2000 Annual Survey of Service Providers

A Report to the Delaware Division of Child Mental Health Services

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Division of Child Mental Health
FY 2000 Service Provider Survey
Executive Summary

Survey Implementation and Response Rate

The University of Delaware conducted the DCMHS' FY 2000 Service Provider Survey in June and July of 2000. A total of 91 surveys were mailed. Surveys were sent to both contracting organizations and agencies providing services at a total of 59 different sites. This year, surveys were distributed to Chief Executive Officers/Executive Directors (CEOs), Program Site Directors (PDs), and Clinical Directors/Supervisors (CDs) identified as the total number of CEOs, PDs, and CDs in the network. Comparatively, in previous years only the CEOs and PDs within DCMHS' provider network were surveyed. A total of forty surveys were returned from the original set of 91 distributed, **representing a (44%) response rate in FY 2000.** In addition, three individuals who received the survey indicated that they were unfamiliar with DCMHS or that the site had not worked with any clients through DCMHS in FY 2000 and so could not respond to the survey. **The response rate represents coverage of approximately one half of the sites that were surveyed.** Thirty-two (54%) of the fifty-nine sites were represented by at least one response from a CEO, PD, or CD.

Client Safety and Positive Client Outcomes

Among DCMHS' Aims are Client Safety and Positive Client Outcomes. When queried about these particular Aims, approximately half of the respondents (51.3%) felt that DCMHS ensured a safe environment for delivery and care of services to a great or very great extent of the time. Sixty-two percent of the respondents felt that DCMHS was effective to a high extent in promoting positive client outcomes in its system. Specific respondent comments regarding client outcomes included:

- Appropriate to issues faced by providers
- Update problem issues quickly

Accessibility of services

Another important area for DCMHS is the accessibility of services for its clients. Approximately 50% of the respondents rated service accessibility positively. Respondents also offered the following information regarding DCMHS service accessibility:

- Good continuum of care
- Focuses on treatment needs of clients
- Advocate for children seeing to it they have treatment

- Offers opportunity for long term coverage across a wide range of behavioral health care services
- Dedicated to the youth

While many respondents were positive, some noted areas within the realm of accessibility to services that need to be improved. These included:

- Greater coordination between providers and services for children's welfare
- If they were easier to obtain for children without Medicaid
- Difficult to get children assigned to a CSMT
- Look at the bureaucratic structure that slows the process and make changes
- Acknowledge the expertise of the providers in recommendation of additional services

Barriers to Providing Excellent Quality Healthcare

One very positive finding from this year's survey is the response to the question, "To what extent are there barriers to you as a provider in providing excellent quality behavioral healthcare?" **Most respondents (66.7%) indicated that they confront few barriers in providing excellent quality behavioral healthcare.**

Strengths of the DCMHS System

Respondents identified several strengths of the DCMHS system. These strengths start with a common goal, including a client centered approach to mental health/substance abuse services, and continue through DCMHS staff and actions until the system as a whole is viewed positively. Specifically, the most positive responses from the questionnaire are in the following areas:

- Consistency of DCMHS mission with providers' agencies
- Concern for clients
- Quality of DCMHS staff
- Timely feedback from monitoring sessions
- Well-organized system

Identified weaknesses from the FY 1999 survey, such as transition planning and facilitation and communication between DCMHS and the providers were improved upon and received higher satisfaction ratings on the FY 2000 survey. In addition to these strengths, additional areas for improvement were also identified this year.

Areas for Improvement

While the system as a whole is seen by providers in a positive light, there are several areas in which improvement is possible. Respondents identified these areas as including:

- Quality Improvement Administration
- The amount of paperwork providers are required to complete
- Communication across all spectrums

- Collaboration between DCMHS and providers
- Timeliness of DCMHS Intake Unit response

Quality improvement administration was the central weakness identified by the respondents. Almost all of the questions in the section "quality improvement administration" received a low rating from the respondents. For instance, approximately 30% felt that incident reporting procedures for providers were clear to a low extent, 38% felt that monitoring feedback was accurate to a low extent, and 24% stated that the process for provider appeals was clear to a low extent.

Other identified weaknesses such as paperwork, communication, and collaboration are areas in which much time has already been invested. However, as there is no 'quick fix' for improving such extensive issues like paperwork, communication, and collaboration, these are areas in which DCMHS can expect a continued need for attention.

Next Steps

To go beyond maintaining the range and quality of current services to children, DCMHS needs to continue developing the successful aspects of its system. Additionally, DCMHS should continue improving the consistency of its relationship with service providers. The challenge DCMHS currently faces is to remain engaged in this process. In other words, the momentum already gained in improvement of several areas can not be allowed to become static. DCMHS needs to bring renewed effort and enthusiasm to ongoing issues such as communication, collaboration, and paperwork, involving providers in the development of policies and procedures whenever possible. Only through such continued efforts will DCMHS achieve progress toward its mission of "developing the potential of this generation and the next through effective treatment for children and their families and collaboration with service providers."

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INTRODUCTION

The Division of Child Mental Health Services (DCMHS) relies on a network of service providers to offer managed behavioral care for Medicaid and non-Medicaid funded children with mental/emotional issues, substance abuse issues, or both. DCMHS has a variety of ways of communicating with the service providers, including a provider newsletter, a provider manual, and other formal and informal means. The purpose of this report is to present information from one of these communication tools, an annual survey that asks service providers how the DCMHS system is working and how it can be improved.

Survey Content and Administration

The FY 2000 survey was altered slightly from the FY 1999 survey in content and format in order to respond to suggestions made last year. Specifically, the FY 1999 survey section on network administration satisfaction has been deleted from the FY 2000 questionnaire and a section has been added focusing on identification of barriers to excellent behavioral healthcare. Additionally, in FY 2000, clinical directors were asked to provide their feedback. The survey begins by asking service providers to identify the type of service they provide (crisis, outpatient, residential, and so on) and the focus of their services (mental health, substance abuse, or both). Then, specific questions were organized into eight sections:

- DCMHS Mission and Vision
- DCMHS Behavioral Healthcare System Performance
- Role of Provider in the DCMHS Managed Behavioral Healthcare System
- DCMHS Intake
- DCMHS Clinical Services Management
- DCMHS Quality Improvement Administration
- Identification of Barriers to Excellent Services
- Additional Provider Comments

Sections used a variety of open-ended and closed-ended questions to examine the experiences of the agencies. A five-point Likert scale (1=little or no extent and 5=a very great extent) was employed for closed-ended questions. Respondents were then asked open-ended questions regarding strengths and areas needing improvement within several if the sections. The survey concluded by asking providers to address any other areas they felt DCMHS could use improvement.

The University of Delaware conducted the DCMHS' FY 2000 Service Provider Survey in June and July of 2000. A total of 91 surveys were mailed. A total of 91 surveys were mailed to service providers at a total of 59 different sites. This year, surveys were distributed to Chief Executive Officers/Executive Directors (CEOs), Program Site Directors (PDs), and Clinical Directors/Supervisors (CDs) identified as the total number of CEOs, PDs, and CDs in the network. Comparatively, in previous years only the CEOs and PDs within DCMHS' provider network were surveyed.

A total of forty surveys were returned from the original set of 91 distributed, representing a (44%) response rate in FY 2000. In addition, three individuals who received the survey were excluded from the survey because they were unfamiliar with DCMHS or that the site had not worked with any clients through DCMHS in FY 2000 and so could not respond to the survey. Appendix A details how this response rate was calculated.

The FY 2000 response rate compares unfavorably to the FY 1999 survey which had a response rate of 70% (46 surveys returned from 66 distributed). In an effort to obtain a response from as many organizations as possible, the survey was administered by an external organization (University of Delaware), enabling confidentiality of the responses to be protected. Additionally, by coding surveys by agency, the University researchers were able to identify the agencies from which a survey had not been received. These providers were mailed a second survey. Those who did not respond after that were called in an effort to increase the number of responses. One reason for the low response rate may be DCMHS' attempt to reach a larger portion of the service providers' staff this year than in the past. However, reasons articulated by providers during phone conversations for non-response included scheduling problems (including simple busyness), unfamiliarity with the DCMHS system, and staff turnover (i.e., the person to whom the survey was addressed had changed jobs and an appropriate alternate respondent could not be identified).

Of the surveys returned, **16 (62%) were completed by site program directors**. Twelve CEOs and 12 CDs (36% each respectively) also completed the questionnaire. By site, the response rate represents coverage of approximately one half of the sites that were surveyed. **Thirty-two (54%) of the fifty-nine sites were represented by at least one response from a CEO, PD, or CD.**

Table 1
Response Rate Across Time

Year	*# Distributed*	*# Responses*	*% Response Rate*
FY 2000*	91	40	44%
FY 1999	66	46	70%
FY 1998**	76	28	38%
FY 1997	33	20	61%

* In FY 2000, the survey was expanded to include Clinical Directors/Supervisors
** FY 1998 was the first year the DCMHS surveyed all program sites (instead of just contacted organizations)

Strengths and Limitations of Data

The major strength of the data from this year's survey is that responses from CEOs, CDs, and PDs can be distinguished from one another by group. While in many cases,

the CEO, CD, and PD responses have similar patterns, the data can be viewed by group in order to ascertain each group's unique perspective.

A second strength of this year's survey is the high proportion of service providers who responded to the open-ended questions. The lowest number of responses was received on the question how to eliminate barriers to excellent quality healthcare (11 responses or 28%). The topic receiving the next lowest number of remarks was the closing question "what other feedback can you provide?" with 13 (33%) of the respondents writing their suggestions. All other questions elicited responses from more than one half of the respondents, with the largest response- 29 respondents (73%) suggesting areas for improvement with DCMHS System Performance

The major limitation to the data from this year's survey is the low response rate. Only 40 surveys were returned of the 91 that were sent. The views that are expressed are those of only a select group of the providers and their views might not accurately reflect those of the providers who did not respond. Had a larger proportion of the providers responded, the results from the survey might paint a different picture. Therefore, the analysis of the data in this report includes only data from those providers who did respond. Caution should be taken when applying generalizations from this data to the entire provider network.

A second limitation on the data is the inability to compare the results in specific sections from this year's survey to those from FY 1999. In particular, the intake and barriers sections of this year's survey were newly added to the questionnaire. Also, questions from the FY 1999 instrument regarding the contract administrator were not repeated this year.

Organization of Report

This report is presented in a way that corresponds to the survey instrument itself. The sections are presented in the same order that they appear on the survey. The first section describes type of services provided and methods of delivery of those services. The second section describes the DCMHS Mission and Vision and provider responses to questions about the mission and vision. The third section reports on DCMHS Behavioral Healthcare System Performance. Following the system performance section are the findings on the Role of the Healthcare Provider in the DCMHS Managed Behavioral Healthcare System, DCMHS Intake, DCMHS Clinical Services Management, and DCMHS Quality Improvement Administration. The following section discusses identification of Barriers to Excellent Services. There is a focus on paperwork section at the end that looks more in depth at one of the issues that was raised throughout the survey.

Within the body of the report, tables and figures are used to display data. The responses to closed-ended questions were collapsed into Low (little or no & some extent), Moderate, and High (great & very great). Percentages were calculated from the total number of responses to the question. In other words, those who either skipped the

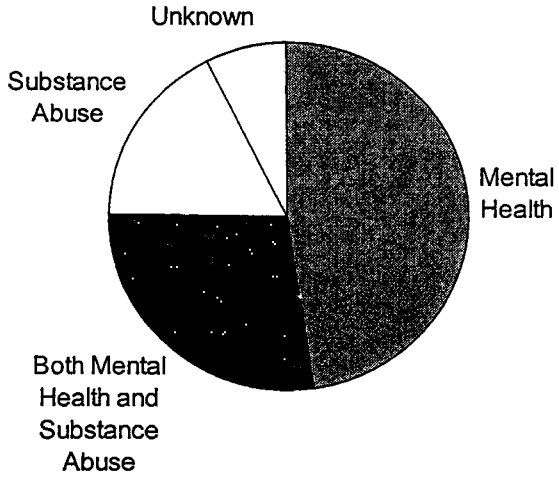
question or wrote "not applicable" next to it were not included in the analysis. Please note that this is why actual numbers of respondents are recorded in addition to percentages.

Open-ended comments are included in both text and tables throughout the report. Additionally, each respondent's comments are included in his or her own words. An inductive approach was then taken with respect to analyzing the responses to the open-ended questions. In other words, comments in response to each question were sorted into groups based on the similarity of their comments and then assigned labels (sometimes referred to as "focus"). Thus, within a table, the group with the most bullet points indicates the focus most often cited by respondents and that with the least number of bullets is the focus least often cited by respondents.

TYPES OF SERVICES PROVIDED

Most of the DCMHS providers who responded to the survey provide mental health services only. Nineteen of the forty (47.5%) providers checked that option. Only seven (17.5%) checked substance abuse services only. Eleven of the forty (25%) checked that they provide both mental health and substance abuse services. (Three respondents did not check any option). Figure 1 represents this pattern

Figure 1
Type of Services Offered by DCMHS Service Providers (n=40)



Across the different types of providers, a variety of service delivery methods were used. Of the nineteen mental health providers, the most common method of treatment used is day/partial day treatment used by 11 of the nineteen providers (57.8%). The second most common methods of delivery of services for mental health providers were outpatient and residential, with 8 (42.1%) of the providers using these methods. Of the substance abuse only providers, the most common method of treatment is outpatient treatment; all 7 use

this method. Day/partial day treatment is the next common type of service delivery for substance abuse providers with 6 of the 7 using this method. Of the providers who offer both types of services, outpatient treatment is the most common type of service delivery used; 9 of the providers who deliver mental health and substance abuse treatment use this method. The next common method of treatment used was residential treatment (50%). The least common method used by all service type providers across all spectrums was in-patient psychiatric hospital; only 1 agency uses this method of treatment. Figures 2, 3, and 4 illustrate the total number of delivery methods, by type of service provided by an agency.

Figure 2. Delivery Methods of Mental Health Service Providers, n=19

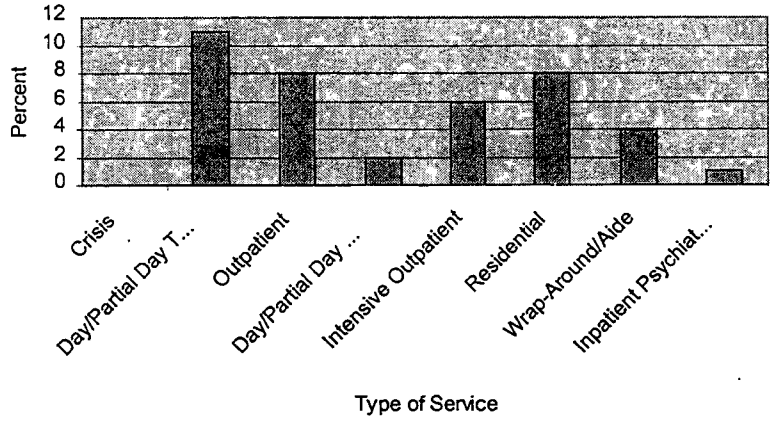


Figure 3. Delivery Methods of Substance Abuse Service Providers, n=7

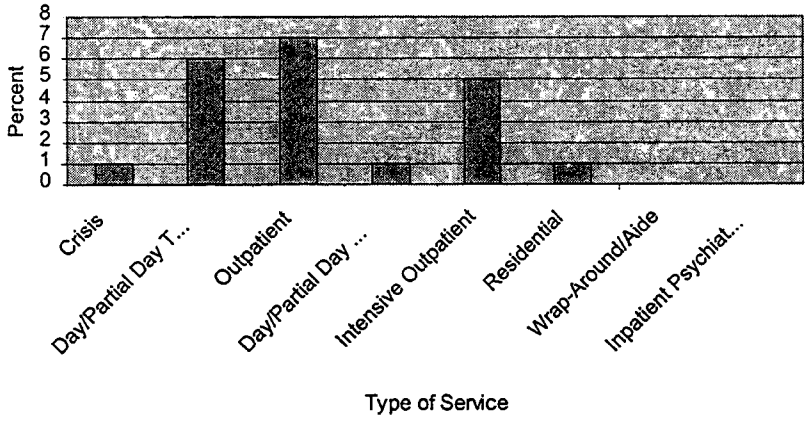
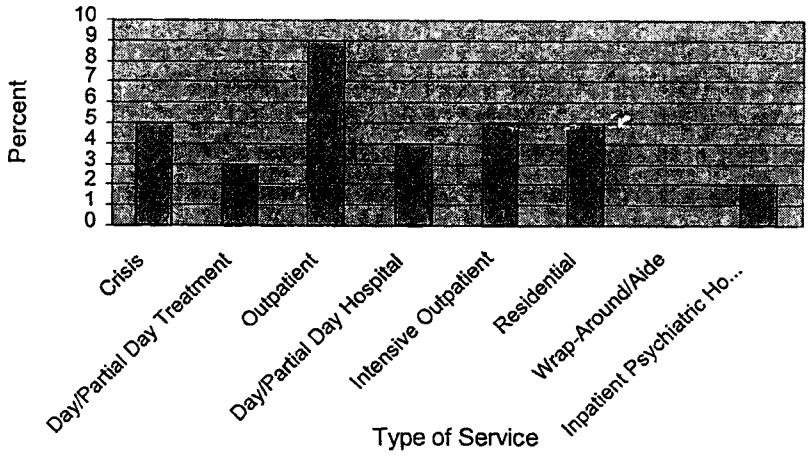


Figure 4. Delivery Methods of Substance Abuse/Mental Health Providers, n=11



DCMHS MISSION AND VISION

DCMHS Mission:	Developing the potential of this generation and the next through effective treatment for children and their families and collaboration with service partners.
DCMHS Vision:	Excellence in behavioral healthcare by leading the nation with innovative care for a changing world.
DCMHS Aims:	• Mental health/substance abuse services are safe, • Client outcomes are positive, • Services are appropriate, • Services do the right thing well, and • Continual positive alignment exists.

Familiarity with Mission, Vision, and Aims

Because its mission, vision, and aims direct DCMHS' actions, these tenants become central to its operation and thus, may affect service delivery. Therefore, respondents were asked several questions specifically directed at the mission:

1. Are you familiar with the DCMHS' mission?
2. Is the DCMHS' mission consistent with the mission of your own agency?
3. How effective was DCMHS in ensuring client safety in its system?
4. How effective was DCMHS in promoting positive client outcomes in its system?

As shown in Table 2, twenty-five of the thirty-six individuals (69.4%) who answered the question, "Are you familiar with the DCMHS mission?" reported a great or very great extent of familiarity with the mission and twenty-seven (77.1%) reported that the mission was consistent with their agencies' missions to a great or very great extent. Eighteen of those twenty-seven reported that the mission was consistent with their agencies to a very great extent.

Table 2
DCMHS Mission and Vision: Distribution of Responses to Survey Questions

	Low	Moderate	High	Total
Are you familiar with the DCMHS mission?	4	7	25	36
	11.1%	19.4%	69.4%	100%
Is the DCMHS' mission consistent with the	2	6	27	35
mission of your own agency?	5.7%	17.1%	77.1%	100%
How effective was DCMHS in ensuring client	3	14	18	35
safety in its system?	8.6%	40%	51.4%	100%
How effective was DCMHS in promoting	6	7	21	34
positive client outcomes in its system?	17.6%	20.6%	61.8%	100%

DCMHS Provider Network Forum

The mission section of the questionnaire goes on to ask several questions about the DCMHS- Provider Network Forum. Specifically, DCMHS is interested in how the Provider Network Forum promotes the tenants of its mission, vision, and aims.

Table 3 displays the distribution of responses to survey questions regarding the DCMHS-Provider Network Forum. Respondents indicated several strengths, including:

- Affords providers an opportunity for input and open dialogue
- Shares information in an effective manner
- Identifies topics of discussion that are germane to providers
- Promotes effective treatment for DCMHS clients/families
- Promotes collaboration between DCMHS and its service providers
- Is useful to its providers

Respondents identified two weaknesses. One area for improvement is collaboration with service providers in order to further the DCMHS mission. Secondly, respondents indicated that **communication should be improved between DCMHS and its providers.**

Table 3
DCMHS Mission and Vision (Provider Forum): Distribution of Responses to Survey Questions

	Low	Moderate	High	Total
To what extent does the DCMHS- Provider Network Forum quarterly meeting series...				
...further the DCMHS mission by promoting effective treatment?	10 7.7%	14 35.9%	15 38.5%	39 100%
...further the DCMHS mission by collaboration with service providers?	9 24.3%	14 37.8%	14 37.8%	37 100%
...ensure consistent information exchanges?	5 13.5%	17 48.5%	15 40.5%	37 100%
...afford providers an opportunity of input and open dialogue?	4 12.1%	10 30.3%	19 57.6%	33 100%
...share information in an effective manner?	2 7.1%	11 39.2%	15 53.6%	28 100%
...identify topics of discussion that are germane to providers?	3 8.8%	9 26.4%	22 64.7%	34 100%
...improve communication between DCMHS and providers?	12 32.4%	13 35.1%	12 32.4%	37 100%
To what extent are the training/workshops provided by DCMHS and made available to providers effective in...				
...promoting effective treatment for DCMHS clients/families?	1 3.5%	6 21.4%	21 75%	28 100%
...promoting collaboration between DCMHS and its service providers?	5 14.3%	8 22.8%	25 71.4%	28 100%
Useful to its providers?	5 13.1%	14 36.8%	19 50%	38 100%

Areas for Improvement

The section on DCMHS Mission and Vision closed with an open-ended question which asks, "What improvements can be made to the DCMHS- Network Provider Forum?" Nineteen respondents answered this question. Of those nineteen, one respondent noted an inability to answer (i.e. "regrettably, I cannot attend. I am in private practice and would lose approximately $400-$600 to be out a day). Responses from the remaining eighteen individuals are shown in Table 4. **Overall, providers thought that the Network Provider Forum meetings could be improved with:**

- **Additional input on content of meeting**
- **Simple logistical changes (i.e., length of meeting & location)**

Table 4
Suggestions for Improvements to the DCMHS- Network Provider Forum (n=18)

Focus	*Suggestion for Improvement*
Agenda/ Topics addressed	• Allow providers to suggest specific topics/problems to be addressed • Include providers in planning and evaluation process • Appropriate to issues faced by providers • Ask provider input before agenda finalized • Case review- where system DID or DID NOT work • Meeting agendas smaller and better focus • Breakout by service level (if can)… needs and issues at different levels are different- whole group process waters down each • To be more open to current status and patients needs at time of forum • Update problem issues quickly • To be more open to current status and patients needs at tome of forum • To be more open to current status and patients needs at time of forum • Treatment teams should have a clearer understanding of items being communicated in the provider meetings
Communication	• Ask more questions of providers • Make sure issues that come up are addressed and follow up actions are communicated • Ensure topics of discussion and feedback is truly considered • If providers were part of the process from the planning stages/ committee activity, all of the above would be improved • Allow for discussion • More open dialogue within the system can look at provider issues and make changes
Length of meeting	• Prefer half rather than full day sessions • Less meetings • Make better use of time (too long too much time away from agency to attend meetings)
Meeting setting	• The meetings held downstate were conducted in a round table format that was conducive to discussion. The annual meeting, however, was held in an auditorium with poor acoustics. This did not allow for open discussion. • Select a location consistently that is centrally located to all providers (i.e., Kent County)
Other	• DCMHS should spend less time promoting itself and more time promoting client services, effective access procedures and provider service support • All treatment teams should make clinical decisions consistently but the criteria which is already established

DCMHS BEHAVIORAL HEALTHCARE SYSTEM PERFORMANCE

System Performance Measures

The system performance section was designed to learn how providers view DCMHS compared to other managed care organizations. In this vein, questions in this section focused on access to services, information management, and client treatment options. There were also questions regarding administrative concerns (i.e., amount and complexity of paperwork, timeliness of payments, and provider knowledge of the appeals process). Specific questions asked included:

1. To what extent does the DCMHS system provide access to services for clients?
2. To what extent does the DCMHS system ensure that a safe environment is provided for delivery of care/services?
3. To what extent does the DCMHS system ensure that clients receive appropriate services for the conditions presented?
4. To what extent does the DCMHS system inform providers about DCMHS' expectations of providers?
5. To what extent does the DCMHS system require a reasonable amount of paperwork from providers?
6. To what extent does the DCMHS system make payments within 30 days after bills are submitted?

A majority of respondents indicated that DCMHS is strong at ensuring that a safe environment is provided for delivery of care/services. Additionally, over half of the respondents stated that DCMHS makes payments within 30 days after bills are submitted.

Although many respondents were pleased with timeliness of payments, 25% (9 respondents) stated that making payments within 30 days after bills are submitted is an area where DCMHS needs to focus efforts for improvement. Because this characteristic was rated both a strength and an area for improvement, further analysis was completed (see below). **Additionally, providers indicated two other areas that DCMHS can focus its improvement efforts:**

- **Informing providers about DCMHS' expectations of providers**
- **Requiring a reasonable amount of paperwork from providers**

Table 5
DCMHS Behavioral Healthcare System Performance: Distribution of Responses to Survey Questions

	Low	Moderate	High	Total
To what extent does the DCMHS system...				
...provide access to services for clients?	3 7.7%	17 43.5%	19 48.7%	39 100%
...ensure that a safe environment is provided for delivery of care/services?	4 10.2%	15 38.4%	20 51.3%	39 100%
...ensure that clients receive appropriate services for the conditions presented?	7 18.4%	15 39.4%	16 42.1%	38 100%
...inform providers about DCMHS' expectations of providers?	8 21.6%	12 32.4%	17 45.9%	37 100%
...require a reasonable amount of paperwork from providers?	13 36.1%	6 16.6%	17 47.2%	36 100%
...make payments within 30 days after bills are submitted?	9 25%	6 16.6%	21 58.3%	36 100%

The question, "To what extent does DCMHS make payments within 30 days after bills are submitted?" was identified as both a strength and an area for improvement. Therefore, responses to this question were analyzed by the respondent's position. Because DCMHS makes payments to provider agencies' CEOs, in this question (timeliness of payments), it is particularly helpful to know that CEO respondents answered differently than CDs and PDs. Specifically, the majority of CEOs (75%) were satisfied with the timeliness of DCMHS payments (see Table 5-A).

Table 5-A
Satisfaction with Timeliness of Payments by Respondent Position

	Low	Moderate	High	Total
To what extent does the DCMHS system make payments within 30 days after bills are submitted?				
CEO	2	1	9	12
	16.7%	8.3%	75%	100%
CD	2	2	5	9
	22.2%	22.2%	55.6%	100%
PD	5	3	7	15
	33.3%	20%	46.7%	100%

Strengths and Areas for Improvement

The first open-ended question about DCMHS system performance asked providers, "what are the specific strengths of DCMHS System Performance?" All twenty-three of the respondents who answered this question were very positive in identifying strengths. As shown in Table 6, these twenty-three providers identified communication and collaboration, concern for clients, and system organization as major strengths of the DCMHS system.

Each respondent who identified a strength of DCMHS System Performance also identified an area in which they would like to see improvement. Several providers who did not articulate a strength of the system did list an area for improvement. Twenty-nine providers responded to the question, "What are the specific areas in which DCMHS system performance could improve?" Of these 29 respondents, two stated that there were currently no areas in need of improvement (i.e. "none at this time" and "no suggestions"). Of the remaining 27, **improvements were suggested with regard to paperwork, communication, coordination, and collaboration.** The specific suggestions given are provided in Table 6.

Table 6
Strengths and Areas for Improvement within DCMHS System Performance Classified by Focus of Strength/Area for Improvement

Strengths (n=23)	**Area for Improvement** (n=27)
Communication	
• Better communication with CMH representatives • Contract managers are informative and consistent • Can discuss system operation with most • Improved processes for communication and review • Response time is good	• Communication with providers • Provide data re: critical incidents no less than quarterly. Feedback if problems receiving deliverables in a timely manner- a quarterly list of missing info • Communication on relative client information • Be friendlier • Communication
Collaboration	
• Significant improvement in relationships of local teams and providers since last survey • In Sussex County, there appears to be real collaborative activities and mutual openness	• Consultation and assessment • Work more as a team with other agencies • Acknowledge the expertise of the providers in recommendation of additional services • Don't micromanage cases • Flexibility in treatment collaboration • Allow focus of service delivery to be driven by client need, not predetermined ratios • Difficult decision making process • Decisions sometimes based on availability not client need
Coordination	
• Organized and proactive • Organization, quality standards • System usually works • Well organized system • The meetings and flexibility of the new system	• Inconsistency with case managers • Inconsistent implementation of processes • Need to consistently apply standards • Quickening the timeline between the request for service and the delivery of the service • Greater coordination between providers and services for children's welfare • Decrease CSC caseload. Limited ranges of services are available, especially in area of IOP services. In terms of safety, youth referred to this level of care are sometimes quite violent/aggressive: should be in other types of facilities • If they were easier to obtain for children without Medicaid • Streamline their system in short, CMG should operate as it expects providers to operate • Difficult to get children assigned to a CSMT • Time between referral and authorization • Look at the bureaucratic structure that slows the process and make changes

(Table 6 continued...)

Concern for Clients as Demonstrated in Treatment	
• Ability to authorize creative use of treatment time • CMH ensures appropriate access to clients for services • Focuses on treatment needs of clients • Many points of access for routine outpatient services • Good continuum of care • Advocate for children seeing to it they have treatment • Offers opportunity for long term coverage across a wide range of behavioral healthcare services • Wide array of services • The coordinators really work to engage kids in treatment	• Access to treatment in Kent County • Improve access
Staff	
• Knowledgeable clinical staff • Personable approachable personnel • Highly professional clinicians at treatment level • Committed to quality • Dedicated to the youth	• Too great turnover of staff • Team leaders are condescending, inflexible, arrogant, and completely out of touch with the reality of these kids lives
Paperwork	
	• Streamlining the paperwork necessary to request a service • Cut paperwork by 60% • Continue to simplify paperwork requirements • Reduce documentation expectations for indirect services • Modify and simplify authorization process • Decrease the amount of paperwork- move to electronic system • Decrease the amount and redundancy of paperwork • Give contractors more latitude- putting the child into treatment firs and dotting I's and crossing T's second
Other	
• Provider network manual	• Be accountable for mistakes

ROLE OF PROVIDER IN THE DCMHS MANAGED BEHAVIORAL HEALTHCARE SYSTEM

The next section of the report focuses on the Role of the Provider in the DCMHS Managed Behavioral Healthcare System. Questions in this section addressed issues including requirements for providing services, understanding of providers' place on the continuum, DCMHS expectations, and opportunity for provider input. Table 7 details the distribution of provider responses to each of the questions.

Overall, respondents' satisfaction with the role of the provider and the provider network forum was quite high. Respondents indicated that administrative staff and clinical staff both had easy access to the FY00 DCMHS Provider Manual. Additionally, providers identified several other aspects of the 'role of provider' as strengths. These include:

- Clarity of agency's role as service provider within the DCMHS managed care system
- Clarity of requirements for providing mental health/substance abuse services under agency contract with DCMHS
- Degree to which DCMHS expectations for agency are reasonable

Providers identified two particular areas for improvement. These are both related to the provider agency's opportunities to give feedback to DCMHS. **Respondents indicated that they would like to see improvement in the opportunities to comment on DCMHS policies/procedures and on the provider manual.**

Table 7
Role of Provider in the DCMHS Managed Behavioral Healthcare System: Distribution of Responses to Survey Questions

	Low	Moderate	High	Total
How available was the FY 00 DCMHS Provider Manual to key staff in my agency?				
...to administrative staff?	0	4	34	38
		10.5%	89.5%	100%
...to clinical staff?	1	5	32	38
	2.6%	13.1%	84.2%	100%
How clear is your agency's role as service provider within the DCMHS managed care system?	1	6	31	38
	2.3%	15.7%	81.6%	100%
How clear are the requirements for providing mental health/substance abuse services under your agency's contract/provider agreement with DCMHS?	3	6	30	39
	7.7%	15.3%	76.9%	100%
How reasonable are DCMHS expectations for your agency?	5	11	22	38
	13.2%	28.9%	57.9%	100%
How adequate are the opportunities to comment on DCMHS...				
...policies and procedures?	12	10	16	38
	31.6%	26.3%	42.1%	100%
...provider manual?	11	12	16	39
	28.2%	30.7%	41%	100%
...provider satisfaction surveys?	7	14	17	38
	18.4%	36.8%	44.7%	100%

There were no open-ended questions asked in this section regarding the role of provider in the DCMHS Managed Behavioral Healthcare System.

DCMHS INTAKE

This section asked respondents to identify how timely the DCMHS Intake Unit was in providing responses a provider can make on a client's behalf and to what extent does the Intake unit include information about the status of referral. The exact questions asked are as follows:

1. To what extent does the DCMHS Intake Unit provide timely response which you can make on a client's behalf?
2. To what extent does the DCMHS Intake Unit's response to you include information about the status of referral?

In analyzing the responses in this section, answers were broken out by position of respondent (CEO/CD/PD). As shown in Table 8, **the extent to which the Intake Unit's response was rated timely was highly influenced by the respondent's position.** CEOs were generally satisfied with response time, PDs were moderately satisfied, and clinical directors as a group were not satisfied.

On a more positive note, 4 of 6 clinical directors (66.7%) and 7 of 11 CEOs (63.6%) indicated that the DCMHS Intake Unit's response includes information about the status of the referral to a great or very great extent of the time.

Table 8
DCMHS Intake: Distribution of Responses to Survey Questions Classified by Position of Respondent

	LOW			MODERATE			HIGH			TOTAL		
	CEO	CD	PD	CEO	CD	PD	CEO	CD	PD	CEO	CD	PD
1	3 33.3%	6 60%	3 23.1%	1 11.1%	4 40%	8 61.5%	5 55.6%	0	2 15.4%	9 100%	10 100%	13 100%
2	2 18.2%	1 16.7%	3 23.1%	2 18.2%	1 16.7%	7 53.8%	7 63.6%	4 66.7%	3 23.1%	11 100%	6 100%	13 100%

There were no open-ended questions asked in this section regarding DCMHS Intake.

DCMHS CLINICAL SERVICES MANAGEMENT

Clinical Service Management Measures

The next section asked the service providers about their experiences with the clinical services management team. Questions in this section asked providers to describe their experiences with Clinical Services Management team leaders and coordinators and supervisors, how familiar the providers are with the DCMHS authorization process, and how consultation by CSM team leaders has been helpful in complex situations. Table 9 shows responses to the following questions:

1. To what extent is the DCMHS Service Admission Form (faxed by DCMHS to provider at service authorization) useful in developing the client treatment plans?

To what extent does DCMHS Clinical Services Management staff effectively perform its functions regarding DCMHS clients, specifically to...

2. ...plan?
3. ...authorize?
4. ...monitor?
5. ...evaluate those services?

In your clinical staff's experience, to what extent are the DCMHS Clinical Service Coordinators/Supervisors...

6. ...accessible/available?
7. ...professional in their working relationships?
8. ...willing to explain DCMHS decisions?
9. ...knowledgeable about the spectrum of children's services in Delaware?

In your clinical staff's experience, to what extent are the DCMHS Clinical Services Management Team Leaders...

10. ...accessible/available?
11. ...professional in their working relationships?
12. To what extent has the clinical consultation provided by CSM Team Leaders in complex, difficult cases been helpful to you as a provider?
13. To what extent is the response of the DCMHS CSM Team timely when called by the provider with a clinical emergency?
14. To what extent are you familiar with the DCMHS authorization process, which is outlined in the DCMHS Provider Manual?
15. To what extent does the provider have an opportunity to provide input in making clinical and discharge decisions?
16. To what extent does the DCMHS Client Progress Review provide a comprehensive clinical snapshot of the client's condition for DCMHS?

Because clinical directors have the most direct contact with clinical services management, the responses to questions in this section were broken out by position of respondent. **Ninety percent of the clinical directors (9 CDs) rated accessibility/availability of Clinical Services Coordinators/Supervisors as an area for**

improvement. CDs as a group also noted that improvement should focus on the CSM staff's performance of its functions, in particular:

- Planning for clients
- Evaluation of client services

CDs as a whole were very positive with their feedback regarding CSM Team Leaders. Team Leaders were seen as:

- Accessible/available
- Professional in their working relationships

Table 9
DCMHS Clinical Services Management: Distribution of Responses to Survey Questions Classified by Position of Respondent

	LOW			MODERATE			HIGH			TOTAL		
	CEO	CD	PD	CEO	CD	PD	CEO	CD	PD	CEO	CD	PD
1	2 25%	2 22.2%	6 40%	0	3 33.3%	3 20%	6 75%	4 44.4%	6 40%	8 100%	9 100%	15 100%
2	5 45.5%	5 50%	6 40%	4 36.4%	2 20%	5 33.3%	2 18.2%	3 30%	4 26.7%	11 100%	10 100%	15 100%
3	2 22.2%	3 37.5%	4 44.4%	5 55.6%	5 62.5%	5 55.6%	2 22.2%	0	0	9 100%	8 100%	9 100%
4	2 18.2%	3 27.3%	4 26.7%	6 54.5%	5 45.5%	5 33.3%	3 27.3%	3 27.3%	6 40%	11 100%	11 100%	15 100%
5	4 33.3%	8 72.7%	8 57.1%	0	0	2 14.3%	8 66.7%	3 27.2%	4 28.6%	12 100%	11 100%	14 100%
6	8 66.7%	9 90%	2 25%	3 25%	0	5 62.5%	1 8.3%	1 10%	1 12.5%	12 100%	10 100%	8 100%
7	0	1 10%	1 7.1%	5 45.5%	4 40%	5 35.7%	6 54.5%	5 50%	8 57.1%	11 100%	10 100%	14 100%
8	2 18.2%	1 12.5%	2 16.7%	5 45.5%	3 37.5%	3 25%	4 36.4%	4 50%	7 58.3%	11 100%	8 100%	12 100%
9	1 33.3%	2 22.2%	1 11.1%	1 33.3%	6 66.7%	4 44.4%	1 33.3%	1 11.1%	4 44.4%	3 100%	9 100%	9 100%
10	2 16.7%	1 9.1%	4 26.7%	3 25%	1 9.1%	5 33.3%	7 58.3%	9 81.9%	6 40%	12 100%	11 100%	15 100%
11	1 14.3%	1 12.5%	1 11.1%	2 28.6%	1 12.5%	0	4 57.1%	6 75%	8 88.9%	7 100%	8 100%	9 100%
12	0	0	0	4 44.4%	4 50%	7 63.6%	5 55.6%	4 50%	4 36.4%	9 100%	8 100%	11 100%
13	0	0	7 46.7%	4 36.4%	4 40%	1 6.7%	7 63.6%	6 60%	7 46.7%	11 100%	10 100%	15 100%
14	0	2 20%	0	1 8.3%	2 20%	3 20%	11 91.7%	6 60%	12 80%	12 100%	10 100%	15 100%
15	0	2 20%	3 20%	2 16.7%	2 20%	2 13.3%	10 83.3%	6 60%	10 66.7%	12 100%	10 100%	15 100%
16	0	1 11.1%	2 14.3%	4 40%	5 55.6%	8 57.1%	6 60%	3 33.3%	4 28.6%	10 100%	9 100%	14 100%

Client Progress Review: Areas for Improvement

Of the twenty-one service providers who responded to the open-ended question "What improvements could you suggest for the DCMHS Client Progress Review?" two respondents (a CEO and a PD) stated "none." However, as detailed in Table 10, the remaining nineteen service providers identified areas for improvement that have a variety of focuses.

Table 10
Suggestions for Improvement of DCMHS Client Progress Review Classified by Focus of Suggestion and Position of Respondent (n=19)

CEO	CD	PD
	Paperwork	
• Modify and simplify- very time consuming for DCMHS worker and provider	• Reduce paperwork	
	Communication	
• Move to electronic automated system to decrease the amount of time spent on telephone • Referral information sometimes old, inaccurate, or incomplete • It sometimes appears that no information is collected • The review appears to be mostly data collection. It would service the patients better of the (CMH) were also getting a clinical point of view on how they're doing. Currently they ask for their progress but do not give time for a response	• Clinicians not always informed of date of review- business office informed of this? • Automate the system/process (i.e., e-mail) • The review appears to be mostly data collection. It would service the patients better of the (CMH) were also getting a clinical point of view on how they're doing. Currently they ask for their progress but do not give time for a response	• Get rid of form and allow for dialogue • The review appears to be mostly data collection. It would service the patients better of the (CMH) were also getting a clinical point of view on how they're doing. Currently they ask for their progress but do not give time for a response
	Coordination	
• In terms of specific review, we find it intermittently used	• Need to make sure review occur and decisions made and communicated to providers before authorization expires	• If these reviews were completed in conjunction with our regular reviews, both parties would benefit from vital feedback • Combine the client progress reviews and provider's treatment plan reviews into one process • Shorten time • Schedule clinical reviews to lessen phone tag • Give written authorizations

(Table 10 continued...)

	Service	
• Recognize some of the realities of working with the substance abusing clients and need for timely intervention	• Several questions cannot be effective answered on the "less-more" improvement continuum- e.g. "provide urine screens"	• Consider recommendations based on child's needs not where budget or pocket money will come from
	Staff	
• There is a rather great variability in the performance of the CSC staff in wide number of areas		• Still sense there are issues with referrals in Dover especially? The reviews? There are no or minimum referrals for 0-9 age group in NCC/Wilmington and in Sussex (Georgetown & Milford) things seem to go well
	Collaboration	
	• Make it more of a partnership	

Clinical Services Management Teams

The survey then continues to ask additional questions about clinical services management. Specifically:
To what extent do the DCMHS Clinical Services Management Teams effectively plan and facilitate client service transitions...

1. ...at admissions?
2. ...at discharges?
3. ...during transitions to adult service systems?
4. To what extent are you familiar with the DCMHS Level of Care Criteria?
5. To what extent do CSM Team Leaders implement the Level of Care Criteria consistently across team leaders?

As detailed in Table 11, CDs saw CSM Teams planning and facilitation of client service transitions as strong for admissions and discharges. However, planning and facilitation of client services during transitions to adult service systems is indicated as an area in which to improve. **Additionally, the consistent implementation of Level of Care Criteria by CSM Team Leaders was rated low by 80% of the clinical directors (4 CDs).**

Table 11
DCMHS Clinical Services Management (cont): Distribution of Responses to Survey Questions Classified by Position of Respondent

	LOW			MODERATE			HIGH			TOTAL		
	CEO	CD	PD	CEO	CD	PD	CEO	CD	PD	CEO	CD	PD
1	2 40%	1 20%	3 37.5%	0	0	0	3 60%	4 80%	5 62.5%	5 100%	5 100%	8 100%
2	1 16.7%	0	1 16.7%	2 33.3%	1 16.7%	2 33.3%	3 50%	5 83.3%	3 50%	6 100%	6 100%	6 100%
3	3 50%	3 60%	3 50%	0	1 20%	3 50%	3 50%	1 20%	0	6 100%	5 100%	6 100%
4	1 20%	0	0	0	0	3 75%	4 80%	1 100%	1 25%	5 100%	1 100%	4 100%
5	5 83.3%	4 80%	4 66.7%	1 16.7%	1 20%	1 16.7%	0	0	1 16.7%	6 100%	5 100%	6 100%

Strengths and Areas for Improvement

Next, this section contained open-ended questions that asked strengths and areas for improvement of DCMHS Clinical Services Management. Twenty-five respondents identified strengths. One provider (PD) noted, "We could better answer this question if the lines of responsibility within CMH were better defined for us with respect to specific clients." Table 12 shows the strengths articulated by the other 24 respondents with respect to quality of staff, coordination/collaboration, access, focus on clients, and other.

Table 12
Strengths of DCMHS Clinical Services Management Classified by Focus of Strength and Position of Respondent (n=24)

CEO	*CD*	*PD*
	Quality of Staff	
• Local teams clinical service coordinators are very helpful and available downstate • Knowledge and commitment • They are aware of the resources and limitations so they can foresee the problems with certain plans of action • Some very dedicated workers	• Make decisions promptly • They are aware of the resources and limitations so they can foresee the problems with certain plans of action	• Some are excellent clinicians, flexible and creative • Clinical expertise networking with the providers better in Georgetown, Milford, and Wilmington • Compassion, problem focused • Adjunct assessments are generally very good • They are aware of the resources and limitations so they can foresee the problems with certain plans of action • They are knowledgeable about resources available
	Coordination/Collaboration	
• Significant improvement in face to face contact with providers • Access to a wide range of providers, services, and funding	• Willingness to assist in accessing other systems to facilitate client care	• They at times are helpful in providing specific case suggestions or recommendations
	Access	
	• Available • Promptly return calls • Supervisor and coordinator accessibility • Not hard to get a hold of	• Accessibility

(Table 12 continued...)

	Focus on Clients	
• NCC and Sussex, strong with evaluation for admission to substance abuse treatment. Kent very poor at determining need for substance abuse treatment	• Front line workers will informed of clients' progress/needs • Ability to fine tune clinical services	• Caring, client supportive
	Other	
	• Compared to some systems, the amount of time allowed between reviews of care (30 days) is very reasonable	

Almost every respondent who identified a strength of DCMHS Clinical Services Management also identified an area where improvement is needed. Additionally, some of the respondents who did not cite a system strength articulated an area in need of improvement. Two respondents (a CD and a PD) articulated that there were no areas in need of improvement (i.e., "none" and "we have had a positive experience- no suggestions") and one program site director noted, just as in the 'strengths' question, "We could better answer this question if the lines of responsibility within CMH were better defined for us with regard to specific clients." The remaining twenty-three respondents answered that a variety of areas need improvement. These areas for improvement are grouped by focus in Table 13.

Table 13
Areas for Improvement in DCMHS Clinical Services Management Classified by Focus of Area and Position of Respondent (n=23)

CEO	*CD*	*PD*
	Inconsistent Quality	
• Consistency • This seems to be dictated by the established process/computer system not by the client or agency needs	• There are variations between teams/locations- Kent County is particularly difficult • More consistent in making level of care decisions	
	Paperwork	
• Modify and simplify authorization process • Good work up front will take care of the paperwork • Be flexible and concentrate primarily on providing access to services rather than on paperwork • Bureaucracy		

(Table 13 continued...)

Coordination		
	• Difficult to get children assigned to a CSMT	• Intake criteria, treatment plan and provide for a sufficient and realistic discharge transition plan
Communication		
• There is great variability in terms of communication skills, responsiveness, timeliness, etc. (CSC) The TLLs are much more consistent/responsive • Communication and decision making • Keeping communication open to work objectively based on diagnosis treatment, prognosis	• Keeping communication open to work objectively based on diagnosis treatment, prognosis • Increased opportunity for providers to meet with team leaders for feedback	• Keeping communication open to work objectively based on diagnosis treatment, prognosis • More regular contact with providers
Education		
• Teach/train Kent County team to identify and view substance abuse as treatable disease not a system of mental/emotional problems	• Increase awareness of substance abuse as a possible contributor to client destabilization	
Collaboration		
	• Develop more partnership with providers • Provider is not an integral member of the treatment team- clinicians feel that DCMHS decides upon length of stay and discharge date without seeking or considering clinician's input	• Improve "partnership mentality" • Head to lunch with the Dover team • More ideas in difficult cases • Have an eye towards team effort in case management. Too many times we are "managed" by a DCMHS clinician that is unaware of the many variances of the case • Flexibility on treatment collaboration

DCMHS QUALITY IMPROVEMENT ADMINISTRATION

Table 14 shows the distribution of provider responses to survey questions regarding DCMHS Quality Improvement Administrators and Administration. This is the section of the survey that providers indicated the greatest need overall for improvement. While **timeliness of monitoring feedback was indicated as a strength,** weaknesses included:

- Availability of assistance from DCMHS Quality Improvement Administrators in the interpretation of standards, development of provider standards and records

- Clarity of incident reporting procedures
- Accuracy of monitoring feedback
- Clarity of process for provider appeals

Table 14
DCMHS Quality Improvement Administration: Distribution of Responses to Survey Questions

	Low	Moderate	High	Total
Is assistance from DCMHS Quality Improvement Administrators in the interpretation of standards, development of provider standards, and records available?	4 36.4%	3 27.2%	4 36.4%	11 100%
Are the incident reporting procedures for providers clear?	10 29.4%	11 32.3%	13 12.2%	34 100%
Was there adequate notification provided for the scheduling of monitoring visits?	4 13.3%	15 50%	11 36.7%	30 100%
Was the monitoring feedback accurate?	11 37.9%	9 31%	9 31%	29 100%
Was the monitoring feedback timely?	3 10%	11 36.7%	16 53.3%	30 100%
Is the process for provider appeals clear?	7 24.1%	13 44.8%	9 31%	29 100%

There were no open-ended questions asked in this section regarding DCMHS Quality Improvement Administration.

IDENTIFICATION OF BARRIERS TO EXCELLENT SERVICE

Barriers

This section asked one closed-ended question: To what extent are there barriers to you as a provider in providing excellent quality behavioral healthcare? Table 15 shows that **most respondents (66.7%) thought that there were few barriers in providing excellent quality behavioral healthcare.** Please note that in this table (unlike all others presented in this report) "low" is positive feedback and "high" is negative.

Table 15
Identification of Barriers to Excellent Service: Distribution of Responses to Survey Questions

	Low	Moderate	High	Total
To what extent are there barriers to you as a provider in providing excellent quality behavioral healthcare?	20 66.7%	7 23.3%	3 10%	30 100%

In the section "Identification of Barriers to Excellent Service," there were two open-ended questions. First, providers were asked, "What are the barriers to providing excellent quality health care in the DCMHS system?" Next, providers were asked, "How can barriers be eliminated?" One respondent answered that there are no barriers to providing excellent quality healthcare (i.e., "none"). Responses from the remaining 27 individuals are displayed in Table 16.

The number of respondents to answer, "How can the barriers be eliminated" was much smaller than typical due to the omission of some text on the survey questionnaire. The word "how" was missing on several surveys used. Thus, in answer to "can the barriers be eliminated" most of the respondents (n=21) answered in the affirmative). Eleven providers expanded upon their answers to indicate how DCMHS might go about eliminating these barriers. Table 16 lists suggestions for elimination grouped by barrier.

Table 16
Barriers to Providing Excellent Health Care in the DCMHS System and Suggestions of How to Eliminate Barriers Classified by Focus of Barrier

Barrier (n=27)	**Suggestion for Improvement** (n=11)
Paperwork	
• Excessive paperwork when requesting services • Too much paperwork • Overbearing paperwork • As an outpatient therapist, I need to refer kids to a higher level of care. I feel that the extensive paperwork demanded of me to do is meant as a barrier to intimidate or overtax me from bothering. The process is ridiculous • Paperwork process for everything about outpatient. More interest in the paper process than the client	• Simplify paperwork • I should be able to call the proposed program provider with basic referral info and they should see the patient and verify appropriateness of referral. CMH (who by contracting with that facility should trust its judgement) grant at least a brief authorization and then let them do their jobs • Reduce the layers and monitor turnaround

(Table 16 continued...)

Collaboration	
• Provider is not an integral member of the treatment team- clinicians feel that DCMHS decides upon length of stay and discharge date without seeking or considering clinician's input • DCMHS disregards input from the provider to the extent that it conflicts with the interest of the therapist involved with the case • Bachelors and Masters staff recommend prescription to ER physicians in crisis program • Open less judgmental communication • Less defended (us v them) basis for decisions & actions • Pre-existing judgements and plan of actions built without the current providers feedback or I should say evaluation and consideration of that feedback • Lack of coordination of agencies, DFS, CMH, Providers. • Rarely able to involve 2 agencies even when clinically appropriate, requesting any adjunct services is a waste of time and not worth the energy of being treated by the team leaders as if you are taking their personal money • There seems to be a hostile approach to providers in Kent County • Lack of follow-up for commitments made	• Processes should be reviewed with provider input • Needs to be a function of DCMHS or Kids Dept staff since this role is a perceived conflict of interest for any provider • Get all of the teams on the same page
Access to Services	
• Access to higher end services is limited excessively due to budgetary restrictions • Number of available services at higher service levels • No referrals in Dover for 0-9 in outpatient • More effective use of in state short term residential services below the level of hospital and RTC's • Requests for a higher level of service • Availability of referral sources is limited for crisis cases. • Some IOP referrals need a higher level of care, but due to lack of sufficient placements, they were referred to IOP • Better utilization of level of care, • Clients are denied access to appropriate level of care in Kent County. • There are few resources. • Reliance on legal involvement as an alternative for treatment opportunities	• Wrap around planning and MDT's with backing to support initiatives • With more service availability

(Table 16 continued...)

Inconsistency	
• Greater consistency in decision making • Inconsistent application of standards • Not being sure how clinical and level of care decisions are going to be made	• Train Kent County team to understand and diagnose substance abuse • Perhaps better monitoring of team in Kent County
Process	
• Time delays in accessing services • Authorization process • Transition and discharge barriers because there is no transition plan to bridge day treatment to residential care • Identification and referral of clients eligible and needing services • Timely decision making when CSMT is requested for day treatment or residential treatment • When I wrote an appeal to Quality Assurance Dept. regarding problems in Kent unit in recognizing and appropriate substance abuse treatment, it took DCMH 5 months to respond to my complaint	
Clients	
• Clients' compliance attending their scheduled appointments • Clients' compliance in attending their scheduled appointments	
Other	
• Lack of accountability in management. • Disparity between public statements and actual operations	• It has to be with CMH initiative- sense some resistance

ADDITIONAL PROVIDER COMMENTS

The last section on the provider survey questionnaire simply asks the open-ended question, "What other feedback can you provide which may help DCMHS identify areas for improvement?" Thirteen respondents answered this question, focusing on issues such as paperwork, feedback, and even the survey itself. Three of these respondents indicated that there were no areas in need of improvement (i.e., "none- there was significant improvement, particularly in the last 6 months," "we have enjoyed working with DCMHS and are impressed by the system's functioning," and "in general, the relationship with DCMHS has been positive"). Table 17 details the remaining ten answers received on this question.

Table 17
Other Feedback to help DCMHS Identify Areas for Improvement Classified by Focus of Area (n=10)

Focus	*Area for Improvement*
Paperwork	• Paperwork is easily triple the amount of other managed care groups. Please help us diminish the time spent away from direct services • Redesign administrative procedures to allow providers to concentrate on being providers
Survey	• Have another organization administer the provider survey. This is full of misspellings, incorrect use of language/awkward phrasing. It appears there was no proofreading • Like the questions and form better this year. No question re: contract manager- helpful, accessible, professional, timely responses • We saw only a few DCMHS clients so unable to respond to most questions
Timely Feedback	• The QA/QI team, in general, is fairly inexperienced. They are very slow, if they respond at all, to expressed concerns re: reports/procedure/etc. We were involved in review of youth safety was then 4 months ago and have not heard/received any status report (check- more writing?) • Clean up the appeal process response time should be faster
Client Focus	• Act now issues when a child is at risk. It is always bad on DFS as a placement issue rather than what does the "child" need? • Focus mission on providing quality, timely, and effective health care services to children/families everything else is secondary. • I would like to see the TLL's take a more active role in case knowledge. It is more important to know the client to make lucid insightful clinical decisions
Other	• In Kent County, relationship has been very stressed and professional respect is lacking • When contacting with private clinicians like myself, they should be cognizant of our needs to provide billable services to pay our bills

FOCUS ON PAPERWORK

This section of the report looks more closely at the characteristics of those agencies whose representatives identified paperwork simplification as an area for improvement. In particular, DCMHS is interested in understanding which types of agencies are those most affected by paperwork demands so that they can help to steer their improvement efforts.

Table 18 shows characteristics of the 13 respondent agencies that indicated a low satisfaction on the question; "To what extent does the DCMHS system require a reasonable amount of paperwork from providers?" **Of those respondents who answered this question to little or no extent or to some extent, 8 (61.5%) provide outpatient services.**

Table 18
Focus of Paperwork: Characteristics of Respondents in Closed-Ended Question (n=13)

	Crisis	Day/Partial Day Treatment	Outpatient	Day/Partial Day Hospital	Intensive Outpatient	Residential	Wrap-Around/Aide	Inpatient Psychiatric Hospital
Mental Health	✓							
Unknown						✓		
Unknown						✓		
Substance Abuse		✓	✓		✓			
Mental Health	✓	✓	✓		✓		✓	
Mental Health				✓				
Unknown						✓	✓	
Both		✓	✓		✓			
Mental Health		✓	✓			✓		
Substance Abuse			✓					
Mental Health			✓					
Substance Abuse		✓	✓		✓			
Substance Abuse		✓	✓		✓			
Percentage of Total	*15.4%*	*46.2%*	*61.5%*	*7.7%*	*38.5%*	*30.8%*	*15.4%*	*0*

Of the forty providers to respond to the survey, nine cited paperwork as an area for improvement and/or barrier in response to one of the open-ended questions presented. The characteristics for each of these respondents are presented in Table 19 below. Once again, **providers who cited paperwork were more likely to provide outpatient services than any other service.**

Table19
Focus on Paperwork: Characteristics of Respondents of Open-Ended Questions (n=9)

	Crisis	Day/Partial Day Treatment	Outpatient	Day/Partial Day Hospital	Intensive Outpatient	Residential	Wrap-Around/Aide	Inpatient Psychiatric Hospital
Mental Health	✓	✓	✓		✓		✓	
Mental Health	✓	✓	✓		✓		✓	
Substance Abuse			✓					
Substance Abuse		✓	✓		✓			
Unknown						✓		
Substance Abuse		✓	✓		✓			
Both			✓		✓	✓		
Substance Abuse		✓	✓		✓			
Mental Health			✓					
Percentage of Total	*22.2%*	*55.6%*	*88.9%*	*0*	*66.7%*	*22.2%*	*22.2%*	*0*

NEXT STEPS

To recap, providers who responded to the FY 2000 survey identified both strengths of the DCMHS system and areas for improvement within the system.

Most notable among the strengths were:

- Consistency of DCMHS mission with providers' agencies
- Concern for clients
- Quality of DCMHS staff
- Timely feedback from monitoring sessions
- Well-organized system

Areas for improvement most likely to be cited included:

- Quality Improvement Administration
- The amount of paperwork providers are required to complete
- Communication across all spectrums
- Collaboration between DCMHS and providers
- Timeliness of DCMHS Intake Unit response

To go beyond maintaining the range and quality of current services to children, DCMHS needs to continue developing the successful aspects of its system. Additionally, DCMHS should continue improving the consistency of its relationship with service providers. The challenge DCMHS currently faces is to remain engaged in this process. In other words, the momentum already gained in improvement of several areas can not be allowed to become static. DCMHS needs to bring renewed effort and enthusiasm to ongoing issues such as communication, collaboration, and paperwork, involving providers in the development of policies and procedures whenever possible. Only through such continued efforts will DCMHS achieve progress toward its mission of "developing the potential of this generation and the next through effective treatment for children and their families and collaboration with service providers."

APPENDICES

APPENDIX A

SURVEY RESPONSE RATE AND NON-RESPONSE

Calculating the Response Rate

Table A1 describes the actions taken in calculating the response rate. The first row represents the number of surveys that were returned to us in the mail. The second row describes how we dealt with single surveys that represented responses from two or more of the addresses on the distribution list: For each respondent identified on the survey, we entered the data from the single survey. The rationale for our decision to multiply single surveys representing multiple responses is to maintain the weight given to each entity on the mailing list. The third row identifies our action with three individuals in which the respondents had indicated that they were unfamiliar with DCMHS or had not served any DCMHS clients within the last fiscal year. Two of these three people, a CEO and a CD, were identified by a Delaware-based PD as being unfamiliar with DCMHS because they worked in the organization's main office (outside of DE). The third respondent, a PD, explained that while her agency as a whole serves DCMHS clients, during this fiscal year, her particular site had not served any. She referred us to a person at the agency's main office (who had already been sent a survey). After subtracting that response from the total, our final response rate was 44%.

Table A1
Calculating the Response Rate

	Result of Action			
Action in calculating the response rate	**CEO**	**CD**	**PD**	**Total**
We compiled the surveys we received from the agencies	13 39 %	12 36 %	16 62 %	41 45 %
We added surveys when a single survey represented the responses from more than one site	13 39 %	13 39 %	17 65 %	43 47 %
We subtracted the response from service providers who were not familiar with DCMHS/ had not served clients in FY 2000	12 36 %	12 36 %	16 62 %	40 44 %
Final Response Rate	12 36 %	12 36 %	16 62 %	40 44 %

While these fixes enable us to calculate a response rate based on the lists of executive directors and program directors provided by DCMHS, the need to make these adjustments suggest that the number of people who should return surveys is fluid, making the response rate difficult to calculate in a meaningful way.

APPENDIX B

TYPES OF SERVICES PROVIDED

This appendix presents summaries of the responses to the questions about types of services and service delivery methods (or types of treatment).

Table B1
Type of Service Offered by DCMHS Service Providers (n=40)

Type of Respondent	**Mental Health**	**Substance Abuse**	**Both**	**Unknown**
CEO	5	3	5	0
	26.3%	42.9%	45.5%	
CD	6	0	5	0
	31.6%		45.5%	
PD	8	4	1	3
	42.1%	57.1%	9.1%	100%
Total	19	7	11	3
	100%	100%	100%	100%

Table B2
Types of Services by Service Delivery Methods- Distribution of Responses for Total (n=40)

	Mental Health	**Substance Abuse**	**Both**	**Total**
Crisis	0	1	5	6
		16.7%	83.3%	100%
Day/Partial Day Treatment	11	6	3	20
	55%	30%	15%	100%
Outpatient	8	7	9	24
	33.3%	29.2%	37.5%	100%
Day/Partial Day Hospital	2	1	4	7
	28.6%	14.3%	57.1%	100%
Intensive Outpatient	6	5	5	16
	37.5%	31.3%	31.3%	100%
Residential	8	1	5	14
	57.1%	7.1%	35.7%	100%
Wrap-Around/Aide	4	0	0	4
	100%			100%
Inpatient Psychiatric Hospital	1	0	2	3
	33.3%		66.7%	100%