts Management Team addresses (at a minimum) the following areas:

Contract Costing & Marketing

Contract and grant costs are critical to the marketing of services. The Functional Team identifies methods for determining costs of services provided under individual agreements and providing that information to individuals responsible for marketing the organization's services to outside parties.

Contract Analysis & Definition

Once contracts for reimbursement are identified, they must be tracked such that fees can be correctly assigned. The Functional Team identifies staffing and procedures for analyzing contractual agreements in a timely and efficient fashion.

Human Resources Team

Behavioral health organizations are people. How the people who staff behavioral health organizations are selected, trained and supported has a great effect upon the quality of any consumer-centered organization. The Human Resources Team reviews the organization's Human Resources requirements and procedures, some of which are stand-alone and others of which are linked to other processes (e.g., fee computation, payroll).

In addition to the issues identified in the general guidelines for Functional Teams, the Human Resources Team addresses (at a minimum) the following areas:

Recruiting, Hiring & Firing	<i>Consumer-centered clinical care is enhanced when appropriate staff provide appropriate services to consumers. The Functional Team reviews the organization's Recruiting, Hiring & Firing procedures to identify areas where they intersect with the principles of consumer-centered clinical practice.</i>
Credentialing, Licensure & Privileging	<i>Credentialing, Licensure & Privileging are both Human Resources and Contracts Management issues (i.e., reimbursement rates are often affected by credentialing issues). The Functional Team identifies procedures for capturing and ensuring timely and appropriate monitoring of credentialing, licensure & privileging information to address both Human Resources and Contracts Management needs.</i>
Service Recording & Payroll	<i>The Functional Team explores appropriate interfaces of time and service recording with either internal payroll or an external payroll system and recommends an appropriate approach for payroll information (e.g., time recording, importing of payroll financial information).</i>
Unions & Labor Relations	<i>The Functional Team reviews and evaluates Unions & Labor Relations issues that have impact upon the clinical process and recommends ways to incorporate them within a consumer-centered model.</i>
Disciplinary Procedures	<i>The Functional Team reviews and evaluates Disciplinary Procedural issues that have impact upon the clinical process and recommends ways to incorporate them within a consumer-centered model.</i>
Training & Staff Development	<i>The Functional Team identifies training and staff development needs that improve staff members' abilities to provide high quality, consumer-centered clinical care.</i>
Other Human Resources Issues	<i>The Functional Team identifies and defines procedural issues related to other Human Resources issues, as appropriate.</i>

Financial Services Team

The organization also undertakes a number of financial functions, including General Ledger, Accounts Payable, Purchasing & Materials Management, Fixed Assets and Financial Reporting. The Financial Services Team identifies procedures for continual review of the financial needs of the organization and the ongoing revision of the system and processes required to address those needs.

In addition to the issues identified in the general guidelines for Functional Teams, the Financial Services Team addresses (at a minimum) the following areas:

Accounts Payable Operations	<i>The Functional Team reviews its Invoicing and Accounts Payable requirements and identifies issues related to the overall operation of the organization.</i>
Purchasing & Materials Management	<i>The Functional Team identifies its Purchasing and Materials Management requirements and identifies issues related to the overall operation of the organization.</i>
Fixed Asset Management	<i>The Functional Team identifies its Fixed Asset Management requirements and identifies issues related to the overall operation of the organization.</i>
Financial Reporting	<i>The Functional Team identifies those financial reports and indicators required for monitoring and management of the organization.</i>

Non-Clinical Operations Team

There are a number of non-clinical areas that exert a strong influence on the nature of the clinical process within the organization. The Non-Clinical Operations Team is chartered with the review of each such area to evaluate its interrelationship with the delivery of consumer-centered clinical services.

In addition to the issues identified in the general guidelines for Functional Teams, the Non-Clinical Operations Team addresses (at a minimum) the following areas:

Marketing & Public Relations	<i>The Functional Team reviews and evaluates Marketing & Public Relations issues that have impact upon the clinical process and recommends ways to incorporate them within a consumer-centered model.</i>
Quality Issues	<i>The Functional Team reviews and evaluates issues related to quality that have impact upon the clinical process and recommends ways to incorporate them within a consumer-centered model.</i>
Security	<i>The Functional Team reviews and evaluates Security & Police issues that have impact upon the clinical process and recommends ways to incorporate them within a consumer-centered model.</i>
Risk Management	<i>The Functional Team reviews and evaluates Risk Management issues that have impact upon the clinical process and recommends ways to incorporate them within a consumer-centered model.</i>
Dietary	<i>The Functional Team reviews and evaluates Dietary issues that have impact upon the clinical process and recommends ways to incorporate them within a consumer-centered model.</i>
Prevention	<i>The Functional Team reviews and evaluates issues that have impact upon the clinical process and recommends ways to incorporate them within a consumer-centered model.</i>
Community Awareness	<i>The Functional Team reviews and evaluates Community Awareness issues that have impact upon the clinical process and recommends ways to incorporate them within a consumer-centered model.</i>

Executive Information Team

The organization requires a wide variety of reporting to provide managers and decision-makers with the information it needs for effective management. In a consumer-centered organization, much of the information will relate to how the consumer fares, and not simply on what the organization did. Combined with traditional organizational management reports, consumer-centered reporting provides important information for the management of consumer care, the improvement of the care delivery system, and accountability for public resources.

The Executive Information Team identifies the general approach to be used in developing high-level decision-making tools for management.

Key Performance Indicators *The Functional Team identifies those key performance indicators that are appropriate for “taking the pulse” of the organization.*

Report Formats *The Functional Team identifies those reports required for monitoring and management of the organization.*

11

Helpful Re-engineering Tools

Give a small boy a hammer and he will find that everything he encounters needs pounding.

Abraham Kaplan

Using the right tool in the right place can make a difficult job easy. That statement is as true when undertaking an organizational re-engineering project as in any other endeavor.

Three of the most important situations people encounter in organizational projects are accurate identification of the issues, setting of goals and dealing with people who don't perform as expected. How those areas are handled can easily make or break the most worthy of projects.

Therefore, this chapter outlines three techniques that can be used to help you over these potential rough spots.

- **Getting at the Real Issue: The Whereas/Therefore Technique** — The technique described enables groups and individuals to outline the “real” issues being faced without getting diverted into juggling with premature solution attempts.
- **Organizational Goal Setting: A Results-Based Approach** — The technique described provides a structured approach to setting organizational goals that are based upon the effects you're trying to achieve, as opposed to simply revising goals for existing programs that may no longer be relevant in our world of change.
- **When Things Go Wrong: Analyzing Staff Performance Problems** — The technique described provides a straightforward process to help assess the nature of people “problems” that occur in organizations, and then determine the appropriate intervention to keep the project on track.

Getting to the Real Issue: The Whereas/Therefore Technique

*... an elemental response to the human instinct for group action
in dealing with group problems.*

William Green

People in organizations frequently encounter previous decisions that appear to be inappropriate, incomplete and/or inadequate. Those who made the decisions may have thought they were right at the time, but others seem to see the flaws almost immediately.

How do such poor decisions get made in the first place?

When a problem arises most people try to help, and the best way they know to help is by immediately solving the problem. So the first person to think about the problem announces, "If ABC is the problem, we should do THIS to solve it."

The difficulty arises when the next person comes up with different solution. That second person thinks about the same problem and announces, "If ABC is the problem, we should do THAT to solve it."

The next step is often an argument about THIS vs. THAT, with each person trying to gain allies and reinforce his or her own proposed solution, all the while criticizing the other person's obviously inferior approach. Tempers flare, inappropriate remarks are sometimes made, and everyone walks away grumbling about the narrow-mindedness of others. Finally, the person with the higher station in the organizational pecking order simply imposes his or her decision and everyone else has to live with it.

Sound familiar?

The unfortunate fact is that in such situations there's a very good chance that the people doing the arguing actually agree with each other but just don't know it. Both parties in the above example agreed on the presenting problem (i.e., ABC); they simply jumped to different solutions (i.e., THIS, THAT) and were arguing about those.

How can the cycle be broken?

What's needed is a technique that can lead people to dispassionate solutions that are based upon the real problems and not upon people's premature solutions to those problems. Ideally, such a technique would provide a structured process to:

- Separate problem definitions from proposed solutions;
- Encourage open dialog about what people really need;
- Focus on agreed-upon desired effects, rather than upon any one person's proposed solution;
- Externalize the problem from individual problem-solvers and personalities; and
- Ferret out hidden agenda items.

The Technique

The Whereas/Therefore technique is a simple graphic group approach¹⁰ to defining the parameters of problems and formulating their solutions. The technique’s name makes sense if one thinks about how legal contracts are structured. First the conditions that the agreement is designed to address are listed, usually in sentences that begin with the word “whereas.” Then the body of the agreement itself is outlined, often beginning with the word “therefore.” Conditions first; solution second.

Although it doesn’t actually use the word, the following is a pretty good example of a “Whereas” statement:

We the People of the United States, in Order to form a more perfect Union, establish Justice, insure domestic Tranquility, provide for the common defence, promote the general Welfare, and secure the Blessings of Liberty to ourselves and our Posterity, do ordain and establish this Constitution for the United States of America.

Takes you back to high school, doesn’t it? A simple statement of six “whereas” conditions that laid the groundwork for the rest of the Constitution of the United States. If the information in the rest of the document didn’t help achieve one of the six items, it didn’t belong in the Constitution.

The Whereas/Therefore technique is basic, but important. For each issue being analyzed, one simply lists the conditions that must be satisfied on the left side of a table. When all of the conditions have been listed, one begins listing possible solutions on the right side of the table that address all of the conditions on the left.

<i>(First List These)</i> ↓ Whereas	<i>(Then List These)</i> ↓ Therefore
<i>Condition 1</i>	<i>Solution 1</i>
<i>Condition 2</i>	<i>Solution 2</i>
<i>Condition 3</i>	<i>Each solution should addresses <u>all</u> of the conditions</i>

The greatest value of the technique is that it separates the conditions that must be addressed by any solution from the solution itself. At first glance the distinction may seem pretty obvious, but it’s surprising how often people get conditions and results confused.

¹⁰ An individual can certainly use the technique, but it works best for groups, especially if the members come from diverse backgrounds and may be approaching the problem at hand with different needs and expectations. (It’s particularly suitable for use by Re-engineering Functional Teams.)

Step 1: Whereas — Begin by listing all of the conditions that must be addressed by any proposed solution. Remember, “Whereas” conditions reflect what you’re trying to achieve and are independent of the solutions. (If a “Whereas” list is complete, any “Therefore” solution that addresses them all should be acceptable to the group. If it’s not, you’ve probably forgotten a “Whereas” or two.)

Step 2: Therefore — Once all the “Whereas” conditions are listed, you can begin exploring solutions to the problem. (Not before!) Remember, proposed “Therefore” solutions should address all of the “Whereas” conditions. Compare each proposed solution to the list of “Whereas” conditions and reject the ones that don’t measure up.

Some issues are too complex to be handled with a single solution. If you end up with a “best” solution that doesn’t address everything on the “Whereas” list you may need to come up with an additional “Therefore” to handle the unmet condition(s).

Example #1: Appointment Scheduling

Consider the following simple example related to appointment scheduling. In many organizations the extent of the appointment scheduling technology is the appointment books carried by clinical staff. After all, clinicians need to schedule appointments, so they carry appointment books. What’s wrong with that?

If you used the Whereas/Therefore technique to analyze the above scenario the result might look something like this:

Appointment Scheduling – First Pass

Whereas	Therefore
1. <i>Each clinician needs to be able to schedule appointments with his or her consumers.</i>	<i>Each clinician should carry a personal appointment book for scheduling appointments.</i>

That’s pretty straightforward, isn’t it?

There’s just one problem. We have jumped to a “Therefore” long before the list of “Whereas” conditions was complete. In other words, a solution was generated for a particular symptom of a situation, rather than for the underlying problem, which is much more complex.

Had all of the “Whereas” conditions been listed, the situation might have looked more like the table below.

Appointment Scheduling – Second Pass

Whereas	Therefore
<ol style="list-style-type: none"> 1. <i>Each clinician needs to be able to schedule appointments with his or her consumers.</i> 2. <i>Support staff need to be able to respond to cancels, reschedules and consumer inquiries about next appointment openings.</i> 3. <i>Other clinical staff need to schedule appointments with the same consumer(s) and/or clinicians and need to know what's already scheduled.</i> 4. <i>Other staff need to know dates, times, and scheduled services in order to secure service authorizations from third party payers.</i> 5. <i>Health information management (i.e., medical records) staff need to pull consumer charts in advance of appointments.</i> 6. <i>The list goes on ...</i> 	<p>Each clinician should carry an appointment book for scheduling appointments.</p> <p>↑</p> <p>An appropriate solution is yet to be determined, but the original response falls short of addressing the complete list of “Whereas” conditions.</p>

As you can see, the real appointment scheduling issue is much more complex than originally outlined in the first pass, and the original solution falls way short of the mark when it comes to addressing the full list of requirements. It’s not yet possible to determine the particular “Therefore” solution that would work best because the “Whereas” list is still incomplete. However, it’s obvious that the simple solution of clinicians carrying individual appointment books isn’t it.

Example #2: More Clinical Meeting Rooms

Let's consider another example. One behavioral health center applied the technique to address a debate that was going on regarding the availability of space for meeting with consumers for clinical sessions. For security and privacy reasons, the organization had elected to have all clinical contact occur in special clinical meeting rooms and not in staff offices. But there was a problem; clinical staff reported that there were never clinical meeting rooms available when they tried to schedule appointments. Obviously, the organization needed more clinical meeting rooms. Right?

That's certainly the stance the clinical staff took, but administrative staff pushed back, citing the high costs of remodeling and construction. The classic impasse.

Using the Whereas/Therefore technique, the initial argument for more clinical meeting rooms looked something like this table below. The resulting "Therefore" conclusion, while not necessarily the only possible solution, certainly addressed all of the stated "Whereas" requirements.

More Clinical Meeting Rooms - First Pass

Whereas	Therefore
<ol style="list-style-type: none"> 1. <i>Our organization needs to maintain a high level of productivity in order to: (1) meet consumer needs for service; and (2) meet financial targets necessary for organizational survival.</i> 2. <i>Organizational policy is to meet with consumers in rooms other than staff offices.</i> 3. <i>We have a limited number of clinical meeting rooms.</i> 4. <i>Clinical meeting rooms are frequently fully booked when clinicians want to schedule appointments, causing clinical staff to postpone appointments.</i> 	<p><i>We need more clinical meeting rooms available for seeing consumers.</i></p>

But like most things in life, the "we need more rooms" situation wasn't that clear-cut. A bit of investigation into the start times of recent appointments showed that many staff were avoiding the beginnings and endings of the work day for scheduling appointments. In addition, appointments were seldom scheduled right after the lunch break. Were such patterns based upon consumer choice? No; staff made the decisions simply to allow themselves to ease into and out of the day, and to ensure that they wouldn't have to rush back to work after the lunch break.

So apparently all the "Whereas" conditions weren't stated in the initial pass. Once they were, the overall picture changed. No longer was the original conclusion the obvious solution to the problem. In fact, the only thing obvious about original conclusion was that it was premature, at best. An alternative solution quickly presented itself, as shown below.

More Clinical Meeting Rooms – Second Pass

Whereas	Therefore
<ol style="list-style-type: none"> 1. <i>Our organization needs to maintain a high level of productivity in order to: (1) meet consumer needs for service; and (2) meet financial targets necessary for organizational survival.</i> 2. <i>Organizational policy is to meet with consumers in rooms other than staff offices.</i> 3. <i>We have a limited number of clinical meeting rooms.</i> 4. <i>Clinical meeting rooms are frequently fully booked when clinicians want to schedule appointments, causing clinical staff to postpone appointments.</i> 5. <i>Clinical meeting room utilization is not even. Clinical staff schedule most of their appointments in the middle of the mornings and afternoons (e.g., 10:00 am, 11:00 am, 2:00 pm, 3:00 pm) out of personal preference not related to consumer requirements. Rooms are usually available at other times.</i> 	<p>We need more clinical meeting rooms available for seeing consumers.</p> <p><i>Clinical staff need to schedule more of their appointments for other times (e.g., 8:00 AM, 9:00 AM, 1:00 PM, 4:00 PM). Once that pattern is established we will re-evaluate the need for additional clinical meeting rooms.</i></p>

βββββ

There is no “magic bullet” for problem solving; there are only tools to make the process easier. The Whereas/Therefore technique doesn’t provide any magic way to generate solutions; it simply gives you a set of criteria with which to evaluate the ones you propose.

No technique is perfect, nor will it be applicable in all situations. However, start thinking about problems and solutions in a Whereas/Therefore context and you’ll be surprised how much clearer formerly confusing situations can become.

Organizational Goal Setting: A Results-Based Approach

After all, there is a difference between living in some kind of day to day chaos where there is no hierarchy to your thoughts ... and knowing in advance the whole conclusive order ...

E.L. Doctorow

Behavioral health organizations have changed during the past decade. Small, storefront organizations have expanded, and more established care providers have grown into non-profit corporations employing hundreds of individuals. At the same time, costs have increased and revenues have flattened, and in some cases declined. Together these factors have created pressures to maintain core mission while streamlining work processes.

You might assume that along with such pressures would come an increase in the sophistication of the techniques used to manage care organizations. On the whole, however, this has not occurred. The behavioral health world has repeated many of the basic errors committed by the private business sector by assuming that the transition from small to large organizational structures was merely a question of size. Now, as funding dollars have become tighter, the fallacy of this assumption has become painfully evident.

To compound the issue, there has been a tendency in the past to fill the leadership roles of behavioral health organizations with clinicians who have risen through the ranks instead of with individuals with stronger backgrounds in administration and management. Partially because of this, the management style of those organizations has frequently been one of “management by crisis” where critical issues are dealt with as they arise, governing boards and management staff fight each other for territory, and goals and objectives are generated more for accountability to others than for direction for the organization.

If organizations are to survive, they will have to become more efficient, better managed, and a more successful candidates for future funding than their competitors. An effective results-based technique for setting organizational goals is a tool that can facilitate the re-engineering process.

The Old Way: Cost and Budget-Based Goal Setting

Tradition often drives the goal setting process in organizations. The process goes something like this:

- Cost — What would did the program cost last year? What do we think we'll get next year?
- Program — How can we use those funds in our existing programs?
- Services — What services did those programs deliver last year? How many will we have to deliver next year to capture the funds?
- Result — We'll accomplish what we can.

Granted, the above is a pretty simplistic view, but unfortunately it's also pretty accurate for a lot of organizations.

When planning is based purely on the funds that are available, the results tend to be passive, after-the-fact, and often have little relationship to consumers and their recovery. Existing programs and services are maintained blindly, and funding is viewed simply as fuel for the existing organizational engine. The status quo guides the future.

The New Way: Results-Based Goal Setting

Result: 1. a) *Anything that comes about as a consequence or outcome of some action, process, etc.* b) *the consequence or consequences desired.*

We tend to think about “results” as being an end product of a process. While that's appropriate in most situations, when it comes to planning and goal setting, results should be the first step in the process.

Knowing the intended results before you start is the fundamental “given” for an effective planning process.

There's a delightful exchange in Lewis Carroll's *Alice in Wonderland* in which the Cheshire Cat illustrates for Alice the problem inherent in proceeding along a course of action without already having the result in mind:



"Cheshire-Puss," she began,... "Would you tell me, please, which way I ought to go from here?"

"That depends a good deal on where you want to get to," said the Cat.

"I don't much care where," said Alice.

"Then it doesn't matter which way you go," said the Cat.

"So long as I get somewhere," Alice added as an explanation.

"Oh, you're sure to do that," said the Cat, "if you only walk long enough."

In other words, if we hope to arrive at any destination close to where we'd like, we have to make our journey within the context of a plan, and that plan needs to be focused on our desired results; simply weaving together multiple answers to multiple questions won't suffice.

When planning is based upon desired consumer results, the conclusions are proactive, and are based upon consumers and what is needed to support their recovery. Programs and services are innovative, fluid, and change as the results-based goals direct. The status quo has little or no link to the future. Costs, once the first step in the process, are now at the end where they belong.

and the first one now will later be last for the times they are a-changin'
Bob Dylan

The Technique

The following pages outline a goal setting technique that can be used to create an organization plan that is concise and understandable (and best of all, free of those endless pages of narrative that usually comprise organizational plans).

The goal setting process should be undertaken as a cooperative effort between staff of the organization, consumers and family members, and the governing board.

Basically, the technique¹¹ prescribes: (1) the stating of overall objectives, which are then prioritized; (2) the establishment of a perfect score for measuring complete achievement of the objectives; (3) the specific criteria to be used for measuring less than perfect progress toward meeting of the objectives; (4) a statement of the programs or interventions to be used to accomplish the objectives; (5) and a notation of the cost of that program or intervention.

1. **Introductory Statement** — Central to the technique is an introductory statement that guides the structure of every goal statement. All goals should begin with the phrase, *“Reduce toward zero, and/or resolve successfully ...”* The format is important, as it avoids subjective assessments such as “more” or “less” and provides a fixed target against which to measure progress.
2. **Desired Effect** — Identify each desired effect to be achieved by the organization and restate the effect in the form of the introductory statement (e.g., *“Reduce toward zero, and/or resolve successfully, psychosocial distress experienced by youth.”*) Once all the issues are identified, they should be prioritized.
3. **Perfect Score** — Once the desired effects are identified and prioritized, the next step is to ask, “What is the best we could do in each area?” In other words, if it were possible to achieve totally the desired effect, how would we know when we got there?

In the current example, there are at least two perfect scores. We will know we have *reduced to zero, and/or resolved successfully, psychosocial distress experienced by youth* when: (1) every youth in need of care receives care; and (2) every youth who receives care exits the system as a success.

4. **Measure** — Any goal or objective must be measurable. (If objectives weren’t meant to be measurable, they would have been called “subjectives.”) The next step is to describe how we are going to measure progress toward each of the perfect scores.

In our example, the measure for the two perfect scores would be: (1) the percentage of youth in need who are served; and (2) the percentage of youth who receive care who exit the system as a success.

¹¹ The technique is adapted from unpublished work conducted by a group from Applied Human Service Systems of the Florence Heller School at Brandeis University. It was discussed in the midst of a series of talks on the application of systems technology to human services.

For the first measure, the only way we can know the percentage of youth in need who are being served is by first knowing the number of youth in need, and that requires some form of needs assessment.

Obviously, for the second measure we need a definition for what constitutes a “success” before we can measure progress. One approach might be to implement a comprehensive outcomes system and establish internal criteria for what constitutes a “success” based upon change in outcomes scores.

5. Program — Now that you know where you’re going and what you want to achieve, it’s time to determine what programs and interventions would be most appropriate to achieve the goal.
6. Cost — Once you have determined what programs and interventions are required to achieve the desired effect(s), then (and only then) should you make the determination of what the program would cost.

The overall organizational costs will be the total of the costs of all the individual desired effects. Unfortunately, if you’re like most organizations, the total cost may exceed the funds you have available. If that is the case, it’s time to sharpen your pencil and review the components of your plan.

Remember, in any project there are three characteristics that determine how the job can be done — scope, quality and cost.

- Scope — The number and scope of the desired effects may need to be reviewed. Approaches to scope reduction might include reprioritization of desired effects and/or removal of low priority desired effects from the plan.
- Quality — The quality standard used in defining programs and interventions may have to be reviewed. Obviously, we wouldn’t lower the quality standard of any given service, but the overall mix of services might have to altered. There may simply be services and activities we cannot afford to include.
- Cost — The total cost of the project may have to be adjusted. Approaches to revenue enhancement might include exploration of alternative funding sources and/or negotiating reimbursement for previously non-reimbursed services and activities.

The key project characteristics — scope, quality and cost — are not independent. Changes in any one (or two) affect the third. In other words:

Any given Scope and Quality determine the Cost

Any given Scope and Cost determine the Quality

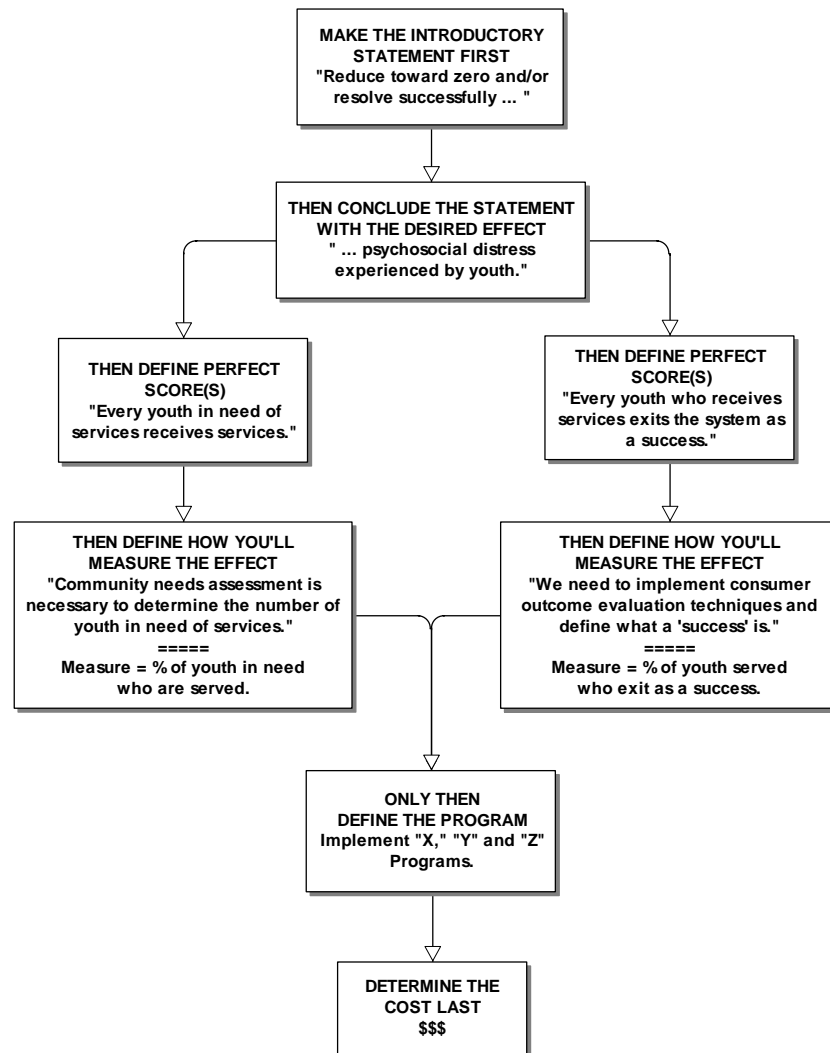
Any given Quality and Cost determine the Scope

Therefore, you must be very careful if you change more than two of the characteristics in any revision of your plan.

Process Flow

The diagram below outlines the Results-Based Goal Setting flow for a sample goal statement. A typical organizational plan might have five to ten such goal statements.

Results-Based Goal Setting



The encounter with such a specific planning technique may leave its mark upon the organization, the net result of which may be better and more appropriate work plans, higher levels of staff comfort and participation, and a much better planned and managed behavioral health organization.

Advantages and Disadvantages

While the results-based goal setting technique is almost invariably a positive one, like any other technique, it is not perfect. Following are some of the positive and negative features of the technique in the real world. These are observations based upon the application of the technique in a behavioral health organization and are made in the 20:20 vision of hindsight. Hopefully they can be of help to others considering introduction of a similar approach in their own organizations.

Advantages

1. A simple and straightforward technique allows a governing board of lay people to make clear and concise statements of organizational objectives.
2. An effects-based technique can help keep the board from becoming perplexed and overwhelmed by esoteric program issues.
3. The process ensures a division of labor between goal setting and programming. With the board responsible for the former and the staff responsible for the latter, there is a clarification of board/staff responsibilities.
4. The process avoids problems inherent in having a single individual generate a work plan narrative from a position insulated from input.
5. Planning follows a logical order. Through its sequential and step-by-step order, participants are kept from getting too far ahead of the process, thus avoiding the pitfall of program territoriality and its resultant bias.
6. The process uses “Reduce to 0...” statements rather than “Reduce/increase to some quantity X ...” statements. Thus, measures of effectiveness are tied into some absolute quantity instead of an arbitrary figure. As a result, you become your own baseline and can better measure progress over time.
7. The overall focus of the process is at all times on “What is the ultimate goal of the organization?” The original objective is always in sight and is not easily overlooked.
8. By structuring the goal setting process in the order shown in Figure 1., it is possible to define almost all planning concepts without knowing exact budgetary figures.
9. The process constitutes an easily generated, task-oriented, five-part system that is both logical and sequential.
10. Management and program staff are able to make program changes wisely and appropriately because the overall focus of the program is readily visible.
11. Methods for measuring the effectiveness of a program are defined before the program itself is actually planned. The technique keeps one from getting swallowed up in trying to measure secondary effects (programs) rather than primary effects (desired impact).

12. Given a desired impact, the definition of an appropriate evaluation measure becomes relatively simple.
13. By examining each of the prioritized goals in the same method (desired effect, perfect score, measure, program, etc.), the commonality of types of measurement for differing objectives is often made evident.
14. The technique can be applied rapidly even in extremely complex organizations.
15. By breaking up the planning process into its component parts, planning can be generated through division of labor at different levels within the organization; board, management, and staff each contributes their part to the whole process.
16. The establishment of measures related to the desired effects often points out a necessary division of labor among various governance levels (e.g., state, county, city). For example, the measure in the diagram related to needs assessment is one that, for reasons of insufficient resources, cannot usually be addressed by an individual organization. The leading role in such a situation must be played by some larger entity such as the state or board.
17. A clear goal-setting process ties almost all activities into a single “organization” rather than a proliferation of programs.
18. The overall focus and desired effects of the organization are now clear and concise.
19. Staff members can easily see where they fit in the overall scheme of things. As a result, the morale and comfort level of organizational personnel can be increased.
20. Because of its simple and straightforward nature, the technique makes it easy to communicate the organization’s aims to members of the community.
21. With a clear and simple approach to planning, one can neither hide from nor cover up one’s own mistakes. Everything is straightforward and clear.

Disadvantages

1. The technique maintains its own terminology that is not usually the a priori terminology of staff.
2. Individuals not familiar with the procedure may confuse the “perfect score” with the program objective.
3. Staff are often used to thinking in program terms rather than in terms of overall organizational objectives. Thus, there is a chance for the introduction of some artificiality and territoriality in the earlier, more abstract parts of the process.
4. The technique can place less emphasis on “enhancement of behavioral health” and more emphasis on problem areas.

5. It is often difficult to assess adequately the qualitative value of program gains. How does one truly evaluate movement toward zero as stated in the introductory statement?
6. Conveying the details of the approach to a governing board of lay people can be a difficult task.
7. The expertise and technology of the technique frequent reside at the wrong administrative level. Planning of this nature should also be done at higher levels than the individual behavioral health organization (e.g., board, state). If the planning does not occur at a higher level, continuity between separate care providers may be impeded.

When Things Go Wrong: Analyzing Performance Problems

People don't do things for a lot of reasons. Despite your best intentions, things won't always work out the way you want. Expect problems. Take a close look at Murphy's Laws and consider them seriously. You will no doubt have to deal with each of them before the re-engineered system is functioning smoothly.

Murphy's Laws

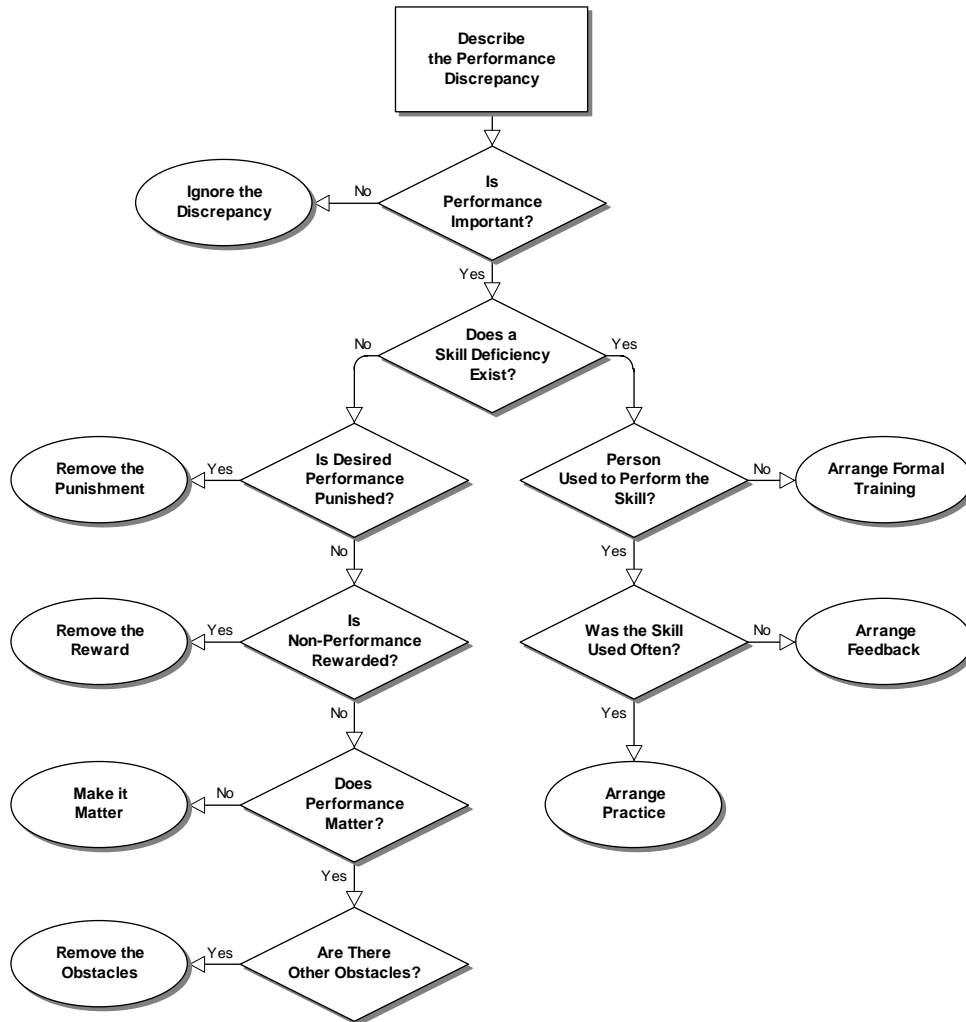
- *If anything can go wrong, it will.*
- *Nothing is ever as simple as it seems.*
- *Everything takes longer than you expect.*
- *If there is a possibility of several things going wrong, the one that will go wrong first will be the one that will do the most damage.*
- *If you play with something long enough, you will surely break it.*
- *If everything seems to be going well, you have obviously overlooked something.*
- *If you see that there are four possible ways in which a procedure can go wrong, and circumvent these, then a fifth way, unprepared for, will promptly develop.*
- *Nature always sides with the hidden flaw.*
- *It is impossible to make anything foolproof, because fools are so ingenious.*
- *If a great deal of time has been expended seeking the answer to a problem with the only result being failure, the answer will be immediately obvious to the first unqualified person.*

Unfortunately, many of the problems you will probably encounter won't be the simple, mechanical ones. Rather, the significant issues will usually occur when other people don't do something you think they should. Now those are problems!

Or are they?

The following diagram¹² outlines a simple process to apply when you encounter people “problems.”

Analyzing Performance Problems



¹² Adapted from *Analyzing Performance Problems, or 'You Really Oughta Wanna'* by Robert F. Mager and Peter Pipe (1970). This is a marvelous little book that is highly recommended. It is currently available in a 1997 revised 3rd edition.

The Process

The process starts off by rejecting the term “problem” itself and encourages the use of the term “performance discrepancy.” In other words, you start off by simply identifying that something isn’t as you expected it to be; you have a performance discrepancy.

Now it’s time to analyze what’s really happening by asking yourself a series of questions.

1. Importance — First of all, is the discrepancy important? If it is, continue; if not, forget about it and concentrate on something else.
2. Skill Deficiencies — If the discrepancy is important, determine whether the person has the potential to perform as desired. Ask questions like:
 - Could the person do the job if he or she really had to?
 - Could the person do the job if his or her life depended on it?
 - Are the person’s skills adequate for the desired performance?
 - Could the person learn the job?
 - Does the person have the physical and mental potential to perform as desired?
 - Is the person over-qualified for the job?
 - Did the person once know how to perform as desired?
 - Has the person forgotten how to perform as desired?

If the discrepancy is due to a skill deficiency and the person has never performed the task, arrange for training.¹³ If the person used to be able to perform the task, but didn’t do it often, arrange for feedback. If the person used to be able to perform the task, and did perform it often, arrange for practice.

If the discrepancy is not due to a skill deficiency, you need to ask a few more questions.

3. Is the Desired Performance Punished? — Does the desired performance lead to unfavorable consequences? Ask questions like:
 - What *is* the consequence of performing as desired?
 - Is it punishing to perform as expected?

¹³ Note that this is the sole situation where formal training is the appropriate response. Actually, there’s a simple rule of thumb for determining whether training is necessary: — If there were no barriers preventing performance and the person’s life depended upon doing the job, could he or she do it? If the answer is yes, the person doesn’t need to be trained; he or she already knows how to do the job. Therefore, any performance discrepancy is due to something else.

- Does *the person* perceive desired performance as being geared to penalties?

If the desired performance is punished, remove the punishment. For example, we want people to come on time to meetings, but those who do often have to wait around a half hour before the latecomers arrive and the meeting starts. The desired behavior of coming on time is punished by having to wait, and the non-desired behavior of coming late is reinforced when the meeting starts as soon as the latecomer arrives. The solution? Start meetings on time and don't repeat material for latecomers. You might also arrange to have some positive reinforcement such as refreshments available at the beginning (and only at the beginning) of meetings.

4. Is Non-Performance Rewarded? — Determine whether non-performance or other performance leads to more favorable consequences than would desired performance. Ask questions like:
 - What is the result of doing it the person's way instead of the desired way?
 - What does the person get out of the undesired performance in the way of reward, prestige, status, or jollies?
 - Does the person get more attention for *mis*behaving than for behaving?

If non-performance is rewarded, remove the reward. In the above example, starting the meeting on time places the latecomer in the position of arriving obviously late, and not repeating the material places the latecomer in the awkward position of not knowing what has transpired to that point.

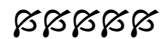
5. Does the Desired Performance Matter? — Determine whether there is a meaningful consequence for the desired performance. Ask questions like:
 - Does performing as desired matter to the person?
 - Is there a favorable outcome for performing?
 - Is there an undesirable outcome for *not* performing?
 - Is there a source of satisfaction for performing?
 - Is the person able to take pride in his or her performance, as an individual or as a member of a group?
 - Does the person get satisfaction of *his or her* needs from the job?

If the performance doesn't matter to the person, arrange consequences for behaviors. In other words, make it matter. For example, completing outcomes instruments takes time and effort. If nothing is ever done with the information other than sending it on to the county or the state, and nobody bothers to check to see if the instruments are even administered, people will stop using the instruments. The solution? Create a process whereby outcomes information

from the instruments is available as soon as the instruments are completed and make sure staff understand how to use the information in treatment planning.

6. Are There Other Obstacles? — Determine whether there are obstacles preventing the desired performance. Ask questions like:
 - What prevents the person from performing?
 - Does the person know *what* is expected?
 - Does the person know *when* to do what is expected?
 - Are there conflicting demands on the person's time?
 - Does the person lack the authority? ... the time? ... the tools?
 - Is the person restricted by policies or by a "traditional way of doing the job" that ought to be changed?
 - Are there competing factors such as phone calls, or other demands of less important but more immediate problems?

If there are other obstacles, figure out what they are and remove them. For example, if people can't find copies of the appropriate outcomes instruments when they need them, they are unlikely to administer them on time. The solution? Make sure copies of all appropriate instruments are available when needed.



Like all models, the above method for analyzing staff performance problems is an approximation, and relates only to those items over which you have some control. Not included are external factors imposed by others that simply may not be able to be done at all.

12

Re-engineering Recommendations

The purpose of the recommendations being prepared for the Re-engineering Steering Committee is to provide clear, persuasive cases that the members of the Committee can be confident in adopting. Additionally, keep in mind that the recommendations may be presented to multiple other interested parties. This means the recommendations are being prepared for several audiences, all of whom will need to be convinced of:

- the need for the proposed changes;
- the appropriateness of the changes to the needs they address;
- the effectiveness of the change in resolving the problems; and
- the validity of the costs and resources needed to accomplish the change.

Therefore, each recommendation must include enough information to build confidence in the audiences who will need to accept them. There may be some differences in how the recommendations are written for each audience, but the detailed information from answering the questions outlined below (and other similar ones) will facilitate writing recommendations for all audiences.¹⁴

Each recommendation should include quantitative and qualitative descriptions of:

- the situation that is being addressed;
- the proposed recommendation and how it addresses the situation;
- what will be needed to accomplish the change; and
- what the results will be from adopting the change and providing the resources to make it possible.

¹⁴ Much of the content in the current “Recommendations” discussion was drawn from materials originally developed by Michael M. Moses of the Moses Group (Columbus, Ohio) for a joint project conducted with Health Systems Consulting.

Understanding the Audience(s)

Because the goal is to convince each audience of the value of the recommendations, understanding each audience is critical to success. Each recommendation needs to be communicated in a credible way that includes the detail each audience needs to have available to make its decision.

Put most simply, you need to put yourself in the audience's shoes and think about what you would need to know to be convinced that the recommendation is a good one. To do this, you should consider questions such as:

- What are the different audiences you need to consider? (For example, the Re-engineering Steering Committee, the medical staff, employees, consumers and families, community agencies, the Department of Behavioral Health, etc.)
- Who are the members of each audience?
- What is the purpose of each audience?
- What are the areas where each audience needs to deliver value? What is that value?
- What role does each audience play in making a decision for or against the recommendations?
- What credibility in making recommendations do you have with each audience? That is, how much convincing will they take?
- What formats have been successful in the past in communicating recommendations to each audience?

Describing the Current Situation

The description of the current situation should provide a complete understanding of the circumstances into which the recommendation will be introduced. It should communicate what is working well, the factors that need to be balanced for a recommendation to succeed, and the issues and problems that need to be addressed.

The description needs to be both quantitative and qualitative. It should also provide measures that can be used to describe and assess the expected results.

Some questions to consider answering are:

- What are the current processes and how are they organized to work together?
- What goals are the current processes supposed to accomplish, including how much is supposed to be done?
- How did the current situation come about? What issues or problems was this set of processes intended to address or resolve?

- How well or poorly are the goals being accomplished? Include both positives and negatives.
- Who is involved in the current situation? What does each participant, kind of participant, or organizational unit contribute?
- What resources do all participants commit to the current processes? Staff? Budget? Equipment?
- What legislative and/or administrative authorities or authorizations are involved in the situation? Who has the authority to either change or maintain the current situation?
- What issues or problems have arisen because the current processes fail to achieve the intended results? Include all the impacts of failing to achieve the intended results; for example, other work that cannot be done, costs incurred as a result, loss of credibility or authority, dissatisfaction of customers, etc.

Framing the Recommendation

The description of the recommendation should provide a complete understanding of the proposed change and how it will affect the current situation. Both the quantitative and the qualitative aspects of how the recommendation will change the current processes should be discussed, including how it will preserve the current successes, as well as resolve the current problems and issues.

The measures used to describe the current situation should also be used in this section to describe the recommendation and to compare it to the current processes.

Some questions to consider answering are:

- Is this an ongoing change or a time-limited process intended to rectify an existing, finite problem such as a backlog or the need for a new program?
- If time-limited, how long will it take to accomplish the needed change?
- If ongoing, what are the proposed changes and how will they change the current processes or introduce new processes?
- How will the changes affect the organizational structure?
- Will the participants involved in the processes change? If so, who will become involved and who will no longer be involved?

Outlining Prerequisites & Resources

The description of what will have to be done or provided to implement the recommendation should describe everything that needs to change and should be both quantitative and qualitative. There will be one-time events and resources and ongoing processes and resources that will be needed for most recommendations. For example: investing in hardware and software is a one-time capital purchase with ongoing maintenance costs; hiring staff is an ongoing cost; a legislative change would be a one-time event; training on a new process may be a one-time expense.

Some questions to consider answering are:

- What one-time funding is needed for contract help, equipment, software, data, software development, etc.?
- What are the ongoing costs associated with the one-time expenses?
- What organizational changes should be made?
- What new skills and tasks will be required to implement the recommendation and are people with appropriate skills available on staff? Will any existing staff need to be reassigned?
- What new space is needed for expansion? What existing space can be given up?
- What changes need to be made in regulatory or administrative code?
- Will the resources needed to accomplish existing goals change? If so, how?
- What changes need to be made in the mission, purposes, or priorities of the organizational units affected by the recommendation?
- What actions does each audience need to take to implement the recommendation?

Describing the Expected Results

The most important set of questions to answer is the one concerning the quantitative and qualitative results that are expected as a result of implementing the recommendation. These results need to be stated in a way that clearly advances the cause of the organization, but also in a way that communicates to each audience. So, aligning the value to be produced with the areas where the audience is charged with producing value is critical.

Some questions to consider answering are:

- How will each audience identify perceived value in the recommendation (that is, consistent with the value they need to produce)?
- Will the goals of the organization change? If so, what are the new goals?

- How will the changes accomplish the goals better or faster or both? On what basis do you anticipate the improvement? How much improvement do you expect? On what basis are you estimating the improvement?
- How will the changes affect the processes that are working well? Are there any improvements in those processes as a result or are there any expected reductions in performance? If so, how much improvement or loss, and on what do you base your estimates?
- How will the changes affect other areas such as other organizational units or customers? How much change do you expect and on what basis are you making the estimates?
- Will the new processes better address the issues or problems that were the reason for the current processes? Or, have the issues and problems changed, requiring new processes?
- What will be the effect on customers of the processes? How much change should they see? What do you anticipate their reaction will be? On what do you base your estimates?

Conclusion

Remember that these questions are only to prompt thought about how to present the case for the recommendations. The key is to present the cases in the ways that the audiences need to hear them, so they will understand and accept the rationales for implementing them.

On the following pages is a sample format for preparing recommendations for consideration by the Re-engineering Steering Committee. You should complete a separate Functional Team Recommendation each time you wish to suggest an action to the Re-engineering Steering Committee regarding a specific task. Do not combine multiple tasks on a single form.

Functional Team Recommendation Format

Specific Recommendation	Date

Team Submitting the Recommendation	
<input type="checkbox"/> Clinical Decision Making & Documentation <input type="checkbox"/> Service Delivery & Clinical Operations <input type="checkbox"/> Program Development, Outcomes & Utilization Review <input type="checkbox"/> Consumer Financial Eligibility & Authorizations <input type="checkbox"/> Consumer Financial Services	<input type="checkbox"/> Contracts Management <input type="checkbox"/> Human Resources <input type="checkbox"/> Financial Services <input type="checkbox"/> Non-Clinical Operations <input type="checkbox"/> Executive Information

Who Identified the Item?	Nature of this Recommendation	What Resources Do You Need?
<input type="checkbox"/> Steering Committee <input type="checkbox"/> Functional Team	<input type="checkbox"/> Final Solution <input type="checkbox"/> Interim Solution <input type="checkbox"/> Status Report Only	<input type="checkbox"/> System Documentation <input type="checkbox"/> Consultation & Training <input type="checkbox"/> Other (Specify)

Recommendation has been Reviewed with the Following Teams or Groups:	
<input type="checkbox"/> Re-engineering Steering Committee <input type="checkbox"/> IT Department (Technical Feasibility) <input type="checkbox"/> Clinical Decision Making & Documentation <input type="checkbox"/> Service Delivery & Clinical Operations <input type="checkbox"/> Program Development, Outcomes & Utilization Review <input type="checkbox"/> Consumer Financial Eligibility & Authorizations	<input type="checkbox"/> Consumer Financial Services <input type="checkbox"/> Contracts Management <input type="checkbox"/> Human Resources <input type="checkbox"/> Financial Services <input type="checkbox"/> Non-Clinical Operations <input type="checkbox"/> Executive Information

Estimated Priority	Estimated Benefit	Estimated Cost
<input type="checkbox"/> High Priority <input type="checkbox"/> Moderate Priority <input type="checkbox"/> Low Priority	<input type="checkbox"/> Major Benefit <input type="checkbox"/> Moderate Benefit <input type="checkbox"/> Slight Benefit	<input type="checkbox"/> High Cost <input type="checkbox"/> Moderate Cost <input type="checkbox"/> Low Cost

Recommendation Supporting Information

Audience	Who is/are the intended audience(s) of the current recommendation?
Current Situation	What is the current situation that is the focus of the current recommendation?
Recommendation	How do you recommend that the above item be handled? Attach copies of any flow charts or other materials that may clarify the recommendation.
Prerequisites & Resources	What prerequisites and resources must be available for the current recommendation to be successful?
Expected Results	What are the expected results of the current recommendation?

Additional Recommendation Detail

Required Information	What types of information will be required to implement the above recommendation? Attach copies of any screen “mock-ups” or lists of data elements that will be needed. Who needs access to what information?
Required Reporting	What type of reporting is required to support the above recommendation? Which reports can be “canned” and which need to be run on an ad hoc basis? Attach copies of any report “mock-ups” you have developed.
Documentation & Training	What documentation and training are required to implement the recommendation (i.e., who requires what training, what types of documentation need to be developed and/or distributed)?
Equipment Needs	What additional equipment is required to implement the above recommendation? If significant equipment expansion is required, describe how the equipment expansion should be staged (i.e., what do we need now, next quarter, next year, after that?).
Monitoring & Management	How will the above recommendation be monitored and managed if implemented? What tools and techniques will be required by managers to ensure that the recommendation is working appropriately?

RE-ENGINEERING RECOMMENDATIONS

Policies & Procedures	What policies are needed to support the approach outlined above? If the policies are adopted by the Re-engineering Steering Committee, what procedures would be required to implement the proposed recommendation? Attach a separate sheet, if necessary.
Implementation & Review	What is the projected implementation timeframe for the above recommendation? When should the recommendation be reviewed for update?
Cost & Benefit Considerations	What are the approximate costs of the above recommendation (e.g., additional equipment, new staff, increased workload)? What are the potential benefits of the above recommendation (e.g., increased productivity, reduced staff, enhanced revenue, better clinical care, contract and/or requirements compliance)?
Existing Processes	What existing operational processes are affected by the proposed recommendation? What impact will the proposed recommendation have on those processes (e.g., negate, replace, modify)?

13

Life Signs: Measuring How You're Doing

Burns' Balance

If the assumptions are wrong, the conclusions aren't likely to be very good.

Sounds pretty logical, doesn't it? Well, not so fast. The principle refers to the late radio comedian Robert Burns and his method for weighing hogs. Burns got a perfectly symmetrical plank and balanced it across a sawhorse. He would then put a hog on one end of the plank and begin piling rocks on the other end until the plank was again perfectly balanced across the sawhorse. At this point he would carefully guess the weight of the rocks.

Don't be like Burns. In order to make appropriate organizational management and re-engineering decisions, you must have a set of measures that provide a clear and accurate picture of the health of your organization at any given point in time.

While it is possible to create elaborate and detailed analyses that report virtually everything that is occurring within the organization, such compilations of data are better suited to exploring the underlying causes of previously identified problems, rather than identifying the problems themselves. To identify problems, you should have a few easy to compute, intuitive measures that allow you to make a quick assessments of the health of the organization — critical "life signs" that give you a measure of how you're doing.¹⁵

Organizational life signs serve the same function as symptomatic measures in a health evaluation. Seeing a value outside of normal expectations doesn't necessarily tell you what the specific problem is, but it does indicate the general systemic area that is affected by the underlying problem(s). Subsequent investigation can then determine the exact issue.

Life signs such as the ones described below are intended to provide rapid, high level indications of the overall status of the organization. They are not precise analyses of status, but they do combine a variety of factors that can be investigated further to identify the

¹⁵ Much of the content in the current "Life Signs" discussion was drawn from materials originally developed by Michael M. Moses of the Moses Group (Columbus, Ohio) for a joint project conducted with Health Systems Consulting.

nature of the issues and concerns affecting the organization's ability to meet some basic criteria for ongoing operations.

Part of the *art* of developing life signs is to create relatively intuitive measures. A good life sign measures something that is easily seen as reflecting the organization's status.

Life Sign Indicators

Life signs results should be presented in an easy to understand and simple fashion. One method is to use color coding to identify factors that are within normal expectations and those that are outside those expectations. The color coding could be green for results within expectations, yellow for those somewhat outside those expectations, and red for those that deviate significantly from expectations.

Thresholds & Margins — Each life sign should have a threshold for success and at least two margins set for it.

- **Life Sign Threshold** — A life sign's threshold for success is a number that represents the goal the organization is trying to achieve for that life sign. So, the value of the threshold should reflect objectives from the organization's strategic plan.
- **Life Sign Margin(s)** — A life sign's margins should reflect the deviation from the threshold that provides an early warning that some part of the operation needs attention. So, there are usually two margins below the threshold and, possibly, one or two above it. The first of the lower margins should be the basis for a cautionary warning in the given life sign and the second one should signal a dangerous variation below expectations. Margins are frequently expressed as percentages of the threshold for success, but may be set as absolute values, if such are applicable.

Validation — Keep in mind that the effectiveness of a life sign must be validated over time. So, periodically you need to assess the status of the organization more thoroughly and compare the current life signs to the results of the detailed assessment. Such a process will help ensure that the life signs are yielding appropriate and timely information, and may also suggest other life signs that should be added to or substituted for the ones in place.

Primary & Secondary Life Signs — Life signs can be grouped into two categories — primary and secondary. Primary life signs are indicators of key factors that affect organizational health, and are useful in identifying when a potential problem might exist. Secondary life signs are better suited for investigating the underlying causes of the problem.

Keep It Simple — Finally, don't get too detailed and define so many life signs that you end up not measuring anything at all. All too frequently people look for unnecessary precision when generating information for decisions that don't require precision. You usually don't need to measure to three decimal places just to determine that one program provides about twice as much service as another.

In other words, it makes little sense to measure something with a micrometer, mark it with a grease pencil, and then cut it with an axe.

Ratios

Ratios are a common element in life signs. Using ratios accomplishes two things. First, they simplify determining the values of the margins. Second, they provide scalable tools that can be used for analysis and comparison at different levels of the organization.

- **Insensitivity to Absolute Values** — Ratios simplify setting margins because they are insensitive to absolute values. Whether the absolute values are large or small, the threshold for success can remain the same for a life sign. This is because the ratio expresses the relationship between factors, as opposed to the factors themselves. For example, the success of an organization closely depends upon revenues meeting or exceeding costs. Whether cost and revenue are measured in thousands or millions of dollars, the ratio of revenue to cost must be equal to or greater than 1.0 for an organization to survive.

Insensitivity to absolute values is also the drawback of ratios. Ratios may not always indicate the full impact of a problem, because they do not reflect the absolute values. A life sign may show a problem in a relationship between values when the values themselves may not be problematic. For example, a minor program may cost \$15,000 and revenues may only be \$13,000. If the threshold for success of revenues to cost is 1.0 and the cautionary margin is 0.9, the stated values would trigger a warning. However, \$2,000 may not represent a serious variance for the organization. Care should always be used in picking ratios where the relationship is a key concern.

- **Scalability** — The scalability of the ratios is also based upon their independence from absolute values. If the relationship between values is significant across different levels of the organization, then the ratio can help indicate which levels are contributing to the warning. For example, if the ratio of revenues to costs is slightly greater than 1.0 for the entire organization, the same ratio can be applied to individual programs to determine how each is contributing to the organizational ratio. Some programs may have ratios greater than the organizational ratio; others may be less. Again, the ratio does not diagnose the problem, but it does provide a tool to identify where to search and what to investigate.

Care needs to be taken to ensure the life sign is applicable across different levels of the organization. It may be that some parts of the organization may be less sensitive to a particular relationship than others. It is also true that a life sign could trigger a warning for the whole organization, but not any of its parts. Several parts may be marginal, but within limits, while the total impact creates a warning for the whole entity.

Primary Life Signs

Primary life signs are indicators of key factors that affect organizational health, and are useful in identifying when a potential problem might exist. Such life signs should be thought of as “question generators” rather than as answers, per se. This means that a warning from a primary life sign might lead to further analysis of the two or more factors that contribute to the life sign. You shouldn't have too many primary life signs; between five and seven is probably appropriate. Too many detract from the purpose of providing an immediate sense of the organization's health.

Five typical primary life signs are described on the following pages. Each is discussed in terms of its basic purpose, suggested threshold for success, margins and/or factors to consider, and other issues that may be useful in understanding its use.

1. Revenue & Cost

Every organization is affected by how closely its revenues match its costs of operation. Some payers contract for cost-based reimbursement rates that are intended to cover that provider's anticipated costs exactly; others negotiate contract rates based upon generalized data across multiple providers. In both cases, the challenge is to keep your organization's overhead down so actual service costs do not exceed the rates in the contract. Therefore, some measure of revenue in proportion to its costs is vital.

One possible life sign uses year-to-date (YTD) revenue and year-to-date (YTD) cost and is:

$$\frac{\text{YTD Revenue}}{\text{YTD Cost}} > 1.0$$

Basic Purpose

This life sign indicates how close the organization is to paying for itself, and reflects variations in both revenue and costs. Ideally, all costs and all revenues should be included. However, there may be subsets of revenue or cost that provide more timely feedback.

For example, you may have revenue or cost streams that can only be measured on a quarterly or semiannual basis. If these vary significantly, the life sign will be most accurate only two to four times a year. However, if these revenue and/or cost streams are relatively constant (e.g., the quarterly grant revenue is the same amount each quarter), other streams that vary and can be collected monthly can be used to indicate the status of the organization. This would require changing the threshold for success to one that reflects the proportion the monitored streams are of the total costs and revenues.

Even if the amounts do vary significantly on a time basis longer than a month, monthly measures of some of the streams may still be valuable. This is particularly true if these streams represent a “make or break” factor for the success of the organization.

Frequency

Success of the organization is closely tied to claims revenue, therefore this life sign should be monitored frequently. Revenue streams for the organization may be monthly, bimonthly or even weekly. You should monitor according to your particular mix.

Threshold for Success & Margins

The obvious threshold for success is that revenues exceed costs by a reasonable margin. Even for organizations that contract on cost-based rates, having revenues exceed costs somewhat is still advisable to fund changes in care delivery or to provide a margin to address other problems that arise during the year.

An alternative approach (if your costing rules allow) might be to budget some organizational development dollars as costs and include them in setting the rates. Should the mix of payers change, the ability to exceed costs could become more critical to the future of the organization. Although this could lead to some paybacks to payers, the value of ensuring that all normal and some unforeseen costs are covered might still be worthwhile. Such an approach would also mean a careful monitoring and accounting of revenues would be required, so any payback could be handled out of cash reserves.

Another factor to consider is variations in cost. Although costs may not vary significantly on a regular basis, costs and rates are extremely sensitive to changes in personnel. Should there be a change of personnel, especially senior personnel (who tend to be paid more than newer staff), actual costs could increase or decrease sufficiently to warrant investigation.

Margins are set above and below the threshold for success. Two ranges should be set below — one as a warning to pay closer attention and one to signal a critical issue. Margins should be set at levels that, once triggered, still provide ample time to address a problem before it becomes a serious threat.

At least one margin needs to be set above the threshold to flag when the revenues exceed costs by too much. Although the issue may not seem as serious from the organization's perspective, payers will not want to have too much “advance” money in the hands of their providers, and could use a history of overpayment as the basis for a reduction of reimbursable rates in future contract periods. In addition, as was noted above, you want to make sure that you don't “draw down” your payments too far beyond your costs so that when you reconcile with the payer you can handle any potential payback out of cash reserves.

2. Medicaid Reimbursement

Most organizations are not in a position to ensure Medicaid reimbursement levels, because they do not control the referral of consumers who are Medicaid eligible. Nevertheless, you are probably still responsible for maintaining services and staff that are certified as eligible for Medicaid.

Given that: M_r = # of Units Reimbursed by Medicaid
 M_b = # of Units Budgeted to be Reimbursed by Medicaid,

One possible life sign is:

$$\frac{M_r}{M_b} \geq 1.0$$

This measure could also be calculated substituting Medicaid revenue numbers for units. However, the step of identifying the units reimbursed would also be a step toward investigating any problems. Any units that were not reimbursed by Medicaid would need to be examined to determine why. The budgeted number of units may need to be calculated based upon budgeted Medicaid revenue and the average reimbursement from Medicaid.

Another measure that could be valuable in this area would be a comparison of the number of Medicaid eligible consumers to the number expected. However, the eligibility for any given consumer frequently changes over time and most organizations aren't capable of tracking rapidly fluctuating Medicaid eligibility.

Basic Purpose

This life sign can serve as a warning of potential trouble in multiple areas — referral rates, clinician certification, service certification, and quality of service documentation.

The referral rate of Medicaid eligible consumers is sometimes a measure of contract compliance. If a referral source (e.g., a “gatekeeper” agency) is contracting with your organization and expecting a certain level of Medicaid reimbursement, then it is incumbent on that referral source to refer sufficient numbers of eligible consumers who require enough Medicaid eligible services to generate that reimbursement.

There may also be a need for you to address internal issues that prevent reimbursement of services to Medicaid eligible consumers. If the staff who serve Medicaid eligible consumers are not certified for Medicaid, then you may need to examine: (1) how services are scheduled; (2) whether clinicians are maintaining their certifications; and (3) whether your organization is staffing the needed clinicians in sufficient numbers.

If the delivered service is not eligible for reimbursement, you may need to investigate: (1) why the denied services are not eligible for Medicaid; (2) why ineligible

services are scheduled for the consumer; and (3) whether the service documentation is being completed accurately.

You may also want to make sure that the budgeting and contracting process with Medicaid-related payers is accurate and appropriate. Potentially interesting sub-levels of investigation could involve calculating this life sign not only for different subsets of your organization but also by payer.

Frequency

This life sign should be monitored on a period directly related to claims payment cycle. If you are reimbursed monthly, monitor it monthly. If you are reimbursed weekly, monitor it weekly.

Threshold for Success & Margins

Success for this life sign is achieved when you meet or exceed the budgeted Medicaid reimbursement. However, as Medicaid payers examine the increasing amount of money required to match federal dollars, they could impose a ceiling on how much to bill Medicaid. Additionally, Medicaid reimbursement may become less desirable as your organization's payer mix changes. In all such cases, you must determine how close the actual Medicaid reimbursement should be to the budgeted level.

Since Medicaid is a payer of last resort, seeing Medicaid reimbursement increase may mean that other payers are not providing coverage for claims. This may or may not be a desirable situation and should lead to further checking to find out why it's increasing.

If there are no concerns about the balance of payments from other payers or for ceilings set by Medicaid payers, this life sign needs two margins below the threshold level. If one or both of the above concerns exists, two more margins will be needed above the threshold.

3. Service Collections

Collection of all the money that an organization bills is one measure of that organization's success. In the world of health claims, however, 100% reimbursement is often an unrealistic expectation, because contracts are negotiated that disallow certain charges or set rates lower than the provider bills. Therefore, providers frequently bill at rates higher than some of their contracts provide, thereby unintentionally ensuring that their collections will be lower than the total billings.

So how should you determine "expected" collections? Historical patterns and contracts can often be used to estimate what percentage of the billed amounts can be expected in collections. So, you should be able to set a realistic threshold for success.

One possible life sign is:

$$\frac{\text{YTD Billed Dollars Collected}}{\text{YTD Dollars Billed}} = \text{Expected}$$

where “Expected” is the threshold for success.

Basic Purpose

As was the case with the Medicaid reimbursement life sign, this life sign can indicate potential problems in several areas. Certainly, contract compliance can be evaluated based upon whether the payer is paying claims in a timely fashion. Additionally, this life sign can serve as an indicator of whether contract referral sources and payers are meeting their obligations.

Other issues that affect payment of bills (e.g., service appropriateness, documentation, staff credentials) can also affect this life sign. All the areas of potential investigation mentioned under the Medicaid reimbursement life sign are also appropriate if this life sign shows a warning.

Frequency

As was the case with previous life signs, this life sign should be monitored on a period directly related to claims payment cycle. If you are reimbursed monthly, monitor it monthly. If you are reimbursed weekly, monitor it weekly.

Threshold for Success & Margins

The threshold for success should probably be set below 1.0 and should be based upon historical reimbursement patterns. In fact, as this life sign gets close to 1.0, it may indicate a problem with achieving the desired level of Medicaid reimbursement, in that Medicaid rates are frequently lower than the organization's other billing rates. So, watching the interrelationship of this life sign with the Medicaid reimbursement life sign could yield insight into the optimal threshold for success. Computation of the life sign for individual payers might also show where the greatest fluctuations are occurring.

A margin also could be set above the threshold to flag when it gets too high, although it probably is not needed. Margins below the threshold are certainly appropriate, however.

4. Staff Productivity

Productivity of clinical staff is a critical organizational life sign. There are multiple ways to calculate productivity, depending on the purpose being served. One possible measure is a simple one designed to tie the level of work to the revenue of the organization.

That life sign is:

$$\frac{\text{YTD Reimbursable Hours}}{\text{YTD Available Hours}} \geq \text{Expected}$$

where “Expected” is the threshold for success (e.g., 50%).

A key issue for this life sign is what measure to use as the denominator. If all staff time (that is, administrative and clinical) is used, this life sign will show how effective the organization is in using its total staff resource to produce revenue. The drawback is that it will be less sensitive to changes in clinician productivity. Conversely, using clinician time only as the denominator (and a correspondingly higher threshold) will yield a better understanding of clinician productivity, but will not reflect the overhead that needs to be supported by billable time.

One key complicating factor in this life sign is how or when the number of reimbursable hours is calculated. If there is a wide discrepancy between what is thought to be reimbursable and what is actually reimbursable, this ratio will be difficult to use. The simple fact that a service was billed may not be assurance that the service was reimbursable.

If this is a concern, a better life sign may be:

$$\frac{\text{YTD Paid Hours}}{\text{YTD Available Hours}} \geq \text{Expected}$$

This measure would have to be calculated after payment is made, so the information provided by the life sign would be available later than if billable hours were used, but the increased accuracy could make the delay worthwhile.

Basic Purpose

There are several factors that affect this percentage, all of which should be monitored. They generally fall into two categories — appropriate internal levels of effort and external referral patterns.

- **Internal Levels of Effort** — The appropriate internal levels of effort include the work habits of the staff, the proper assignment of staff to consumers, and the proper delivery of service to those consumers. Cer-

tainly, if clinicians are not delivering services to the full extent they could, this life sign will reflect the fact. However, inappropriate staff assigned to consumers and/or inappropriate services being delivered to the consumers will also adversely affect the life sign. In such a case, the actual issues may be related to staffing levels and/or qualifications, or simply scheduling procedures and/or monitoring of service authorizations.

- **Referral Patterns** — Contract compliance will also be monitored because a failure on the part of a referral source to refer the appropriate consumers in promised numbers will create a problem, too. Referring too few consumers will mean that clinical staff will be underutilized. However, referring consumers who do not need the services the organization is staffed to deliver could also result in shortfalls.

Frequency

As is the case with all life signs that use billing data, this life sign should be monitored on a period directly related to claims payment cycle.

Threshold for Success & Margins

Setting the threshold for success is critical to the effectiveness of this life sign, which can be one of the most important for the organization. Determining the threshold level will also depend on what definition of “Available Hours” is used in the denominator, as one would expect the threshold to be lower with the inclusion of administrative time.

5. Service Breakeven Point

One way to monitor capacity is to measure the workload carried by the clinical staff of the organization. Basically, the measure is simply the number of services provided in a given period divided by the number of people available to provide them.

The suggested life sign is:

$$\frac{\text{Services Provided}}{\text{Clinical FTE}} \geq \text{Expected}$$

Basic Purpose

This life sign is designed to provide a view of whether staffing and service delivery expectations are appropriate to meet your organization’s needs. If you have more staff than your service delivery demands, the value will be less than expected. Conversely, if the organization is understaffed, the value will significantly

exceed the expected amount and will indicate a potential need for additional clinical staff.

A similar issue to the previous life sign needs to be addressed (i.e., which staff will be included in this calculation). If you include clinical staff only, the life sign becomes a measure of clinical workload and capacity. Including all staff expands the measure to include a measure of total capacity of the organization to handle active consumers. Since work related to consumers requires both clinical and non-clinical staff time, including all staff may provide a better overall picture of how well the organization is staffed.

Frequency

Calculating the number of services and dividing by the number of active staff gives a snapshot of workload at a point in time, but it does not allow a view across time. Therefore, the life sign should be monitored over time to look for trends. You may decide later to adjust the frequency, based upon changes in staffing or service levels.

Threshold for Success & Margins

You may find it difficult to set the initial threshold for success. One method to determine an approximate threshold would be to back into a value. (Note that the following method assumes that services and hours are equivalent.)

Let's make the following assumptions to compute a sample threshold:

- Month = Calculation Period**
- \$100,000 = Total Revenues (TR)**
- .75 = Service Revenues Proportion (SP)**
- .75 = Collection Ratio (CR)**
- 12 = Clinical FTE Staff (FTE)**
- .65 = Target Productivity Ratio (PR)**
- 146 = Work Hours/FTE (WH)**
- \$85 = Average Billing Amount/Service (BA)**
- 4.3 = Average Services/Consumer (CS)**
- 400 = Total Services Delivered (TS)**

Obviously all of the above factors are very closely interdependent. A change in any of the factors (e.g., revenue proportions, service rates, collection ratio, productivity expectation, FTE staff) changes the entire picture. If such a change occurs, you should recalculate the threshold.

The table below identifies the steps required to compute a threshold for the Service Breakeven Point life sign. Each step describes how the step is computed, provides the formula for computing the step value, and lists the result (based upon the numbers above).

	Description	Formula	Sample Result
Service Revenues (SR)	Step 1. Determine from historical data the portion of total revenues (i.e., dollar amount per month) in the first life sign (Revenue & Cost) that is represented by service revenue. Multiply the Total Revenues by the Service Revenues Proportion.	$\text{TR} \times \text{SP} = \text{SR}$	$\begin{aligned} &\$100,000 \\ &\times .75 \\ &= \\ &\$75,000 \end{aligned}$
Amount Needed to Bill (BA)	Step 2. Divide the computed Service Revenues dollar amount by the historical Collection Ratio used for the third life sign (Service Collections) to determine the amount you must bill in order to collect what you need.	$\text{SR} / \text{CR} = \text{BA}$	$\begin{aligned} &\$75,000 \\ &/ .75 \\ &= \\ &\$100,000 \end{aligned}$
Revenues Per FTE (FTE\$)	Step 3. Divide the Amount Needed to Bill by the number of clinical FTE staff to get the billable amount each clinical FTE must generate in the period.	$\text{BA} / \text{FTE} = \text{FTE\$}$	$\begin{aligned} &\$100,000 \\ &/ 12 \\ &= \\ &\$8,333 \end{aligned}$
Available Hours Per FTE (AH)	Step 4. Multiply the number of Working Hours in the period by the Target Productivity Ratio expected in the fourth life sign (Staff Productivity) to get the number of hours available per FTE for seeing consumers in reimbursable activities. (If your productivity expectation is based upon actual hours worked, remember to subtract average sick leave and vacation time before multiplying.)	$\text{WH} \times \text{PR} = \text{AH}$	$\begin{aligned} &146 \times .65 \\ &= \\ &94.9 \end{aligned}$
Hourly Amount Per FTE (H\$)	Step 5. Divide the Revenues/FTE by the Available Hours/FTE to get the amount each FTE must generate per Available Hour.	$\text{FTE\$} / \text{AH} = \text{H\$}$	$\begin{aligned} &\$8,333 \\ &/ 94.9 \\ &= \\ &\$87.81 \end{aligned}$
Average Billing Amount Per Clinical Service (S\$)	<p>Step 6. Determine from historical data the Billing Amount per Service. (Unless your information system tracks receipts against specific services, this value will have to be based upon a comparison of total services delivered and total reimbursement received over some extended period such as YTD).</p> <p>Divide the Average Billing Amount per Service by the Hourly Amount/FTE.</p> <p>If this number is significantly smaller than 1.0, you should increase your expected productivity ratio and repeat steps 4 through 6. If, on the other hand, the number is significantly larger, you could decrease your expected productivity ratio and repeat the calculations. If the number is approximately equal to 1.0, it means that the Available Hours per FTE (AH) is a close approximation of the life sign expected value.</p>	$\text{S\$} / \text{H\$} \geq 1.0$	$\begin{aligned} &\$85 \\ &/ \$87.81 \\ &= \\ &0.97 \end{aligned}$

Secondary Life Signs

Once the primary life signs indicate there may be a problem, there will be a need for other measures to help investigate the issues. Secondary life signs are designed to investigate the underlying causes of the problem(s).

Some of these may be preferred to those recommended as primary life signs. The key issues in choosing one over another are: (1) to minimize the number of primary life signs (a good number is four to six); (2) to make sure the critical factors for the organization influence the life sign; and (3) to have a rationale for why one measure is better than another and how it should be calculated and applied. Remember that a good life sign should be relatively intuitive, too.

The following indicators may be helpful:

- **YTD Dollars Collected/YTD Dollars Budgeted**

This measure would be one that could be used after any of the life signs affected by revenue showed a problem. If the collections are on target for the budget, then it is less pressing an issue than if the budget is in jeopardy.

- **Late Service Tracking Documents**

Delayed recording of services delivered can be an indicator of multiple organizational ailments. At the least is the simple delay, and in extreme cases the complete loss, of reimbursement for services delivered. But late recording of services may also be indicative of lax procedures and enforcement, poor accountability, simple disciplinary issues, and whether there may be significant unbilled revenue that would affect other life signs.

This life sign could be useful for investigating revenue issues, as well. Basically, late service tracking documents could be calculated by averaging the difference for each service between the date of service and the date the service was entered into the information system.

- **Denials of Reimbursement**

One of the assumptions behind using late service as a life sign is that those documents record services for which the organization will be reimbursed. But recording and billing of services is not the same as getting paid for those services. Like it or not, we seldom receive reimbursement for everything we bill.

Therefore, another facet to examine if revenue is a problem is the denials of payment. This is not a measure, per se, but an area to investigate using reports showing a distribution of denials by reason code. Any reason codes that show denials for reasons the organization could have avoided (e.g., inadequate documentation, inappropriate or unauthorized service, improper staff credentials) should be investigated.

- **No-Show and Cancellation Rate**

One of the simplest measures of program effectiveness is the no-show and cancellation rate. This measure can be used to investigate issues of poor scheduling, quality of service being delivered, or the likelihood of consumers to be available for appointments.

If a program does not bill for no-shows and cancellations, every missed appointment represents a loss of revenue and therefore, becomes a problem. If revenue flags, no-show and cancellation rates should be checked.

The "Productivity" Diversion

In the push for demonstrated "increased productivity," it's easy for organizations to get diverted into measuring something other than what they intended. Possibly one of the most frequently encountered measures is the amount of revenue generated by the typical clinical staff member.

$$\frac{\text{Average Revenue}}{\text{FTE}}$$

FTE

The above measure is different than other life signs that have been discussed, in that it represents an absolute value instead of a ratio. Because it is an absolute value, it is of little help in assessing an organization's without having some sort of "baseline" reference against which to measure it.

Otherwise, you have nothing to tell you what a desired value would be. Is \$1,000 per FTE good or bad? What about \$10,000? \$100,000? It's no different than the problem one would encounter knowing only half of a football score. "Team A had 38 points at the end of the game." Interesting, maybe ... but did they win or lose? Without a comparative value for their competitor, you don't know.

In order to make the measure more useful, it should be compared to some other known or expected quantity. One such expansion of the above measure might be the following:

$$\frac{\text{Average Revenue}}{\text{FTE}} \geq \frac{\text{Average Cost}}{\text{FTE}}$$

If you were to use a comparative measure such as the above, you would at least know if you had more coming in than going out. But it wouldn't tell you anything about staff productivity.

Why not? A productivity (or efficiency) standard, by definition, is a calculation of output or throughput divided by resources consumed in producing the output. So, in the case of

the above measure, the organization has a numerator, but no denominator. (Technically, the each side of the relationship is a single value, and not a rate, per se.)

Furthermore, application of a little basic algebra (multiplying both sides by "FTE") reduces the above relationship to:

$$\text{Average Revenue} \geq \text{Average Cost}$$

And then by dividing both sides by "Average Cost" you get:

$$\frac{\text{Average Revenue}}{\text{Average Cost}} \geq 1.0$$

This is equivalent to the first life sign discussed, under "Revenue and Cost." In other words, what started out looking like something to measure staff productivity, turned out to be a repeat of another measure that was designed to track revenue and had nothing to do with productivity, per se.

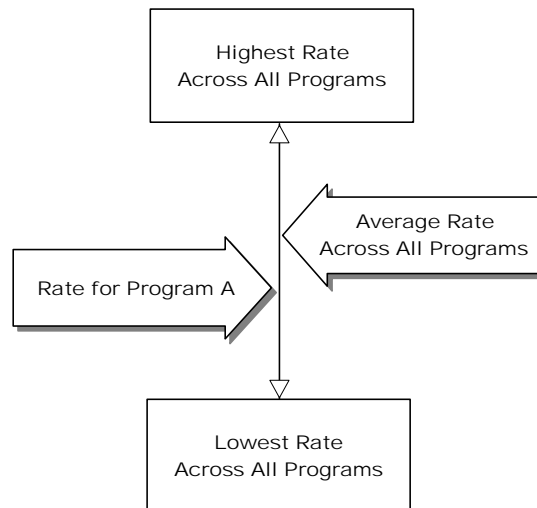
Although it is highly advisable to make sure that employees have clear goals for their performance and to educate them about their contribution to the survival of the organization, measures such as the above need to be recognized as revenue standards, not productivity standards.

Presenting Life Sign Information

One effective method of presentation for life sign and similar measures is to display the information in a format that allows the viewer to understand not only the actual values being reported, but also how those values relate to similar measures for comparative groups.

In the example below, the rate for Program A is being reported. By reporting the rate in comparison to the high, low and average rates across all similar programs, decision makers within Program A know where they stand in absolute terms (i.e., their own rate), and in relative terms compared to the best, worst and average program. Displays of this type are most effective in facilitating behavior change when the only identification on the report is for the entity being reported (Program A in the example). In other words, while the rate for the high and low values is reported, the specific programs that achieved those rates are not.

Measuring Where You Stand Compared to Others



Note that presentations such as the above aren't limited to program-level reporting. Reports could be prepared for different organizational subsets down to the individual staff member. One could also prepare a report using only the high, low, and average rates and use the report as feedback to the entire organization.

Using a Cost–Outcome Matrix

Finally, we come to the cost–outcome matrix. While not an indicator or “life sign” in itself, the cost–outcome matrix is a simple approach to looking at selected consumer and cost information that provides a sophisticated analysis capability. The model is dependent upon the presence of some indicator of consumer status that can be assessed at various times to provide both “before” and “after” measures of consumer functioning. In addition, you must have some method of aggregating services and their resultant costs by consumer. When those two measures (i.e., cost and outcome) are combined, it is possible to produce a picture of groups of consumers and the costs associated with them.

Although it is preferable to have an accurate measure of consumer clinical status, you can begin with any indicator of consumer functionality that reasonably reflects overall status. It is more important that repeated measurements of the indicator reflect whether the consumer is doing “better” or “worse” over time than to provide an absolute assessment of the consumer’s status.

Once such an indicator is identified, the door is opened to developing a matrix that associates cost and results. Basically, the matrix is a two-dimensional array. Both axes consist of the scale for the indicator of status, with the vertical axis representing the indicator’s value at some initial point (e.g., intake) and the horizontal axis representing the indicator’s value at some follow-up point (e.g., termination).

Similar to a spreadsheet, the matrix yields cells where consumers can be counted and the costs for those consumers can be totaled. The example shown uses a scale of 10 levels of functioning, and contains 100 cells. The top left cell (marked “A”) would contain the total numbers of consumers and costs for those who had an initial functioning level of 1 and a follow-up level of functioning of 1. Halfway down, the first cell on that row (marked “B”) would be for those consumers who started at level 5 and ended at level 1, and so on. The diagonal cells (shaded gray) would be contain those consumers who had the same level of functioning at both the initial and follow-up points (i.e., showed no change in functioning between assessment points).

One nice feature of the cost–outcome matrix is the ease with which you can identify which consumers have improved and which have not. Any consumers located in cells above and to the right of the diagonal (marked “+”) have progressed. Any consumers located in cells below and left of the shaded cells (marked “–”) have regressed.

If a status of 6 or higher means the consumer is in a functional state, as opposed to a dysfunctional state, those consumers above and to the right of the double lines (i.e., the upper right quadrant of the matrix) have moved from dysfunctional to functional. Those that are to the left and below those lines (i.e., the lower left quadrant of the matrix) began at a functional level and regressed to a dysfunctional level.

		Follow-Up Outcome Level (LOF)									
		1	2	3	4	5	6	7	8	9	10
Initial Outcome Level (LOF)	1	A	+	+	+	+	+	+	+	+	+
	2	-		+	+	+	+	+	+	+	+
	3	-	-		+	+	+	+	+	+	+
	4	-	-	-		+	+	+	+	+	+
	5	B	-	-	-		+	+	+	+	+
	6	-	-	-	-	-		+	+	+	+
	7	-	-	-	-	-	-		+	+	+
	8	-	-	-	-	-	-	-		+	+
	9	-	-	-	-	-	-	-	-		+
	10	-	-	-	-	-	-	-	-	-	

Likewise, those consumers above and to the left of the double lines (i.e., the upper left quadrant of the matrix) have improved, but are still considered to be in a dysfunctional state. Those that are to the right and below those lines (i.e., the lower right quadrant of the matrix) began at a functional level and have progressed to a higher functional level.

The real power of the cost-outcome matrix is unlocked when it is used to analyze costs and effects for subsets of the overall consumer population. For example, one could analyze the effectiveness of treatment for consumers who received one type of treatment intervention and compare it to consumers who received a different treatment intervention. One could also perform comparative analyses based upon consumer characteristics, service providers, or any of a number of other factors.

Clearly, once the status indicator is available and the totals of consumers and costs are aggregated in each cell, you would have a valuable tool at your disposal. The first issue will be agreeing to an indicator of status, given what is currently available in your information system(s). There are several diagnostic assessments, but one is needed as a global assessment indicator. It needs to be used consistently and should at least be able to indicate relative movement, if not an absolute measure.

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Appendix A:

A Few Thoughts About Productivity

The term “productivity” is a slippery one at best; it means different things to different people. The situation is similar to that of reporting an “average” score. Is the party to whom the report is being sent looking for the mean, the median, or the mode? All three are valid measures of “average,” but may give widely disparate results. Report the wrong measure and you could be creating a problem for your organization.

There are a number of valid definitions of “productivity” that you might encounter. Understanding which one is being asked before you answer may represent the difference between your organization’s ultimate success and failure.

Never assume the intent of another party’s use of the term without first verifying what is being asked, because a high productivity level using one measure may equate to a much lower level when a different measure is applied to the same data.

Components of a Productivity Measure

Productivity is often based upon the use of staff time and how it is distributed across the following categories:¹⁶

	Category Description
Total Staff Time (SH)	<i>The total amount of time available for staff members. This number is usually equivalent to 35-40 hours per week for a full-time staff person. Note that some program productivity definitions may require total hours for all staff (including administrative and support staff), while others may only require total hours for "direct service" staff. Just be sure you know which definition is being applied. In order to report total staff hours, you must have a mechanism to record all staff time worked, and not just what is commonly thought of as "productive" time.</i>
"Key" Activities (KA)	<i>Activities that are deemed important enough to track as a gauge of organizational activity. Key activities have little meaning to anyone other than the organization tracking them, bridge the gap between direct billable services and total time recording, and generally include those activities that the organization needs in order to track its resources and make management decisions. Some organizations may wish to track activities in great detail; others may wish to track very little.</i>
Consumer-Directed Time (CD)	<i>Time spent in activities that are directly related to an individual consumer. In addition to traditional, face-to-face services, consumer-directed activities could (but do not necessarily) include activities such as meeting with collaterals, transporting a consumer, or monitoring a consumer or his/her environment. Note that this category does <u>not</u> have any direct relationship with "billable" activities, per se.</i>
Face-to-Face Time (FF)	<i>Time spent in traditional, face-to-face activities with a consumer or consumers. Note that this category does <u>not</u> have any direct relationship with "billable" activities, per se.</i>
Billable Time (B)	<i>Services that are billable to a third party for reimbursement (either direct fee for service or through after-the-fact reconciliation).</i>

¹⁶ The current example is based upon the use of reported hours only; there are other "families" of productivity measures that could be based upon units of service or other measure. In other words, the possible valid "productivity" measures are even greater than shown. Note that each category is inclusive of all the categories below it except for Billable Time, which is subject to independent contracts and could include anything a contract allows.

A FEW THOUGHTS ABOUT PRODUCTIVITY

As a general rule of thumb, when comparing the above time categories, one can expect the following relationships to hold:

$$SH \geq KA \geq CD \geq FF \geq B$$

In other words,

- Total Staff Hours will be greater than or equal to hours spent in Key Activities,
- Hours spent in Key Activities will be greater than or equal to Consumer-Directed hours,
- Consumer-Directed hours will be greater than or equal to Face-to-Face hours, and
- Face-to-Face hours will be greater than or equal to Billable hours.

Productivity Computation Examples

Let's make the following assumptions for a given period and see what the various definitions of productivity yield:

1,000 = Total Staff Hours (SH)

800 = Hours Spent in "Key" Activities (KA)

600 = Consumer-Directed Hours (CD)

500 = Face-to-Face Hours (FF)

400 = Billable Hours (B)

The table below identifies a number of valid productivity definitions, describes how each measure might be used, provides the formula for computing the measure, and lists the resultant productivity percentage (based upon the numbers above).

	Productivity Measure Description & Use	Formula	%
Billable Time (BT-1)	<i>Percentage of time spent with consumers that is reimbursable by others. This measure might be used by internal management to assess whether or not you are maximizing your potential reimbursement for services. Most face-to-face activities are usually reimbursable by someone. If this type of productivity is low, you should determine why (e.g., missing potential funding sources, delivering services with non-certified staff, overstaffing consumer services, not tracking service authorizations).</i>	B / FF = 400 / 500	80%

	Productivity Measure Description & Use	Formula	%
Billable Time (BT-2)	<i>Percentage of Consumer-Directed time that is reimbursable by others. This measure might be used to demonstrate the amount of time a program has to invest in consumer-directed activity and the degree to which it is reimbursable. One would expect programs that have a large amount of non-reimbursable, consumer-directed activity (e.g., child and family programs) to prefer reporting productivity with this approach as opposed to one that compares billable time to total time.</i>	$\frac{B}{CD} = \frac{400}{600}$	67%
Billable Time (BT-3)	<i>Percentage of time spent in "Key" Activities that is reimbursable by others. This measure might be used by internal organizational management to keep track of the amount of activities you regard as being "key" and the degree to which you can continue to pursue them and still remain financially viable. If what you think you should be doing is reimbursable ... so much the better. If not ... you need to find alternate ways to pay the bills.</i>	$\frac{B}{KA} = \frac{400}{800}$	50%
Billable Time (BT-4)	<i>Percentage of Total Staff Time that is reimbursable by others. This measure might be used by an external party who was funding your program and wanted to compare it to other programs. If the external party chooses to include all staff time in the total staff time calculation, this productivity model can set a very difficult standard.</i>	$\frac{B}{SH} = \frac{400}{1,000}$	40%
Face-to-Face (FF-1)	<i>Percentage of Consumer-Directed time that is spent in Face-to-Face activities with the consumer. This measure might be used to monitor time spent actually working with consumers (as opposed to work "on behalf" or "in support" of consumers). The degree to which any number may be "good" or "bad" may depend upon additional measures such as B/FF and B/CD, above.</i>	$\frac{FF}{CD} = \frac{500}{600}$	83%
Face-to-Face (FF-2)	<i>Percentage of time spent in "Key" Activities that is spent in Face-to-Face activities with the consumer. This measure might be used as an internal measure of how closely time spent with consumers relates to what your organization thinks is "important." If the number gets too low, <u>you</u> may know why, but others may wonder. Be prepared to educate them so <u>they</u> know why.</i>	$\frac{FF}{KA} = \frac{500}{800}$	63%
Face-to-Face (FF-3)	<i>Percentage of Total Staff Time that is spent in Face-to-Face activities with the consumer. This measure might be used to get an idea of how much of your organizational resources are spent actually working with consumers (as opposed to work "on behalf" or "in support" of consumers). This type of measure is primarily a "face validity" measure — are you doing what you "ought" to be doing? All things being equal, however, the lower the number, the higher your need to be sure others understand exactly what you do and why it is important.</i>	$\frac{FF}{SH} = \frac{500}{1,000}$	50%
Consumer-Directed (CD-1)	<i>Percentage of time spent in "Key" Activities that is spent in Consumer-Directed activities. This measure might be used to monitor the degree to which what you think is "important" has to do with your consumers. The lower the number, the more you need to reconsider what's "important."</i>	$\frac{CD}{KA} = \frac{600}{800}$	75%

	Productivity Measure Description & Use	Formula	%
Consumer-Directed (CD-2)	<i>Percentage of Total Staff Time that is spent in Consumer-Directed activities. This measure might be used to keep tabs on the degree to which organizational resources are being directed toward your consumers. A lower number should suggest that you take a look at whether you're doing what's important, or simply what you want to do. Tough questions ... but they need to be answered.</i>	CD / SH = 600 / 1,000	60%
Supervision	<i>Percentage of Total Staff Time that is spent in "Key" Activities. This category is generally used by internal management to determine if a program is spending its time in tasks and activities that are "key" to the fulfillment of the organizational mission. In other words, if you think activities A, B and C are important, but a large amount of time is being spent in activities D, E and F, you need to take a closer look and see what's going on.</i>	KA / SH = 800 / 1,000	80%
Other (e.g., Union)	<i>Definitions subject to contractual relationships. This category is up for grabs. Whatever someone thinks is important may be included. When faced with this category, your job is to do your best to make sure that the category definition makes sense and that it is appropriate to the question being asked. (It would also be nice if you could score highly, too!)</i>	Varies with the Contract	?

The Bad News

So what's the bad news? Any given set of numbers can result in a wide range of productivity values that can make you look like you are: (a) doing your job; and/or (b) not doing your job. If the right answer is applied to the wrong question (or vice versa), somebody is going to come to the wrong conclusion. In the above example, the same set of numbers yielded "productivity" values that ranged from over 80% to 40%. While neither answer is "bad," per se, giving a 40% answer to an 80% question could be disastrous!

The Good News

So what's the good news? A well-designed management information system should provide the organization and its programs with the ability to report information according to any of the above productivity definitions, and should be able to report the information further subdivided by consumer group, staff group, date range, cost center or other meaningful factors. The main trick will be to know which one to report to answer a given question.

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Appendix B: Case Studies in Clinical Re-engineering

Behavioral health organizations are faced with significant levels of change that they have to incorporate into their environments. Given that such factors cannot be ignored, it is appropriate for organizations to adopt sound, rational methodologies for accomplishing such change in ways that are consistent with their organizational values, vision and mission.

The following pages describe re-engineering efforts of several organizations. They range from major re-engineering of clinical processes, to development of recovery assessment tools, to simple process improvement. In other words, the examples given are as diverse as the organizations they represent.

But they all have two things in common — all represent organizational change related to consumer needs, and all were instituted in response to a recognition that consumer-centered organizations are not only the right business; they are good business.

The case studies that follow are not intended to show what you should do in your organization; they are intended to show what others have done. But, by looking over the work of others, you may refine your own ideas of what you think will work in your organization.

Outcomes-Driven Clinical Reorganization

Nova Behavioral Health

Nova Behavioral Health Center (Canton, Ohio) is a behavioral health agency that, like other organizations, faced numerous clinical and administrative challenges in the rapidly changing behavioral health environment.

Nova served as a pilot site for the Ohio Mental Health Consumer Outcomes Initiative. For the project to be successful, it was important that all stakeholders in the recovery model — consumers, families, caregivers, and providers — “buy in” to the value of the project. The outcomes process needed to be more than just another administrative requirement or “just one more piece of state-mandated paper;” it had to become part of the clinical culture of the organization. New procedures would have to bring clear value to the clinical process without increasing the burden of paperwork for the consumer or the provider.

The Process — Nova’s re-engineering project was to design and implement improved care management processes within the framework of a consumer outcomes and recovery philosophy. Such a change would best be accomplished through a significant shift from operating as a reactive provider-centered organization to a more proactive, consumer-centered one.

The following table shows characteristics of the Nova system both before and after re-engineering.

Before <i>“Reactive”</i>	⇒	After <i>“Proactive”</i>
<i>Compliance</i>	⇒	<i>Re-engineering</i>
<i>Quality Assessment</i>	⇒	<i>Quality Improvement</i>
<i>Punitive Environment</i>	⇒	<i>Learning Environment</i>
<i>Provider Driven</i>	⇒	<i>Consumer Driven</i>
<i>Consumer Termination</i>	⇒	<i>Consumer Outcomes/Results</i>
<i>Hierarchical Leadership</i>	⇒	<i>Diversified Leadership</i>
<i>Generate Reports</i>	⇒	<i>Change Processes</i>
<i>Consumer Dependent/Unaware</i>	⇒	<i>Consumer Independent/Aware</i>

Nova identified the following steps in their re-engineering project:

- Teams — Set up the team(s) for the re-engineering;
- Care Providers — Involve service providers in the re-design;
- Process Review — Analyze the current process to identify strengths and weaknesses;
- Model — Create a model for the re-designed services;
- Measures — Establish performance measures;
- Test — Test the new process;
- Change — Make any necessary corrections and re-test; and
- Implement — Then do what works.

Nova empowered its team to review the processes that the consumer and staff were currently doing. The team then took the information and decided how they would improve those processes. They then developed each new process and tried the change. After the trial, they evaluated the changes and made corrections where needed. The team then developed a plan on how the entire staff would be trained about the changes and what resources would be needed to make the change. They then presented the plan to Nova's leadership for administrative support and/or funding. Finally, the team asked the quality improvement staff to assist in developing the best method(s) to monitor the change to see that it was working.

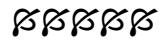
The Solution — Nova identified three important values for incorporation in its re-engineering project — reduction of paperwork, elimination of duplicate questions asked of the consumer during the intake/admission process, and the cost and the potential need for more personnel to implement the Outcomes System.

To address these issues, the outcomes instruments were loaded onto hand-held computerized units that allowed consumers and staff members to complete the instruments without the use of paper and pencils. A “real-time” report was generated from the units within seconds of the completion of an outcomes instrument. The report allowed the consumer and the provider to use the information during the initial visit to formulate individualized care plans for that consumer.

Consumer needs and strengths were identified through use of the outcomes instruments. Self-identified needs and strengths were incorporated into the development of consumer-specific individualized care plans. The “real-time” report quantified the consumer's answers and provided scoring that allowed the consumer and provider to identify changes and improvement over time, following subsequent administrations of the outcomes instruments. Changes could then be made in the consumer's individualized care plan to address the changes in the pattern of outcomes.

To support the incorporation of the outcomes instruments in the clinical culture, a process of re-education and re-design of clinical processes ensued. This re-engineering proc-

ess touched upon all aspects of the clinical and organizational processes and became embedded within the clinical culture of the organization. Clinical processes included the quality improvement plan for each clinical department. Corporate goals and objectives, and individual clinician performance criteria were also retooled to support the use of information provided from the outcomes process and instruments.



Throughout the process, Nova took the approach that the re-engineering project should have meaning for the organization and not be thought of as simply an unfunded mandate. They began by initiating the strategy with the goal of improving and documenting clinical outcomes for consumers to assist in their recovery. What they attained was a product that not only achieved their initial goals, but also improved overall documentation and reduced paperwork for providers.

Integrating Initiatives into Clinical Flow

Ben-El Child Development Center

Ben-El Child Development Center is a children's behavioral health agency in Logan and Champaign counties (Ohio). They became involved in the Ohio Mental Health Consumer Outcomes Initiative fairly early, largely through their contact with Behavior Health Generations (BHG), a regional collaborative group of providers and boards seeking to improve care delivery in western Ohio.

An eye opening aspect of being involved with the UM/QI committee of BHG was the vast array of state, regional and local initiatives affecting care delivery (e.g., Outcomes, MACSIS, Levels of Care). Very early in the process it became clear that most of the initiatives were good ideas in their own right, but taken holistically, they were overwhelming, and at times contradictory. The concept of "layering on" one good idea after another soon became a principle to avoid, in favor of an integrated model.

Ben-El's experience in clinical re-engineering is likely best understood within the limited scope of integrating two initiatives, the Ohio Scales Outcomes Project and the MetNet Level of Care protocols. It was an interest of their local system to utilize the benefits of both these initiatives in serving child and adolescent consumers, as well as to be proactive with the direction ODMH was taking in building an outcomes system. They began both projects within six months of each other.

As previously mentioned, both of these projects were presented and trained as separate ideas. Both had their own manuals, forms and training materials. Questions Ben-El had about integrating these ideas and avoiding duplication were left unanswered. No one they knew had utilized both projects, nor was anyone asking similar integration questions. One of Ben-El's biggest concerns was how they would present this to their staff in a way that made sense clinically and was practical. They needed a sound answer to the anticipated question of why staff should be expected to do additional paperwork along with their other duties. They began by making a commitment to staff that with any new initiatives, their administration would first find ways to integrate the new idea into their current system rather than just adding it to the top.

From Ben-El's perspective, the issue seemed to be two-sided: one was clinical relevance and the second was the burden associated with documentation.

Ben-El addressed the clinical relevance question through training on the managed care principles of clinical appropriateness and accountability. They shared the belief that objective indicators were needed to determine consumer level of care and to track outcomes of treatment.

They adopted a multi-step method of addressing the more challenging issue of increased documentation and paperwork:

1. **Data Requirements Analysis** — Ben-El created a comparison checklist of required items in their clinical forms. They made a list of all the required information they must document for their various funding, credentialing or accreditation organizations. Next, they made a column for each of their clinical

forms to see what information they were collecting. After checking off the required items they saw where information was being duplicated and where things were omitted. This was a helpful process and resulted in eliminating or consolidating several forms to streamline the documentation process. Both the MetNet Level of Care and Ohio Scales documents were included in the comparison checklist.

2. **Forms Design** — Ben-El redesigned their key clinical forms to integrate the essential features of levels of care and outcomes. They knew that new initiatives are more easily adapted if staff are prompted to use them routinely and if staff have those ideas highly visible in their daily work. The main thing they did was revamp their ISP by discarding some of the less useful items and replacing them with level of care criteria and an outcomes graph to track change over time. Both items are now reviewed with the consumer as part of the ISP cycle and do not require many separate forms.
3. **Quality Improvement Redesign** — Ben-El then incorporated the initiatives in their Quality Improvement program by redesigning their QA/QI processes to incorporate the new information requirements. This added further legitimacy to what they were trying to do, both administratively and with staff.
4. **Cost Analysis** — The final step was a cost analysis of the new initiatives. ODMH offered a helpful cost projection template to estimate the cost of administering the Ohio Scales project. The projections that resulted were rarely challenged due to the soundness of the template.

The result? Staff continue to need routine training and supervision to stay on track with these initiatives. However, by taking the time to prepare and consider the integration issues, staff were much more receptive to implementing the new ideas.

Implementing a Cluster-Based Planning System

Zepf Center

Zepf Center (Toledo, Ohio) began its project in 1995 after the Clinical Director and several other staff attended several conference presentations about a Cluster-Based Planning System made by Synthesis, Inc. They saw the potential of a cluster-based planning approach for care and human resource planning in the emerging managed care environment, as well as for outcome evaluation.

Zepf Center began working with Synthesis to identify subgroups (clusters) of their adult SMD consumer population and to develop targeted outcomes for each cluster. In 1996, the agency agreed to become a research site for Synthesis' Goodness of Fit study whose major objective was to identify Preferred Service Models for different clusters and to pilot-test specific service elements of these models. As these models were built as part of the research, Zepf Center's original vision progressed from managing "managed care" to a desire to understand best practices for specific clusters that were working toward more targeted recovery outcomes.

As the research proceeded and the agency prepared to test one of the Preferred Models, new clinical leadership continued to advance the vision. They began to focus on creating an agency whose organization of care was driven by the different strengths, problems, treatment, histories, social contexts, life situations and present functioning of consumers. It was at that point, in the fall of 1998 that they chose to totally re-organize the agency's services by the clusters they had identified. Most recently their vision has evolved to one where the Zepf Center has the necessary information, staff skills, and internal management capacity to adapt to the changing needs of the consumers they serve.

A Commitment of Staff, Dollars and Other Resources

Since 1995, the Zepf Center has made a substantial commitment to the development of clusters and outcomes. To accomplish these tasks agency case managers were trained to assess consumers using a functional assessment instrument developed by members of the research team. A work group comprised of providers, family members, and provider/consumers then met monthly for about 18 months to confirm and enhance prose cluster descriptions and to specify targeted outcomes for each cluster. All Case Management staff were then trained in the cluster assignment process and the outcome rating procedures.

The first major activity in the Goodness of Fit study was the creation of Preferred Service models for each of the clusters. These model services, opportunities, or programs were intended to help consumers in each cluster achieve the outcomes previously developed by the agency work group. To accomplish this task a Local Service Planning Group (LSPG) was established which included agency case managers, supervisors, vocational specialists, psychiatrists, providers from other agencies, family members, and consumers. The LSPG met for a full day each month for a full year. Various group process techniques were employed to develop the Preferred Service Models, and due to the complexity of the task, regular attendance was very important. Zepf's commitment of staff time

and effort was considerable and ongoing support from agency leadership never wavered, helping to insure continuous participation by staff.

Following the model development phase of the research, agency staff then formed an Implementation Team whose purpose was to plan a pilot-test of specific elements of a preferred model for one of the clusters. The Implementation Team met for 3-4 hours each month. Rather than creating a small Implementation Team, the Zepf Center incorporated this into their overall management team meeting. Thus all staff who had been part of the LSPG process, all team managers, and other key clinical administrators participated in planning the pilot-test. Again, the commitment of the agency to the research was clear, consistent from top management, and was the responsibility of the total agency, not just of a few staff members. Many hours of professional time were spent in the Implementation Team meetings and in work that needed to be accomplished between meetings.

The agency commitment to data collection was also substantial over the years. One of the unique situations at the Zepf Center was the close working relationship between clinical leadership and the MIS Department. The MIS manager was involved in model building and planning for the research pilot-test as well as in monitoring the collection of outcome data. Consumer outcome data have been collected annually or semi-annually since 1996. The MIS manager has worked closely with the research team to provide service, hospitalization, and cost data. When needed, she also helped the research team add elements to the agency “service ticket” in order to track the provision of the pilot-test model service elements.

To implement the pilot-test, the agency committed the time and effort of an entire agency care team. This team was involved in additional training and was required to collect additional outcome and service data about the consumers they serve. However, the agency’s commitment went beyond the CSP Pilot Team. In one case, for example, the Psychiatry Department chose to forego earning productivity units in order to provide medication and other education as part of pilot-test groups.

An Attitude That Supports Implementation of New Projects

Since 1995, members of the research team have been struck by the agency’s overall positive attitude toward the planning and implementation of the Goodness of Fit pilot study. First, there were clear images from the top that once a decision was made to undertake a pilot-test, it was going to be an agency responsibility (not just for a few individuals to accomplish). As described above, the Implementation Team was headed by the new Vice President for Clinical Services and the Director of Community Support Services. All Team Leaders and other key staff were also members of the Implementation Team. This insured continuity from development of the Preferred Service Models to their implementation.

Planning for the pilot-test took approximately one year and as the work progressed, specific individuals (called Element Managers) assumed responsibility for more fully developing specific care components. Other members of the Implementation Team, however, were always willing to help and often offered their time, resources and technical assis-

tance. This was critical because some of the Element Managers did not have extensive experience as project directors or managers. Cooperation and support from specific agency components such as MIS and Psychiatry was also always available.

Over the last three years, planning meetings and other staff interactions appeared to focus almost entirely on solving problems rather than pointing out barriers. As time has gone by, agency staff appear to be even more confident in their ability to plan and implement additional care components.

Motivation to Integrate Research Findings or Practices into Ongoing Operations

The clearest example of how the Zepf Center incorporated research results and practices was the decision in the fall of 1998 to reorganize its CSP services by cluster. This decision came about as the Implementation Team was planning for the pilot-test. The agency had decided to create a separate team, and it seemed feasible to consider reorganizing all the teams. In their decision process they utilized all the service, cost, and outcome data by cluster that they had been collecting for several years. Their new organization structure now consists of teams that specialize in serving members of one, two or three clusters. The clinical and programmatic similarity and/or compatibility of the clusters determined the specific clusters served by each team. Staffing patterns, including differential caseload sizes, were determined using a combination of past service utilization, outcome achievement, productivity standards, and desired best practice.

To implement the reorganization, staff were given options to work on the team of their choice. Consumers were also informed of the reorganization and the accompanying changes. Transfers were made over a period of time and honored consumer choice. Reorganization of clinical teams began in December of 1998. Cluster assignment data from the agency's MIS was used by their management team to establish interim transfer targets, monitor the transfer process, and make mid-course corrections as needed.

Over the first year, approximately 1,000 consumers were transferred to newly established treatment teams. By mid 2000, nearly 90% of the more than 2,000 agency consumers were being served by a cluster-specific team. Systematic use of the cluster-based information allowed the pace of staff and consumer transfers to be managed with minimal negative consequences.

Reorganization of clinical teams by cluster has shown evidence of several positive effects:

- Outcomes for consumers are enhanced as care providers become more expert in serving consumers who share common strengths, problems, histories, and life situations.
- Staff training and development efforts are more focused; job satisfaction improves; and staff burnout and turnover decline.
- Overall agency decision-making, goal-setting, and evaluation are also enhanced.

The agency also uses cluster-based data in its quality improvement efforts and in evaluating multiple services for specific clusters of consumers. For example, a special study is in

progress testing the effectiveness of more traditional counseling services for members of specific clusters. This study was designed by one of the new Cluster-Based Team Managers (who also manages the agency's counseling services), and includes comparison groups of individuals from the same clusters who do not receive counseling services. Because service, cost, and outcome data are collected on an ongoing basis on every agency consumer, data to test the effectiveness of counseling are readily available. Preliminary analyses are suggesting that while counseling may be very useful for members of certain clusters, it may actually be counter-productive for members of other clusters.

Most recently, agency managers are talking about "Reorganization #2." Based upon continuously enhanced cluster assessment information and a changing picture of admissions, the management team is discussing adding another team serving the two clusters of adults with co-occurring substance abuse and behavioral health problems. This would affect staffing of other teams as well as recruitment and staff development needs. As part of this reassessment, the agency is presently pursuing certification as a substance abuse provider with ODADAS. Since the reorganization, the agency has consistently met or exceeded county board productivity requirements.

Developing a Recovery Self Assessment Tool

Columbiana Mental Health and Recovery Services Board

As part of its recovery effort, Columbiana County (Ohio) developed a tool to help the Columbiana Mental Health and Recovery Services Board audit its operations from a recovery perspective.¹⁷ The audit idea grew out of a desire to hold their Mental Health and Recovery Services Board's "feet to the fire" to ensure that Board operations fit with recovery principles. Their plan was to recruit an audit team made up of consumers, and to train that team in how to conduct audits.

The goal was for the audit team to review all 10 domains over a span of one year. Audit results would then be forwarded to the system-wide CQI Committee and to the Executive Director of the Board; the Executive Director would then report audit results to the Board of Trustees. The Mental Health and Recovery Services Board would be required to respond to any "findings" or suggestions of the audit team.

While the following audit tool was developed for examining the operations of a Board, the domains, methods and indicators are equally applicable to a provider agency.

Criteria for Recovery Audit of Board Operations — The 10 domains, along with indicators and methods to determine whether or not indicators have been met (*in italics*), are as follows:¹⁸

1. Board Governance

- a. Consumers comprise at least 25% of Board planning and advisory groups.
- b. Consumer participation is supported and respected by other members of the planning and advisory groups, *per their report. Consumers will be able to identify examples of Board actions that included their ideas and suggestions. Information will be collected via consumer survey and/or interview by consumer audit team.*
- c. Board members are trained in recovery and can explain what recovery is and why it is the driving force for the Board's work, *per results of annual training survey.*
- d. Board minutes reflect that decisions on new initiatives are in synchrony with recovery principles.

¹⁷ The Recovery Audit tool was developed by Pamela Hyde, J.D., Senior Consultant for the Technical Assistance Collaborative, consumers active in the Columbiana County (Ohio) Recovery effort, and staff of the Columbiana Mental Health and Recovery Services Board. Input from Martha Hodge, LISW, was also obtained.

¹⁸ While the following audit tool was developed for examining the operations of a Board, the domains, methods and indicators are equally applicable to a provider agency.

2. Human Resources

- a. Consumers are actively recruited for job openings with the Board, and when hired, have equality in assignments, pay, and benefits, *per review of recruitment records when openings occur.*
- b. Staff members are trained in Recovery and can explain what Recovery is and why it is the driving force for the Board's work, *per documentation of staff training records and results of annual training survey.*

3. Public Education/Community Relations

- a. Community education materials are developed with input from consumers and include clear and concise information about recovery, *per review of meeting minutes, and review of information used in community education materials.*
- b. Consumers are included routinely and consistently in community education activities, *per "counting" educational activity, such as presentations, newspaper articles, etc., that are presented by consumers.*
- c. Consumers will feel more accepted in their communities, *per their report, via focus groups.*
- d. The community at large understands and supports the Board's role in promoting recovery, *per passage of the replacement levy in November 2000.*

4. Provider Relations

- a. Leadership and staff of provider agencies can explain what recovery is and why it is crucial to their success with consumers, *per results of the annual training survey.*
- b. The number and types of providers offer meaningful choice and alternatives for consumers, *per report of consumers (focus groups).*
- c. Vocational, recreational, transportation and consumer operated services are sufficient in our community to support recovery, *per consumers' report (focus groups) and results of treatment plan audits within provider agencies.*
- d. Provider contracts with the Board promote recovery in addition to the provision of billable units of Medicaid defined services, *per review of contract language.*

5. Finances

- a. Consumers determine what they need to recover, and the Board contracts with providers that can meet those identified needs, *per comparing needs and preferences as determined by consumers with amount and type of service actually delivered (focus group).*
- b. The Board seeks funds from non-traditional sources, such as local foundations, to promote flexibility.

- c. The Board advocates with its primary funding sources: ODMH and the ODADAS for flexibility in the use of funds, to ensure that what consumers determine they need to recover is paid for, *per review of Mental Health and Recovery staff and Board meeting minutes.*
6. Customer Relations
 - a. Consumers participate actively in the grievance/complaint process, *per the inclusion of consumers in complaint/grievance resolution, and in the review/ updating of the complaint/grievance procedure.*
 - b. Consumers run advisory groups, such as the Recovery Steering Committee, exert appropriate influence on the system, *per review of recommendations submitted to the Board, and what happens with these recommendations.*
7. Management Information Systems
 - a. Data collection and reports are meaningful and clear in measuring things that consumers consider valuable, *per input from consumers who serve on the system-wide CQI Committee.*
 - b. Data are used by decision-makers to make changes necessary to support recovery, *per review of recommendations by the CQI Committee, and follow-up action, and per report of consumers who serve on the CQI Committee.*
 - c. Consumers participate in data collection and data analysis, *per tracking the inclusion of consumers as data collectors and analyzers within the CQI process.*
 - d. Information derived from data and reports leads to services that promote consumer satisfaction and recovery, *per review of consumer satisfaction data and service plan reviews conducted within agencies.*
8. Quality Management and Improvement
 - a. Consumers participate in quality improvement activities, *per consumer involvement in the system-wide CQI Committee.*
 - b. Quality improvement goals and processes reflect recovery principles, *per review of CQI goals and processes.*
 - c. Expected results are clear, measurable, and used by decision-makers, *per review of follow-up actions to recommendations made by the CQI Committee.*
9. Services
 - a. Behavioral health professionals function as helpers assisting consumers in their own recovery rather than as controllers of services, *per feedback from the consumer satisfaction process, and per results of Recovery Research Project.*
 - b. The services offered are those that consumers report are necessary for Recovery, and that are supported by research to promote recovery, *per feedback from consumers and results of treatment plan reviews conducted within agencies.*

- c. Consumer participation in services leads to their recovery, *per consumer satisfaction reports, and per information derived from ODMH outcomes process.*

10. Planning

- a. Consumers are active, equal partners in ongoing individual service planning, *per results of the Recovery Research Project (available in calendar year 2002).*
- b. Consumers are active, equal partners in system planning, *per number of different consumers who participate in planning efforts, and their reports re. the extent to which their input is valued (focus group).*
- c. Planning documents are written in common language with success markers identified and tracked, *per review of documents.*

Creating Consumer-Centered Intake Scheduling

Tacoma Comprehensive Mental Health Center

Before Re-engineering — One of the complaints voiced at the Comprehensive Mental Health Center in Tacoma, Washington was that there weren't enough slots for scheduling new consumers for intake, yet many of the slots that were available went unused. Basically, the organization operated a "staff-centered" model that worked as follows:

- **Staff Scheduling** — Clinicians identified blocks of time they were available for doing consumer intakes.
- **Consumer Scheduling** — Each consumer requesting care was scheduled into one of the available blocks.
- **Waiting List** — The scheduled intake times filled up quickly and new consumers were forced onto a waiting list that could push the scheduled intake appointment days or weeks into the future, in many cases to a point after the consumer's need for care ceased.
- **Intake No-Show Rate** — Approximately half (50%) of the consumers failed to show for the scheduled appointment and clinical staff were left with non-productive time on their hands.
- **Clinical Records** — For the consumers who did keep the intake appointment, clinicians and other staff began the process of opening a clinical record, including initial treatment planning.
- **Subsequent No-Show Rate** — Approximately half (50%) of the consumers who kept their intake appointments failed to show for subsequent appointments and staff had to complete termination summaries and close the clinical record.

Result — Without counting time spent in identifying, requesting, verifying, recording and filing ultimately unnecessary clinical record information, clinical staff ended up using on average four intake slots for every one consumer that entered active treatment. At the same time, many prospective consumers never received care because they could not get an intake appointment.

After Re-engineering — Following is the "consumer-centered" model that the center used to address the problem:

- **Organizational Scheduling** — The organization now identifies blocks of time each day that are available for doing consumer intakes. During those identified times, which can vary on a day-to-day basis, the organization will see any prospective consumer who shows up.
- **Staff Scheduling** — The organization schedules staff on a rotating basis to cover the pre-defined intake times, in proportion to the expected consumer load (based upon past experience). Some staff are designated for "primary" coverage and others for "secondary" coverage. Primary staff can assume that they will be

conducting consumer intakes, but can utilize any unused time for activities that can be interrupted if a consumer arrives. Secondary staff remain available for conducting consumer intakes, but assume they probably will not be needed on a normal day. Secondary staff can plan to use the time for tasks that can be interrupted, such as paperwork, telephone calls or correspondence.

- Consumer Scheduling — Each consumer requesting care is given the times during which the organization does intakes and is asked to come in at the first one that is convenient.
- Waiting List — Each consumer is seen as soon as his or her own schedule permits, thus simultaneously increasing access to the organization, increasing the probability that the organization can be responsive in crisis situations, and eliminating the waiting list for care.
- Intake No-Show Rate — The organization sees only those consumers who actually show for intake, effectively achieving a 0% no-show rate.
- Clinical Records — For those consumers who show for an intake appointment, clinicians treat the session as a brief intervention or walk-in, respond to the issues presented by the consumer, and schedule any appropriate follow-up. Minimal clinical record information appropriate to a brief intervention is obtained and recorded. Only when a consumer actually shows for a subsequent scheduled appointment (thus, signaling a willingness to follow through with treatment), do staff begin the process of opening a formal clinical record, including initial treatment planning.
- Subsequent No-Show Rate — Even if approximately half (50%) of the consumers who showed for an initial brief intervention fail to show for subsequent appointments, staff do not have to complete termination summaries or close the clinical record, thus saving extensive paperwork time.

Result — Staff productivity is better maintained. Clinical staff don't sacrifice identified intake slots for consumers who don't show. Little unnecessary time is spent in identifying, requesting, verifying, recording and filing ultimately unnecessary clinical record information. More prospective consumers receive care because they were able to meet with a clinician almost immediately after contacting the organization. Even in the case that the brief intervention weren't reimbursable by a third party, when compared to the lost time in the old model, the cost savings in the alternative model were still significant.

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Appendix C:

The Ohio Outcomes Initiative

One of the most comprehensive large-scale consumer outcomes efforts is the Ohio Mental Health Consumer Outcomes Initiative, an ongoing endeavor to measure outcomes for consumers served by Ohio's public mental health system.¹⁹

Measuring success in a large, complex behavioral health system requires balanced attention to data in three critical areas: quality, access, and cost. In order to resolve Ohio's lack of data on consumer outcomes as an aspect of quality, the Ohio Mental Health Outcomes Task Force (OTF) was convened in 1996 by the ODMH. The OTF was charged with developing an initial set of critical consumer outcomes and recommending a standard, statewide, ongoing approach to identifying and measuring consumer outcomes of Ohio's behavioral health system. This approach reflects the wide range of consumers, payers, providers, and human care systems, and will support planned change at the individual, agency, and all human care system levels.

The rationale for this effort included the need for better accountability; the need for benchmarks; the need to use data for improving care; national efforts in outcomes and performance measurement, clinical guidelines and improved business practices; the statewide encounter-based data system; the value of continuous quality improvement approaches; and the need to tailor outcomes measurement to Ohio's unique dynamics and characteristics.

OTF membership consisted of a culturally diverse group of consumers, families, providers, boards, researchers and evaluators and staff from both ODMH and the Ohio Department of Alcohol and Drug Abuse Services (ODADAS). The group met monthly for sixteen months and developed recommendations for a standardized approach to measuring outcomes for adults, children and adolescents.

¹⁹ Additional information about the Ohio Mental Health Consumer Outcomes Initiative can be found on the Outcomes System web site at:

<http://www.mh.state.oh.us/oper/outcomes/outcomes.index.html>

Values-Based Decision-Making

Before beginning to work with the content of outcomes measurement, the OTF decided to invest time and energy in grounding its work in a common vision, mission and set of consensual values. These were referred to throughout the work of the OTF and were used as a screen to review the final recommendations. With only a few editorial changes to the original wording, the following were endorsed as an enduring foundation for the work of the OTF:

- **OTF Vision** — All participants in Ohio’s publicly supported human care system are accountable to monitor and continually improve the outcomes for consumers. Outcomes such as choice, respect, dignity, and cultural and clinical competence, embrace the values of recovery for consumers and families. To achieve this quality improvement, Ohio’s systems use a variety of compatible data sources and reporting mechanisms, including a standard, statewide approach to measuring consumer outcomes.
- **OTF Mission** — The Ohio Mental Health Outcomes Task Force will identify an initial set of critical consumer outcomes and will recommend to ODMH a standard, statewide, ongoing approach to identifying and measuring consumer outcomes and performance of Ohio’s behavioral health system. This approach will reflect the wide range of consumers, payers, providers and human care systems and will support planned change at the individual, agency and all human care system levels.
- **OTF Values** — The OTF shared the following values that underlie both the Vision and the Mission and were used to direct and evaluate the outcomes developed. All of the values apply equally to adults as well as children/adolescents and their families.
 - The concept of recovery drives care provision. Providers, consumers and their families share responsibility to: (1) create an environment of hope for recovery; (2) determine the services and supports provided; and (3) participate actively in a flexible, evolving treatment process that reflects the evolving nature of these conditions.
 - Behavioral health services should be high-quality, clinically and culturally-competent, strengths-based, flexibly developed and delivered, built on natural supports, driven by consumer-identified needs and preferences and are linked with other human care services essential for recovery.
 - Clear, accurate and timely information is used for the continuous improvement of outcomes for consumers and provides a basis for accountability to consumers, families, communities and payers.
 - Outcomes measurement and performance monitoring are based upon methodologically sound, cost-effective approaches that incorporate both positive and negative events and that apply to a range of consumer

populations and perspectives, including those of children and their families.

- The OTF process respects others' values, perspectives, ideas and roles, and is based upon development of a shared language of measurement.
- The statewide approach to outcomes measurement seeks a balance between improved accountability and continuous improvement, on one hand, and reasonable implementation on the other hand.
- It is a shared responsibility to promote an environment which ensures the communities' acceptance and integration of consumers.
- All Ohio residents should have access to care which helps them achieve self-determined goals respectful of culture, ethnicity, geographic location, family status, linguistics, gender, age, sexual orientation, creed or disability.

Assumptions

The following assumptions shaped the work and recommendations of the OTF:

- **Commonality** — A common set of desired outcomes is required for measurement statewide. A critical component of the use of outcomes data for all stakeholders is the ability to benchmark at both local and state levels. Without a standard set of measurements to capture outcomes, comparability across settings would be impossible to achieve.
- **Integration with Other Data** — Outcomes data should be used in combination with other data for continuous quality improvement. This means that outcomes findings are used as indicators requiring further exploration and subsequent treatment, program and system planning.
- **Availability** — All stakeholders in Ohio's publicly-supported behavioral health system should be able to use the outcomes findings.
- **Consumer Perspective** — Outcomes should be measured primarily from the perspective of consumers and in a manner that complements rather than replaces the clinical judgment of practitioners.
- **Values-Based** — The OTF approach is an incremental yet innovative addition to Ohio's behavioral health database and should be evaluated during implementation to ensure that it fulfills the OTF values (e.g., it is useful, cost-effective and respectful of all participants).

Outcomes Domains for Measurement

The OTF based its approach on the goal of having each person surveyed by only one key provider, to be determined locally, at intervals specified according to the different population groups (adults with severe mental disabilities, other adults, youth with serious emotional disturbances, other youth). Outcomes to be measured were grouped under the following domains:

- Clinical Status (Symptom Distress)
- Quality of Life (Life Satisfaction, Fulfillment, and Empowerment)
- Functional Status
- Safety and Health

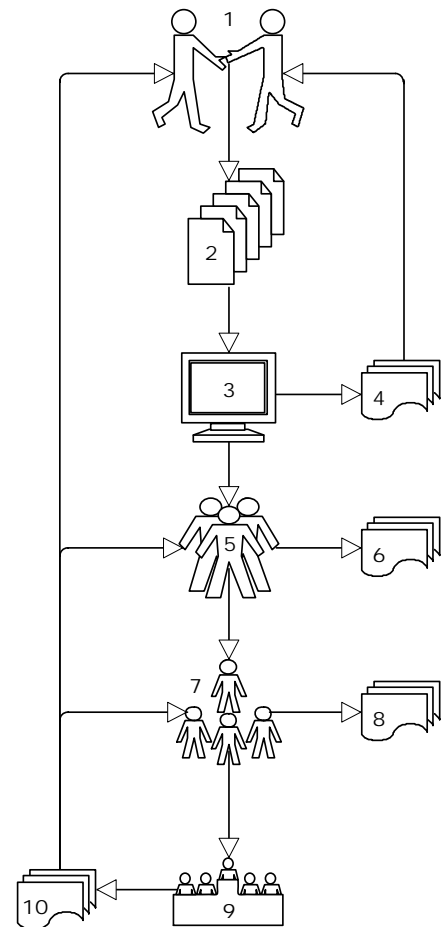
The Ohio Outcomes Model also includes multiple types of respondents who provide different perspectives:

- Consumer
- Family Member of Child/Adolescent Consumer
- Worker/Clinician

The Outcomes System: A Tool for Shaping Consumer Care

A consumer-centered, outcomes-based clinical process can be pretty simple, actually. The following text and diagram illustrate the flow of activity.

1. *The consumer makes contact with the behavioral health agency and is linked with a clinician.*
2. *As part of the evaluation process, consumer outcomes instruments are completed by the consumer, the agency worker and, in the case of children or adolescents, by the parents. The outcomes instruments serve as tools to focus the evaluation and aid in service plan development.*
3. *The information on the outcomes instruments is either captured in real-time or entered after the fact into a system.*
4. *Outcomes reports are produced and used by the consumer and the clinician to decide upon a mutually acceptable course of action.*
5. *Information about the consumer is reviewed by appropriate others (e.g., clinical supervisors) for both appropriateness and quality.*
6. *The information is made available in reports that can be used for agency-level continued quality improvement.*
7. *Certain information is sent to the local board.*
8. *The information is made available in reports that can be used for board-level continued quality improvement.*
9. *Certain information is sent to ODMH.*
10. *That information is made available in reports that can be used to refine and improve care at the state, the board, the agency and the individual consumer-clinician levels.*



Like we said ... pretty simple. And very powerful when it works.

So much for the simple picture. What's really required to make it all work?

Earlier, the statement was made that the successful delivery of care involves a number of parties working together. In order for the above diagram to function "as advertised," the following expectations must be met:

Consumer

- Understands the items and the entire process of how the information will be used
- Completes the instrument with staff assistance as necessary
- Has been involved in training, conducted by peers, to assist understanding of the outcomes process and how to use outcomes information in the recovery management planning process

Support Staff

- Shows orientation video and ensures that consumer understands the instrument, the process and the technology
- Has received training in how to assist consumer/family members with completing the instrument, especially when literacy level, disability or other similar conditions are a factor
- Assists the consumer with the instrument as necessary

Support Staff (MIS)

- Ensures that technology can deliver “real time” report accurately and consistently

Clinician

- Has training and demonstrates competency in recovery principles and applications
- Receives “real time” report(s) and reviews report(s) prior to meeting with consumer and during meeting with consumer
- Continually ensures that consumer understands the outcomes instrument and process
- Has received training in how to assist consumer/family members with completing the instrument, especially when literacy level, disability or other similar conditions are a factor
- Assists the consumer with the instrument as necessary
- Incorporates strengths as well as problem areas in assisting with developing goals
- Can actually tie specific instrument items to specific goals, objectives, tasks on recovery management plan
- Uses reports that show change/no change with consumer, family members

- Uses reports that show discrepancies in perceptions among consumer, family, clinician in working with consumer, family
- Uses reports that show change/no change over time. Discusses with supervisor about how to gain greater improvement, next steps in recovery, termination upon completing goals, etc.

Administrators/Managers

- Ensure that data are provided in timely fashion to supervisors and that supervisors have ongoing training in interpretation and application to decision-making programmatically and with individual supervision
- Develop mechanisms for consumer/family member training
- Engage consumers/family members on decision-making committees and model how their input is valued and used
- Review aggregate data in light of overall “recovery thresholds” for each program and at agency-level. Make program/staffing modifications that are informed by outcomes results
- Adopt a recovery management plan that facilitates the use of outcomes
- Arrange for all staff to have sufficient time, tools and resources to do their work
- Implement quality improvement processes that use outcomes data for all departments
- Incorporates the outcomes-based quality improvement processes into programmatic decision-making
- Share aggregated data with the Board of Directors

Consumer Family Members

- Have been involved in training, done by family members, and understand their roles and how outcomes information can be used to advocate for loved one(s) in the planning process and how aggregate data can be used for advocacy system-wide

Supervisor

- Uses individual instrument results to review plans for persons with significant positive or negative changes
- Uses aggregate data with each supervisee to discuss strengths, areas for improvement
- Uses aggregate data for groups of supervisees for management purposes, shifts in supervisory techniques, etc.

QI/Compliance Staff

- Ensure that outcomes instruments are completed for each consumer in timely fashion
- Ensure that recovery plans reflect use of outcomes information
- Ensure that consumer/family member training is on-going, and that consumers/family members are represented on decision-making committees and their input is valued and used
- Ensure that outcomes reports are used at each department level and that each department loops back to the other (e.g. MIS error reports to clinical supervisors; clinical supervisors to support staff to ensure high quality of instruction to consumers and families; aggregate reports/individual reports are available and used through all levels of clinical staff and with consumer/family members groups)