

Recovery Focused Fee-For-Service Conversion Provider Readiness Self-Assessment Tool

The provider readiness tool is designed to be completed by 30 field test agencies, except for those agencies selected for a site visit. Please review the tool prior to the regional training meeting in your area. The meeting will provide instructions and answer any questions you may have regarding how to respond to each question. The intent of the tool is to measure providers' readiness to perform successfully in a recovery-oriented, fee-for-service environment. At the current phase of Illinois' transition to fee-for-service, field test agencies should not yet be expected to perform at high levels on a readiness scale. The tool is designed for self-report, and agencies are requested to use best efforts to complete the tool in the most candid manner to provide the best readiness assessment data possible. To assist with the integrity of the self-reporting process, readiness data from completed tools will only be reported in aggregate.

Return Instructions

Please return this completed document via e-mail or fax by _____ at close of business. Please send to:

_____ .

Demographics and General Information

1. Organization name:
 - a. Contact person for questions:
 - b. Phone:
 - c. E-mail:
 - d. FEIN:

2. Ownership structure: ___For Profit ___Non Profit ___Govt ___Other (describe)_____

3. Total annual budget size of the total organization
 - ___ Under \$1,000,000
 - ___ \$1,000,000 - 5,999,999
 - ___ \$6,000,000 - 14,999,999
 - ___ Over \$15,000,000

4. Percentage of annual budget from DMH contracts
___ More than 90%
___ 76 - 90%
___ 50 - 75%
___ Less than 50%
5. Approximate number of consumers served under DMH contracts during FY_____ (*Consumers served under DMH contracts is the number of Medicaid and non-Medicaid consumers funded in whole or in part*)
___ Less than 170
___ 170 - 450
___ 451 - 1300
___ More than 1300
6. Percentage of clients served under DMH contracts enrolled in Medicaid (primary, secondary, or Medicaid managed care) during _____
___ Less than 25%
___ 25 - 49%
___ 50 - 74%
___ More than 75%
7. Percentage of clients served under DMH contracts during _____ who were undocumented individuals?
___ Less than 1%
___ 2 - 4%
___ 5 - 9%
___ 10% or greater

8. Which description best describes the range of services covered under the DMH contract? (Mark one or the other description):
- Comprehensive array of services including assessment, case management, crisis, medication services, and therapy/counseling
- Specialty provider for a limited range of services, such as assertive community treatment, day treatment or vocational services
9. What ages does your organization serve? (Check all that apply)
- 0-5 6-12 12-20 21-65 65 and older
10. Which best describes the information system used by your agency to bill for DMH services/consumers?
- ROCS only (no other agency billing system is used)
- Agency billing system with all client billing data, using electronic submission to ROCS
- Agency billing system with required data manually entered into ROCS

If you are using a billing system in addition to ROCS, indicate the type of system below:

- Licensed system available nationally for billing—Name_____
- Licensed national system for billing and clinical record documentation—Name_____
- Locally developed billing system used by multiple Illinois DMH providers—Name_____
- Internally developed billing system
- Other—describe_____

11. Complete the following table indicating which services your agency currently provides in the first column and any plans to add or discontinue services upon full transition to fee-for-service.

X = Current Service	Services	A = added/D = Delete
	Activity therapy	
	Assertive community treatment	
	Case mgt—client ctd consultation	
	Case mgt—mental health	
	Case mgt—linkage/aftercare	
	Comprehensive MH services	
	Crisis intervention	
	Crisis intervention—pre-hospital scr	
	Intensive family-based services	
	Mental health assessment	
	Mental health day treatment	
	Mental health intensive outpatient	
	Psychological evaluation	
	Psych. medication administration	
	Psych. medication monitoring	
	Psych. medication training	
	ST diagnostic and MH services	
	Skills, trng and development	
	Therapeutic behavioral services	
	Therapy/counseling	
	Tx plan dev/review/modification	
	Adaptive/social rehab--vocational	
	Oral interpretation and sign language	
	Supported employment	
	Vocational, education testing/eval	

Please check yes or no for each of the following questions. If the question has more than one part, each part must be yes for the entire answer to be a yes. To fully inform future technical assistance needs, some multi-part questions (i.e. #7) must be answered in two ways—first, indicate the answer to the entire question in the Yes/No column, and then indicate the answer to each part of the question in the check boxes below. At the end of each dimension/section, please total the number of 'yes' and 'no' answers for that section. At the end of the table, please add a grand total of all 'yes' and 'no' responses.

#	Dimension	Yes	No
Governance and Leadership			
1.	Do current versions of organization's mission/vision/values include express commitment to recovery and a process for achieving recovery oriented services?		
2.	Is the board composition inclusive of a primary consumer and/or family member, and a business oriented professional (CPA, attorney, senior manager)?		
3.	Have all members of the board participated in education regarding both fiduciary responsibilities and establishing/monitoring organizational performance indicators?		
4.	Has the board received training regarding provider fee-for-service core competencies and the specific impact of transition to fee-for-service on governance and leadership?		
5.	Does the organization have a written plan (goals, tasks, resources, timelines) to transition to recovery oriented fee-for-service and report progress regularly (at least monthly) to senior management and the board?		
6.	Has the organization developed and communicated a change-management process (inclusive of what to expect in the process, plan for ongoing communication, changes in procedures/responsibilities) to staff and consumers?		
7.	Does organization have <u>all</u> of the following performance indicator information? <i>(Please check each area that is currently in place)</i> ___Written indicators ___Regular measurement against those indicators that is reported to leadership and board ___Demonstrated impact on operations resulting from performance indicator measurement		
Total Governance and Leadership			
Access and Intake			
8.	Is the average time from first call to initiation of assessment less than or equal to ten calendar days?		

#	Dimension	Yes	No
9.	Is eligibility for Medicaid, Medicare and other third party benefits checked and documented in the record at first appointment and once a month thereafter?		
10.	Do front desk (reception or clerical support) staff review financial resources, screen for possible Medicaid eligibility and apply a sliding fee scale to individuals who present without Medicaid or other third party benefits?		
11.	Are front desk staff able to determine the amount of any co-payment (from the record or the billing system) and expected to collect the co-payment at the time of service?		
12.	When indicated by client need (urgent/emergent), does the organization have the ability to provide same day face-to-face assessment appointments?		
13.	When indicated by client need (urgent/emergent), does the organization have the ability to provide same day face-to-face psychiatrist appointments?		
14.	Does the organization have a centralized scheduling process (manual or automated) where appointments are scheduled using a master schedule with ability to schedule urgent, next or missed appointments into any available slot?		
Total Access and Intake			
Services			
15.	Have direct service clinical staff been trained in <u>all</u> of the following areas? <i>(Please check each area where training has been provided)</i> <input type="checkbox"/> New service taxonomy <input type="checkbox"/> Rule 132 requirements <input type="checkbox"/> Recovery based approach to services <input type="checkbox"/> Periodic training updates on changes/clarifications		
16.	Does the assessment process include <u>all</u> of the following? <i>(Please check each area included in the assessment)</i> <input type="checkbox"/> Consistent form (adult and youth forms may be different) <input type="checkbox"/> Completed on a timely basis (within 45 days of admission) <input type="checkbox"/> Standardized functional assessments (e.g., LOCUS, CALOCUS, CAFAS, Multnomah) <input type="checkbox"/> Diagnostic components		
17.	At least 75% of the time, do consumers and parent/guardians (minors) participate in the treatment planning process as evidenced by participation in treatment planning conferences and their signature on the treatment plan?		

#	Dimension	Yes	No
18.	Do at least 75% of treatment plans directly reflect diagnosis, assessed functional needs, consumer preferences, consumer strengths, and natural supports?		
19.	Are at least 75% of treatment plans reviewed and updated as needed or at least once every 180 days inclusive of consumer/family participation in the review process?		
20.	Are core services (assessment, medication monitoring/education, and case management, etc) available at times appropriate to consumer needs and preferences, including evenings and weekends?		
21.	Are the majority (>50%) of service units delivered in the community/natural setting (not office locations)?		
22.	Excluding psychiatric services, is the time from referral to first service < 30 days for Medicaid enrollees?		
23.	Excluding psychiatric services, is the time from referral to first service < 30 days for non-Medicaid consumers?		
24.	Do clinical supervisors receive staff productivity reports at least monthly, use those reports in direct supervision of staff, and demonstrate a change in practice as a result of these efforts?		
25.	Does the organization have a system to monitor and supervise line staff to ensure service delivery (type, frequency, duration), is consistent with the service definitions, and the treatment plan and can demonstrate a change in practice as a result of this system ?		
Total Services			
Billing and Financial Management			
26.	Does the organization require service staff to submit billing information within 1-2 business days from the delivery of service and does data indicate at least a 75% compliance rate with this policy?		
27.	Does the organization use a claims system capable of generating HIPAA compliant electronic claims (837I or 837P)?		
28.	Does the organization track average time from date of service to claims submission, and is the average time less than or equal to 14 calendar days?		
29.	Does the organization consistently bill Medicare (for Medicare eligible services) prior to Medicaid when a consumer is dually eligible?		
30.	Does the organization submit claims to any payor at least twice per month?		
31.	Does the organization submit claims to any payor at least once per week?		

#	Dimension	Yes	No
32.	Does the organization have at least 30 days of cash reserves (Days of cash reserves = Cash + Investments/{Average monthly expenses/30 days})?		
33.	Does the organization have at least 60 days of cash reserves?		
34.	Is there a process to reconcile amounts billed to paid/accepted claims within ten business days of receipt of reports/remittance advice and resubmit claims as indicated?		
35.	Has the organization calculated costs per unit (including delineation of direct and indirect cost components) for each service provided under the DMH contract?		
36.	Have efforts been made during the past 12 months to reduce unit costs?		
37.	Does agency have productivity targets or standards for a majority (more than half) of clinical direct service staff? (Productivity = billed or reimbursable time under rule 132 / paid time)		
38.	Do average productivity rates for all clinical staff equal or exceed 50%?		
39.	Are <u>all</u> of the following financial elements available via report for management review and use? (Please mark each element present in current system) <input type="checkbox"/> Number of consumers by payment source served per month <input type="checkbox"/> Number of units of each type of service per month <input type="checkbox"/> Number of each type of staff and corresponding salary/benefit costs <input type="checkbox"/> Actual productivity rate for each direct service staff <input type="checkbox"/> Indirect costs for each program <input type="checkbox"/> General and administrative overhead rate		
40.	Has the organization prepared a financial impact analysis or projections for the transition to fee for service?		
41.	Do other revenue sources (non-DMH/non-Medicaid) comprise at least 15% of the organization's annual revenues?		
Total Billing and Financial Management			
Compliance			
42.	Does the organization have a compliance plan that has been approved by leadership and the board of directors, and a staff person assigned who is responsible for monitoring and updating the compliance plan?		
43.	Is there evidence that all current staff and new hires are trained on compliance requirements including confidentiality, fraud/abuse, and clinical record documentation requirements (for clinical staff)?		

#	Dimension	Yes	No
44.	Does the organization have a consistent and reliable process to ensure all delivered services are included on a treatment plan that covers the date of service?		
45.	Does the organization have a consistent and reliable process to monitor the accuracy, completeness and timeliness of clinical record documentation for each billed service including matching to units billed?		
46.	Does the organization have a consistent and reliable process to monitor whether services delivered demonstrate fidelity to service definitions and programmatic requirements?		
47.	Does the organization have a written plan to monitor medical necessity & can demonstrate documented practice impact?		
48.	Does the organization have a consistent and reliable process to ensure that services are delivered by staff with credentials required by regulation and/or service definitions?		
Total Compliance			
Management Information			
49.	Does the organization have an information system that is capable of tracking client demographics and billing information?		
50.	Do at least 80% of employees have access to a work station and e-mail?		
51.	Does the information system track treatment plan expiration dates to ensure that services are not being delivered under an expired treatment plan?		
52.	Does the information system include eligibility/payer source for each consumer?		
53.	Is an automated scheduler available and used for at least assessments, therapy/counseling, and psychiatric services?		
54.	Are monthly productivity reports produced within 15 days of the preceding month for each direct service staff and program?		
55.	Are monthly no show rate reports produced within 15 days for the preceding month for each direct service staff and program?		
56.	Are information system functions resourced to ensure production of routine reports according to established deadlines, provide help desk functions within one business day, and produce 80% of <i>ad hoc</i> reporting within 14 business days of request?		
Total Management Information			

Outreach			
57.	Are consumers who have been asked to participate in governance or workgroup activities been offered assistance, training, and ongoing support to maximize their comfort and effectiveness consistent with the nature of their involvement?		
58.	Does the organization offer financial assistance (reimbursement for travel and/or time) for consumer participation in governance and work groups?		
59.	Is there a communication plan (goals, tasks, resources, timelines) targeting consumers and other key stakeholders describing the transition to recovery focused fee-for-service?		
60.	Does the organization have a plan (goals, tasks, resources, timelines) to participate in community activities designed to educate referral sources, consumers, and families regarding availability of services and supports?		
61.	Does the organization demonstrate cultural responsiveness through promotion of inclusion, prohibiting discrimination, staff race/ethnicity reflective of program participants, requiring competency training for all, and availability of translators?		
62.	Does the organization have a process to focus outreach efforts to encourage active engagement for consumers/families in need (both enrolled and new clients)?		
63.	Does the organization have a process to collect information regarding consumer/family satisfaction and can demonstrate the information has been used to change practice or processes?		
Total Outreach			
Grand Total			

Thanks to representatives from the Pilot Test workgroup for their input to tailor this tool to the provider environment in Illinois.