

The background of the cover features a large, faded version of the Vermont State Seal. The seal depicts a landscape with a central evergreen tree, a cow, and a plow. It is surrounded by a wreath of maple leaves and a banner at the bottom that reads "VERMONT FREEDOM AND UNITY".

**STATE OF VERMONT  
AGENCY OF HUMAN SERVICES**

**Analysis of Designated Agency  
Reporting and Documentation Requirements**

***Final Report***

**THE PACIFIC HEALTH POLICY GROUP**

**March 2008**

## **Notes to the Reader:**

This report is a follow-up to an earlier study conducted by the Pacific Health Policy Group in 2007. The final report issued at the conclusion of the earlier study is available through the Agency of Human Services.

The Pacific Health Policy Group (PHPG) would like to thank those who contributed to this study, including state staff, Designated Agency staff, Specialized Service Agency staff and the Vermont Council of Developmental and Mental Health Services.

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## Introduction

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### Background

The State of Vermont has been a national leader in offering community-based service and treatment options to persons with developmental disabilities and mental health/substance abuse disorders. Individuals who in other states would be served on an inpatient basis are able to remain in their communities and enjoy a higher quality of life.

Crucial to Vermont's success are the network of private, nonprofit centers known as Designated Agencies and Specialized Services Agencies (DA's/SSA's). The Designated Agencies are responsible for providing programs, or services, within defined geographic jurisdictions, including, in most instances:

- ✓ Developmental Disability Services (or "Developmental Services") for individuals with developmental disabilities;
- ✓ Community Rehabilitation & Treatment (CRT) services for adults with serious mental illness;
- ✓ Adult Outpatient services for adults with mental health service needs who do not meet CRT clinical eligibility criteria;
- ✓ Children's Mental Health services;
- ✓ Emergency Mental Health services; and
- ✓ Substance Abuse Treatment services.

The Specialized Services Agencies, along with one contracted provider, offer targeted services to particular priority populations. Collectively, the DA's/SSA's are responsible for the majority of publicly-funded, community-based developmental, mental health and substance abuse services provided in Vermont.

The State has conducted two sustainability studies of the DA system.

PHPG issued its final report for the second study in September, 2007. The report included the following recommendations:

- Create a strategic plan that defines sustainability in terms of quality, access and financial performance;
- Re-align the Designated Agency program model from one that is silo-based to one that is individual/family-centered;
- Review oversight/documentation requirements to only retain those standards which are necessary for evaluating quality and assuring accountability;
- Introduce recruitment and retention incentives with State fiscal support; and
- Explore options to reduce the impact of external operating expenses that are creating financial pressure on the DAs (e.g. health insurance).

As a follow-up to the second sustainability study, the Agency retained PHPG to perform a detailed review of reporting requirements and oversight activities. This report provides the

findings of this follow-up study, provides specific recommendations, and identifies tasks necessary to implement each of the recommendations.

## Statement of the Problem

One of the recommendations identified in the 2007 sustainability study was to reduce, consolidate, or otherwise streamline the reporting requirements and State oversight activities. Through interviews with DA staff members, program managers, and administrators, there was a general consensus that reporting requirements were continually becoming more burdensome, and requiring more time to complete, leading staff members to either reduce the number of hours spent providing services to clients, or requiring staff members to complete documentation activities during non-work hours (e.g. nights and weekends, often without compensation.)

The impact of the increasing documentation was cited as causing two main problems:

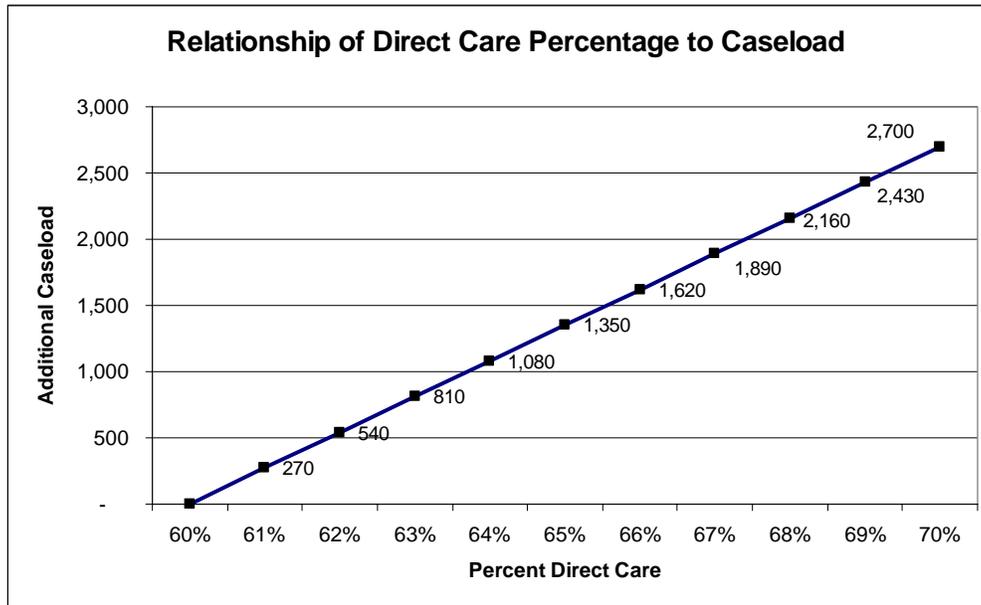
1. When staff members were able to complete paperwork during business hours, any time spent completing forms and otherwise documenting direct service time was not being spent providing services to clients. As the Designated Agencies essentially operate on fixed budgets, financial resources were not available to serve more clients.
2. Staff members who continue to work with the same number of clients often find it necessary to continue working during their “off time” to complete documentation requirements. This leads to a work-life balance that contributes to increased turnover.

During these same conversations, staff members reported that even though the level of documentation was increasing, and that audit and oversight activities were becoming more burdensome, there was not a commensurate improvement in the care that was being provided.

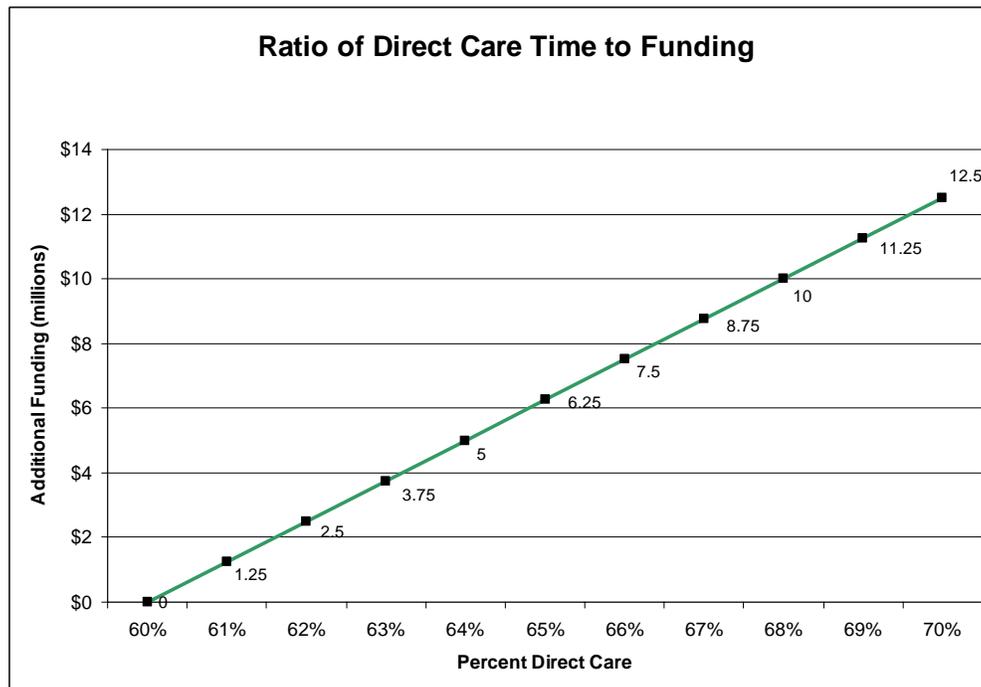
The State undertook a more detailed analysis of documentation requirements and audit activities to determine if existing requirements were no longer necessary, redundant, or not otherwise useful. The State also elected to examine whether the increased flexibility that Vermont was able to realize through its adoption of the Global Commitment to Health Waiver would enable the Agency to realign its requirements to focus more on performance-based measures as opposed to ones focused on auditing units of service.

Using estimates provided by staff members, who said that they often spend 60 percent of their time working with clients and the remaining 40 percent completing non-direct care work, PHPG was able to show that every percentage increase in the amount of time spent with clients allowed an additional 270 individuals to receive services. From a funding perspective, each one percent reduction in the amount of non-direct care time was the equivalent of adding \$1.25 million dollars into the Designated Agency system. Exhibit 1 shows the correlation between the amount of direct care time and the number of clients served. Exhibit 2 provides the potential impact of increased direct care time on program funding.

**Exhibit 1 – Ratio of Direct Care Time to Caseload**



**Exhibit 2 – Ratio of Direct Care Time to Funding**



It was acknowledged that even a seemingly small shift would require time to emerge. Additionally, any programmatic changes would require some level of investment (i.e., changes to information systems, staff training). The realignment itself would need to be approached thoughtfully, to ensure that the focus of the monitoring process remained where it belongs – on ensuring clinically appropriate, high quality care.

It was also noted that members of the Advisory Board held varied opinions regarding the potential impact of this recommendation. However, PHPG observed broad consensus among DA clinical staff and management that reporting requirements are both burdensome and excessive. The actual impact of this recommendation would depend on the breadth of the reform, including state reporting requirements, state oversight activities, and DA corporate compliance requirements.

## Scope of Work

As a result of the 2007 Financial Sustainability Report, the Agency of Human Services asked PHPG to conduct a detailed analysis of reporting and documentation requirements that are completed by the agencies and overseen by the Departments of Mental Health and Aging and Independent Living, and the Alcohol and Drug Abuse Division of the Department of Health.

Primary tasks for this study included:

1. In-depth interviews with agency direct care/supervisory staff for the purpose of:
  - a) identifying current oversight and reporting processes/requirements, including report types, data elements, recipient(s) and intended purpose;
  - b) evaluating internal processes for responding to oversight/reporting requirements, including responsible staff;
  - c) estimating staff hours required to participate in oversight activities (e.g. site visits);
  - d) documenting data collection and reporting considered valuable by the Designated Agencies for internal management purposes; and
  - e) assessing the potential impact of the transition to Electronic Health Records.
2. Prepare a comprehensive matrix of existing requirements and develop specific recommendations for streamlining reporting through: consolidation of duplicate reports; development of uniform compliance standards for adoption by all agencies; and streamlining or elimination of other reports not required by CMS and not essential for monitoring clinical appropriateness and ensuring accountability. Recommendations would be developed in collaboration with Designated Agency Program Directors/Compliance Managers and AHS staff and also will address reporting schedules and benchmarking opportunities.
3. Develop recommendations for streamlining the State's oversight process, for example through adoption of concurrent site reviews (across programs), broader incorporation of CARF (or equivalent) accreditation into review scope, and re-focusing reviews to effectively monitor and promote quality care delivery.

## Field Work & Data Collection

PHPG consulted extensively with providers – through onsite visits, DA program director meetings, and meetings with state personnel throughout the course of the study. The agencies visited included: Counseling Services of Addison County (Middlebury), HowardCenter (Burlington), Northwestern Counseling and Support Services (St. Albans), and Rutland Mental Health Services (Rutland).

Exhibit 3 identifies the organizations and committees with whom PHPG met over the course of the study.

### ***Exhibit 3 – PHPG Meetings***

<b>Agency &amp; Consumer Site Visits</b>	<b>Statewide Director Meetings</b>
Counseling Services of Addison County (Middlebury)	Billing Managers
HowardCenter (Burlington)	Corporate Compliance Managers
Northwestern Counseling and Support Services (St. Albans)	Executive Directors
Rutland Mental Health Services (Rutland)	IT Managers
<b>State Personnel</b>	Substance Abuse Program Managers
Adult Mental Health	
Children’s Mental Health	
Alcohol and Drug Abuse Programs	
<b>Other Meetings</b>	
DA-sponsored Lavender and Wyatt presentation (Electronic Health Record vendor)	

## Findings and Recommendations

The remainder of the report presents findings and recommendations. Each chapter is devoted to a specific finding or topic, and then a recommendation tailored to improving the current system is included. At the conclusion of each chapter, an “Implementation Summary” is provided to aid the State and the Designated Agencies to assess the impact of each recommendation and identify the steps necessary to implement the recommendation.

Through implementation of the recommendations contained in this report, especially Recommendations 1, 2, and 5, PHPG believes that over the course of the next two to three years that approximately 5 to 7 million dollars can be directed away from administrative processes related to documentation and oversight and reinvested into providing services to clients.

## **Recommendation 1- Streamline Data Reporting Elements**

The impetus for this study and report was a frequently-stated concern that reporting requirements had become increasingly complex and redundant. This concern was expressed by DA managers and clinicians, especially those that had been working in the system for many years. The overwhelming consensus was that reporting requirements were taking up an ever-increasing amount of time and placed strains on the direct service staff.

During this study, PHPG consultants met with a variety of direct service staff to discuss how the requirements had changed and why documentation was becoming increasingly burdensome. Demand for additional documentation is driven by the following:

- The public mental health system has transitioned to an organized, medical model; DAs' quality assurance initiatives and accreditation requirements have prompted management to increase documentation requirements;
- DAs have expressed concern regarding program audits and the possibility of audit findings that provided services are not adequately supported by documentation; and
- Federal programs have increased reporting requirements.

The exhibit below details the different reports that the DAs submit to the State.

<b>Summary of Program Reporting Requirements</b>		
<b>Agency / Department</b>	<b>Requirement</b>	<b>Submission Timeline</b>
<b>Alcohol and Drug Abuse Programs</b>	<ul style="list-style-type: none"> <li>• Admission, service, and discharge reports</li> <li>• Screen &amp; Disposition Report for Public Inebriants</li> <li>• Quarterly financials</li> <li>• Audited annual reports</li> <li>• Waiting List Reports</li> <li>• Conifer Park Referral</li> </ul>	<ul style="list-style-type: none"> <li>• Within 30 days of the end of the month</li> <li>• 15 days after the end of the month</li> <li>• 45 days after the end of the quarter</li> <li>• 90 days after the end of the provider fiscal year</li> <li>• 15 days after the end of the month</li> </ul>
<b>Adult Mental Health</b>	<ul style="list-style-type: none"> <li>• MSR Data</li> <li>• Quarterly HRD Data</li> <li>• Clinical Care Audits</li> <li>• PATH Audit</li> <li>• Housing Contingency Fund Utilization</li> <li>• Monthly Financial Submissions</li> <li>• Annual related party transactions</li> <li>• Annual audit and associated management letter</li> <li>• Fee-for-Service Medicaid audit reconciliation</li> <li>• CRT Enrollment/Disenrollment</li> </ul>	<ul style="list-style-type: none"> <li>• Monthly</li> <li>• Quarterly</li> <li>• Biennial</li> <li>• Annual</li> <li>• Monthly</li> <li>• Annual</li> <li>• Annual</li> </ul>

<b>Summary of Program Reporting Requirements</b>		
<b>Agency / Department</b>	<b>Requirement</b>	<b>Submission Timeline</b>
<b>Adult Mental Health (cont)</b>	<ul style="list-style-type: none"> <li>• CRT quarterly grievance and complaint summary</li> <li>• Significant Event Reporting</li> <li>• Local System of Care Plans</li> <li>• Involuntary Transportation Checklist</li> <li>• Medicaid Child Admission Information</li> <li>• CRT Grievance and Appeal Information</li> <li>• CRT Monthly Cash Payment reports (non-MSR)</li> <li>• CRT Special Services Fund request form</li> </ul>	<ul style="list-style-type: none"> <li>• Quarterly</li> <li>• As needed</li> <li>• Every 3 years, updates annually</li> <li>• As needed</li> <li>• As needed</li> <li>• Monthly</li> </ul>
<b>Children’s Mental Health</b>	<ul style="list-style-type: none"> <li>• MSR Data</li> <li>• Packets for youths with services funded through Waiver or ISB</li> <li>• Special Service Funding Request</li> <li>• Emergency Beds</li> <li>• Act 264</li> <li>• Program Review</li> <li>• System of Care Plan</li> </ul>	<ul style="list-style-type: none"> <li>• Monthly</li> <li>• Admission &amp; every 6 months</li> <li>• Baird: every two weeks; NFI: monthly</li> <li>• Every two years</li> <li>• Every 3 years, annual updates</li> </ul>
<b>Developmental Services</b>	<ul style="list-style-type: none"> <li>• Funding reports (can be consolidated into MSR)</li> <li>• Supported Employment Services</li> <li>• Annual survey</li> <li>• Critical Incident Reports</li> <li>• Documentation aligns to Individual Care plans – not standardized across program</li> </ul>	
<b>Department for Children and Families</b>	<ul style="list-style-type: none"> <li>• Plan of Care</li> <li>• Review of Plan of Care</li> <li>• Assessment of child’s behavior in placement</li> <li>• Individual Service Plan</li> <li>• Delivery of Services</li> <li>• Quarterly Financial Reports</li> <li>• Annual Summary Financial Reports</li> </ul>	<ul style="list-style-type: none"> <li>• Approval within 15 days by “Licensed Practitioner of Healing Arts”</li> <li>• Monthly</li> <li>• 30 days after the end of the quarter</li> <li>• By August 15</li> </ul>

### **Monthly Service Reports and Human Resources Data**

One of the main frustrations voiced during the interviews relates to the ongoing collection of both the Monthly Service Reports (MSRs) and Human Resource Datasets (HRD). In response to feedback from the DAs, the Agency of Human Services, in collaboration with the Departments of Health/Mental Health proposed a reduction in the items collected in the MSRs/HRDs. After a comprehensive review of the data collected, the State determined which items were necessary to

support its role in monitoring the level of care provided at the DAs and meet Federal requirements, and which items could be suspended.

Exhibit 1 (below) shows which elements were identified for suspension by AHS. At the time, the DAs decided to not make changes to their systems absent assurances that such changes would be permanent. Appendix 1 presents all of the current MSR datasets, and includes notations about which elements are necessary for Medicaid FFS claims or encounter data, were proposed for suspension by AHS, or are required by SAMHSA.

**Exhibit 1.1: MSR Data Elements Proposed for Suspension**

Columns	Column Name	Medicaid FFS	Medicaid Encounter	Proposed Suspension	SAMHSA Reporting	AHS Additional Notes
27-28	Client payment responsibility			SUSPEND		
41	Marital/family problem			SUSPEND		
42	Social/interpersonal problem			SUSPEND		
43	Coping problem			SUSPEND		
45	Depression or mood disorder			SUSPEND		
49	Eating disorder			SUSPEND		
50	Thought disorder			SUSPEND		
53	Runaway behavior			SUSPEND		VCRHYP Database is established statewide; the DA's that serve as part of that network report runaway and other data into that vehicle
54	Condition on termination			SUSPEND		
69-72	Date of "income at intake"			SUSPEND		
32	Client status			SUSPEND		
33-35	Name fragment			SUSPEND		
36-40	Statewide MH/DS client identifier			SUSPEND		
41	Previous tx by MH organization of any kind			SUSPEND		
42	Previous tx by this organization			SUSPEND		
65	SSI eligibility at intake			SUSPEND		
67-68	Referral upon discontinuation			SUSPEND		
69-73	Current primary therapist or cm			SUSPEND		
2	Current SSI eligibility			SUSPEND		
46	ADAP transfer			SUSPEND		
1-27	Blank			SUSPEND		
3-9	Blank			SUSPEND		
16-16	Blank			SUSPEND		
43-49	Family ID #			SUSPEND		
50	HIV info given			SUSPEND		
51-62	Account # [same # as line 6, col. 37-48 of the client record]			SUSPEND		

In Recommendation 2, PHPG proposes that the State begin transitioning from a fee-for-service reimbursement structure to a case rate system, which is currently being utilized for the CRT program. As part of a case rate system, the DAs would need to collect encounter data that mimics the information collected for fee-for-service claims. PHPG has identified the elements of the MSRs that would need to be retained in order to adequately comply with the encounter data requirements. Exhibit 2 (below) shows which elements should be retained. The elements retained for encounter data are consistent with industry standards, as validated by the Mental Health Statistics Improvement Program, a SAMHSA supported project.

**Exhibit 1.2: MSR Data Elements Necessary for Fee-for-Service Claims or Encounter Data**

Columns	Column Name	Medicaid FFS	Medicaid Encounter	Proposed Suspension	SAMHSA Reporting	AHS Additional Notes
2-10	Client ID	x	x			AHS, VDH and Dail proposes a work group be formed to create 1 unique ID process (SSN, name fragments, etc.) throughout the system - All Medicaid recipients need to be identifiable and the state must be able to link MSR information to other Medicaid databa
11-12	Provider ID	x	x			To accurately identify/process data
13-14	Primary program assignment	x	x			To accurately identify/process data
7-11	Diagnosis DSM-IV Axis I Secondary	x	x			AHS, VDH and DAIL proposes the creation of a work group to identify the training and implementation steps needed to move all service and reporting to ICD-9 codes. (Commercial and Medicaid billing already requires the use of ICD-9).
12-16	Diagnosis DSM-IV Axis II Primary	x	x			
29-39	First name	x	x			Required for Medicaid clients only
40	Middle initial	x	x			
41-55	Last name	x	x			
56-58	Modifier	x	x			
59-67	SSN	x	x			
68-75	Date of death	o	o			Required for Medicaid clients only Required for service and encounter data
76-79	SSN suffix	o	o			Required for everyone for constructed identifier
1-24	Street address 1	x	o			Required for Medicaid clients only
25-48	Street address 2	x	o			
49-63	City	x	o			
64-65	Statewide MH/DS client identifier	x	o			
66-74	Zip Code	x	o			
75-77	Town code	x	o			
28-36	Medicaid billing #	x	x			Links to Medicaid eligibility, encounter and claims data
10-15	Date of service	x	x			Required for service and encounter data
20-25	Duration of service	x	x			Required for service and encounter data
26-27	Program of service	x	x			Required for service and encounter data
28-29	Cost center	o	o			Required for service and encounter data
30-32	Type of service code	x	o			Required for service and encounter data
33	Location code	x	o			Required for service and encounter data

x= required o = optional

**Alcohol and Drug Abuse Program (ADAP) Reporting**

In addition to the MSR data, the Alcohol and Drug Abuse Program (ADAP) is a target of criticism regarding over-burdensome documentation and reporting requirements. Managers often felt that a majority of their time spent reporting data to the State was disproportionate to the number of clients and the amount of dollars spent on substance abuse services.

The provision that was considered most cumbersome requires a client who has not received services in the previous thirty days to be discharged from the agency’s caseload, and if the client decides to continue seeking services at the same agency, a new case has to be created – a fresh admission.

The substance abuse managers also voiced significant concern regarding requirements related to assessment questionnaires that needed to be completed during the first visit. The questions often revolved around peripheral issues – sexual habits, etc. – that were often potentially embarrassing for the client to reveal when they were seeking substance abuse services. The questionnaires often take hours to complete, reduce the ability of the clinician to establish a working rapport with the client, and impede the effectiveness of future services – if the client decides to return at all. However, while the ADAP staff understood this frustration, they felt strongly that these assessments are integral to best practices. PHPG recommends that the program managers work closely with the ADAP staff to confirm that the extent and timing of assessment activities

comport with best practices while ensuring that the focus of services remains on providing compassionate, high quality care.

While many of the other recommendations in this report should benefit substance abuse programs to the same extent as other programs, after reviewing Federal requirements, the State currently lacks the ability to reduce substance abuse reporting requirements. The thirty day discharge requirement, noted above, relates to Substance Abuse Mental Health Service Administration (SAMHSA) Substance Abuse Prevention and Treatment Block Grant (SAPTBG) reporting requirements<sup>1</sup>. As SAMHSA continues to transition to performance-based reporting requirements, it is likely that these types of reporting requirements will increase. In order to continue receiving block grant funding, the State of Vermont will need to comply with all current reporting requirements.

### *Federal Waiver Process*

PHPG explored the prospect of the State applying for a waiver from this requirement, but believes that any effort is unlikely to yield beneficial results. The 30-day discharge clause is used to establish a basis for comparison across the states as it relates to the other performance-based measures. In SAMHSA's Supporting Statement for the "Substance Abuse Prevention and Treatment Block Grant Regulations (45 CFR Part 96) and FY 2005-2007 Application, five different criteria were identified as being available for waiver. They include:

1. "The reporting requirement related to the percentage increase in treatment services designed for pregnant woman and woman with dependant children;
2. "The improvement of the referral process and the coordination of prevention activities and treatment services with other public and private nonprofit entities;
3. "The provision of continuing education in treatment services and prevention activities for the employees of the facilities who provide the services or activities;
4. "The coordination of prevention activities and treatment services with the provision of other appropriate services;
5. "The maintenance of state expenditures for prevention activities and treatment services; and
6. "The prohibition against the use of block grant funds for construction."

Given that SAMHSA identifies certain discrete requirements as being eligible for a possible waiver, it is unlikely that SAMHSA would agree to allow Vermont the option of waiving reporting requirements and/or the underlying definitions that have been studied in pervious years and are now applicable to all states.

### **ADAP and the MSR**

Currently, only two of the DAs have chosen to report required ADAP elements using the MSR. Other DAs have chosen to report data directly to ADAP. However, a large portion of the MSR data elements currently pertain only to Federal reporting requirements which affect ADAP. Exhibit 3 (below) details these elements.

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<sup>1</sup> PHPG verified that the 30 day discharge requirement was in fact a Federal requirement. See: Section IV-A "Voluntary Treatment Performance Measures" Instructions; Federal Register, Volume 72, Number 56 (3/23/07) pg. 13809 removes reference to "voluntary" as requirements are no longer voluntary.

### Exhibit 1.3: ADAP-specific MSR Data Elements

Columns	Column Name	Medicaid FFS	Medicaid Encounter	Proposed Suspension	SAMHSA Reporting	AHS Additional Notes
15-20	Date of Birth				BLOCK GRANT	National Outcomes Measurement System (NOMS) - required to sustain ADAP federal funds. Also used in Probabilistic Population Estimates (PPE) to match sensitive data base information in a non-identifiable manner
21	Gender				BLOCK GRANT	NOMS & PPE
22-26	Gross annual family income at intake				BLOCK GRANT	Federal Report for ADAP
29	Individuals on income				BLOCK GRANT	Federal Report for ADAP
47	Alcohol				BLOCK GRANT	Required for identification of co-occurring disorders and grant reporting
48	Drugs				BLOCK GRANT	Required for identification of co-occurring disorders and grant reporting
50	Race				BLOCK GRANT	NOMS: Needs review to ensure the definitions represent the most up to date federal requirements across AHS & ADAP
50	Hispanic origin				BLOCK GRANT	NOMS - Federal Reporting
53-57	Zip code of residence at admission to this agency				BLOCK GRANT	NOMS - Federal Reporting
62-69	Residential arrangement at intake				BLOCK GRANT	NOMS [ADAP re homelessness & MH block grant] - Federal Reporting
64	Living arrangement at intake				BLOCK GRANT	NOMS [ADAP re dependency] - Federal Reporting
66	Discontinuation status				BLOCK GRANT	NOMS [ADAP] - Federal Reporting
79-80	Current residential arrangement				BLOCK GRANT	ADAP - Federal Reporting
1	Current living arrangement				BLOCK GRANT	ADAP - Federal Reporting
3-7	Current gross annual family income				BLOCK GRANT	NOMS - Federal Reporting
14	ADAP program of service					Needs to be reviewed and updated
15-20	ADAP client identifier					AHS, VDH and Dail proposes a work group be formed to create 1 unique ID process (SSN, name fragments, etc.) throughout the system - All Medicaid recipients need to be identifiable and the state must be able to link MSR information to other Medicaid databases. Currently, it appears that ADAP, MH and DS have separate unique ID processes.
21	Significant other					ADAP - Federal Reporting
22-23	# of prior admissions to tx					ADAP - Federal Reporting
24-25	Primary problem at intake					ADAP - Federal Reporting
26-27	Secondary problem at intake				BLOCK GRANT	ADAP - Federal Reporting
28-29	Tertiary problem at intake				BLOCK GRANT	ADAP - Federal Reporting
30	Primary problem, usual route of administration at intake					ADAP
31	Secondary problem, usual route of administration at intake				BLOCK GRANT	ADAP - Federal Reporting
32	Tertiary problem, usual route of administration at intake				BLOCK GRANT	ADAP - Federal Reporting
33	Primary problem frequency of use at intake				BLOCK GRANT	ADAP - Federal Reporting
34	Secondary problem frequency of use at intake				BLOCK GRANT	ADAP - Federal Reporting
35	Tertiary problem frequency of use at intake				BLOCK GRANT	ADAP - Federal Reporting
36-37	Age of first drug use as related to the primary problem reported				BLOCK GRANT	ADAP - Federal Reporting
38-39	Age of first drug use as related to secondary problem reported				BLOCK GRANT	ADAP - Federal Reporting
40-41	Age of first drug use as related to tertiary problem reported				BLOCK GRANT	ADAP - Federal Reporting
42	Use of methadone as part of tx					ADAP - Federal Reporting
43-44	Level of education at intake				BLOCK GRANT	NOMS - Federal Reporting
45	Pregnant at time of admission					ADAP - Federal Reporting
47-48	Employment status				BLOCK GRANT	NOMS-Federal Reporting
49-54	Date of transfer to ADAP intensive outpatient					ADAP - Federal Reporting
55-60	Date of transfer to ADAP outpatient					ADAP - Federal Reporting
61-66	Date of transfer to ADAP residential					ADAP - Federal Reporting
67-72	Date of discharge from ADAP					ADAP - Federal Reporting
1	Medical health level of functioning at intake				BLOCK GRANT	NOMS - Item is Changing to # of arrests

Columns	Column Name	Medicaid FFS	Medicaid Encounter	Proposed Suspension	SAMHSA Reporting	AHS Additional Notes
6	Medical health LOF at discharge				BLOCK GRANT	NOMS - Federal Reporting [Change to # of arrests]
11-12	Level of education at discharge				BLOCK GRANT	NOMS-Federal Reporting
13-14	Employment status at discharge				BLOCK GRANT	NOMS-Federal Reporting
15-16	Primary problem at discharge				BLOCK GRANT	NOMS-Federal Reporting
17-18	Secondary problem at discharge				BLOCK GRANT	ADAP - Federal Reporting
19-20	Tertiary problem at discharge				BLOCK GRANT	ADAP - Federal Reporting
21	Primary problem usual route of administration at discharge				BLOCK GRANT	ADAP - Federal Reporting
22	Secondary problem usual route of administration at discharge				BLOCK GRANT	ADAP - Federal Reporting
23	Tertiary problem usual route of administration at discharge				BLOCK GRANT	ADAP - Federal Reporting
24	Primary problem frequency of use at discharge				BLOCK GRANT	ADAP - Federal Reporting
25	Secondary problem FOU at discharge				BLOCK GRANT	ADAP - Federal Reporting
26	Tertiary problem FOU at discharge				BLOCK GRANT	ADAP - Federal Reporting
27	Pattern & FOU at improved				BLOCK GRANT	NOMS-Federal Reporting
28	Degree of physical and/or psychological dependence improved				BLOCK GRANT	NOMS-Federal Reporting

## Recommendation

While the data that is currently collected at the clinician level is appropriate to reflect the services provided, the process of collecting the data from patient files through transmission to the State creates more work, which ultimately requires DA staff time to complete, and ultimately draws dollars away from service provision to clients. A vast majority of the clinicians reported that obtaining access to a computer is a challenge, requiring them to complete all paperwork by hand. This limits their ability to revise or update paperwork, as often a new form needs to be completed, by hand, and data that remains relevant needs to be recopied. In addition, most of the reporting is completed electronically, which means that the DAs need to hire staff to convert the information from the clients' file into an electronic format.

Recommendation 3 (“Facilitate Electronic Health Record Implementation”) provides a more detailed analysis of the current technological environment at the DAs, but it suffices to say that providing the necessary hardware and software to the clinicians would allow for the direct input of data and reduce the time and resources spent converting the information from the paper file.

In addition to utilizing technology to minimize the redundant efforts inherent to a paper-based system, the State program managers should assess reporting elements that are not required for a fee-for-service claim or encounter data, have not already been proposed for suspension, or are not related to a Federal requirement. Exhibit 4 (next page) identifies each of these elements.

## Exhibit 1.4: MSR Elements Utilized by the State

Columns	Column Name	Medicaid FFS	Medicaid Encounter	Proposed Suspension	SAMHSA Reporting	AHS Additional Notes
1	Record identifier					
30-31	Responsible for fee: primary					Monitoring: System of Care Plan
32-33	Responsible for fee: secondary					Monitoring: System of Care Plan
34-35	Responsible for fee: tertiary					Monitoring: System of Care Plan
36-40	Diagnosis DSM-IV Axis I					AHS, VDH and DAIL proposes the creation of a work group to identify the training and implementation steps needed to move all service and reporting to ICD-9 codes. (Commercial and Medicaid billing already requires the use of ICD-9).
44	Medical somatic problem					
46	Attempt, threat or danger of suicide					
51	Involvement w/ criminal justice					Used in reporting, case load overlap with DOC and ADAP
52	Abuse/assault/Rape victim					
55-60	Begin date of report					To accurately identify/process data
61-66	End date of report					To accurately identify/process data
67-68	C & E recipient type					Used for CUPS program payments and reporting
73-78	Date case opened					Billing and LOS indicator
1-6	Date case closed					Billing and LOS indicator
17-21	Diagnosis DSM-IV Axis II Secondary					
25-26	Diagnosis DSM-IV Axis 5: current level of functioning					
30-31	Diagnosis DSM-IV Axis 5: level of functioning at admission					
44	Inpatient					Service profiles and encounter data
45	Residential					Service profiles and encounter data
46	Partial day					Service profiles and encounter data
47	Outpatient					Service profiles and encounter data
48	Case management					Service profiles and encounter data
49	Emergency					Service profiles and encounter data
52	Marital status					Used in reports to identify categories involving "child of single parent", service recipient profile information for primary household wage earners for System of Care Plans; legal status relational indicator not identified elsewhere in MSR
58	Veteran status					
59	Legal status					Categories and Definitions need updating
60-61	Source of referral					Categories and Definitions need updating
74-78	Zip code of current residence					To track accessibility and penetration of DA services into the catchment area. Used by ADAP to track update info
8-13	Date of most recent review					Time stamp for data updates and ensure federal information up to date and reported
14	ADAP program of service					Needs to be reviewed and updated
15-20	ADAP client identifier					AHS, VDH and Dail proposes a work group be formed to create 1 unique ID process (SSN, name fragments, etc.) throughout the system - All Medicaid recipients need to be identifiable and the state must be able to link MSR information to other Medicaid databases. Currently, it appears that ADAP, MH and DS have separate unique ID processes.
2	Family/social LOF at intake					Changing to one item: last 4 digits of SSN
3	MH/social LOF at intake					
4	Vocational LOF at intake					
5	Legal/social LOF at intake					
7	Family/social LOF at discharge					Changing to one item: last 4 digits of SSN
8	MH LOF at discharge					
9	Vocational LOF at discharge					
10	Legal LOF at discharge					
37-48	Account #					DA field
49-56	Primary program assignment effective date					Required for service and encounter data
57-64	Primary program assignment end date					Required for service and encounter data
65-66	Birth year prefix					PPE
1	Record identifier					Links data
2	Action code					Validate and updates changes; time stamp
34	Count					Used by DA's to avoid double billing (2 staff at same clinical meeting)
36-40	Staff ID #					Links to client and staff data
41-42	Total # of individuals seen in each direct family contact					Demonstrates broader impact of single client service and need for family focused care

Each of these elements should have a justifiable purpose for continued collection. The State collects audited financials, monthly financial reports and Medicaid data. In addition, program reviews are performed to ensure that the DAs are providing quality services to clients. It needs to be remembered that while no one element creates a significant burden, the ongoing collection of data requires resources at the DA level. Furthermore, for every one percent reduction in time not being spent on administrative processes, an additional \$1.25 million dollars can be redirected towards providing patient care.

PHPG also proposes that the State evaluates whether to collect the HRD data. As opposed to submitting human resource data on a monthly basis to the State, PHPG recommends that the Vermont Council annually reports to the State the current status of human resource issues occurring across the DAs, including the number of staff at the DAs, salary information, and other necessary information. To facilitate this change, DMH and DAIL would need to work with the Vermont Council to develop a report template that includes the necessary data to be presented, as well as a timeline for submission.

Finally, the two different reporting structures for ADAP-required elements introduce an added complexity into the system. It may be feasible that upon reducing the data elements reported through the MSRs, that non-DA providers who submit data to ADAP can do so through the MSRs. If technological constraints make this solution impractical, then the two remaining DAs that submit data to ADAP through the MSRs should convert to the same process as the other DAs. This would then allow the State to eliminate the ADAP elements from the MSR dataset and retain only those elements necessary for either claims or encounter data, or those determined necessary by the State for oversight.

<b>Implementation Summary</b>	
<b>Recommendation</b>	Eliminate unnecessary MSR data elements and discontinue collection of HRD data.
<b>Challenges for Implementation</b>	<ul style="list-style-type: none"> <li>• Determination of which elements are not necessary to ensure appropriate care</li> </ul>
<b>Benefits for Implementation</b>	<ul style="list-style-type: none"> <li>• Improved data integrity</li> <li>• Simplified reporting for the DAs</li> <li>• Encounter data will support a transition to a case rate reimbursement structure (Recommendation 2)</li> <li>• Refined dataset will facilitate development of EHR &amp; automated reporting functions</li> </ul>
<b>Implementation Steps</b>	<ul style="list-style-type: none"> <li>• State needs to determine what elements are needed for each program</li> <li>• DAs need to realign IT systems to only report necessary elements</li> <li>• Vermont Council would collect and report HRD data.</li> </ul>
<b>Target Start Date</b>	<ul style="list-style-type: none"> <li>• April 1, 2008</li> </ul>

## **Recommendation 2 - Transition to a Case Rate Reimbursement Structure**

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In 2001, the State of Vermont transitioned from reimbursing services for Community Rehabilitation and Treatment clients from a system based on fee-for-service claims to one that involves a tiered case rate system. Depending on the intensity of services needed, a client received a set amount of dollars that could be expended by the DAs for services, without regard to what services were actually provided. This reimbursement system allowed the DAs to improve patient care by providing a wider range of services, which were more appropriate to the needs of the client, than what would have been allowed under a traditional fee-for-service structure. In addition, the case rate enables program oversight to move from a quantitative audit function to an assessment of the quality of services provided.

Other program areas, however, continue to operate on a mostly fee-for-service reimbursement structure. Facilitating the documentation and audit functions to ensure claim accuracy with this structure requires a considerable amount of time and human resources investment. For example, the Counseling Services of Addison County (CSAC) maintains 4 full time equivalents whose sole responsibility is to cross-reference case documentation and claims to ensure that the appropriate documentation is in the client's file to support every claim. On a relative scale, CSAC is a mid-sized agency and if this level of internal auditing is taking place at each of the DAs, a significant amount of resources could be re-directed towards direct care for clients.

While there was initial resistance to transitioning the CRT program to a case rate reimbursement system, there is now considerable support for the flexibility offered, and few people, if any, would recommend a return to a fee-for-service reimbursement structure. PHPG recommends that the State begin taking transitioning the remaining programs, wherever possible, to ones that rely primarily on a case rate reimbursement structure.

To begin, PHPG recommends that a case rate system be implemented on a program-by-program basis, as opposed to transitioning all programs at the same time. The Children's Mental Health Program presents the next best program to begin a transition. While the CRT programs and Children's Mental Health programs work with clients who differ in many regards, both sets of clients are similar in that they typically have ongoing contact with the DAs, as opposed to Adult Outpatient or Substance Abuse clients, who are more likely to use the services on an "on again, off again" basis.

Upon agreement that a case rate system is the most advantageous reimbursement structure for the DAs – in terms of both the ability to improve patient care while subsequently reducing the documentation and auditing of claims data – the State needs to begin collecting historical claims data and segment different clients based on historical service utilization – use of primary/secondary diagnosis codes should provide a good baseline for developing a case rate system. It would be advisable for the staff members at Children's Mental Health to learn from the successes and mistakes of their counterparts in the Adult Mental Health division when implementing the CRT case rate structure to improve the process. The case rate system must be designed to reasonably and equitably reimburse DAs for the services provided.

If the State transitions Children's Mental Health to a case rate system, it would also need to address reimbursement of school-based clinicians funded through the Success beyond Six

program. Inclusion of the Success beyond Six services in the case rate system presents both opportunities and challenges. A case rate approach would provide additional flexibility with regard to the scope of services delivered to students. However, the State also would need to establish a case rate system that has the flexibility to support multiple and varied funding streams.

In January, 2008, the Department of Mental Health released a report subsequent to a legislatively-mandated summer study regarding the Success beyond Six program. The advisory group overseeing the study identified multiple current challenges in the provision of mental health services in schools, two of which are germane to this report. They are:

1. *“Should we be doing more work on prevention, school climate, and teacher training?”*  
*“Best practice literature on school-based mental health indicates that these activities are cost effective and positively impact the larger school population. We have not been able to deliver them to the fullest because of limitations on fee-for-service Medicaid regulations.”*
2. *“Are we using the most efficient funding mechanisms?”*  
*“Vermont has always used a fee-for-service funding mechanism to pay for Success beyond Six services. This means that funding is generated by each unit of services delivered. Each unit of service must be “medically necessary and prescribed in an Individual Plan of Care for a Medicaid enrolled student. Progress notes must meet federal Medicaid standards. The mechanism has been cumbersome and inefficient in schools because of the classroom setting and the pace of a school day. It also does not pay for needed services such as training and consultation to groups of teachers and other services focused on addressing issues in or generally improving the school environment.”*

Transitioning to a case rate system in Children’s Mental Health will allow for the continued provision of services to students in the school system, while also alleviating the above concerns related to the fee-for-service reimbursement structure. Clinicians would be able to provide some of the services identified above (e.g. training and consultation to groups of teachers) when the pressure to document and bill for a certain number of Medicaid-billable units of services is alleviated. So long as the particular student is receiving the amount of services prescribed in the IEP, the DA would draw down funding, allowing for a wider range of services, including those that have an impact on not just the student, but the larger population as well.

Subsequent to a successful transition for Children’s Mental Health, the next program that should be transitioned is the Adult Outpatient program. As funding for adult outpatient services becomes more restrictive, fewer clients are able to clear the waitlists. Since clients presenting with the most severe symptoms are more likely to obtain services, the client population has treatment needs similar to those served by the CRT population. While it is still necessary to maintain discrete boundaries between clients that are legally entitled to receive services and those that are not, the services needed by both sets are becoming more similar.

Similar to the success in improving the quality of services for CRT patients, transitioning to a case rate system in the Adult Outpatient program should yield comparable results as the DAs can

focus on providing a range of services that are clinically appropriate to the client’s condition with a less stringent focus on which services are Medicaid-billable. The implementation process will be similar to the one used for both CRT and Children’s Mental Health.

In addition, the continued use of the MSR data set provides the necessary encounter data to ensure compliance with Medicaid rules. Staff members at the DAs that are currently engaged in internal auditing to ensure that claims submissions are accurate can transition to a job focus that monitors the quality – from a clinical perspective – of the documentation, ensuring that each client has a case file that allows for a seamless transition of care should the current clinician/caseworker be reassigned, or if the client transfers to a new DA.

<b>Implementation Summary</b>	
<b>Recommendation</b>	Begin transition of programs to a case rate reimbursement structure
<b>Challenges for Implementation</b>	<ul style="list-style-type: none"> <li>• Determining appropriate rates</li> <li>• Alleviate concern at DA level regarding lack of claims data that will be needed</li> <li>• Ensuring compliance with Federal Medicaid requirements for billing under Global Commitment</li> <li>• Ensure that each client receives the required amount of services to receive funding</li> </ul>
<b>Benefits for Implementation</b>	<ul style="list-style-type: none"> <li>• Increased flexibility to ensure appropriate services are delivered</li> <li>• Reduce the need to audit claims data with case notes to ensure a service was provided</li> <li>• Case notes can shift to a qualitative focus</li> </ul>
<b>Implementation Steps</b>	<ul style="list-style-type: none"> <li>• Determine appropriate rates for Children’s Mental Health Services</li> <li>• Work with CMH staff to determine which reporting requirements are only needed in a fee-for-service environment</li> <li>• Coordinate with Adult Mental Health to learn from CRT case rate conversion</li> <li>• Revise school contracts to reflect a case rate system</li> </ul>
<b>Target Start Date</b>	<ul style="list-style-type: none"> <li>• Planning stages prior to next DA budgeting cycle</li> <li>• Implementation of Children’s Mental Health at the next budgeting process</li> <li>• Begin transitioning Adult Mental Health after successful implementation of Children’s Mental Health case rate system</li> </ul>

### **Recommendation 3 - Transition Payment Structure for Emergency Services to Performance-Based Model**

Similar in design to EMS systems, the DAs operate Emergency Services divisions that respond to members of the community in times of mental health crisis. To provide these needed services, and aid clients in ways that the acute care providers and the correctional system cannot, the DAs have staff members on-call twenty-four hours a day/seven days a week. However, these services are still funded on a fee-for-service basis, as opposed to block grants or otherwise guaranteed levels of funding.

Forcing the DAs to rely on the number of clients served through Emergency Services is fiscally-unsustainable at the program level. Currently, DAs often needed to divert funding from other programs to maintain adequate ES capacity. Since the personnel and other resources need to be funded at a “base” level to ensure that the services are available at the times of need, it would be more prudent to establish a minimum level of funding for each DA and then allow for adjustment if utilization rates differ dramatically – if the utilization rates are higher than anticipated during the budgeting process, there would be a mechanism to reimburse the DAs through a readjust of the budget; if utilization rates are lower, this would be taken into account during the next budgeting cycle so that the DA can adequately reduce capacity to the funding levels while still maintaining adequate capacity to ensure that clients receive services as needed.

To initiate this recommendation, prior to the next budgeting cycle for the DAs, collaboration with the appropriate program managers/administers at the DAs and members of the Department of Mental Health needs to occur. A determination needs to be made for each DA, based on the size of the catchment area, about the minimum level of funding necessary to maintain Emergency Services at least at a “break-even” level. To establish this, it needs to be determined how many staff members are needed to provide comprehensive coverage and then be adjusted for other costs (travel expenses, time for documentation, referrals, etc.) It would also be useful to analyze historical utilization trends to establish the number of staff members necessary to respond to the average number of clients seeking services.

<b>Implementation Summary</b>	
<b>Recommendation</b>	Transition Emergency Services from a fee-for-service reimbursement structure to a capacity based system (similar to EMS)
<b>Challenges for Implementation</b>	<ul style="list-style-type: none"> <li>• Determining the appropriate base level of funding for each DA</li> <li>• Determining the anticipated utilization at each DA to inform the needed resources to serve all clients</li> <li>• Ensuring that funds set aside for Emergency Services are not used by the DAs for other programs</li> </ul>

<b>Implementation Summary</b>	
<b>Benefits for Implementation</b>	<ul style="list-style-type: none"> <li>• Operate Emergency Services on a “break-even” level – DAs should not expect to make money on services, but also will not need to supplement funds from profits received in other program areas</li> <li>• Contingencies to ensure that only the appropriate funding is provided for each DA</li> </ul>
<b>Implementation Steps</b>	<ul style="list-style-type: none"> <li>• Determine appropriate funding for each DA based on catchment area</li> <li>• Determine a mechanism for reimbursing DAs if utilization is higher than anticipated</li> <li>• Develop a methodology to inform funding for future years based on previous utilization and anticipated future utilization</li> </ul>
<b>Target Start Date</b>	<ul style="list-style-type: none"> <li>• Prior to the next budgeting cycle</li> </ul>

## **Recommendation 4 - Implement Pilot of CARF “Deemed” Designation**

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To improve service delivery and their internal organizational structures, some Designated Agencies have chosen to independently pursue Commission on Accreditation of Rehabilitation Facilities (CARF) designation. Agencies which have chosen to pursue such accreditation have expressed the desire for the State to waive, in whole or in part, its own oversight activities and accept CARF designation as sufficient evidence that the DA is providing quality services to its clients.

In order to determine whether CARF designation should be considered as a replacement for State audit functions, the PHPG cataloged the 2007 CARF Behavioral Standards and compared those to the standards enumerated by the State (Appendix 2). While there is overlap between CARF and State standards, it is not currently desirable for the State to deem full accreditation to CARF-accredited DAs in lieu of formal State reviews.

Through interviews with both State staff members and DA personnel, there was a general consensus that while CARF had, in some areas, the same (or substantially similar) requirements, its review process focused on analyzing policies in place at a facility, as opposed to conducting a comprehensive review of client records to validate compliance with program policies. State audits and reviews filled this void through case file reviews to ensure that standards were in fact being met, rather than tacit agreement on the part of the DAs that the direct service staff were supposed to be completing documentation in a desired manner.

Additionally, CARF’s flexibility – in that it allows a facility to “pick and choose” which programs to submit for accreditation – creates an undue burden on the State in matching program standards. To accept CARF accreditation in lieu of State designation, State staff would need to compare its own standards to those of the programs that the DA had chosen for accreditation. As CARF is continually updating and revising its own standards, this is a process that the State would need to undertake on a regular basis to ensure that standards remain comparable. As it stands, since CARF accreditation is voluntary, the State would need to also conduct this analysis – by program area - for each DA that had chosen CARF accreditation, causing a significant increase in the amount of work imposed on the State, as well as the necessity for increased resources to carry-out such a comparison.

Many DAs have chosen to submit their programs for CARF designation, while one has chosen to work with the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO). The table on the following page shows a listing of the eleven DAs, the CARF programs in Behavior Health available for designation, as well as the programs each DA has chosen to accredit. Agencies that pursue JCAHO accreditation would also likely desire “deemed” status if such a methodology was instituted for CARF accreditation. As there are currently various different ways for agencies to improve their service delivery through external oversight, it is not feasible for the State to continually analyze standards and potentially waive its own review standards. Given the current framework, it is commendable that Designated Agencies are willing to commit both the financial resources and staff time to achieve designation, and reap the associated benefits (e.g. improved service delivery, lower insurance rates, etc.) as a supplement to State designation and program reviews.

**Exhibit 4.1: CARF Programs Available for Designation and which Programs DAs have Submitted for Accreditation**

CARF Program	Clara Martin Center	Counseling Services of Addison County	HCRS Of Southern Vermont	HowardCenter	Lamoille County Mental Health	Northeast Kingdom Human Services	Northwestern Counseling and Support Services	Rutland Mental Health Services	United Counseling Service	Upper Valley Services	Washington County Mental Health Services
<b>Business Practices</b>	x			x			x	x	x		
<b>Governance Standards Applied (Optional)</b>								x	x		
<b>General Program Standards</b>	x			x			x	x	x		
<b>Behavioral Health Core Program Standards</b>											
Assertive Community Treatment											
Assessment and Referral	x										
Case Management/Service Coordination	x			x			X	x	x		
Community Housing								x	x		
Community Integration							x	x	x		
Crisis and Information Call Centers											
Crisis Intervention	x			x			x	x	x		
Crisis Stabilization				x					x		
Day Treatment											
Detoxification											
Drug Court Treatment											
Employee Assistance											
Inpatient Treatment											
Intensive Family-Based Services								x			
Intensive Outpatient Treatment											
Out-of-Home Treatment											
Outpatient Treatment	x			x			x	x	x		
Partial Hospitalization								x			
Prevention/Diversion											
Residential Treatment											
Supported Living									x		
Therapeutic Communities											
<b>Behavioral Health Specific Population Standards</b>											
Children and Adolescents	x						x	x	x		
Consumer-Run											
Criminal Justice											
Juvenile Justice	x										
Addictions Pharmacotherapy	x			x					x		
<b>Employment and Community Standards</b>											
Individual-Centered Service Planning, Design, and Delivery											
Employment Services Principle Standards											
Employment Services Coordination											
Employment Transition Services											
Employment Planning Services											
Comprehensive Vocational Evaluation Services											
Employee Development Services							x				
Employment Skills Training Services											
Organizational Employment Services								x			
Job Development							x	x	x		
Job Supports							x	x	x		
Job-Site Training							x	x	x		
Community Employment Services											
Community Integration							x		x		
Community Housing								x	x		
Community Service Coordination									x		
Host Family Services								x	x		
Family Services								x			
Case Management / Service Coordination								x			
Supported Living								x	x		
Self-Employment Services											

## Notes regarding CARF Designation

### Crosswalk with State programs

In addition to its Business Practices and General Program Standards, which would most closely correlate with the State’s Designation process, attempting to directly line up different sub-programs is difficult. CARF accredits 41 different Behavioral Health programs, which are often times subsets of the larger program divisions that the State employs.

However, after analyzing the programs that DAs have chosen for CARF designation, the following table was developed to align each program area with the corresponding State program:

<p><b>Mental Health</b></p> <ul style="list-style-type: none"> <li>▪ Case Management / Service Coordination (CMC, HowardCenter, NCSS, RMHS, UCS).</li> <li>▪ Outpatient Treatment (CMC, HowrdCenter, NCSS, RMHS, UCS)</li> </ul> <p><i>Note: CARF has specific population standards for programs serving children – DAs can also apply to have their Children’s services designated as well, for the same programs named above.</i></p>	<p><b>Emergency Services</b></p> <ul style="list-style-type: none"> <li>▪ Crisis Intervention (CMC, HowardCenter, NCSS, RMHS, UCS)</li> <li>▪ Crisis Stabilization (HowardCenter, UCS)</li> </ul>
<p><b>Substance Abuse Services</b></p> <ul style="list-style-type: none"> <li>▪ Addictions Pharmacotherapy has “Specific Population Standards” (CMC, HowardCenter, UCS)</li> </ul>	<p><b>Developmental Services</b></p> <ul style="list-style-type: none"> <li>▪ Community Housing (RMHS, UCS)</li> <li>▪ Community Integration (NCSS, RMHS, UCS)</li> <li>▪ Community Service Coordination (UCS)</li> <li>▪ Family Services (RMHS)</li> <li>▪ Host Family Services (RMHS, UCS)</li> <li>▪ Supported Living (UCS)</li> </ul>
<p><b>Employment Services</b></p> <ul style="list-style-type: none"> <li>▪ Employee Development Services (NCSS)</li> <li>▪ Organizational Employment Services (RMHS)</li> <li>▪ Job Development (NCSS, RMHS, UCS)</li> <li>▪ Job Supports (NCSS, RMHS, UCS)</li> <li>▪ Job-Site Training (NCSS, RMHS, UCS)</li> </ul>	

### Fee Schedule:

CARF charges each organization seeking CARF designation an Intent to Survey fee of \$900. In addition, CARF charges the facility \$1,300 per surveyor, per day. Since CARF determines the amount of time and the number of reviewers needed to complete a site survey, there is no “standard” cost associated with CARF designation. At UCS Bennington, for example, CARF usually utilizes four surveyors over a period of three days. CARFs survey fees, therefore,

would be \$16,500 per accreditation. In 2005, HowardCenter paid \$21,600 for their accreditation survey, which included six surveyors for four days (using the current fee schedule, this would cost \$32,100).

### **Joint Commission Accreditation**

Health Care & Rehabilitation Services of Southern Vermont has chosen to pursue JCAHO accreditation to demonstrate its commitment to quality services.

HCRS has accredited the following services:

- Behavioral Health (Non 24 Hour Care – Adult / Child / Youth)
- Case Management (Non 24 Hour Care – Adult / Child / Youth)
- Chemical Dependency (Non 24 Hour Care – Adult / Child / Youth)
- In-Home Behavioral Health Services (Non 24 Hour Care – Adult / Child / Youth)

While there are a multitude of components that comprise CARF designation, the one area that seems the most appropriate for State recognition is the “Business Practices” and “General Program Standards” section. State oversight in this area is similarly focused on the policies in place at the Designated Agencies, and there is a significantly reduced need for comprehensive case file review to ensure compliance. As a pilot, the State should begin a process of reducing redundancy in its designation standards for agencies that have chosen this broad-level accreditation. There are certain standards that are specific to DA operation and organization structure that will likely never be replicated by CARF (e.g. Board composition, Medicaid certification) and for these the State would need to continue its own audits to ensure compliance; however, standards that focus on areas that are generally applicable to mental health facilities are comparable between the State standards and CARF standards and present an opportunity for the State to reduce its own activities while ensuring that the DAs are meeting their obligations to the State.

CARF designation can last for either one or three years, while State designation activities occur once every four years. According to the CARF, a one year accreditation shows that “the organization satisfies each of the CARF Accreditation Conditions and demonstrates conformance to many of the standards. Although there are significant areas of deficiency in relation to the standards, there is evidence of the organization’s capability to correct the deficiencies and commitment to progress toward their correction” whereas three-year accreditation “demonstrates substantial conformance...” As such, to initiate a pilot of deeming designation status to CARF-accredited facilities, only three-year designation should be considered sufficiently compliant to warrant a reduction in State oversight.

Given the different timelines used by the State and CARF, Designated Agencies that had three-year CARF accreditation at the time of their next Designation review would be subject to an abridged process that takes into account State of Vermont / DA specific standards that are not enumerated by CARF.<sup>2</sup> If the Designated Agency shows compliance with the reduced designation review, the full-review would be waived until the next four year designation cycle. A DA which then passes the full designation review would then only be subject to the reduced State review in the future, assuming that it continues to achieve three-year CARF accreditation and maintains compliance with the abridged review. However, if the agency chooses to not continue pursuing CARF accreditation, or is granted less than a three-year accreditation certificate, the agency immediately becomes subject to a full State designation review and will be subject to full State reviews on an ongoing basis. Only after demonstrating compliance during two full State reviews and maintaining three-year CARF accreditation for (at least) six years would a DA be able to apply for the reduced State review.

While at this time it is not recommended that the State deem status in lieu of specific program reviews, there is an opportunity for the State to amend its own requirements, using CARF standards as guidelines, in a way that will improve the quality of its own reviews. One of the main criticisms of the State reviews is that the standards are not sufficiently described. This is leading the DAs to instruct their staff to “over-document” in an attempt to ensure standard

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<sup>2</sup> It should be noted that the CARF requires facilities to ensure compliance with all State and local requirements and requires facility commitment to compliance. However, CARF does not specifically review each State (or local) requirement to ensure compliance, necessitating continued State oversight.

compliance, necessarily increasing the amount of time required to complete documentation activities.

Through its review of standards, PHPG agrees that the State’s standards are sufficiently vague and that this vagueness places the onus of interpretation on the DAs. To aid the DAs in more fully understanding the requirements, the State should begin to revise its standards so that each standard is clear and understandable. This can be accomplished by adding definitions for words that can be open to interpretation, as well as adding instructions describing the intent of the standard. This clarity would allow the DAs to develop internal documentation policies that comply with the standards while not requiring the direct services staff to over-document. In addition, this provides for a more transparent review process, removing the potential for State reviewers to interpret standards in different ways.

The CARF manual provides a sufficient organizational structure that could be replicated in order to carry-out this recommendation. According to the manual, “The organization is expected to demonstrate conformance to the **applicable standards** [emphasis in original] during the site survey so that the survey team will be able to determine the organization’s overall level of conformance...” However, instead of merely presenting the applicable standard (as the State currently does), CARF standards are supplemented with:

- An Intent Statement
- Examples
- A Glossary

These clarifying statements allow the facility to understand more completely what is required to meet the standard, and allows the survey team to provide a uniform review mechanism. By implementing a similar framework in its own standards, the State would address the valid frustration that the DAs describe when attempting to maintain compliance with State standards.

In 2004, the State of Vermont published a guide to aid the agencies as well as the reviewers in interpreting Designation rules. However, this guide only covers the Designation process, not program reviews. Additionally, DA administrators still reported that the rules are too vague and there is too much room for interpretation among auditors. The following exhibit (Exhibit 4.2) demonstrates the difference in formats between the State’s guide and the CARF manual as it relates to Information Management and security.

**Exhibit 4.2: Comparison of Interpretative Guides for IT**

State of Vermont Administrative Interpretive Guide
<ul style="list-style-type: none"> <li>▪ Document appropriate system access controls.</li> <li>▪ Document membership in a private network or otherwise provide evidence for secure and/or encrypted transmission to external entities.</li> </ul>
CARF Manual
<p><b>Standard</b>            Appropriate safeguards of records include:</p> <ol style="list-style-type: none"> <li>a. The organization of records in a systemic fashion</li> <li>b. The designation of one or more staff members with responsibility for:               <ol style="list-style-type: none"> <li>(1) Controlling the records</li> </ol> </li> </ol>

- (2) Implementing the policies and procedures pertaining to the records
- c. Procedures for ensuring that only authorized personnel have access to:
  - (1) Records of the persons served
  - (2) Administrative records
  - (3) Electronically generated documents (including facsimiles or electronic mail)
- d. Procedures for:
  - (1) Protecting confidential information
  - (2) Securing all records
  - (3) Reasonably protecting them against fire, water damage, or other hazards
- e. A routine procedure to be followed for the backup of electronic records
- f. A policy for the retention and destruction of records that is implemented and:
  - (1) Identifies procedures for paper and/or electronic records
  - (2) Includes a provision for stopping the destruction of records in the event that a legal process is initiated against the organization
  - (3) Complies with applicable state, federal, or provincial laws.

**Intent Statement**

Organizations in the United States are encouraged to review current provisions of HIPPA and the Freedom of Information and Protection of Personal Information Act (FOIPA) for potential impact on the maintenance and transmission of protected health information. Of particular note are provisions related to information security, privacy, and electronic data interchange.

12.c(3) The organization takes measures to ensure that electronic health information that includes consumer identifiable information is secure and that confidentiality is maintained.

12.d. Records are not required to be kept in a single location. However, if they are kept in several locations, they may be controlled from a central location by a designated staff member, with the location of each file readily identified. If records are stored in locations other than the central location, the safeguards for each of these locations may be similar to the safeguards for the central location. Safeguards such as reasonable protection against fire, water damage, and other hazards do not need to be described in writing.

12.e. Backup of electronic records occurs regularly in relation to the organization’s use of electronic systems, including security in case of a fire or other destruction.

**Examples**

Safeguards can include:

- Limited access
- Storage under lock (in a locking drawer or a room that is locked when unattended)
- Storage in a portable case that can be locked. This is particularly necessary for case managers and other behavioral health practitioners who use records in the field, while conducting home visits, or at satellite offices used for periodic service delivery.
- Appropriate protection against fire, water damage, and theft. This is particularly important if records are not returned to the central records area for overnight storage.
- Fireproof file cabinets are not required; however, organizations without complete fire protection of records may choose to provide off-site storage of duplicated critical data.
- Backup of electronic systems may occur to a server that is located in another building, to a network system, or to a portable disk or other format that is taken off site.

Implementation Summary	
<b>Recommendation</b>	<p>Allow DAs who are CARF accredited in Business Practices and General Program standards an opportunity to receive a limited State designation audit</p> <p>Update State standards using CARF model to reduce DA and reviewer interpretation</p>
<b>Challenges for Implementation</b>	<ul style="list-style-type: none"> <li>• Determining which elements need to be</li> </ul>

<b>Implementation Summary</b>	
	<p>included in the State’s “limited” audit</p> <ul style="list-style-type: none"> <li>• Coordinating intent for current State standards</li> <li>• Promulgating changes to the DAs and ensuring consistency at reviews</li> </ul>
<b>Benefits for Implementation</b>	<ul style="list-style-type: none"> <li>• Both the State and the DAs are on the same page as to what is being monitored</li> <li>• DA clinicians will be instructed to document in compliance with State standards without feeling compelled to over-document</li> </ul>
<b>Implementation Steps</b>	<ul style="list-style-type: none"> <li>• Review current State designation audit standards and CARF standards using guide included in this report to establish which elements will no longer need to be included in the “limited” audit</li> <li>• State staff members need to begin revising current standards</li> <li>• State and DA coordination to ensure understanding of new rules</li> <li>• Changes need to be communicated to the DAs</li> <li>• Process established for the DAs to petition the State for a reduced audit by showing current CARF compliance</li> </ul>
<b>Target Start Date</b>	<ul style="list-style-type: none"> <li>• Next two years</li> </ul>

## **Recommendation 5 - Facilitate Electronic Health Record Implementation**

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The Designated Agencies, following the lead of their counterparts in the physical health sector, are in the process of implementing electronic health records to speed the flow of information among providers and provide more accurate and timely access to data. Agencies are at various places with regard to how far along each is in the implementation process. Concurrently, the Vermont State Hospital is also exploring its own options with regard to selecting a vendor.

On a systems level, PHPG concurs that selection and implementation of an electronic health record system is a necessary and important goal for each of the Designated Agencies. However, to yield the most valuable returns on the capital investment, it is recommended that a leadership structure be established to ensure that the agencies, the Vermont State Hospital, and possibly acute care providers are able to electronically communicate efficiently with each other. Additionally, it is imperative that each of the Designated Agencies is able to offer input and ultimately be responsible for selection of a system that fulfills the needs of the agency.

Implementation of an appropriate electronic health records system provides a multitude of benefits to the DAs, the State, and, most importantly, the clients served. While documentation is one of the least enjoyable aspects of a clinician's job, it is necessary – from a clinical perspective – for each client to have a file that includes his or her goals for treatment, the steps taken towards realizing those goals, and the impact of each step. A comprehensive record provides continuity of treatment should a new clinician begin providing care to a client. It also allows the DAs and the State to track whether services are being adequately rendered, and allow research into the effectiveness of treatments.

An electronic health record allows for increased realization of the above benefits of documentation. The software is developed to address the appropriate fields and data elements necessary to maintain the appropriate documentation for a particular client; it can also be programmed to provide notification to the clinician that an individual file needs to be updated: these tools provide an automated process, reducing the amount of time that a clinician needs to spend organizing and keeping track of what work remains undone. An electronic health record can treat a file as a “living” document, so when a client transfers to a different program, or if treatment needs change, only relevant portions needed to be updated, as opposed to re-creating the entire file. In addition, because data is stored in a “real-time” fashion, program managers and DA administration can create “live” reports that update to provide information as needed, as opposed to having administrative staff compile the data. When it is necessary for the DA to report data to the State, the DAs will already have the data stored electronically, eliminating the need for medical records staff to input data from a paper file that can then be transferred to the State. For any given case, these benefits yield relatively little impact; however, on a large, systems-level scale, these incremental changes yield increased time and cost savings that can be reinvested into providing quality care to clients.

The State should continue to work with all of the DAs to promulgate a common standard for file and data transmission. DAs with an existing vendor should be able to modify their current systems to support a common standard, likely HL7. While deployment of a common standard will not yield the same simplicity as a common system, the end product will be comparable,

yielding the benefits associated with increased ease of electronic communication between other providers and the State.

At the State-level, there has been discussion regarding the advantages of utilizing the Clinical Research Information System (CRIS) developed by Dartmouth as the EHR program of choice. While the research functions in this software provide extensive benefits for tracking and recommending treatment reforms, there are also drawbacks. Namely, the DAs are almost uniformly opposed to the CRIS system: they do not believe that its clinical application is as easily adaptable to their needs, which would compromise the effectiveness of an EHR. Additionally, most of the DAs have already implemented and are utilizing an electronic billing system, and the CRIS system would not tie in as seamlessly as an EHR developed by the same vendor as the billing system.

Currently, none of the DAs have converted entirely to an electronic system; some, however, are close and are in the process of going live as a pilot with a limited number of staff members using the EHR. There are a number of barriers that are limiting the DAs in their ability to convert to electronic systems. One of the main barriers involves the capital and resource investment necessary to convert away from a paper system. A successful conversion requires:

- Selecting an EHR vendor;
- Reviewing all paper documents and creating electronic versions that capture the same data;
- Purchasing the hardware necessary to support EHR client users;
- Purchasing the hardware necessary for EHR clients (the end-user); and
- The lack of comprehensive wireless coverage in Vermont reduces the ability of staff members to complete information in the field then transmit it electronically back to the agency

Each of these barriers needs to be addressed prior to a successful conversion to an electronic documentation structure. In addition, with the potential changes for reporting and documentation requirements as a result of this study and subsequent workgroups, it is advisable to finalize the new requirements prior to venturing further into a conversion.

<b>Implementation Summary</b>	
<b>Recommendation</b>	The State needs to facilitate a transition to an electronic health record
<b>Challenges for Implementation</b>	<ul style="list-style-type: none"> <li>• Process needs to be informed by impact of other recommendations</li> <li>• DAs need to work together to align systems so that each DA can communicate with each other and the State</li> <li>• Determination of the appropriate vendor</li> <li>• Establish the fiscal resources necessary to complete a transition</li> </ul>
<b>Benefits for Implementation</b>	<ul style="list-style-type: none"> <li>• Reduce amount of time DA clinicians spend on paperwork</li> <li>• Provide real-time data to the DAs and the State</li> <li>• Data transmission simplified through common standards</li> </ul>
<b>Implementation Steps</b>	<ul style="list-style-type: none"> <li>• Determining an appropriate vendor for each DA</li> <li>• Development of a common transmission standard</li> <li>• Begin reviewing current documents for conversion to an electronic format</li> <li>• Purchasing necessary software and hardware</li> </ul>
<b>Target Start Date</b>	<ul style="list-style-type: none"> <li>• While informal meetings can begin immediately, substantive work should not commence until January 1, 2009, allowing the transition to be informed by the work completed in implementing other recommendations.</li> </ul>

## **Recommendation 6 - Establish Priority System for Developmental Services Critical Incident Reports**

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The Department of Aging and Independent Living has committed to working to ensure that all individuals, when possible, are able to reside and receive services in the community – a markedly more humane approach than institutionalization. In helping to ensure both the safety and security of the individual receiving services, as well as the community as whole, the Department has instituted a process to receive reports of critical incidents.

In December, 2002, the Division of Developmental Services published a series of guidelines stipulating what events should be deemed critical enough to report. These included:

- Death;
- Restraint;
- Injury, Medication Error, and Hospitalization;
- Missing Person;
- Suspected Abuse, Neglect, or Exploitation;
- Fire, Theft, or Destruction of Property;
- Criminal Acts; and
- Other Unusual or Significant Incidents

More recently, however, there is concern, at the State level, that there is an over-reporting of critical incidents. While PHPG was unable to determine the root cause of this perception, it did identify possible factors:

- Incidents are being defined by clinicians and DAs as critical even though the incident does not meet the reporting requirements established by DAIL;
- There is a misinterpretation of the guidelines, leading to incidents being classified as critical at the local level even though the State staff did not intend for the incident to be classified as such; or
- Incidents being reported as critical do meet the reporting guidelines, but there is not sufficient staff at DAIL reviewing critical incidents, leading existing staff members to feel overburdened.

While PHPG is unable to make recommendations regarding the number of critical incident reports received by DAIL, it does recommend that the State work with the DAs/SSAs to develop a priority ranking system to ensure that the most critical incidents receive immediate attention at the State.

Once the system is established, the State then needs to communicate the priority ranking system to the program managers and corporate compliance managers, perhaps during a monthly meeting, and then respond to different questions raised. After the DAs have received instructions regarding how to prioritize different critical incident reports that are received from the field, the responsibility rests jointly with the local program manager and corporate compliance manager to determine the ranking prior to submission to the State.

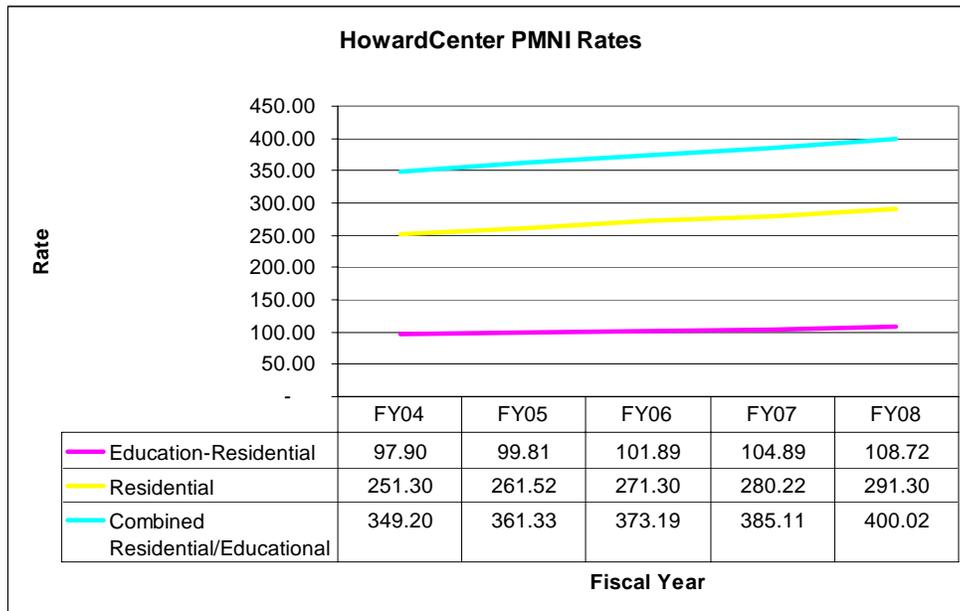
PHPG recognizes that this recommendation creates more work for both the State (in terms of developing the system) and for the staff members at the DAs (who determine the severity of each incident), though it does provide a short-term solution to address the problem that the State is currently unable to respond to all critical incidents in a timely fashion by establishing, prior to reaching the State, a system to identify incidents which require immediate response.

<b>Implementation Summary</b>	
<b>Recommendation</b>	Develop a priority system to allow State staff to respond to the most critical incidents immediately.
<b>Challenges for Implementation</b>	<ul style="list-style-type: none"> <li>• None</li> </ul>
<b>Benefits for Implementation</b>	<ul style="list-style-type: none"> <li>• Critical incidents will be reviewed in order of priority</li> </ul>
<b>Implementation Steps</b>	<ul style="list-style-type: none"> <li>• Determine what type of ranking system will be utilized</li> <li>• Develop standards for appropriate classification</li> <li>• Promulgate standards to the DAs</li> </ul>
<b>Target Start Date</b>	<ul style="list-style-type: none"> <li>• April 1, 2008 – Planning</li> <li>• June 1, 2008 – Go Live</li> </ul>

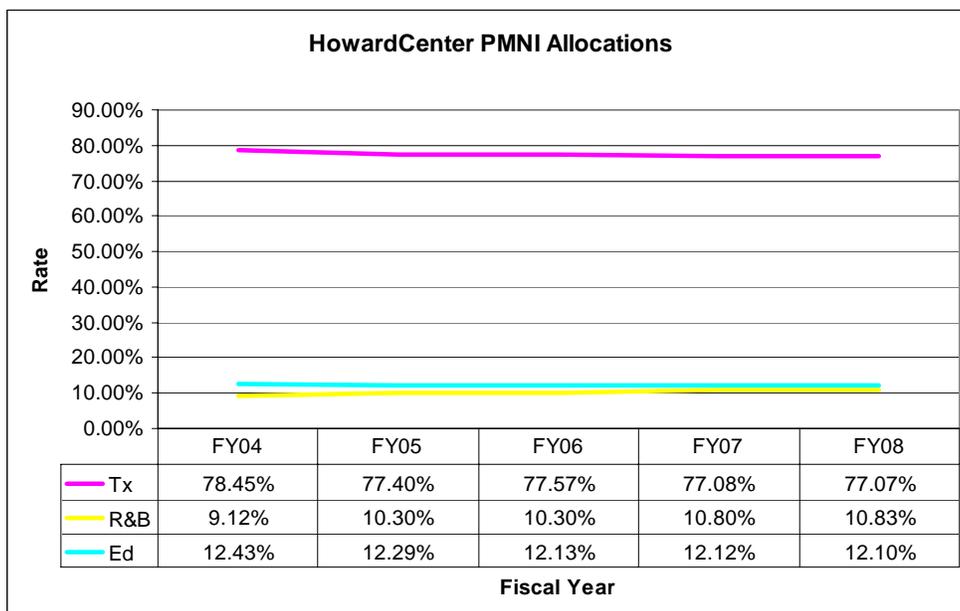
## Recommendation 7 – Revise PNMI Rate Setting and Budgeting Processes

Each year, the Departments of Mental Health (DMH), Children and Families (DCF), and Education, the Division of Rate Setting, and providers engage in a process to set rates for private, non-medical institutions. This is often a multi-day process that entails line-by-line negotiation for each item under review. After reviewing a five-year history of the rates for one large provider, there is modest annual inflation and only minimal fluctuation in the contributions of each department. Exhibit 7.1 shows the rates for PNMI institutions operated by HowardCenter; Exhibit 7.2 shows the allocations by payor.

**Exhibit 7.1: HowardCenter PNMI Rates**



**Exhibit 7.2: HowardCenter PNMI Allocations**



In addition to the relatively stable percentage allocations among various funding sources, anecdotal evidence also show that the actual rates have relatively stable percent increases. Using historical rate data from HowardCenter operated facilities, from Fiscal Year 2005 through Fiscal Year 2008, the rates have grown by roughly three percent, ranging from 2.66 to 3.76 percent.

With relatively stable percentage allocations from each Department during the proceeding five-year period, PHPG proposes that during the next rate-setting exercise the allocations established remain in place for a three-year period. After the three years, the Departments can review the percent allocations to determine what, if any, issues arose from a less frequent distribution process. After the analysis, the Departments should then agree to let the revised allocations remain active for an additional period of time.

Using the historical rates as a guide, the Departments can also establish an appropriate annual inflationary increase without re-setting the rates on an annual basis. While there is no mention of determining allocations among different Departments, the Vermont Private Non-Medical Institution Rules, published by the Division of Rate Setting in August, 2003, does establish an annual rate setting process. After reviewing the legislative basis for those rules, there does not appear to be a legislative mandate requiring an annual rate setting process. To reduce the frequency of the rate setting process, the Agency will need to take the appropriate administrative steps to change the rules, on either a temporary or permanent basis.

<b>Implementation Summary</b>	
<b>Recommendation</b>	Allow PMNI rates and Department allocations to remain in effect for three years
<b>Challenges for Implementation</b>	<ul style="list-style-type: none"> <li>• Revising current administrative rules</li> </ul>
<b>Benefits for Implementation</b>	<ul style="list-style-type: none"> <li>• Less State and DA time needed to set rates</li> </ul>
<b>Implementation Steps</b>	<ul style="list-style-type: none"> <li>• Use historical data to inform rates going forward and provide for an appropriate inflationary adjustment</li> <li>• Determine allocations among the funding Departments</li> </ul>
<b>Target Start Date</b>	<ul style="list-style-type: none"> <li>• Next rate setting process</li> </ul>

## **Recommendation 8 - Standardize Individual Care Plans (Across Programs)**

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In a similar fashion to a program-based funding structure, when a client moves between programs, a new set of documentation standards come into play. Each program, however, requires that a clinician complete an individual care plan for each client that identifies the needs of the client, the treatment goals, and the anticipated courses of treatment to reach those goals.

PHPG recommended that AHS work with the DAs to move towards reducing the silo-based funding that is pervasive in the system in its Financial Sustainability report issued in September, 2007. An incremental step towards reaching this goal could be accomplished by creating a standardized individual care plan for all program areas that can be updated and revised, as appropriate, when a client moves between program areas. As opposed to a clinician creating a new plan each time a client transfers programs, the clinician would review the previously created plan and update and revise the appropriate sections to take into account the new treatment goals and plans for treatment.

Accomplishing this goal rests primarily with the DAs, and more specifically, with the program managers. In collaboration with the other programs, the managers would determine which sections of individual care plan remain static across program areas, and which sections are more program-centered. For example, a client's needs are unlikely to change dramatically from one day to the next, regardless of what program the client is currently receiving services from. However, the treatment plan is likely to be more program specific, as each program has a different approach for treatment. If it is determined that a client is more appropriately treated in CRT than Adult Outpatient, the CRT clinician would then only need to update the treatment approaches that are specific to CRT, as opposed to recreating the entire care plan.

An electronic health record will be useful in this situation as records are more easily updatable in electronic format than a paper copy; in a paper-based system, the clinician would, at a minimum, have to copy the sections that are still relevant from the old plan to the new and then rewrite the sections that are changing. In an EHR, the clinician would merely have to append the appropriate sections with the new information.

Ideally, this is a process that should occur not just within the DAs, but across the different agencies. Creating a standardized plan template that is used statewide would allow for more fluid treatment if the client moves or otherwise changes DAs. The clinicians at the new DA would be better able to understand the treatment modalities used at the previous facility and provide a better bridge and more constant treatment than if client was viewed as a new client to the system.

In addition to standardizing the treatment plans, PHPG learned that each DA, and sometimes each program within a DA, adheres to a different standard for how often progress or case notes are recorded – daily, weekly, or monthly. In order to improve the quality of the notes, and not simply require the writing of notes to comply with the standard, PHPG proposes that at the same time the Individual Care plans are standardized, the DAs agree to allow the clinician to determine the appropriate documentation intervals depending on the needs of the client. This decision, which would likely be reviewed or approved by a program manager, would be

incorporated into the care plan and would allow for documentation that is necessary for an appropriate clinical record to be kept.

<b>Implementation Summary</b>	
<b>Recommendation</b>	<p>All clients receive a common Individual Care plan that becomes a “living” document and is updated only as needed and relevant</p> <p>The progress and case notes would be divided into two separate requirements – progress notes would provide an overview of the services rendered during a session and case notes would provide information regarding the impact the treatment is having. Progress notes would be written after each session; the frequency of case notes would be determined by the clinician for each client</p>
<b>Challenges for Implementation</b>	<ul style="list-style-type: none"> <li>• Coordinating among various programs, which often have different modalities of treatment</li> </ul>
<b>Benefits for Implementation</b>	<ul style="list-style-type: none"> <li>• Improved care for clients</li> <li>• Reduces clinicians’ time spent developing a new care plan</li> </ul>
<b>Implementation Steps</b>	<ul style="list-style-type: none"> <li>• Program managers meet to determine which elements can remain static across programs, which need to be updated</li> <li>• Revise current documents provided to clinicians’ to comply with new standards</li> <li>• Staff training</li> </ul>
<b>Target Start Date</b>	<ul style="list-style-type: none"> <li>• October 1, 2008</li> </ul>

## **Appendix A: Implementation Plan - Transition Behavioral Health Programs to a Case Rate System**

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A case rate system integrates and aligns with many of the recommendations contained in our Follow-Up Study of the Sustainability of the Vermont Designated Agency Provider System, published in September, 2007. A case rate system could serve as a vehicle for reforming the delivery of behavioral healthcare in the State. Potential benefits include:

- ✓ Increased focus on the quality and appropriateness of services provided as opposed to counting units of service;
- ✓ Reduced administrative time related to fee-for-service claiming activities;
- ✓ Additional flexibility in the types of services that can be provided to meet individual needs;
- ✓ Reduced Medicaid claiming audit risk;
- ✓ Improved cash flow management and revenue predictability;
- ✓ Increased focus on family-centered care and the individual needs of each client; and
- ✓ Opportunity to reduce impact of silo-based funding structure.

The process for transitioning other behavioral health programs (Children's Mental Health, Adult Outpatient, and Substance Abuse programs, include the following implementation areas:

- ✓ Setting case rates;
- ✓ Determining documentation needs for Medicaid claiming;
- ✓ Defining State oversight and quality assurance activities; and
- ✓ Implementing Medicaid systems changes.

Based on discussions there was agreement that Children's Mental Health was the best program to begin the transition. The remainder of this section details the specific considerations for each of the four main focus areas described above, the tasks that need to be completed, and a timeline for project implementation.

### Setting Case Rates

Under a case rate system, the DAs would receive a monthly capitated payment for each Medicaid-eligible client that they serve. The first step is to designate a work group, made up of State staff and DA representatives, to address a number of key decisions.

These decisions include:

- ✓ Development of appropriate rate cells for reimbursing clients with different service needs;
- ✓ Determination of what services should be included in the case rate (e.g. inpatient hospital and residential services);
- ✓ Determination of what funding sources will support the case rate (e.g. local schools continuing to provide a match); and

- ✓ Determine a process for assigning new clients to a rate cell, as well as a process for approving changes to an existing client’s rate cell, should his or her service needs change.

The workgroup’s decisions need to be supported through the analysis of historical utilization and enrollment data and development of multiple rate models. Rate modeling activities need to include an analysis of the impact of each model on the State’s budget and each DA’s revenues. Once the first year rates are set, a process needs to be instituted for adjustment and trending of the rates going forward.

### Determining Documentation Needs for Medicaid Claiming

While a case rate system would reduce the documentation burden inherent in a fee-for-service structure, it is still necessary for the providers to submit Medicaid claims for reimbursement. It is necessary to maintain appropriate data within the State’s Medicaid Management Information System (MMIS) for financial management and MCO ratesetting purposes. Exhibit A.1 details the data elements that need to be included in each claim submitted.

#### **Exhibit A.1: Data Elements Necessary for Case Rate Medicaid Claiming<sup>3</sup>**

Minimum Necessary Claims Data
Medicaid ID Number
Patient’s Name
Diagnosis Code(s)
Date(s) of Service
Procedure Codes – each rate cell would be assigned a procedure code
Charges
Days or Service Units
Provider ID Number
Billing Provider NPI

In addition to submitting Medicaid claims to the Fiscal Agent, the DAs would continue to report client data to the Department of Mental Health through the MSR system. This data would continue to be necessary for the State to track and monitor clients as they move through the system, monitor utilization rates, and support the State’s oversight and quality assurance activities.

### State Oversight and Quality Assurance Activities

While a case rate reimbursement structure alleviates the need for the State to focus on reconciling fee-for-service bills with medical records, it is necessary for the State to ensure that clients receive quality care and clinically-appropriate services. Primary oversight will occur through continuation of the program reviews that occur every other year. In conjunction with Recommendation 8 (which details a process for standardizing individual care plans and

<sup>3</sup> The list above is under OVHA/EDS review: a small number of additional data elements may be considered essential for a valid claim.

documentation needs that are specific to the client served) the State will continue to engage in a case-file review to ensure that the clinician has appropriately documented the needs of the client, the types of services that are being provided, and the impact of those services through the progress and case notes.

In addition to the case file reviews, the State would continue to administer client satisfaction surveys and meet with clients, family members, and clinicians to ensure satisfaction with the services provided. The State and DAs could work together to define a basic set of performance measures to facilitate ongoing program monitoring. Performance measures would be identified to monitor the following:

- ✓ Availability and timeliness of services;
- ✓ Effectiveness of services;
- ✓ Safety; and
- ✓ Culturally sensitive service delivery.

An important role for the State is to ensure that clients continue to receive an appropriate level of services. Unlike a fee-for-service system, where a provider receives payment for each unit of service billed, a case rate system allows for reimbursement regardless of the number of units provided, creating an incentive for providers to minimize service delivery. A fundamental consideration of both the case file reviews that occur during the program review, and the performance measures, is to ensure that clients continue to receive a sufficient level of appropriate services to meet their needs and work towards recovery goals.

### MMIS Changes

The Department of Mental Health would need to work with OVHA and the Medicaid Fiscal Agent, EDS, to make appropriate MMIS modifications to support the case rate system.

Exhibit A.2, on the following pages, provides a timeline for transitioning Children's Mental Health to a case rate system. The tasks identified can be subsequently used to transition Adult Mental Health and Substance Abuse services.

**Exhibit A.2: Timeline for Transitioning Children’s Mental Health to a Case Rate System**

Task	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7
<b>1. Setting Case Rates</b>	Green						
1.1 Assign workgroup to oversee conversion process	Yellow						
1.2 Develop appropriate rate cells for reimbursing clients with different service needs		Yellow					
1.3 Determination of which services should be included in the case rate							
1.4 Determination of which funding sources will be included in the case rate							
1.5 Determine process for assigning clients to a rate cell							
1.6 Determine process for moving clients between rate cells							
1.7 Develop dataset for use in establish case rates for each rate cell							
1.8 Establish member months for base period			Yellow				
1.9 Analyze historical Medicaid claims and develop completion estimates				Yellow			
1.10 Establish PMPM baseline estimates							
1.11 Establish capitation rates							
1.12 Conduct modeling activities to determine impact on State and DAs							
1.13 Modify rates as needed, based on modeling activities							
1.14 Develop process for adjusting and trending rates							
1.15a Possible factors that may impact rates include: Medicaid program changes not reflected in historical data Copayments/Coinsurance Third-party liability Claims lag Reinsurance offsets Medical cost/utilization trend factors							
1.16 Develop case rate modifiers for high use clients				Yellow			
1.17 Meet with interested parties to present and discuss ratesetting process and data release							
<b>2. Determine Documentation Needs for Medicaid Claiming</b>				Green			
2.1 Determine what data to include in Medicaid claims to Fiscal Agent				Yellow			
2.2 Determine encounter data for reporting through MSR							
<b>3. Revise State Oversight and Quality Assurance Activities</b>					Green	Green	
3.1 Determine what changes need to be made to program reviews					Yellow	Yellow	
3.2 Define performance measures							
<b>4. MMIS Changes</b>							Green
4.1 State needs to work with OVHA and Fiscal Agent to make changes to the claiming system to support case rate billing							Yellow
4.2 State needs to modify MSR to support encounter data needs							Yellow

## **Appendix B: Implementation Plan - Transition Emergency Services to a Capacity-Based System**

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As opposed to the other services provided by the DAs, Emergency Services provides 24/7 crisis support to all members of the community. Clients may or may not be receiving services on an ongoing basis from the DA, and attempting to reimburse ES services on a fee-for-service basis is flawed in that regardless of service utilization, the DA is still expected to maintain appropriate coverage at all times.

While similar in some aspects to the case rate system that is being recommended for the other Mental Health programs, it is necessary for the State to support the actual costs of the DAs in maintaining the appropriate coverage to continue operation of the ES program. In a performance-based system, the State would work with the DAs to develop the appropriate criteria necessary to ensure that Emergency Services are available on a statewide basis 24/7. Once the minimum necessary services and staffing are developed, the DAs and the State need to develop a grant-based funding structure that supports the DAs in operating the ES program.

The size of the grant will be based on the historic utilization of ES services in the geographic catchment areas served by the DAs. There are two approaches which can be utilized in a performance-based contract schema. In one model, the DAs would be provided with a base grant, and upon successfully completing the performance measures in the contract, would be eligible to receive an enhanced rate. In the other, a majority of the funding is provided upfront to the DAs, and at the end of each fiscal quarter, the DAs would submit the appropriate encounter data to support the performance measures developed at the beginning of the transition. If the DAs provide data which shows they provided the services, and met their performance goals, they would receive the remainder of the funding. If utilization deviates by greater than 10 percent from the expected utilization, a process needs to be developed to reimburse the DAs at higher level to support the additional clients; if a lower level of services is provided, the DAs would not receive the entire holdback.

Exhibit B.1, on the following pages, provides a timeline for this transition.

**Exhibit B.1: Timeline for Transitioning ES to a Performance-Based Contract**

	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6
<b>Task</b>						
<b>1. Establish Performance-Based Emergency Services Contract</b>						
1.1 Establish workgroup of State staff and DA representatives services	Yellow					
1.2 Determine what services should be included in the grant		Yellow				
1.3 Determine what funding sources will be utilized						
1.4 Collect historic Medicaid claims for each DA's ES program		Yellow				
1.5 Establish approximate cost for provision of ES services DAs			Yellow	Yellow		
1.8 Determine if a hold-back or enhanced rate model will be utilized			Yellow	Yellow		
1.9 Determine process for transitioning to a performance-based contract			Yellow	Yellow		
<b>2. Determine Documentation Needs for Medicaid Claiming</b>						
2.1 Determine what data to include in Medicaid claims to Fiscal Agent				Yellow		
2.2 Determine encounter data for reporting through MSR				Yellow		
<b>3. Revise State Oversight and Quality Assurance Activities</b>						
3.1 Determine what changes need to be made to program reviews					Yellow	
3.2 Define performance measures					Yellow	
<b>4. MMIS Changes</b>						
4.1 State needs to work with OVHA and Fiscal Agent to make changes						Yellow
4.2 State needs to modify MSR to support encounter data needs						Yellow

## **Appendix C – MSR Data Requirements**

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The following table shows the current MSR data elements that are currently collected by the State. In May, 2007, AHS proposed suspension of certain elements that are no longer required. Additional notations are made regarding what information is required for a Medicaid fee-for-service claim or for encounter data. In addition, a column is included for elements that are required for SAMHSA Block Grant compliance.

Columns	Column Name	Medicaid FFS	Medicaid Encounter	Proposed Suspension	SAMHSA Reporting	AHS Additional Notes
1	Record identifier					
2-10	Client ID	x	x			AHS, VDH and Dail proposes a work group be formed to create 1 unique ID process (SSN, name fragments, etc.) throughout the system - All Medicaid recipients need to be identifiable and the state must be able to link MSR information to other Medicaid databases. Currently, it appears that ADAP, MH and DS have separate unique ID processes.
11-12	Provider ID	x	x			To accurately identify/process data
13-14	Primary program assignment	x	x			To accurately identify/process data
15-20	Date of Birth				BLOCK GRANT	National Outcomes Measurement System (NOMS) - required to sustain ADAP federal funds. Also used in Probabilistic Population Estimates (PPE) to match sensitive data base information in a non-identifiable manner
21	Gender				BLOCK GRANT	NOMS & PPE
22-26	Gross annual family income at intake				BLOCK GRANT	Federal Report for ADAP
27-28	Client payment responsibility			SUSPEND		
29	Individuals on income				BLOCK GRANT	Federal Report for ADAP
30-31	Responsible for fee: primary					Monitoring: System of Care Plan
32-33	Responsible for fee: secondary					Monitoring: System of Care Plan
34-35	Responsible for fee: tertiary					Monitoring: System of Care Plan
36-40	Diagnosis DSM-IV Axis I					AHS, VDH and DAIL proposes the creation of a work group to identify the training and implementation steps needed to move all service and reporting to ICD-9 codes. (Commercial and Medicaid billing already requires the use of ICD-9).
41	Marital/family problem			SUSPEND		
42	Social/interpersonal problem			SUSPEND		
43	Coping problem			SUSPEND		
44	Medical somatic problem					
45	Depression or mood disorder			SUSPEND		
46	Attempt, threat or danger of suicide					

x= required o=optional

Columns	Column Name	Medicaid FFS	Medicaid Encounter	Proposed Suspension	SAMHSA Reporting	AHS Additional Notes
47	Alcohol				BLOCK GRANT	Required for identification of co-occurring disorders and grant reporting
48	Drugs				BLOCK GRANT	Required for identification of co-occurring disorders and grant reporting
49	Eating disorder			SUSPEND		
50	Thought disorder			SUSPEND		
51	Involvement w/ criminal justice					Used in reporting, case load overlap with DOC and ADAP
52	Abuse/assault/Rape victim					
53	Runaway behavior			SUSPEND		VCRHYP Database is established statewide; the DA's that serve as part of that network report runaway and other data into that vehicle
54	Condition on termination			SUSPEND		
55-60	Begin date of report					To accurately identify/process data
61-66	End date of report					To accurately identify/process data
67-68	C & E recipient type					Used for CUPS program payments and reporting
69-72	Date of "income at intake"			SUSPEND		
73-78	Date case opened					Billing and LOS indicator
1-6	Date case closed					Billing and LOS indicator
7-11	Diagnosis DSM-IV Axis I Secondary	x	x			AHS, VDH and DAIL proposes the creation of a work group to identify the training and implementation steps needed to move all service and reporting to ICD-9 codes. (Commercial and Medicaid billing already requires the use of ICD-9).
12-16	Diagnosis DSM-IV Axis II Primary	x	x			
17-21	Diagnosis DSM-IV Axis II Secondary					
25-26	Diagnosis DSM-IV Axis 5: current level of functioning					
30-31	Diagnosis DSM-IV Axis 5: level of functioning at admission					
32	Client status			SUSPEND		
33-35	Name fragment			SUSPEND		
36-40	Statewide MH/DS client identifier			SUSPEND		
41	Previous tx by MH organization of any kind			SUSPEND		
42	Previous tx by this organization			SUSPEND		
44	Inpatient					Service profiles and encounter data
45	Residential					Service profiles and encounter data
46	Partial day					Service profiles and encounter data
47	Outpatient					Service profiles and encounter data

x= required o=optional

Columns	Column Name	Medicaid FFS	Medicaid Encounter	Proposed Suspension	SAMHSA Reporting	AHS Additional Notes
48	Case management					Service profiles and encounter data
49	Emergency					Service profiles and encounter data
50	Race				BLOCK GRANT	NOMS: Needs review to ensure the definitions represent the most up to date federal requirements across AHS & ADAP
50	Hispanic origin				BLOCK GRANT	NOMS - Federal Reporting
52	Marital status					Used in reports to identify categories involving "child of single parent", service recipient profile information for primary household wage earners for System of Care Plans; legal status relational indicator not identified elsewhere in MSR
53-57	Zip code of residence at admission to this agency				BLOCK GRANT	NOMS - Federal Reporting
58	Veteran status					
59	Legal status					Categories and Definitions need updating
60-61	Source of referral					Categories and Definitions need updating
62-69	Residential arrangement at intake				BLOCK GRANT	NOMS [ADAP re homelessness & MH block grant] - Federal Reporting
64	Living arrangement at intake				BLOCK GRANT	NOMS [ADAP re dependency] - Federal Reporting
65	SSI eligibility at intake			SUSPEND		
66	Discontinuation status				BLOCK GRANT	NOMS [ADAP] - Federal Reporting
67-68	Referral upon discontinuation			SUSPEND		
69-73	Current primary therapist or cm			SUSPEND		
74-78	Zip code of current residence					To track accessibility and penetration of DA services into the catchment area. Used by ADAP to track update info
79-80	Current residential arrangement				BLOCK GRANT	ADAP - Federal Reporting
1	Current living arrangement				BLOCK GRANT	ADAP - Federal Reporting
2	Current SSI eligibility			SUSPEND		
3-7	Current gross annual family income				BLOCK GRANT	NOMS - Federal Reporting

x= required o=optional

Columns	Column Name	Medicaid FFS	Medicaid Encounter	Proposed Suspension	SAMHSA Reporting	AHS Additional Notes
8-13	Date of most recent review					Time stamp for data updates and ensure federal information up to date and reported
14	ADAP program of service					Needs to be reviewed and updated
15-20	ADAP client identifier					AHS, VDH and Dail proposes a work group be formed to create 1 unique ID process (SSN, name fragments, etc.) throughout the system - All Medicaid recipients need to be identifiable and the state must be able to link MSR information to other Medicaid databases. Currently, it appears that ADAP, MH and DS have separate unique ID processes.
21	Significant other					ADAP - Federal Reporting
22-23	# of prior admissions to tx					ADAP - Federal Reporting
24-25	Primary problem at intake					ADAP - Federal Reporting
26-27	Secondary problem at intake				BLOCK GRANT	ADAP - Federal Reporting
28-29	Tertiary problem at intake				BLOCK GRANT	ADAP - Federal Reporting
30	Primary problem, usual route of administration at intake					ADAP
31	Secondary problem, usual route of administration at intake				BLOCK GRANT	ADAP - Federal Reporting
32	Tertiary problem, usual route of administration at intake				BLOCK GRANT	ADAP - Federal Reporting
33	Primary problem frequency of use at intake				BLOCK GRANT	ADAP - Federal Reporting
34	Secondary problem frequency of use at intake				BLOCK GRANT	ADAP - Federal Reporting
35	Tertiary problem frequency of use at intake				BLOCK GRANT	ADAP - Federal Reporting
36-37	Age of first drug use as related to the primary problem reported				BLOCK GRANT	ADAP - Federal Reporting
38-39	Age of first drug use as related to secondary problem reported				BLOCK GRANT	ADAP - Federal Reporting
40-41	Age of first drug use as related to tertiary problem reported				BLOCK GRANT	ADAP - Federal Reporting
42	Use of methadone as part of tx					ADAP - Federal Reporting
43-44	Level of education at intake				BLOCK GRANT	NOMS - Federal Reporting

x= required o=optional

Columns	Column Name	Medicaid FFS	Medicaid Encounter	Proposed Suspension	SAMHSA Reporting	AHS Additional Notes
45	Pregnant at time of admission					ADAP - Federal Reporting
46	ADAP transfer			SUSPEND		
47-48	Employment status				BLOCK GRANT	NOMS-Federal Reporting
49-54	Date of transfer to ADAP intensive outpatient					ADAP - Federal Reporting
55-60	Date of transfer to ADAP outpatient					ADAP - Federal Reporting
61-66	Date of transfer to ADAP residential					ADAP - Federal Reporting
67-72	Date of discharge from ADAP					ADAP - Federal Reporting
1	Medical health level of functioning at intake				BLOCK GRANT	NOMS - Item is Changing to # of arrests
2	Family/social LOF at intake					Changing to one item: last 4 digits of SSN
3	MH/social LOF at intake					
4	Vocational LOF at intake					
5	Legal/social LOF at intake					
6	Medical health LOF at discharge				BLOCK GRANT	
7	Family/social LOF at discharge					Changing to one item: last 4 digits of SSN
8	MH LOF at discharge					
9	Vocational LOF at discharge					
10	Legal LOF at discharge					
11-12	Level of education at discharge				BLOCK GRANT	NOMS-Federal Reporting
13-14	Employment status at discharge				BLOCK GRANT	NOMS-Federal Reporting
15-16	Primary problem at discharge				BLOCK GRANT	NOMS-Federal Reporting
17-18	Secondary problem at discharge				BLOCK GRANT	ADAP - Federal Reporting
19-20	Tertiary problem at discharge				BLOCK GRANT	ADAP - Federal Reporting
21	Primary problem usual route of administration at discharge				BLOCK GRANT	ADAP - Federal Reporting
22	Secondary problem usual route of administration at discharge				BLOCK GRANT	ADAP - Federal Reporting
23	Tertiary problem usual route of administration at discharge				BLOCK GRANT	ADAP - Federal Reporting
24	Primary problem frequency of use at discharge				BLOCK GRANT	ADAP - Federal Reporting
25	Secondary problem FOU at discharge				BLOCK GRANT	ADAP - Federal Reporting
26	Tertiary problem FOU at discharge				BLOCK GRANT	ADAP - Federal Reporting
27	Pattern & FOU at improved				BLOCK GRANT	NOMS-Federal Reporting
28	Degree of physical and/or psychological dependence improved				BLOCK GRANT	NOMS-Federal Reporting

x= required o=optional

Columns	Column Name	Medicaid FFS	Medicaid Encounter	Proposed Suspension	SAMHSA Reporting	AHS Additional Notes
29-39	First name	x	x			Required for Medicaid clients only
40	Middle initial	x	x			
41-55	Last name	x	x			
56-58	Modifier	x	x			
59-67	SSN	x	x			Required for Medicaid clients only
68-75	Date of death	o	o			Required for service and encounter data
76-79	SSN suffix	o	o			Required for everyone for constructed identifier
1-24	Street address 1	x	o			Required for Medicaid clients only
25-48	Street address 2	x	o			
49-63	City	x	o			
64-65	Statewide MH/DS client identifier	x	o			
66-74	Zip Code	x	o			
75-77	Town code	x	o			
1-27	Blank			SUSPEND		
28-36	Medicaid billing #	x	x			Links to Medicaid eligibility, encounter and claims data
37-48	Account #					DA field
49-56	Primary program assignment effective date					Required for service and encounter data
57-64	Primary program assignment end date					Required for service and encounter data
65-66	Birth year prefix					PPE
1	Record identifier					Links data
2	Action code					Validate and updates changes; time stamp
3-9	Blank			SUSPEND		
10-15	Date of service	x	x			Required for service and encounter data
16-16	Blank			SUSPEND		
20-25	Duration of service	x	x			Required for service and encounter data
26-27	Program of service	x	x			Required for service and encounter data
28-29	Cost center	o	o			Required for service and encounter data
30-32	Type of service code	x	o			Required for service and encounter data
33	Location code	x	o			Required for service and encounter data
34	Count					Used by DA's to avoid double billing (2 staff at same clinical meeting)
35	ADAP billable					ADAP - Federal Reporting
36-40	Staff ID #					Links to client and staff data

x= required o=optional

Columns	Column Name	Medicaid FFS	Medicaid Encounter	Proposed Suspension	SAMHSA Reporting	AHS Additional Notes
41-42	Total # of individuals seen in each direct family contact					Demonstrates broader impact of single client service and need for family focused care
43-49	Family ID #			SUSPEND		
50	HIV info given			SUSPEND		
51-62	Account # [same # as line 6, col. 37-48 of the client record]			SUSPEND		

## **Appendix D – Comparison of State Designation and Program Standards to CARF Standards**

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The following tables depict PHPG’s comparative analysis of State standards to CARF standards. Many DA representatives voiced frustration that there was no mechanism for the State to reduce its audit requirements when the DA has obtained CARF accreditation.

To determine whether CARF accreditation could be considered a reliable proxy for State designation and program review activities, PHPG obtained audit materials, as well as rules and regulations, to ascertain the standards that the DAs must meet in order to remain obtain re-designation or pass the program reviews. These standards were then compared to the 2007 CARF Behavioral Health Standards Manual to determine if CARF accreditation could be considered a suitable replacement for State oversight activities.

Each program area was analyzed independently, except for the Alcohol and Drug Abuse Program.<sup>4</sup> The requirements listed are those that PHPG determined to be State requirements for each area, and then an X under the CARF heading indicates that PHPG consultants believe that a corresponding CARF standard exists in such a way that there is no ambiguity as to whether CARF accreditation could be reasonably inferred to be in compliance with the corresponding State standard.

The following tables are presented:

- Appendix D.1: Designation Review Standards and CARF Standards
- Appendix D.2: Adult Mental Health Standards and CARF Standards
- Appendix D.3: Children’s Mental Health Standards and CARF Standards
- Appendix D.4: Developmental Disability Service Standards and CARF Standards

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<sup>4</sup> ADAP currently is in the process of re-writing its program standards. It currently utilizes the 2004 CARF Standards.

## Appendix D.1: Designation Review Standards and CARF Standards

Requirement	State	CARF	
	Update / Review Frequency	Required	Update / Review Frequency
Incorporated as non-profit in VT	Annually		
Federal Recognition as tax-exempt organization	Annually		
Review of Governance	Annually		
>Terms of office, selection criteria, powers and duties of Board officers	Designation Review		
>Established percentage necessary to constitute a quorum of board members for a final vote	Designation Review		
>Meeting schedules and timelines for the distribution of meeting agendas and minutes	Designation Review		
>Board members must be representative of clients served in the demographic area	Designation Review		
>51% of board members must be consumers and family members	Designation Review		
>Special provisions for Developmental Services	Designation Review		
>All agencies must employ an Executive Director	Designation Review		
Overall operations of agency promote innovation and organizational stability	Designation Review		
Agency must accommodate consumer and family involvement	Designation Review		
IT infrastructure accommodates information collection, analysis, and telecommunications functions	Designation Review	x	CARF Certification
Financial submissions with key performance indicators	Monthly		
Medicaid certified	Initial Designation		
Published fee schedule	Designation Review	x	CARF Certification
Monitoring of expenditures vs. revenues by consumer, staff, service, program area	Designation Review		
Timely notification to DS consumers of annual individualized service budget	Designation Review		
Assure all funds received from other sources as Medicaid match are state general fund dollars (CMH only)	Designation Review		
Internal procedure to track and reconcile billing under the Medicaid home and community waiver program (CMH only)	Designation Review		
Accounting practices in accordance with DDMHS standards and procedures	Designation Review		

Requirement	State	CARF	
	Update / Review Frequency	Required	Update / Review Frequency
Financial compliance and compliance audit in accordance with audit guide	Annually		
Adequate fire, personal, professional, and general liability insurance	Annually	x	CARF Certification
Efficient administrative practices	Designation Review	x	CARF Certification
Assure or assurance of provision of all services for which DDMHS contracts	Designation Review		
Services are accessible and available across the designated demographic region for eligible persons	Designation Review		
Agency actively engaged in quality improvement	Designation Review	x	CARF Certification
Institutes Utilization Review and Management program (Adult Mental Health only)	Designation Review		
Document consumer/family/caregiver participation in service/care planning	Designation Review	x	CARF Certification
Adherence to written personnel practices, policies, and procedures	Designation Review	x	CARF Certification
Identify training needs for staff, boards, and committees, and demonstrate commitment to address these needs	Designation Review	x	CARF Certification
Agency facilities are accessible to individuals with disabilities	Designation Review	x	CARF Certification
Written policy assuring the rights of all service recipients	Designation Review	x	CARF Certification
Established policies and practices assuring the rights of all service recipients	Designation Review	x	CARF Certification
Written policy and procedures for complaints and appeals	Designation Review	x	CARF Certification
Develop local system of care plan based on service needs in geographic area	Designation Review		

Appendix D.2: Adult Mental Health Standards and CARF Standards

Requirement	State	CARF	
	Update / Review Frequency	Required	Update / Review Frequency
State System of Care Plan	Annually		
Local System of Care Plan	Every Three Years		
Adult Program Review	Every Two Years	X	Dependent on Accreditation
Minimum Standards Review	Every Two Years	X	Dependent on Accreditation
Agency Designation	Every Four Years	X	Dependent on Accreditation
Medicaid Fee-for-Service Audit	Annually		
Interview: Agency Administration	Every Two Years		
Interview: Agency Staff	Every Two Years		
Interview: Clients and Families	Every Two Years		
<i>CRT Monthly Reports</i>			
Case Rate Payment Analysis			
Monthly Client Report			
Client-Level Tier Cluster and Service Report			
CRT Service Utilization by DA Cost Center			
Tier cluster, 105 Day, Unit Cost & Payment Variance			
Crisis Bed Non-DA Clients			
Medicaid Status Report			
No Service in 2 or More Years			

## Appendix D.3: Children's Mental Health Standards and CARF Standards

Requirement	State	CARF	
	Update / Review Frequency	Required	Update / Review Frequency
Discussions with Agency Administration	Program Review		
Discussions with Agency Staff	Program Review		
Discussions with stakeholders	Program Review		
<b>Record Review</b>			
Record is current, organized and legible. Entries identify client and are dated and signed by qualified provider and the information is easily accessible and understandable for the consumers	Program Review	x	CARF Certification
Releases signed yearly	Program Review	x	CARF Certification
The assessment represents thoughts, feelings, behaviors, and issues with are presented from the youth's and family's	Program Review		
Assessment is completed using information from at least 2 informants and includes information about the youth in multiple environments (home, school, and community)	Program Review		
Assessment includes the child's and family's strengths and family and community's resources	Program Review	x	CARF Certification
The assessment clearly indicates why the family and youth have asked for help and what they hope to accomplish. It is clear what they would consider a successful outcome	Program Review	x	CARF Certification
>If referred by another agency or court, it is clear what they would consider a successful outcome	Program Review		
Family context is respected, and includes information about relationships with family and friends as well as how the youth and family wishes others to be involved in treatment	Program Review	x	CARF Certification
>The assessment explores cultural, ethnic and spiritual resources and influences	Program Review		
Medical History is explored with a summary or health issues/events and allergies (including medication allergies and adverse reactions)	Program Review	x	CARF Certification
If the child receives psycho-pharmacological supports, the medications are listed with dosage, route and schedule. There is a list of medication changes, start dates and refills	Program Review	x	CARF Certification
Substances use has been explored, including type, frequency and current usage. The impact of the substance use is discussed.	Program Review	x	CARF Certification
A full substance use assessment is completed for treatment implications if indicated	Program Review	x	CARF Certification
A complete mental status assessment for child includes review and/or discussion of the following: appearance, attitude, behavior, speech, affect, eye contact, mood, thought process, hallucinations, delusions, perception, orientation, attention, memory, insight, judgment, neurovegetative symptoms, harm to self or others	Program Review		

Requirement	State	CARF	
	Update / Review Frequency	Required	Update / Review Frequency
The Axis I diagnosis is consistent with assessment findings	Program Review		
The interpretive summary includes the individual's needs and treatment preferences, strengths, and abilities demonstrating that the clinician respects the consumer's priorities and goals and draws from the client's competencies identified within the assessment	Program Review	x	CARF Certification
>The clinical formulation integrates the information gathered during the assessment	Program Review	x	CARF Certification
>Treatment recommendations are fully consistent with findings of the clinical assessment	Program Review	x	CARF Certification
Special status situations, such as imminent risk of harm, suicidal/homicidal ideation, are actively considered and integrated into care plan	Program Review	x	CARF Certification
Assessment has clinician's signature with degree and title and Doctor's signature	Program Review		
Treatment plan (IPC) is current - no more than 1 year old	Program Review		CARF Certification
The IPC is accessible and easy to understand for the consumer	Program Review	x	CARF Certification
>The IPC contains mental health goals that are consistent with the assessment and family requests. They are stated in the words of the youth and the family, cross several life domains, and reflect the family's context.	Program Review		
The objectives/interventions specify strategies and services that will clearly lead to achieving the IPC's stated mental health goal(s)	Program Review	x	CARF Certification
>The steps/objectives have realistic, measurable action steps that specify strategies across multiple environments and indicate the client's activities, staff methods, frequency and time frame needed to achieve the goals	Program Review	x	CARF Certification
>The IPC reflects the strengths and resources of the youth, family and community.	Program Review	x	CARF Certification
If there is a need reflected in the assessment and treatment plan for a proactive crisis and family support plan, it is >present >addresses crisis management considerations, dangerousness, & family/consumer education, & >utilizes family or significant others for support	Program Review	x	CARF Certification

Requirement	State	CARF	
	Update / Review Frequency	Required	Update / Review Frequency
Interagency coordination is evident in plan if appropriate	Program Review		
IPC is signed by: >The family and/or child >The appropriate credentialed clinician >The psychiatrist/doctor	Program Review		
Expected outcomes are described for each goal (i.e., how do you know when the goal is achieved?)	Program Review	x	CARF Certification
IPC reviews and updates identify the results of services provided	Program Review		
IPC reviews and updates identify any changes in goals, services, and supports needed to meet the child's and family's mental health needs	Program Review		
Progress notes are complete and consistent with objectives and goals. They provide thorough clinical documentation of >the type of intervention used and >the client's response	Program Review	x	CARF Certification
Progress notes are >individualized to the client's service interactions >and do not contain excessive repetition over time	Program Review		
The progress notes maintain focus and continuity of treatment methodology and, if goals have changed, the progress notes reflect the rationale for change	Program Review		
Notes reflect the progress being made toward goals and the outcomes of each service episode	Program Review		
Medication use or benefits are reflected as well as medical/psychiatric information changes	Program Review	x	CARF Certification
Are there any crisis screenings? (If no, review is complete)			
Crisis notes are individualized, strength-based, and include thoughts, feelings, behaviors and issues from the youth's and family's perspective	Program Review		
It is clear what the family and youth expect for stabilization, and why the family and youth are asking for help at the time of the screening	Program Review	x	CARF Certification
The screening assesses safety issues, including >harm to self or others >the youth's ability to contract for safety, and >the support system or community's ability to supervise a safety plan	Program Review	x	
Each note documents that the crisis clinician >assisted in the creation of a plan for immediate safety and >obtained information to coordinate care (releases signed if necessary)	Program Review		
If there is a full crisis assessment, it includes: >the youth's and family's strengths >resources in the school and community >other factors that may be influencing the crisis (e.g. medical, legal, or substance use/abuse issues), >medication use and allergies or adverse reactions are recorded, >a mental status assessment, and >the youth's and family's cultural context, ethnic influences and spiritual resources	Program Review	x	CARF Certification
For discharge planning and stabilization planning, there is evidence that the clinician >assisted in the creation of a proactive crisis plan or >indicated information from the screening would be forwarded to the appropriate clinician to initiate and move care forward	Program Review	x	CARF Certification

Requirement	State	CARF	
	Update / Review Frequency	Required	Update / Review Frequency
<b>Policy and Procedure Review</b>	Program Review		
Does the agency have a written policy to reimburse expenses of the Local Program Standing Committee?	Program Review		
Does the LPSC have meeting minutes?	Program Review		
Do the minutes of the LPSC show the committee working on topics relevant to their responsibilities?	Program Review		
Does this agency have written procedures to ensure transportation for consumers who could otherwise not receive services?	Program Review		
Does this agency have written procedures to inform service recipients of their rights and responsibilities at least annually?	Program Review	x	CARF Certification
Review DA's policies to assure health and safety of C/F (e.g., critical incident reports, APS & Children's Protective Services policy, duty to warn, medication information sheets)	Program Review	x	CARF Certification
Does this agency have written description of the Quality Improvement program that defines Quality Improvement structure, procedure and assigns responsibility to maintain service quality?	Program Review	x	CARF Certification
Does this agency have annual update including changes, monitor's previous year's issues and evaluates Quality Improvement program?	Program Review	x	CARF Certification
Review of written policies and procedures for complaint, grievance, and appeal process with protection (re: individual identity)	Program Review	x	CARF Certification
Review of reports summarizing grievance and dispute resolutions per policy for disseminating such information.	Program Review	x	CARF Certification
Random sample to determine existence of written position description for each employee.	Program Review	x	CARF Certification
Annual training plan or other evidence of professional development and staff training	Program Review	x	CARF Certification
Random sample of HRD records show that staff are appropriately credentialed	Program Review		
Documentation of locally measured results of crisis response program	Program Review		

Requirement	State	CARF	
	Update / Review Frequency	Required	Update / Review Frequency
Documentation of locally measured results of outreach treatment capacity	Program Review		
Documentation of locally measured clinic based treatment capacity	Program Review		
Referral information and linkages available for C/F (materials, fact sheet, interagency work)	Program Review	x	CARF Certification
DA provides education and awareness material on support groups	Program Review		
Prevention protocols are linked to a community needs assessment and the local system of care plan	Program Review		
DA interventions and prevention protocols are developed from evidence-based practice	Program Review		
Documentation in prevention protocols that referral information and linkages are present	Program Review		
Documentation that screening and referrals related to prevention, early screening are done with pediatricians, schools, child care programs, and other community agencies.	Program Review		
C/F satisfaction data analysis exists	Program Review		
Documentation of use of C/F satisfaction data in minutes of program and agency meetings	Program Review		
Documentation that C/F satisfaction data was reviewed and used for improvement	Program Review		
Data RE: C/F satisfaction show positive level or trends	Program Review		
Documented use of data in Quality Improvement plan	Program Review		
Review satisfaction feedback information (re: service quality from C/F, agency staff, and greater community, esp. distribution of data and review of meeting minutes or other documents).	Program Review		
C/F satisfaction data (re: quality of services indicating positive levels or trends)	Program Review		

## Appendix D.4: Developmental Services Standards and CARF Standards

Requirement	State	CARF	
	Update / Review Frequency	Required	Update / Review Frequency
<b>Individual Record</b>			
Emergency Fact Sheet	PRN / Annually	x	
Guardianship documentation	On File	x	
Assessments/evaluations supporting eligibility	On File	x	
Needs assessment and periodic reviews	Intake	x	
ISA and all component parts, reviews & changes	Intake / Annually	x	
Critical Incident Reports	PRN / Annually	x	
Written Doctor's orders for medications; medication administration procedures	On File	x	
Written Special Care Procedures	PRN	x	
Progress (Case) Notes	Based on ISA	x	
Home Safety & Accessibility Inspection Report*	On File	x	
Copy of Annual Physical / Vision / Dental Exam*	On File / Annual	x	At Intake
Immunization Record*	On File	x	For Children
<b>Policies on File at the Designated Agency</b>			
Rights	Intake / Annual**	x	Explained during orientation
Grievance and Appeals	Intake / Annual**	x	
Request for Change in Staff	On File		
Positive Behavior Supports	On File		
<b>Other Agency Level Documentation</b>			
Intake material describing service options	Intake	x	
Internal Quality Plan	Ongoing	x	
Local System of Care plan			
Staff Training Records for required training	On File	x	
Background check documentation	New Hire	x	
Initial Waiver Documentation	On File		

\*For individuals receiving 24-hour home support

\*\*On File and Provided to Clients

## **Appendix E – Summary of State Audits and Personnel Investment**

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As part of its study, PHPG documented the number of audits that are conducted – from the perspectives of both the State staff as well as the Designated Agencies. In addition to the number of audits conducted, PHPG asked State staff to approximate the number of personnel hours necessary to support the number of audits at the current level in terms of FTEs. The following pages reflect the responses received.

### *Adult and Children’s Mental Health*

- Program Reviews occur every two years
- Clinical Care & Minimum Standards Reviews occur every two years (Adult Mental Health only)
- Every DA is visited annually for Medicaid Fee-for-Service audits, in addition to other reviews
- 5 Total FTEs
  - 1 Director
  - 1 Child Program Chief
  - 3 QM Coordinators
- Staff hours required
  - Conducting the reviews
    - Fee-for-service Audit – 3 staff for one day, per audit
    - Clinical Care and Minimum Standards Review – 3 staff for one day
    - Program Review – 1 psychiatrist for one day and 3 to 4 staff for 2 days
  - Post Audit Activities
    - Clinical Care and Minimum Staff – 5 hours
    - Program Review – 8 hours
    - Medicaid Fee-for-Service – 3 hours

### *Developmental Disability Services*

The Developmental Disability Services Unit is responsible for monitoring quality at 10 DAs and 5 SSAs.

- Quality Service reviews occur every two years
- Designation Reviews occur concurrently with the Quality Service review once every four years

- The length of site visits range from 2-7 days, depending on the number of clients served: staff may be present for all or part of the days
- The Developmental Disability Services unit employs approximately 3.25 FTEs to carry out these review functions

### *Substance Abuse*

The Developmental Disability Services Unit is responsible for monitoring quality at 7 DAs and 41 other sites (this includes facilities that provide substance abuse treatment but are not part of the Designated Agency system).

- Program reviews occur once every year
- Visits last approximately 1 day per site and require 2 staff members
- The amount of time spent on post audit activities varies depending on if the facility is granted full or conditional approval.

### *Audits/Reviews conducted at UCS Bennington for the previous twelve months*

- Children's Program Review (& DA Review)
- Medicaid Audit
- DCF Review – Rehab Option
- ADAP Audit
- DDAS Quality Review (& DA Review)
- Co-Occurring Disorders Fidelity Visit
- KBS Financial Audit
- CARF accreditation review
- Designated Agency Review
- CRES / Outpatient Review
- Information / Technology Audit
- *Annual Licensing Reviews for Group Homes have not yet occurred, but are scheduled for 2007*