1999 Annual Survey of Service Providers

A Report to the Delaware Division of Child Mental Health Services

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1999 ANNUAL SURVEY OF SERVICE PROVIDERS

EXECUTIVE SUMMARY

The Division of Child Mental Health Services (DCMHS) relies on a network of service providers to offer managed behavioral health care for Medicaid and non-Medicaid funded children with mental/emotional and/or substance abuse issues. DCMHS conducts an annual survey that asks providers about system performance and possible improvements. This summary reports the results from this year's survey. The summary is organized by the sections of the survey: (1) types of services provided, (2) DCMHS mission, (3) system performance, (4) provider's role in the system, (5) administration of the network, (6) clinical services management, and (7) the FY 1998 survey and other DCMHS communication tools. The survey was administered by the Center for Community Development and Family Policy (CCDFP) at the University of Delaware. CCDFP sent the survey to the 36 Chief Executive Officers (CEOs) of agencies that provide services for DCMHS, and 30 Program Directors (PDs) of the individual sites where services are delivered. Out of 66 surveys distributed, 46 were returned for a response rate of 70%, with almost equal proportions of CEO and PD respondents. (For information on sampling procedures, response rates, and survey administration, see pages 1 – 4.)

TYPES OF SERVICES

Most (58%) of the DCMHS providers responding to this year's survey offered mental health services only. Another 31% reported offering both mental health and substance abuse services. Only 11% stated that their agency provided substance abuse services only. Looking across the service types (mental health, substance abuse, both), residential and outpatient treatment were the most common methods of providing services. (See pages 4-5 for details.)

DCMHS MISSION

The majority of service providers reported a high extent of both familiarity with the DCMHS mission and consistency between the DCMHS mission and their own. Comments by respondents raised the issues of time to engage someone in the system and the consistency of the interpretation of the DCMHS mission within DCMHS itself. No specific suggestions for improvements were made about the DCMHS mission this year. This contrasts with last year, when suggestions focused on the need for more DCMHS leadership in such areas as increasing the scope of services and providing a structure for collaboration, among others. However, the current mission was new last year. As the mission becomes more established, DCMHS may want to probe more deeply into specific

elements of the mission. The results from the questions about the DCMHS mission are discussed on pages 6 – 7.

DCMHS SYSTEM PERFORMANCE

Findings

The service providers' responses to questions about DCMHS system performance painted an overall picture of at least moderate success. Service providers tended to say that services to clients were accessible and, to a lesser extent, appropriate. Other strengths of DCMHS system performance were the timeliness of their payments and the professionalism of the staff. DCMHS improvements in the organization of the treatment teams and the re-authorization process were also recognized. As in last year's results, communication received both positive and negative reports. For example, the question about the extent to which DCMHS keeps the agency informed received high ratings from more than 50% of the service providers, but also received low ratings from 20%. The program directors were much more negative than the executive directors about the degree to which they had been kept informed. A large proportion of both executive and program directors reported that the complexity of the paperwork required by the DCMHS system was unreasonable compared to other managed care systems. (See pages 7 – 14 for details.)

Areas for Improvement

In contrast to last year, when communication was the major area identified as needing improvement, this year the particular areas needing improvement were DCMHS services to special populations, the planning of client transitions, and paperwork. Based on the findings, DCMHS should:

- Ensure that clients receive appropriate services, especially for populations such as the chronically ill, disturbed adolescents, children performing poorly on intelligence tests in addition to their mental health issues, and those with cultural or linguistic barriers to accessing or receiving services;
- Coordinate transitions between different levels of service more effectively;
- Continue efforts to streamline paperwork requirements; and
- Decrease the time between requests for approvals and the responses to the requests.

THE ROLE OF THE PROVIDER AND THE PROVIDER NETWORK FORUM

Findings

Communication was the major issue in the role of the provider in the DCMHS system. A majority of the respondents found the provider's role clear and DCMHS expectations

reasonable. In addition, some of the service providers recognized DCMHS efforts in the areas of simplifying paperwork and building teamwork. Nonetheless, in responses to both open- and closed-ended questions, the service providers identified problems in the adequacy of their opportunities to comment on policies and procedures, and in the opportunities for information exchange and dialog at the quarterly meeting series. (Pages 14 – 17 present the results on the role of the provider in the DCMHS system.)

Areas for Improvement

Communication, one major issue identified as needing improvement, is strongly related to another area that the providers said needed work -- teamwork. Recommendations for improvements in these areas are:

- Provide opportunities for service providers to participate in the development and review of DCMHS policies and procedures;
- Hold DCMHS staff accountable for working with the service providers collaboratively;
- Develop a culture in which relationships between DCMHS staff and service providers are based on trust and shared commitment to the well-being of children;
- Suggest that CEOs or their designees who attend the Provider Network Forum meetings report relevant information gathered at the meeting to their program directors, if they are not already doing so;
- Select Forum topics that are more relevant to the service providers by asking for and using their input.

Echoing the findings about DCMHS system performance, other suggestions in this section were made about client services, paperwork, and timeliness. These suggestions included:

- Ensure that services provided to young children are appropriate for both their age and their developmental stage;
- Recognize residential care, a service that is currently underused;
- Reduce paperwork requirements; and
- Respond to authorizations more promptly.

PROVIDER NETWORK ADMINISTRATION

Findings

The survey asked the service providers to respond to questions about their experience with three parts of the Provider Network Administration: DCMHS program administrators, quality improvement administrators, and the contracting or monitoring process. Almost all facets of the administration were perceived positively by a majority of the service providers who responded. Particular strengths were found in the

professionalism, accessibility, and expertise of the staff, and the objectivity of the monitoring visits. The areas of particular concern were communication, especially the feedback from incident reporting, and procedures, including the fairness of the process for becoming a network provider panel member. (For more information, see the discussion on pages 18-23.)

Areas for Improvement

Several very specific recommendations for procedures, timeliness, teamwork, accessibility, and consistency were made in response to the question asking the service providers to identify areas needing improvement. They are not listed here, but can be found in appendix F. The areas that were identified as concerns more generally are incident reporting and the process for becoming a network provider panel member. DCMHS should focus on improving the timeliness and nature of the feedback from incident reporting. In addition, DCMHS needs to improve its communication with service providers about the process for becoming a network provider panel member, and seek out information about what areas are considered unfair by members of the provider network. CEOs may also have a role in improving the program directors' understanding of the process.

DCMHS CLINICAL SERVICES MANAGEMENT

Findings

Clinical services management was also examined in three parts: the management teams, the coordinators/supervisors, and the team leaders. Management teams were considered by a large proportion (more than 20%) of respondents to be performing to a low extent in some areas. The areas were: (1) the utility of the client service plan in developing treatment plans, (2) the clarity of the role of the teams, (3) the teams' consideration of agency input in making clinical and discharge decisions, (4) the reasonableness of the information required for continued authorization of services, and the effectiveness of planning and facilitation of client transitions. The major strength of the management teams was their responsiveness when called with an emergency. The information required for continued authorization, was also considered to be reasonable to a high extent by more than 50% of the respondents, despite the large proportion giving it a low rating,. (For details, see pages 23 – 27.)

Clinical services coordinators/supervisors were rated positively by a majority of the service providers on such criteria as their approachability and accessibility, their professionalism and responsiveness, and their knowledge about the spectrum of children's services in Delaware. Areas of concern appeared to be the willingness of the coordinators/supervisors to explain decisions and resolve disagreements. In addition, while the role of the DCMHS coordinators in the agency's treatment of families was rated high by 50% of the respondents, more than a quarter did not consider their role to be

particularly important in the provider's decisions about the treatment of families. (Pages 27 – 30 present the findings on the coordinators/supervisors.)

Similar to the coordinators/supervisors, the team leaders were most likely to be recognized for their clinical expertise, professional behavior, and approachability. The team leaders were most likely to receive low marks for their willingness to resolve disagreements, willingness to explain decisions, and accessibility. This pattern of results in the quantitative data was reinforced by comments that identified teamwork as a major area needing improvement. (See pages 30 – 34 for the full discussion.)

Areas for Improvement

The two major areas in clinical services management were identified as needing improvement. The first is client transitions into, within, and out of the system. The second is the relationship between the clinical services management staff and the service providers. Although many aspects of the clinical services management staff were perceived positively by the respondents, other important elements were seen more negatively. Both of these areas are tied to the issue of teamwork, as the following recommendations indicate.

- Clarify roles so that it is clear who should be included in decisions about client treatment as well as who is responsible for specific decisions;
- Clarify roles so that the degree to which coordinators/supervisors should have an important role in the service providers' treatment of families is made explicit;
- Solicit and use agency input in decisions;
- Communicate with the agencies about client transitions;
- Ask service providers how DCMHS can more effectively plan and facilitate client transitions, and use their ideas to improve that aspect of clinical services management;
- Make authorizations more quickly (see similar recommendations under DCMHS system performance and the provider role);
- Simplify paperwork requirements for services that require month-to-month reauthorization; and
- Work as partners with service providers so that disagreements are resolved and the rationale for decisions is clear.

THE DCMHS PROVIDER SURVEY AND OTHER COMMUNICATION TOOLS

Findings

With some exceptions, DCMHS staff were appreciated for their accessibility and responsiveness, among other characteristics. However, DCMHS does not seem to have been as successful in communicating with the provider network in ways that are less

personal. Specifically, DCMHS responsiveness to the feedback from the 1998 survey, and the value of the Provider Forum series and the Network News in improving communication between DCMHS and the network received mixed ratings. On the other hand, some of the service providers appreciated that the survey offered the opportunity to give DCMHS some feedback and did see signs of responsiveness. Considerations for future implementations of the survey are (1) shorten it so that it does not become another piece of paperwork, and (2) focus the questions on particular aspects of the services, particularly the transitions from one service to another. (For the full discussion, see pages 34 – 36.)

Areas for Improvement

Specific suggestions for improving or replacing DCMHS tools for communicating with the network were not made in this section. However, in order to improve these tools in general, DCMHS should ask the service providers for input and then work with the providers to implement their suggestions.

CONCLUSIONS

Strengths of DCMHS included the quality of the staff, the timeliness with which it pays its bills, the immediacy with which the teams respond to emergencies, and the fairness and accuracy of monitoring feedback, among others. (Pages 36 – 38 summarize the strengths across all areas.) Undoubtedly the areas identified as strengths could be further improved until the service providers had consistently positive experiences with these aspects of their participation in the DCMHS provider network. However, priority areas for improvement should be those in which negative experiences were expressed by a large proportion of the service providers. Using the criterion of 20% or more low marks to identify these priority areas, particular concerns included services to clients, and communication and teamwork between DCMHS and the service providers. (Areas of improvement are listed on pages 38 – 40.)

In terms of services to clients, recommendations focused on ensuring appropriate services for different kinds of youngsters and smoothing the transitions clients make into, around, or out of the system. One of the major ways in which these transitions could be facilitated would be by more timely responses from DCMHS to requests for approvals and authorizations.

In contrast to last year, when communication was a major issue in almost every section of the survey, this year the results were more mixed, with some evidence from both quantitative and qualitative data that communication had improved. At the same time, it was clear that communication continues to be a priority, especially in regard to specific issues. Specific areas in which communication needs to be improved are incident reporting, the development of policies and procedures, the planning of communication

events (the Forum, NETWORK NEWS, and others), and the relationship between clinical services management staff and the service providers.

This last issue, the relationship between DCMHS staff and the service providers, has elements of both communication and role definition problems. In order for communication to be effective, each person's role must be clear and respected by others involved. This year's survey responses included several comments about the need to develop a sense of teamwork between DCMHS and the service providers. These comments were reinforced by the poor ratings received on such items as the clarity of the management team's role, the team's consideration of agency input in clinical and discharge decisions, and the willingness of clinical services management to work with the providers to resolve disagreements and explain their decisions.

To maintain and go beyond its current standards for services to children, DCMHS needs to continue to develop the successful aspects of their work with the provider network and improve the consistency of that work. DCMHS also needs to bring renewed attention to communication and teamwork in order to achieve their 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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DIVISION OF CHILD MENTAL HEALTH SERVICES
SERVICE PROVIDER SURVEY, FY 1999

INTRODUCTION

The Division of Child Mental Health Services (DCMHS) relies on a network of service providers to offer managed behavioral health 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 both 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 could be improved.

Survey Content and Administration

The format and content of the FY 1999 survey were altered from the FY 1998 survey in order to reflect program and policy changes and respond to suggestions made last year. Overall, however, many of the same topics were covered. This year's survey began by asking service providers to identify the focus (mental health and/or substance abuse services) and type (crisis, outpatient, residential, and so on) of services they offer. Then, specific questions were organized into six sections:

- DCMHS Mission;
- DCMHS System Performance;
- Role of Provider in the DCMHS Managed Behavioral Health Care System;
- Provider Network Administration;
- Clinical Services Management; and
- DCMHS Responsiveness to FY 98 Provider Survey.

Each section used both closed-ended and open-ended questions to understand the experiences of service providers in the contracting agencies. For closed-ended questions, a five point extent scale (with 1 = to little or no extent and 5 = a very great extent) was employed. At the end of each of the six sections, respondents were asked open-ended questions about strengths and areas needing improvement. The final section of the survey asked service providers open-ended questions about the survey process, CEU training events, and any other areas for improvement.

The University of Delaware conducted the 1999 DCMHS Service Provider Survey in June and July. Sixty-six surveys were distributed. Thirty-six were mailed to agency Chief Executive Officers (CEOs), and 30 were sent to the Program Directors (PDs) of the individual sites where services were delivered. The survey respondents were identified

by DCMHS as the total number of providers, CEOs and PDs, in the network. The 66 surveys solicited information from administrators and staff at 38 organizations in the network, some with as many as 7 locations. Table 1 shows the response rate by type of respondent and in total.

Table 1. 1999 Response Rate by Type of Respondent

Type of Response	CEOs	PDs	Total
Responses from those familiar with DCMHS	25	21	**46**
	69%	70%	**70%**
Responses from those unfamiliar with DCMHS[a]	0	1	**1**
		3%	**2%**
Nonresponse	11	8	**19**
	31%	27%	**29%**
TOTAL Surveyed	**36**	**30**	**66**
	100%	**100%**	**100%**

[a] The respondent who reported being unfamiliar with DCMHS did not respond to any of the other questions and so is not included as a respondent in the analysis of the other questions.

This year's response rate of 70% compares favorably to FY 1998's response rate of 38% (28 surveys out of 76 distributed) and FY 1997's response rate of 61% (20 surveys out of 33 distributed). The improvement may be attributable to the administration of the survey by an external organization, enabling the confidentiality of the responses to be protected. In addition, by color coding the surveys to distinguish CEOs from PDs and using the questions asking for the agency and title of the person returning the survey, the University researchers were able to identify the agencies from which a survey had not been received. These service providers received a second survey. Those who did not respond after that were called in order to determine the reasons for nonresponse. For details about how the response rate was calculated and the reasons for nonresponse, see Appendix A.

The response rate also represents good coverage of the number of organizations that were surveyed. Twenty-seven (71%) of the 38 organizations were represented by at least one response from a CEO or PD.

Strengths and Limitations of the Data

In addition to the improvements in response rate, the major strength of the data from this year's survey is that responses from CEOs can be distinguished from those of PDs. Last year, both groups were surveyed but the CEO and PD responses could not be separated, so the analysis combined both groups. Although in many cases the CEO and PD

responses have similar patterns, there are issues on which the CEOs and PDs have different perspectives.

A second strength of this year's survey is the high proportion of service providers who responded to the open-ended questions. The questions about the DCMHS mission received only two comments, but the topic receiving the next lowest number of remarks was network administration, with 10 (22%) of the respondents writing their observations. Both of the open-ended questions on system performance garnered comments from more than half of the respondents, with 26 (57%) responding to the question about the strengths of the DCMHS system and 28 (61%) suggesting areas for improvement in the system.

The major limitation of the data is that not every provider receiving a survey returned one. The views of 19 (29%) of the 66 service providers identified as executive or program directors by DCMHS are not included in the survey results. If their experiences have been markedly different from those of the respondents, the results could change considerably. In short, the analyses provided below include the majority, but not all, of the potential respondents or of the organizations within the network. Caution should be used when generalizing these results to the network in general. A second concern is the limitation on comparisons between 1998 and 1999 responses. The changes in question wording or the increased response rate or both are possible explanations for any differences seen between the years.

Organization of the Report

The report presents the survey findings in sections corresponding to those in the survey itself. The first section describes the respondents in terms of the focus and type of services provided by their agencies. The second section reports the responses to questions about DCMHS Mission. This is followed by the findings on DCMHS System Performance, Role of the Provider in the DCMHS System, Provider Network Administration, and Clinical Services Management. Then, the seventh section describes respondents' assessment of DCMHS responsiveness to last year's survey. The eighth and last section of the survey consisted of four open ended questions. The responses to these questions are not presented together, but instead are included in other sections of the report where related issues are discussed. The report concludes by looking across the different survey sections for common areas of strength and concern in the DCMHS system. Appendices contain data tables and the full text of respondent comments. The appendices correspond to the report sections.

Within the body of the report, tables and figures are used to display the 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 responding 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.

In order to identify areas in which DCMHS appears to be strong and those that should be priority areas for improvement, two guidelines were chosen. If 50% or more of the service providers reported that the item being asked about had occurred to a high extent, the item was considered to be one in which DCMHS had some strength. On the other hand, if 20% or more of the respondents found that an item had occurred to a low extent, the item was identified as an area that DCMHS should consider a priority for improvement. Because it is possible for a single item to have 50% or more of the respondents giving it high marks and 20% or more of the respondents giving it low marks, some characteristics are identified as both strengths and areas needing improvement.

An inductive approach was taken to analyzing the comments made in response to the open-ended questions. First, the comments in response to each question were sorted into groups based on the similarity of their content. Then, labels were assigned to the groups. To refine the labels, all the comments with the same label were grouped together and then reviewed for similarity. The complete results of this analysis are provided in the appendices; illustrative quotations from the comments are included in the text. The final set of categories used to organize the open-ended responses were:

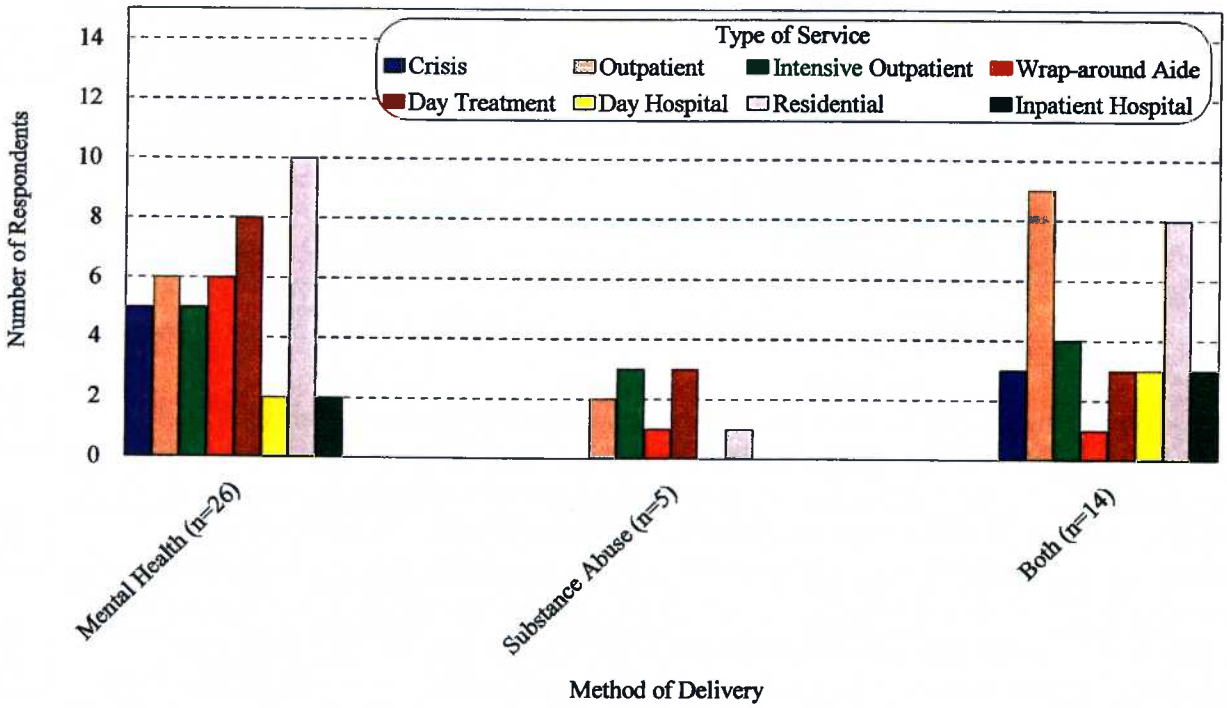
- **Services:** Services provided to children.
- **Communication:** The amount of communication, especially around specific issues.
- **Paperwork:** DCMHS paperwork requirements generally, or for specific areas.
- **Timeliness:** The speed with which providers receive responses or feedback from DCMHS.
- **Consistency:** Consistency across different levels and locations of DCMHS.
- **Teamwork:** Collaborative or cooperative relationships between DCMHS staff and the service providers.
- **Professionalism:** Specific attitudes and behaviors demonstrated by DCMHS staff in working with the service providers.
- **Knowledge/Technical Assistance:** DCMHS staff expertise or willingness to fmd answers to the providers' questions.
- **Accessibility:** The availability of DCMHS staff to the service providers.
- **Procedures:** Processes or characteristics of the organization, other than services.

TYPE OF SERVICES PROVIDED

Most of the DCMHS providers responding to the survey offered mental health services only. Twenty-six (58%) providers checked that option on the survey. Another 14 (31%) reported offering both mental health and substance abuse services. Only five (11%) stated that their agencies provided substance abuse services only. (One respondent did not identify the type of services offered by his or her agency.)

Across these types of services, a variety of methods of delivery are used. Figure 1 shows which delivery methods were used for the different services. Because the number of providers using the treatment types varies widely, the figure uses the actual numbers of service providers in each category instead of proportions. (See table B.2 for details.) The most common treatment methods were residential treatment, provided by 20 (44%) of the respondents, and outpatient services, provided by 17 (37%). Of the 26 providers offering mental health services only, the top two methods were residential and day treatment. Ten (39%) of the mental health treatment providers had residential services and eight (31%) had day treatment programs. Day treatment was also one of the two more frequently used methods by the five providers offering substance abuse services only. The other method was intensive outpatient. Both of these methods of delivery were employed by three (60%) of the five substance abuse treatment providers. The respondents that offered both mental health and substance abuse programs followed the same pattern as the overall results, with eight (62% of 13) providers offering outpatient services and seven (54% of 13) offering residential treatment. Looking across all of the respondents, day hospital and in-hospital programs were the least commonly used methods. Only five (11%) service providers offered each.

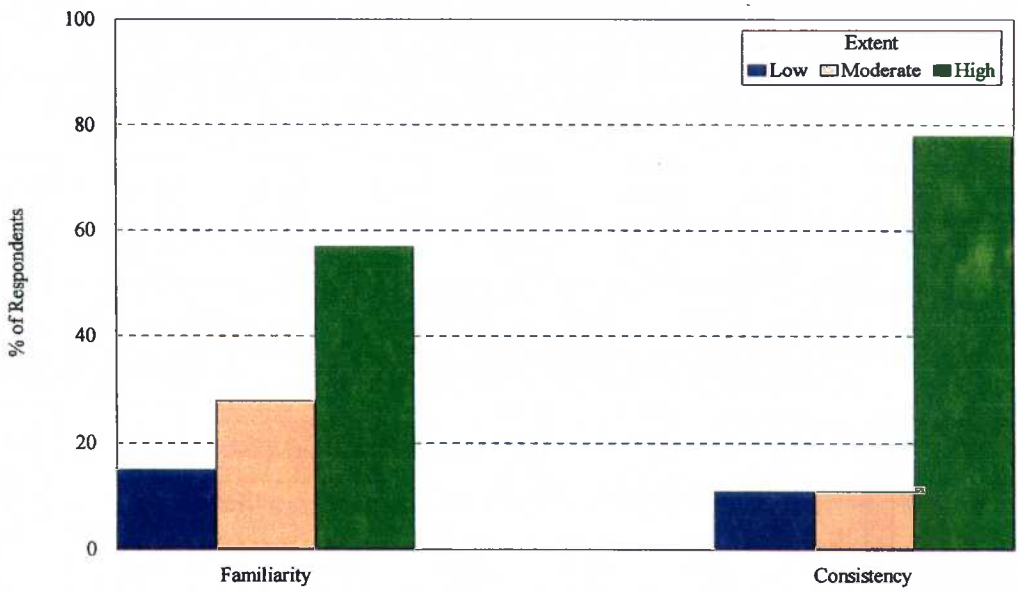
Figure 1. Methods of Delivery Used by Different Types of Services



DCMHS MISSION

The mission of the Division of Child Mental Health Services is to "develop the potential of this generation and the next through effective treatment for children and their families and collaboration with service partners." The survey asked respondents to identify the extent of their familiarity with the mission. Then respondents were asked the extent of consistency between the DCMHS' mission and the mission of their agency. Figure 2 displays how the service providers responded.

Figure 2. Familiarity with and Consistency of DCMHS Mission



Large proportions of both CEOs and PDs reported that they were familiar with the DCMHS mission and that the DCMHS mission was consistent with their own to at least a moderate extent. In 1998, 70% of the respondents agreed with the statement, "I am familiar with the recent changes made to the DCMHS mission." In 1999, when the changes to the mission were no longer new, 85% of the service providers stated that they were familiar with the DCMHS mission to at least a moderate extent. The change from 1998 to 1999 could be accounted for by the passage of the year during which more providers became familiar with the mission, or the improved response rate in 1999 which enables a more accurate estimate of familiarity. As the figure shows, the service providers were more confident about the degree to which their agencies' missions were consistent with the DCMHS mission than they were about their familiarity with the DCMHS mission.

The CEOs were slightly less likely than the PDs to state that they were at least moderately familiar with the DCMHS mission. Compared to 95% of the 21 PDs, 76% of the 25

CEOs gave a moderate or high rating to the question about familiarity. CEO and PD responses to the question about the consistency of missions were more similar than their responses to the familiarity item. Ninety-two percent of the 24 CEOs and 86% of the 21 PDs indicating that the mission of their agency was consistent with the DCMHS mission to at least a moderate extent. (See table C.1 for the data supporting the figure, and table C.2 for the break-down of responses by CEO and PD.)

The questions about the DCMHS mission closed with an open-ended question, asking respondents to provide any comments they wanted to make about the mission. Only two providers responded to this question. One comment was, "Process time to engage a person in the system." The other, "At times the mission implementation becomes unclear as it is interpreted very differently by different team leaders," identifies consistency within DCMHS as a concern.

Conclusions

The majority of service providers reported a high extent of familiarity with the DCMHS and of consistency between the DCMHS mission and their own. In the comments, the issues of time to engage someone in the system and the consistency of the interpretation of the DCMHS mission within DCMHS itself were raised.

SYSTEM PERFORMANCE

The system performance section of the survey was designed to learn how providers view DCMHS compared to other managed care organizations. The survey queried providers about access to services, information management, and client treatment options, as well as administrative concerns such as amount and complexity of paperwork, timeliness of payments, and provider knowledge of the appeals process. The specific questions asked the extent to which the DCMHS accomplished the following:

1. Provide access to services for clients?
2. Keep my agency informed about the DCMHS managed care system?
3. Ensure that the amount of paperwork required for DCMHS managed care is reasonable, compared to other managed care systems?
4. Keep the complexity of paperwork required for DCMHS managed care reasonable, compared to other managed care systems?
5. Make payments within 30 days after bills are submitted?
6. Clearly describe the process for provider appeals?
7. Ensure that clients receive appropriate services for the conditions they present?

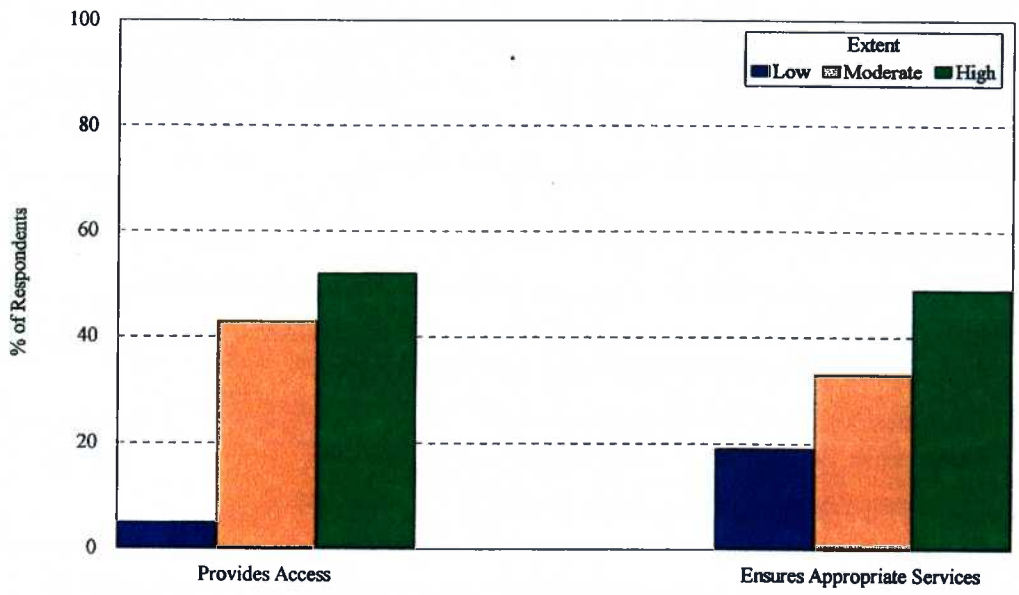
This section displays the distribution of responses to these questions in figures. Figure 3 addresses the questions about services for clients (questions 1 and 7). Figure 4 displays

the information about paperwork (questions 3 and 4). Findings on the communication issues raised in questions 2, 5, and 6 are presented in figure 6. Responses to the open-ended questions about the strengths of DCMHS system performance and the areas in which it could be improved are woven into the discussion of the findings presented in the figures. The complete summary of the data is provided in Appendix D. Table D.1 presents the general distribution of responses, while table D.2 breaks the results out by type of respondent. Table D.3 provides all of the comments made in response to the open-ended questions.

Access and Appropriateness of Client Services

The responses to the questions about client access to services and the appropriateness of the services indicated at least a moderate extent of satisfaction (see figure 3). Out of 44 respondents, 19 (43%) perceived the DCMHS system as providing access to clients at a moderate extent and 23 (52%) reported that the system provided access to a high extent. The pattern is similar but a little less positive for the appropriateness of the services. Out of 43 respondents, 14 (33%) reported that DCMHS ensured that the client receives appropriate services to a moderate extent, and 21 (49%) stated DCMHS ensured the appropriateness of services to a high extent. CEOs and PDs were both more positive than negative. However, a substantial proportion of the 21 PDs (7, or 33%) said that DCMHS ensures that clients receive appropriate services to a low extent, while only one (5%) of the 22 CEOs gave that item a low rating.

Figure 3. System Performance – Access to and Appropriateness of Client Services



Many of the comments made in response to the open-ended questions about DCMHS system performance focused on services. Most of the service-related comments were

written in response to the question about areas for improvement. The service areas needing improvement included services for specific populations and transitions. The specific populations mentioned in the comments included the chronically ill, severely disturbed adolescents, children with low IQ in addition to mental health issues, and those with cultural or linguistic barriers to accessing or receiving services. The comments about transitions focused on the changes from one level of service to another. The two following comments fall into this category:

- "There is poor coordination between different levels of service."
- "Allow for gradual step down from intensive services. There is a tendency to send clients to routine outpatient when being discharged from inpatient or RTC. Often a step down to Day Treatment or IOP would be more effective/appropriate for a while and then outpatient."

In addition to comments directly focusing on services, some of the comments that were classified under the procedures category related to the accessibility of services. For example, one respondent wrote, "Problems with families accessing services and with referral process. Gate is very high."

The above results suggest that DCMHS needs to work harder to ensure that clients receive the appropriate services, transitions are appropriate, and special populations are included. However, some of the comments reinforce the positive trend in figure 3. For example, the statements below mention the wide range of services and the ability to provide the services that are needed.

- "Ability to provide a wide range of services - commitment to provide whatever service is needed."
- "The DCMHS system offers and manages a wide variety of programs and has been able to maintain many programs as program funded and not fee for services. This allows services to provide intensive services for difficult situations."

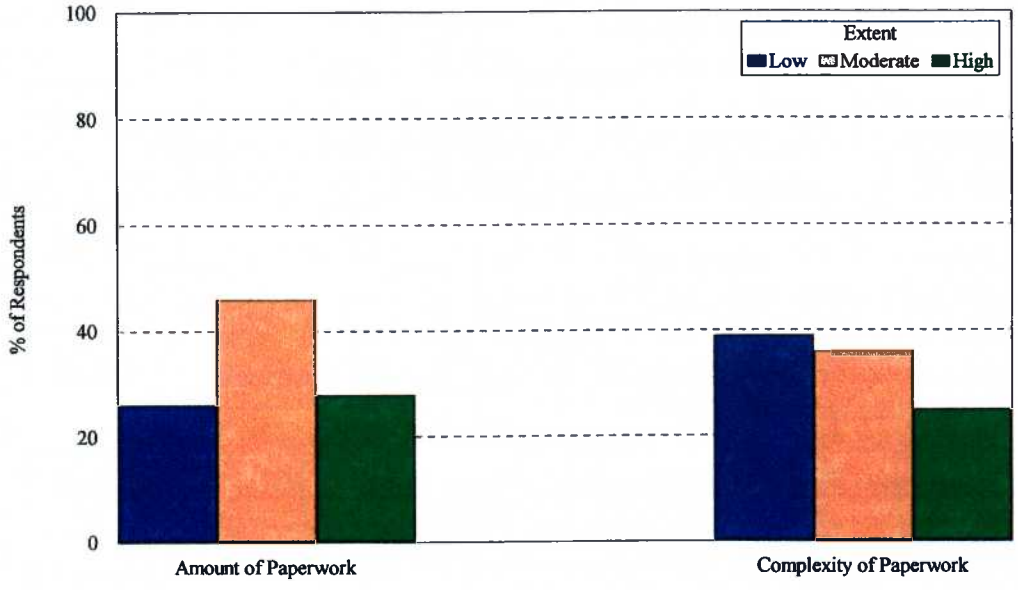
Amount and Complexity of Paperwork

While one in two respondents said that DCMHS ensured the access to and appropriateness of client services to a high extent, only one in four stated that paperwork complexity was reasonable to the same extent. The amount of paperwork received a slightly higher proportion (27% compared to 25%) of high ratings, but the pattern was still markedly less positive than that for access to and appropriateness of client services. This pattern was consistent across both CEO and PD respondents.

As shown in figure 4, respondents were most likely to give a moderate rating to the item about the amount of paperwork. Twenty-one (46%) of the 46 respondents said that the amount of DCMHS paperwork was moderately reasonable compared to that required by other managed care systems. In contrast, by marking the low options in the survey, 17 (39%) of 44 service providers indicated that the complexity of DCMHS paperwork was not reasonable compared to other managed care systems. Looking across all of the

system performance items, the complexity of the paperwork received the largest proportion of low marks.

Figure 4. System Performance – Paperwork



There were fewer comments about paperwork than about client services. The comments on paperwork were about equally mixed between strengths and areas needing improvement. Paperwork-related comments in response to the question about DCMHS system strengths included:

– "Tries to keep paperwork updated to combine 1 or 2 forms together, which makes less forms for clinicians to complete."
– "The paperwork for the service we provide is minimal."
– "Paperwork is more manageable than other systems but can be streamlined further."

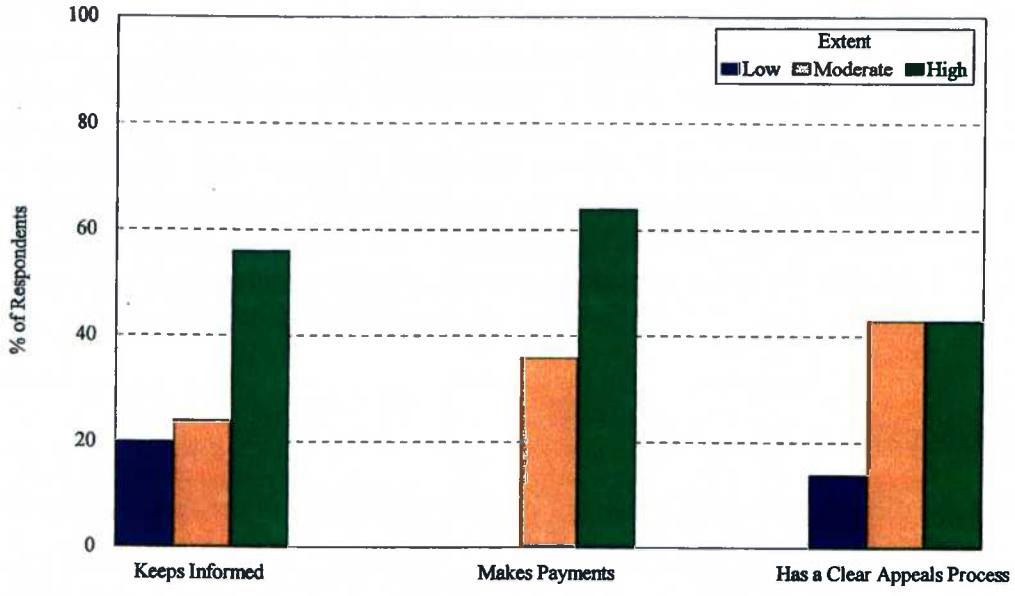
These two comments illustrate the kinds of comments that identified paperwork as an area that DCMHS needs to improve:

– "Overwhelming paperwork."
– "They could reassess the amount of paperwork required and eliminate some of it."

Other System Performance Items

The other three questions about system performance addressed the extent to which DCMHS keeps the agencies informed about the managed care system, the timeliness of the payment of bills, and the clarity of the process for provider appeals. The distribution of the responses to these questions is displayed in figure 5.

Figure 5. Other System Performance Items



Keeps Agencies Informed

Overall, the responses to the question about keeping agencies informed about the system were positive, with 56% of the 45 respondents reporting that their agency had been kept informed to a high extent. However, 20% of the service providers gave this item a low rating. In thinking of how to improve this record, DCMHS should taking into consideration that PDs were much more likely than CEOs to give low ratings to the item. While 8% of the CEOs said that DCMHS kept their agency informed to a low extent, 33% of the PDs had the same response. This may indicate that DCMHS needs to broaden the distribution of information or that CEOs need to take more responsibility for distributing DCMHS information within their agencies.

Comments related to how DCMHS keeps the service providers informed appeared in responses to both of the open-ended questions. Typical comments about communication as a strength were:

- "Willingness of most staff to discuss and improve the system."
- "DCMHS actively communicates needed information to providers in a timely manner."
- "Contract administrator provides both open and regular communication."

In suggesting areas for improvement in the way that DCMHS communicates with the service providers, comments such as the following were made:

- "We get no assistance or feedback regarding program performance as compared to other similar programs."
- "Communicate to us how we can better negotiate their system and provide quarterly updates regarding organizational structure and changes in the system."

Makes Payments

When asked whether DCMHS makes payments within 30 days after bills are submitted, 23 (64%) of the 36 service providers responding to this question reported that DCMHS does that to a high extent, with CEOs and PDs similarly positive. Matching the 1998

results in which none of the providers had said that they disagreed with a statement about the timeliness with which DCMHS paid its bills, none of the 1999 respondents said that payments were made within 30 days to a low extent. However, one of the comments about improving the paperwork requirements stated, "Paperwork is too cumbersome. Bills due 10 days after close of month with no subsequent bills allowed."

Has a Clear Appeals Process

While this item did not receive high marks from more than 50% of the respondents, some evidence suggests that the appeals process may have become clearer since last year. Of this year's 43 respondents, 18 (42%) said that the appeals process was clear to a high extent and 19 (44%) rated it clear to a moderate extent, for a total of 86% reporting at least a moderate extent of clarity. In 1998, only 52% of the respondents agreed that the process was clear. (As in any 1998-99 comparison made in this report, the reader needs to consider the fact that either question wording or response rate alone or in combination could account for the differences observed.)

Comparing across respondent types, there was almost no difference in the pattern of responses across CEOs and PDs in terms of high ratings, but CEOs were slightly more likely than PDs to give the clarity of the appeals process a low mark. The appeals process was the subject of a positive statement about timeliness, "On one occasion recently when an appeal was made, the response was prompt and appropriate." On the other hand, two service providers responding to the question about areas needing improvement targeted the appeals process. One stated, "Appeals write or define process; requiring less paperwork - have DCMHS do chart reviews + not collect /store records." The other wrote, "The appeal process, treat inquiries as such, not as challenges to the 'system'."

Other Themes from the Open-Ended Responses

In addition to the issues described above, service providers raised other issues in their responses to the open-ended questions about strengths and areas needing improvement. (All comments are provided in table D.3.) These issues included timeliness, consistency, work relationships (teamwork, professionalism, expertise, accessibility), and procedures. The comments about consistency and teamwork focused on clinical services management teams and will be discussed further in the section on clinical services management. Expertise and accessibility each garnered one comment each, both identifying strengths in "knowledge of clients; clinical expertise," on the one hand, and the availability of the

contract manager, on the other. The three remaining topics, timeliness, professionalism, and procedures, were the subjects of more comments.

Timeliness. With the exception of the comment provided above on the timeliness of an appeal, statements about timeliness identified ways in which DCMHS needs to improve. Approvals were a particular concern, as evidenced by comments such as:

– "Slow response with approval."

– "Lengthy delay in applications being accepted for admission by central intake."

Authorizations for more intensive services were also identified as needing to be made more quickly.

Professionalism. In contrast to timeliness, which the respondents clearly identified as an area needing improvement, professionalism was mentioned as a strength in the comments about DCMHS system performance. Such statements as, "Case managers are active with parents of clients," and "The contract manager appears to be a strong advocate of our program," illustrate the ways in which the service providers recognized the professional commitment of some of the DCMHS staff. The only comment identifying a need for improvement was about the need for local teams to promote professionalism with providers.

Procedures. The organization of the DCMHS system and the improvement in some areas, including the re-authorization process, were recognized as strengths by the respondents making comments about procedures. While some service providers complimented the organization for being streamlined, others commented that it was complicated and recommended simplifying the system. Other procedures needing improvements were contracts ("need more money for services"), the referral process, and the appeal process. (See discussions above about client access to services and the clarity of the appeal process.) In contrast to last year, when the provider manual was one of the items identified as needing improvement, the provider manual was mentioned in only one comment this year: "When writing provider manual, be cautious about referencing other documents unless included in new contract envelope."

Conclusions

The overall picture is one of at least moderately successful system performance, with some strengths and some areas needing improvement. The strengths identified by the service providers included the accessibility of DCMHS services to clients, the timeliness with which DCMHS pays bills, and the professionalism of the staff. DCMHS improvements in the organization of the treatment teams and the re-authorization process were also recognized. The CEOs reported that DCMHS was successful in keeping their agencies informed, but the PDs were much less positive. With 20% of the providers giving DCMHS low ratings for keeping their agencies informed, this is an area that needs improvement despite its high marks. Similarly, despite some strengths in these areas,

some service providers reported deficits in the accessibility and appropriateness of client services for special populations, and in the transitions within the system. Paperwork was another area needing improvement. Neither the amount nor the complexity of paperwork received many high ratings; both received low ratings from more than 20% of the respondents; and the complexity of paperwork was particularly singled out as unreasonable compared to other managed care systems, with 39% of the providers giving it a low mark. A related issue, communication, is more mixed. In their comments, service providers were almost equally divided between those who said something positive about DCMHS communication and those who said that communication was an area needing improvement. In short, despite the evidence of strengths in DCMHS performance, several areas are in need of improvement.

THE ROLE OF PROVIDER AND THE PROVIDER NETWORK FORUM

This section of the report focuses on the role of the provider in the DCMHS managed behavioral health care system. Questions in this section of the survey were separated into two parts. The first part addressed DCMHS requirements and expectations for service providers. The second part asked about the DCMHS-Provider Network Forum quarterly meeting series. These two topics are discussed below. Ideas for continuing education training events, which were solicited with a question at the end of the survey, are also presented in this section. Background tables and the full texts of all of the comments are provided in appendix E.

Role of the Provider

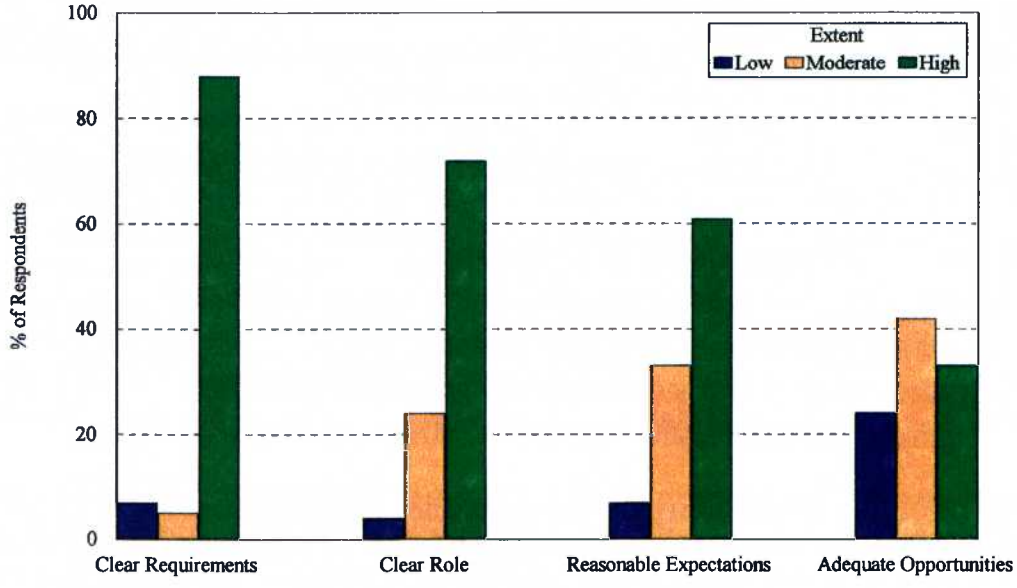
In seeking to understand whether they are supporting the providers with clear expectations and opportunities to interact, DCMHS posed the following questions:

1. How clear (if at all) are the requirements for providing mental health/substance abuse services under my agency's contract/provider agreement with DCMHS?
2. How clear (if at all) is your agency's role as service provider within the DCMHS managed care system?
3. How reasonable (if at all) are DCMHS expectations for your agency?
4. How adequate (if at all) are the opportunities to comment on policy and service delivery/provision procedures?

As shown in figure 6, a majority of the respondents gave high ratings to the clarity of the requirements, the clarity of the agency's role as service provider, and the reasonableness of the expectations for the agency. These items were marked low by 3 (7%) or fewer service providers. The clarity of the requirements received the most high ratings, with 38 (88%) of 43 respondents reporting that the requirements were clear to a high extent. In contrast to the positive pattern established in these three items, only 15 (33%) of 45

respondents said that the opportunities to comment on policies and procedures were adequate to a high extent. Eleven (24%) said that the opportunities were adequate to a low extent. The pattern of large proportions of high ratings on the questions about requirements, role, and expectations, and a small proportion of high ratings on the question about opportunities to comment parallels the pattern in the 1998 survey. DCMHS needs to continue to seek opportunities to include service providers in decisions. The pattern of responses was also similar across CEOs and PDs, although PDs were somewhat less positive than CEOs on the questions of the clarity of the role and the reasonableness of the expectations and somewhat less negative about the adequacy of the opportunities to comment.

Figure 6. Role of the Provider



The survey asked respondents, "What can DCMHS do to assist you, as a provider within the DCMHS managed behavioral health care system, to provide the best services to Delaware children?" Twenty-four (53%) of 45 providers responded to this question. Their comments are presented in appendix E. Both compliments and constructive suggestions were made. For example, one respondent wrote, "Forms have been simplified over last few years – Thanks!" In contrast, another comment was simply, "Reduce paperwork requirements."

As in the comments made about system performance, services emerged as one of the major themes in the providers' remarks about how DCMHS could assist them. Moreover, the issue of services to specific populations came up again in two comments that recommended providing age-appropriate services to young children. The other service-related comments asked DCMHS to recognize specific services, especially

residential care. These comments are especially interesting because residential care was one of the more common methods of service delivery (see figure 1).

Paperwork, timeliness, and teamwork were the other major issues identified in the comments. The comments provided above capture the tone of the paperwork comments. The major timeliness issue is the time involved in authorizations, as in this comment: "Quicker authorization response." In the area of teamwork, one comment was positive, but the others focused on the need to work collaboratively. The positive comment was, "They are already most helpful, we have worked collaboratively to create solutions to service gaps." The others emphasized the need to have trusting relationships in which the focus is on the children.

DCMHS-Provider Network Forum and CEU Training

Within the survey section on the role of the provider, DCMHS asked a set of questions about the Provider Network Forum. These questions were:

To what extent, if any, does the DCMHS-Provider Network Forum quarterly meeting series:

1. Ensure consistent information exchange?
2. Afford providers an opportunity of input and open dialogue?
3. Share information in an effective manner?
4. Identify topics of discussion that are germane to providers?
5. Improve communication between DCMHS and providers?

Thirty-six (82%) of the 45 service providers responded to the questions about the quarterly meeting series. Table 2 displays the distribution of the responses to these items broken out by CEO and PD respondents. (See table E.3 for the distribution of the combined responses.) The CEOs were positive about the degree to which the meeting series had achieved the objectives implied in the questions. For each item, four out of every five (80%) of the CEOs gave ratings of at least a moderate extent. In contrast, the highest proportion of moderate and high ratings given to any of these items by PDs was 67% for the effective sharing of information. The other items had no more than two out of every three (60%) PDs reporting that the objectives had been achieved to at least a moderate extent. In other words, at least 40% of the PDs reported that the quarterly meeting series was unsuccessful in providing opportunities for input and open dialogue, facilitating the effective sharing of information, focusing on relevant topics, or improving communication between DCMHS and the providers. However, this is probably explained by the fact that the Provider Network Forum is intended for CEOs or their designee. PDs were much less likely than CEOs to participate in the quarterly meeting series.

Table 2. DCMHS-Provider Network Forum Quarterly Meeting Series

To what extent, if any, does the DCMHS-Provider Network Forum quarterly meeting series:	Low		Moderate		High		Total	
	CEO	PD	CEO	PD	CEO	PD	CEO	PD
Ensure consistent information exchange?	1 5%	6 40%	7 33%	4 27%	13 62%	5 33%	21 100%	15 100%
Afford providers an opportunity of input and open dialogue?	3 14%	8 53%	7 33%	4 27%	11 52%	3 20%	21 100%	15 100%
Share information in effective manner?	1 5%	5 33%	9 43%	4 27%	11 52%	6 40%	21 100%	15 100%
Identify topics for discussions that are germane for providers?	4 19%	7 47%	6 29%	1 7%	11 52%	7 47%	21 100%	15 100%
Improve communication between DCMHS and providers?	1 5%	6 40%	12 57%	6 40%	8 38%	3 20%	21 100%	15 100%

In response to the open-ended question asking service providers to identify what improvements can be made to the DCMHS-Network Provider Forum, 23 service providers suggested changes. The main issue for this group was communication. In looking at responses within the category of communication, every comment indicated a lack of awareness of the forums, a failure of the notification process, or both. This issue probably reflects the concerns of the PDs who are not participants in the meeting series. While some of the other comments stated the need for more provider input into the forum agenda, other service providers used the survey to suggest topics for future meetings and preferred formats and locations. The specific suggestions can be found in table E.4.

In a related question, DCMHS asked what CEU training events they could sponsor for the network. Twelve of the service providers responded. The majority of suggested topics related to clinical issues, but some were about professional and procedural topics as well. See table E.5 for the recommendations.

Conclusions

Communication was the major issue in the role of the provider in the DCMHS system. Some aspects of the provider's role were clear and expectations seemed reasonable to a majority of the respondents. However, in both open- and closed-ended questions, the service providers identified communication problems in the adequacy of their opportunities to comment on policies and procedures, and in the opportunities for information exchange and dialog at the quarterly meeting series. The adequacy of opportunities to comment is a concern that was raised in the 1998 survey as well. For the quarterly meeting series, improvements were suggested in notifying providers about the meetings and in improving the relevance of the topics.

PROVIDER NETWORK ADMINISTRATION

The following presentation of the data from the survey items on the administration of the provider network is divided into four sections. The first section contains the providers' responses to questions about their experience with DCMHS Program Administrators. The second section reports the findings on Quality Improvement Administrators. The contracting and monitoring process is covered in the third section. General comments about the strengths of and areas for improvement in the network administration and monitoring process are provided in the last section. For tables and the full text of the responses to the open-ended comments, see appendix F.

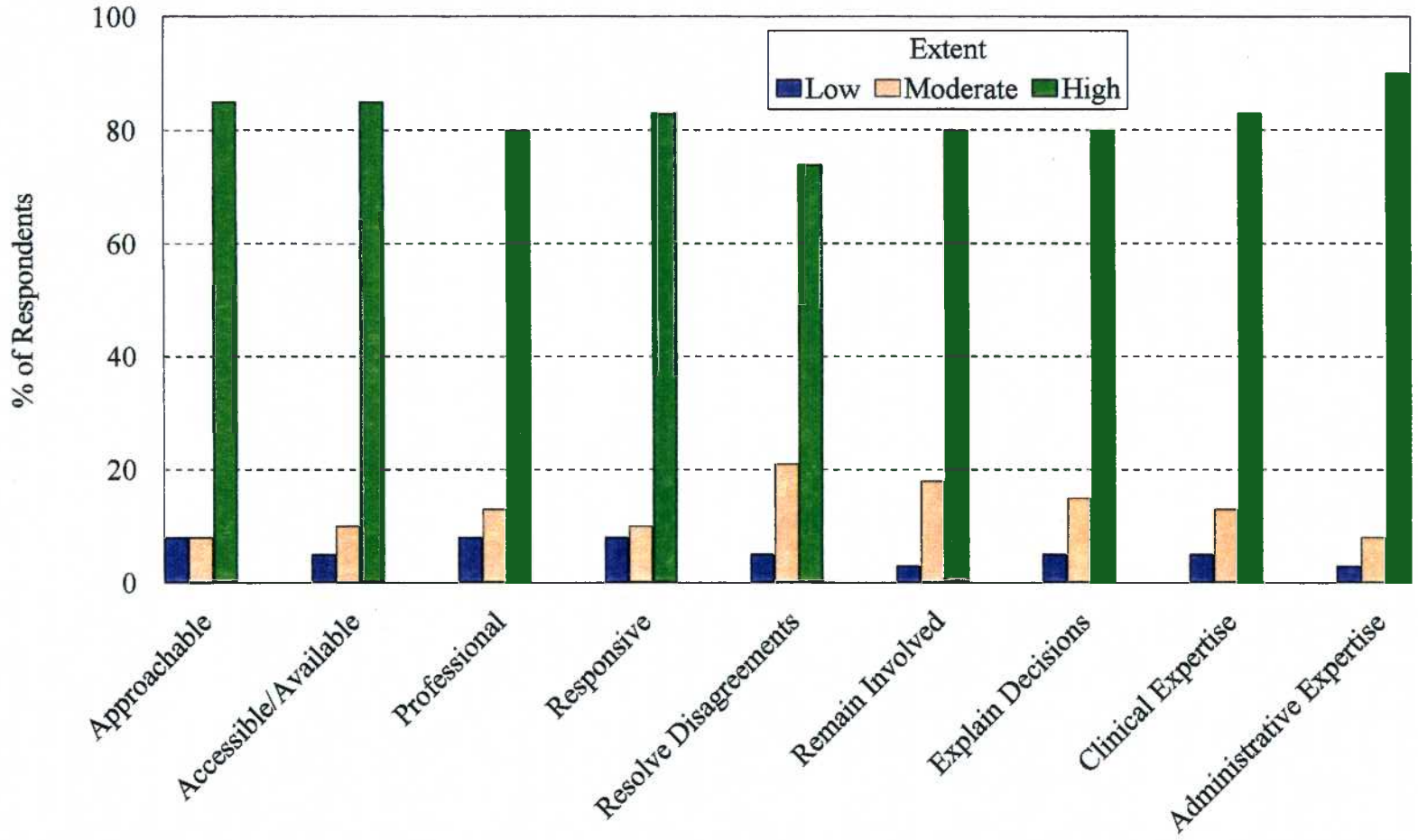
Provider Experience with DCMHS Program Administrators

The survey asked respondents to answer the questions about program administrators only if they had direct experience with one or more of the administrators. Forty service providers responded to the section, although not every respondent answered every question. Using the stem, "In your experience, to what extent, if at all, are the DCMHS Program Administrators:" the items were:

1. Approachable?
2. Accessible/available?
3. Professional in their working relationships?
4. Responsive to questions?
5. Willing to resolve disagreements?
6. Willing to remain involved?
7. Willing to explain DCMHS decisions?
8. Knowledgeable about clinical processes?
9. Knowledgeable about administrative processes?

As shown in figure 7, all of the questions about program administrators received high ratings by at least 74% of the respondents. The item receiving the highest proportion of high ratings was the administrators' knowledge about administrative processes which 90% of the respondents marked high. This item is closely followed by the approachability and accessibility of the administrators. Eighty-five percent of the service providers said that the administrators had those characteristics to a high extent. No more than three (8%) of the 40 respondents reported that program administrators had the qualities identified in the questions to a low extent. In the comments about DCMHS network administration overall, one respondent wrote that his or her assessment would vary depending on the specific administrator. In general, however, respondents indicated that their experience with the DCMHS Program Administrators has been positive. The responses to similar questions in the 1998 survey were also positive, so this year's results could indicate that DCMHS has not lost any ground in this area. In addition, high proportions of both CEOs and PDs gave the items positive marks, suggesting equal satisfaction with the program administrators across the two groups.

Figure 7. Program Administrators



Provider Experience with DCMHS Quality Improvement Administrators

The second part of the Provider Network Administration section of the survey directed service providers to respond only if they had direct experience with Quality Improvement Administrators. Twenty-five (56%) of the 45 respondents answered this section. The questions and the distribution of responses are displayed in table 3. To see how CEO and PD responses compare, see table F.3.

Table 3. Quality Improvement Administrators – Distribution of Responses for Total

To what extent, if any:	Low	Moderate	High	Total
Is assistance from DCMHS Quality Improvement Administrators … clear?[a]	3 12%	10 40%	12 48%	25 100%
Are incident reporting procedures for providers clear?	1 4%	7 28%	17 68%	25 100%
Is feedback from incident reporting informative?	9 39%	8 35%	6 26%	23 100%

[a]Full text of the question is: Is assistance from DCMHS Quality Improvement Administrators in the interpretation of standards, development of provider standards and records available?

The responses to the question about the availability of the QI administrators were almost evenly balanced across moderate (40%) and high (48%). The 88% of the service providers giving at least moderate marks on this item is similar to the 86% of last year's respondents that agreed with a similar statement about the availability of assistance. Although the administrators did not receive many low ratings on their availability, the sizable proportion of moderate ratings indicates that there is room for improvement. For this item, as for the other two questions, higher proportions of PDs than of CEOs said that the characteristic was present to a high extent. However, because the number of respondents is so small, one or two additional respondents could change the distribution considerably. Thus, the CEO and PD comparison must be made with caution.

The item that received the most positive ratings is the clarity of the incident reporting procedures, with 24 (96%) of the 25 service providers stating that the procedures were clear to a moderate or high extent and only 1 (4%) finding the procedures unclear. This appears to be an improvement over last year when 19 (79%) of 24 respondents agreed that the procedures for incident reporting were clear and 5 (21%) disagreed. (Of course this improvement could be explained by differences in the respondents from one year to the next.)

Compared to the other two questions, the item about the feedback from incident reporting received moderate or high marks from a much lower proportion of respondents (14, or 61% of 23). Nine (39%) of the service providers said that feedback was informative to a low extent, indicating that this issue should be a priority concern. These proportions are similar to those found in the analysis of a comparable question in 1998: Sixty-seven percent of the 1998 respondents agreed that the feedback was informative and 33%

disagreed. (The 1998 proportions are derived by calculating the percent of agree and disagree responses from those who gave agree or disagree responses. The providers who marked Don't Know or not applicable were excluded.)

Two 1999 respondents wrote marginal comments that reinforced the ratings given to the feedback. These comments were:

- "we did not receive any information from them"
- "no feedback!"

Experience with Contracting or Monitoring Process

The third part of the Provider Network Administration section of the survey directed service providers to respond only if they had direct experience with the contracting or monitoring process in FY 1998. Seventeen to eighteen (38 - 40%) of the 45 respondents answered this section. Table 4 lists the questions and displays the distribution of responses for each item.

Table 4. Contracting and Monitoring – Distribution of Responses

TO WHAT EXTENT, IF ANY:	Low	Moderate	High	Total
Is the DCMHS process for becoming a network provider panel member clear?	3 17%	3 17%	12 67%	18 100%
Is the DCMHS process for becoming a network provider panel member fair?	4 24%	2 12%	11 65%	17 100%
Is adequate notification provided for the scheduling of monitoring visits?	3 17%	2 11%	13 72%	18 100%
Are the monitoring visits conducted in an objective fashion?	1 6%	2 12%	14 82%	17 100%
Is monitoring feedback fair?	0	4 24%	13 77%	17 100%
Is monitoring feedback accurate?	1 6%	4 24%	12 71%	17 100%

The contracting and monitoring questions received high ratings from 65% or more of the respondents, so, in general, this aspect of DCMHS management appears to be successful. Within the overall picture, however, the process for becoming a member of the network provider panel appeared least positive. The two questions about process for becoming a network panel member had the smallest proportion of high marks, with 12 (67%) reporting that the process was clear to a high extent and 11 (65%) giving the same rating to the fairness of the process. While fewer providers gave high ratings to these items, the questions still garnered positive responses from a majority of the respondents. Of more concern is the proportion of respondents who reported that the desirable characteristics occurred to a low extent. In the questions about contracting and monitoring, only the

item about the fairness of the process for becoming a panel member received a substantial (more than 20%) proportion of low ratings. Although only 4 service providers said that the process was fair to a low extent, they made up 24% of the 17 who responded to this question.

In the 1998 survey, there was no comparable question about the fairness of the process for becoming a member of a network provider panel. The three issues on which there were comparable questions are the clarity of the process for becoming a panel member, the objectivity of the monitoring visits, and the fairness of the feedback. In 1998, over 90% of the respondents (excluding those who did not give an agree or disagree response) agreed with positive statements about these issues. The proportions of 1999 providers who reported that these characteristics were found to at least a moderate degree are similarly large.

The 1999 respondents were generally positive about the monitoring visits, but a respondent recommended that the monitoring team "offer specific information on response required following site visit." Two other improvements were also suggested, (1) "Utilize a peer review system," and (2) "It would be more fair if the monitoring team could monitor us at the same time versus scheduling pieces at different times." The only other comment echoed the generally positive responses on the other questions -- "good process."

Strengths and Areas Needing Improvement

Two open-ended questions asked the respondents to identify specific strengths and areas needing improvement of the DCMHS provider network administration. The full text of these comments can be found in table F.4. The major strengths were in the working relationship topics of professionalism, technical assistance, and accessibility. For example, some of the comments were:

- "Currently they are very supportive and work toward quality improvement."
- "Professional, committed to developing a successful network."
- "Our contract manager is willing to seek out information when she does not readily have it."
- "Within the last years, DCMHS has become more accessible, although expectations may change daily."

While respondents tended to identify the quality of the working relationships as strengths, they named procedural issues as the major area for improvement. The comments did not have a single theme, but included the standards for inclusion as a network provider, the routing of decisions between DCMHS funders, the need for DCMHS to meet its own deadlines, and local DCMHS teams. The two comments about communication focused on provider performance, asking for increased communication and for DCMHS to be open to feedback itself. Timeliness, consistency, teamwork, and accessibility were also

identified as needing improvement, but only one comment was made about each of these topics.

Conclusions

In general, the administration of the provider network in terms of the characteristics of the program administrators, quality improvement, and contracting and monitoring were perceived positively by the majority of the respondents. Across the three topics, program administrators were perceived positively by the largest proportions of respondents. In the comments by the respondents, specific strengths of the provider network administration were identified in the areas of professionalism, knowledge/technical assistance, and accessibility.

Only two of the closed-ended items, both about quality improvement, were reported to occur to a high extent by less than 50% of the respondents. These items were the assistance from the quality improvement administrators and the feedback from incident reporting. While high ratings from fewer than 50% of the service providers indicates an area that could be improved, priority areas should be those that also have an appreciable proportion of low marks. Using the criterion of 20% or more low ratings to identify these priority areas, the two most critical issues in provider network administration were feedback from incident reporting and the fairness of the process for becoming a member of the panel. Communication and feedback from incident reporting were also identified as issues needing improvement in the providers' comments.

DCMHS CLINICAL SERVICES MANAGEMENT

The next section of the survey asked the service providers about their experiences with clinical services management. The service providers were instructed to answer the questions with input from their clinical staff. The answers that the service providers gave are discussed below in three sections. The first describes the responses about the Clinical Services Management Teams. The second section discusses the experiences of the service providers with Coordinators/Supervisors. The Management Team Leaders are the subject of the third section. Appendix G contains supporting tables and respondent comments.

Clinical Services Management Teams

To learn how the clinical services management teams were perceived by the service providers, DCMHS asked questions about the client service plan, the role and responsiveness of the team, the information that the teams require from the providers, the teams' consideration of agency input in making decisions, and the planning and

facilitating of client transitions. The responses are presented in four parts, each addressing a different aspect of the teams.

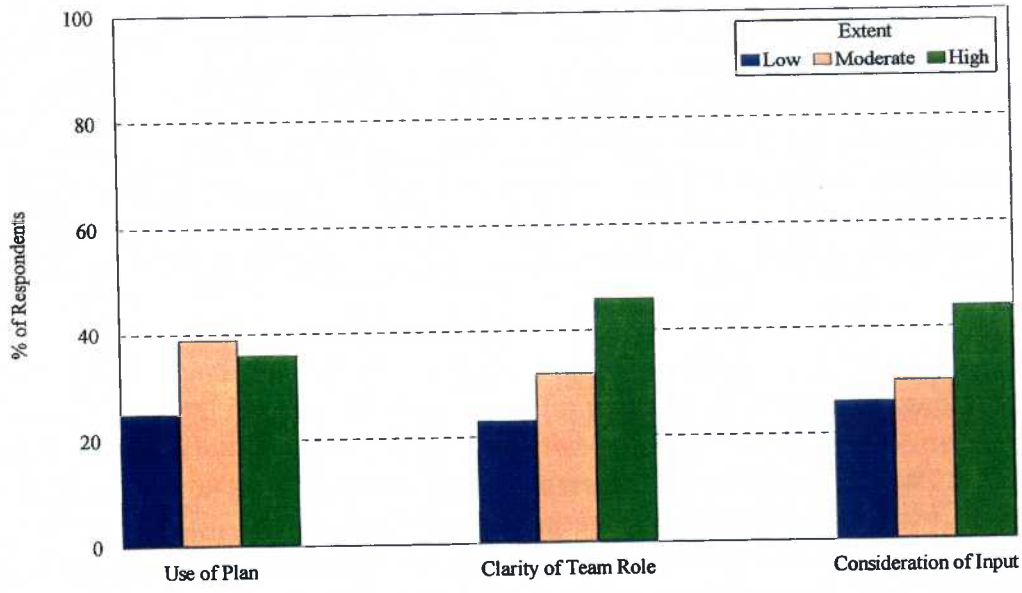
Utility of Plan, Clarity of Role, and Consideration of Input

Figure 8 displays the distribution of answers to the questions:

1. To what extent (if at all) is the DCMHS Client Service Plan useful to my agency in developing treatment plans?
2. To what extent (if at all) is the role of the Clinical Services Management Team clear?
3. To what extent (if at all) do the DCMHS Clinical Services Management Teams appropriately consider the input of my agency's therapist(s) in making clinical and discharge decisions?

At least one out of every five of the 44 respondents gave a low rating to these three questions. None of the items received high marks by more than 20 (46%) of the respondents. This pattern of responses indicates that all three of the issues – the utility of the plan, the clarity of the teams' role, and the consideration of the agency's input in team decisions – are priority areas for improvement. The pattern may also suggest that little improvement has been made since last year, when 23% or more of the respondents disagreed with statements about the usefulness of the service plan, the clarity of the team's role, and the consideration of the agency's input. In looking for ways to improve performance in these areas, it may useful to know that PDs were more likely than CEOs to report that these objectives of DCMHS had been achieved to a low extent (see table G.2).

Figure 8. Clinical Services Management – Teams



The issues of the clarity of the role and the consideration of the agency's input also came up in the comments made by the service providers. In answering the question about areas in clinical services management that need improvement, providers responded with such comments as:

- "There are times when the CSMTs get very involved in the management of treatment, seemingly confusing role of consulting/manager vs. direct supervision of case."
- "Clearer expectations + role definitions (these vary from county to county)."

Some of the comments that have been classified under the topic of teamwork directly addressed the consideration of the agency's input. Some of the comments were:

- "Greater weight should be given to providers' decision-making in clinical + discharge issues."
- "Consider provider's input."
- "Agency site works directly with clients and families enrolled in program. DCMHS/CSM should take our recommendations for treatment in consideration when they have to make clinical decisions regarding clients or family."

Response to Clinical Emergencies

DCMHS responsiveness to clinical emergencies is a strength of the system. DCMHS asked service providers, "How immediate, if at all, is the response of the DCMHS Clinical Services Management Teams when called with a clinical emergency?" Twenty-six (65%) of the 40 service providers said that when called with a clinical emergency the teams respond immediately to a high extent, while only 10% gave it a low rating. The majority of both CEOs and PDs were positive about this aspect of clinical services management. Responsiveness to clinical emergencies was also perceived positively by last year's respondents.

Authorization Procedures

Two questions were asked about the authorization procedures. One addressed the clarity of the procedures; the other inquired about the reasonableness of the information required for authorization. As shown in table 5, the information required for authorization was reported to be reasonable to a high extent by 23 (56%) service providers. This compares favorably with the clarity of the procedures, which received high ratings from 19 (43%) respondents. While the item about the information for authorization had more high marks than the clarity of the procedures, it also garnered more low ratings. The information requirements were reported to be reasonable to only a low extent by nine (22%), while six (15%) of the respondents reported a low extent of clarity in the procedures. Although the high proportion of low marks for the reasonableness of the requirements is cause for concern, both of the authorization items received higher proportions of positive (moderate and high) ratings this year than they did last year. Once again, it is difficult to know if the difference is related to actual improvement or methodological changes in the survey administration.

Table 5. Clinical Services Management Authorization Procedures – Distribution of Responses

Questions about authorization procedures:	Low	Moderate	High	Total
How clear (if at all) are the Clinical Services Management authorization procedures?	6 15%	16 39%	19 46%	41 100%
Compared to other managed care systems, how reasonable (if at all) is the clinical information required by the DCMHS Clinical Services Management Team for continued authorization of services?	9 22%	9 22%	23 56%	41 100%

Not many of the comments responding to the general questions about the strengths and areas for improvement addressed authorization procedures. However, the suggestions that were made targeted a facet of the authorization procedures not addressed in the above questions. Specifically, timeliness and timing of authorizations were the topics of the few suggestions about authorization. For example, one comment under timeliness was "Respond faster - DCMHS deadlines are frequently missed - resulting in delays in services." In terms of the timing of authorizations, two comments were made. The first focuses on when authorizations are made: "Supports are not authorized when the child begins to deteriorate, only as child de[teriorates] to a serious extent." (The brackets indicate that the word was not legible in the service provider's response.) The second comment addressed the frequency with which authorizations are required: "For outpatient services sessions are frequently authorized month to month requiring frequent reauthorization requests (paperwork)."

In short, while there does not appear to be widespread dissatisfaction with the authorization procedures, there is room for improvement in the clarity and timing of the procedures, as well as the information required for authorization.

Client Transitions

The last topic addressed by the questions about the Clinical Services Management Teams was client transitions. Table 6 lists the questions and displays the distribution of responses.

Table 6. Planning and Facilitation of Client Transitions – Distribution of Responses

To what extent, if any, do the Clinical Services Management Teams effectively plan and facilitate client service transitions:	Low	Moderate	High	Total
At admissions?	11	13	19	43
	26%	30%	44%	100%
At discharges?	10	15	18	43
	23%	35%	42%	100%
During transitions to the adult services system?	9	11	15	35
	26%	31%	43%	100%

The responses to the three questions have very similar patterns, with 42 - 44% of the respondents rating the teams as effective in planning and facilitating transitions to a high extent, 30 - 35% stating they were effective to a moderate extent, and 23 - 26% giving the teams a low rating.

Overall, the planning and facilitation of transitions appear to have significant room for improvement. Less than 50% of the service providers reported that the transitions were effective to a high extent, and over 20% reported low effectiveness in transition planning and facilitation. Compared to 1998 when 50% of the respondents disagreed with a statement about the effective planning and facilitation of the transition to adult services, a larger proportion of this year's respondents (74%) found the transition to adult services effectively planned to at least a moderate degree. However, with 26% of this year's respondents stating that the transition to adult services was not effective, this transition still needs attention.

Clients transitions into, across, and out of DCMHS services were also identified as an area of improvement in the comments made by some service providers in this section as well as in the section on system performance (see pages 8-9 above). Two respondents targeted the transition to adult services in their comments. One stated, "Adult mental health services need to be in process 6 months or more prior to age 18 as our clients are most often on their own at age 18." Another two comments suggested that DCMHS should communicate with the providers more effectively about transitions. (All comments are presented in table G.9.)

Clinical Services Coordinators/Supervisors

The questions about clinical services coordinators/supervisors are similar to those asked about program administrators (e.g., approachable, professional, willing to resolve disagreements). Two additional questions were also posed: (1) To what extent, if any, are the DCMHS Clinical Services Coordinators/Supervisors knowledgeable about the

spectrum of children's services in Delaware? and (2) How important, if at all, is the role of the DCMHS managed care coordinators in your agency's treatment of families?

Figure 9 displays the responses to these questions. The number of respondents giving high marks to each item ranged from 20 (47%) to 31 (71%). The only item receiving high marks from less than 50% of the respondents was the willingness of the coordinators/supervisors to resolve disagreements (20 out of 43, or 47%). In a similar list of desirable characteristics for coordinators/supervisors in the 1998 survey, the item about resolving disagreements also had fewer positive responses than the other items.

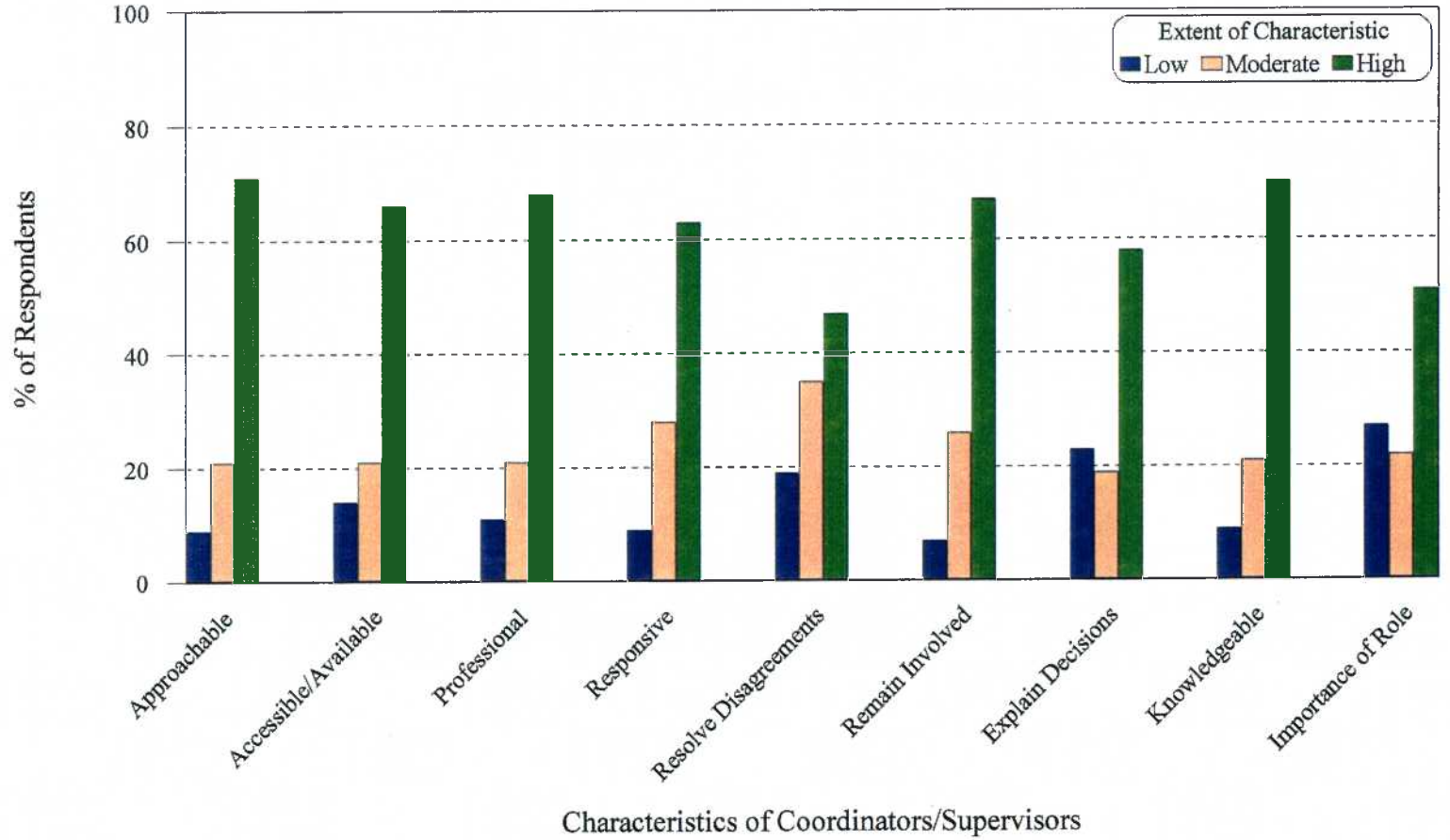
The item that was observed to a low extent by 20% or more of the respondents was the importance of the coordinators in the agency's treatment of families which had low marks from 11 (21%) of 41 service providers. There was a similar proportion of disagree answers to a similar item in 1998 . Other items receiving large proportions of low marks in this year's analysis were the willingness to explain decisions and to resolve disagreements. Ten (23%) of 43 service providers reported that coordinators/supervisors were willing to explain decisions to a low extent. Eight (19% of 43) had the same opinion about their willingness to resolve disagreements.

Within the generally positive trend of responses about the characteristics of the coordinators/supervisors, the two items that received the highest proportions of positive responses were (1) approachability, and (2) knowledge of children's services in Delaware. The coordinators/supervisors were considered to be highly approachable by 31 (71%) of the 44 service providers. Thirty (70%) reported that the coordinators/supervisors were knowledgeable about Delaware's spectrum of children's services. These two items also received fewer low marks than some of the items, with 4 (9%) finding these characteristics to a low extent. In 1998, service providers were not asked about the aproachability of the coordinators/supervisors, but had a comparable question about the knowledge of coordinators/supervisors. The 89% of the 1998 respondents who agreed that coordinators/supervisors were knowledgeable about children's services is close to the 91% of 1999 respondents who reported that coordinators/supervisors were knowledgeable to at least a moderate extent.

There were some differences in the pattern of responses across CEOs and PDs. For example, compared to PDs, CEOs gave higher ratings to coordinators/supervisors on accessibility, professionalism, responsiveness, willingness to remain involved, willingness to explain decisions, and knowledge. (See table G.6 for details.)

The comments about clinical services management in general included some remarks specific to the coordinators/supervisors. Service providers referred to coordinators' dedication, willingness to work hard for children, and accessibility. While these comments praised coordinators/supervisors particularly, other comments about both strengths and areas for improvement may also be applicable to coordinators/supervisors.

Figure 9. Coordinators/Supervisors



In summary, a majority of service providers reported that the coordinators/supervisors have the desired characteristics, with one exception, to a high degree. These positive responses were supported by the complimentary remarks made by some of the service providers in answering the open-ended questions. The only item receiving less than a majority of high ratings was the willingness of coordinators/supervisors to resolve disagreements. Other areas of concern include the willingness of the coordinators/supervisors to explain their decisions and the perceived importance of their role in the treatment of families. As will be discussed under the section on team leaders, the poor marks about the resolution of disagreements may reflect the need for a more collaborative approach.

Clinical Services Management Team Leaders

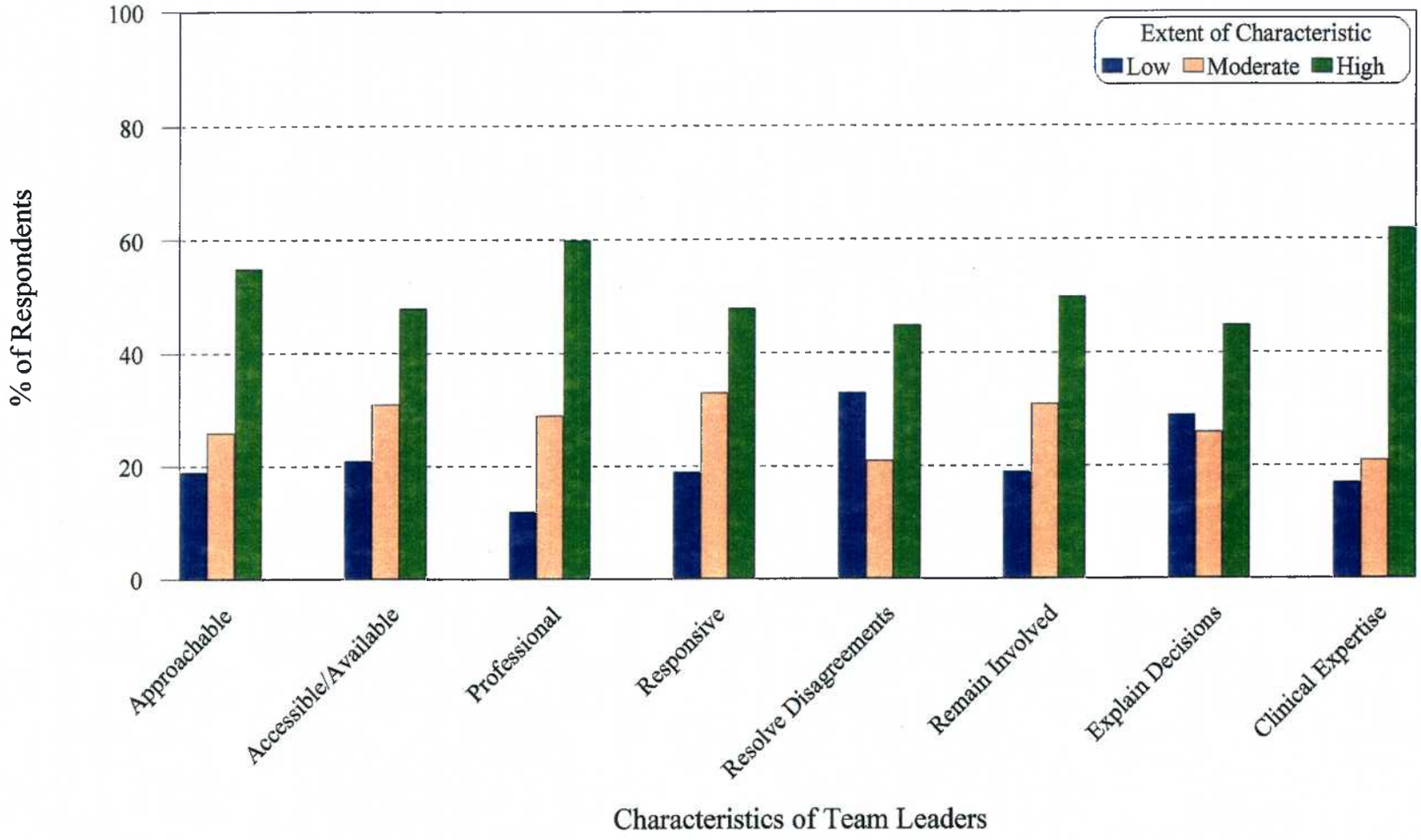
The next set of survey items focused on the performance of the team leaders. With two exceptions, they are the same as the questions about the performance of the coordinators/supervisors. Instead of asking about "knowledge of the spectrum of children's services," the survey asked about the extent to which the team leaders "have adequate clinical expertise." The other difference between the two sets of questions is that service providers were not asked about the importance of the team leaders in the agency's treatment of families.

As can be seen by comparing figure 10 to figure 9, the pattern of responses to the items about team leaders is similar to those for the coordinators/supervisors. For both coordinators/supervisors and team leaders, more service providers rated the characteristics as occurring to a high extent than those who rated the items as occurring to either a moderate or low extent. While the overall trend was similar across the two staff positions, results for the team leaders were slightly less favorable than those for coordinators/supervisors. Where there are comparable items, the proportion of moderate and high ratings this year resembles the proportion of respondents agreeing to statements in 1998.

Professionalism and Clinical Expertise

The characteristics of team leaders that received the largest number of high ratings were adequate clinical experience (26, or 62%), and professionalism in their working relationships (25, or 60%). Both the characteristics were also mentioned as strengths in comments made about clinical services management in general. For example, one of the respondents wrote that "clinical expertise of most of the CSMT leaders" was a strength, expressing an opinion that was repeated in other comments. On the topic of professionalism, one service provider wrote, "Members have been strong advocates for supplementary services that seek to enhance/support existing services. Team members, excellent advocates, became involved with families."

Figure 10. Team Leaders



While the professionalism and expertise of the team leaders are identified as strengths by a majority of the respondents, there were recommendations for improvements in these areas. Specific concerns included the inconsistency of the skills and professionalism of the local case managers and the lack of trust in team leaders resulting from unprofessional behavior. The service providers that commented also identified particular topics in which expertise is needed. These were substance abuse and its impact on adolescent functioning, residential mental health, and the impact of long-term placement in a restrictive setting. (All comments made about strengths of and areas for improvement in clinical services management are provided in table G.9.)

Approachability and Accessibility/Availability

In the responses to the open-ended questions about clinical services management, the approachability and accessibility of the team leaders were mentioned as both a strength and an area needing improvement. The figure shows that approachability was one of the characteristics receiving many high ratings (23, or 55%), while accessibility received fewer high ratings (20, or 48%). Accessibility/availability also received more low ratings (9, or 21%) than all but two other variables. In answering the question about strengths, service providers tended to be brief on the topic of accessibility (e.g., "accessibility"). However, one discussed the team leaders in particular. The service provider wrote that strengths of clinical services management included, "The monthly meetings with team leaders. The diversity of the team leaders and willingness to look into substance abuse issues." There were three comments recommending improvements to approachability and accessibility, including "the teams are not always approachable."

Teamwork: Willingness to Resolve Disagreements and Explain Decisions

Team leaders received the fewest high marks from the service providers on the characteristics of their willingness to resolve disagreements and to explain decisions. Nineteen (45%) respondents gave these items high ratings. If the relatively few high ratings received for these characteristics were balanced in the moderate category, the items would not necessarily be identified as areas that would be a high priority for improvement. However, the willingness of team leaders to resolve disagreements and explain decisions were also more likely than the other items to be reported as low. Fourteen (33%) service providers said that team leaders were willing to resolve disagreements to only a low extent, and 12 (29%) said the same thing about their willingness to explain decisions.

The concerns about resolving disagreements and explaining decisions may underlie the large number of comments recommending that DCMHS clinical services management needs to work more as a team with the providers. Among the comments about teamwork (first discussed on pages 24-25), one comment specifically mentioned the team leaders:

- "The treatment teams leaders in Kent and Sussex counties need to work in a collaborative manner and be more aware of contract obligations of providers."

With the exception of this comment, team leaders were not singled out as needing to be more collaborative. As noted above, the willingness to resolve disagreements was also an issue for the coordinators/supervisors. In addition, most of the comments about teamwork were general, such as,

- "Rather than just asking for information on a client, CMHS should act as a team with providers."
- "It would be extremely helpful for local treatment teams and providers to work collaboratively as staff has reported this relationships feels inflexible and one-sided. Both groups should support each other in working with many difficult situations. It may be helpful to meet on quarterly basis with local teams."

Summary

Overall, the team leaders were most likely to be recognized for their clinical expertise, professional behavior, and approachability, as supported by the quantitative data and the comments identifying these characteristics as strengths. The team leaders were most likely to receive low marks for their willingness to resolve disagreements, willingness to explain decisions, and accessibility. This pattern of results in the quantitative data was reinforced by comments that identified teamwork as a major area needing improvement. As noted above, the comments about professional behavior and accessibility were not all about strengths, but also identified areas needing improvement within those categories.

Conclusions

For clinical services management teams, the main issue needing improvement is the planning and facilitation of client transitions. More than 20% of the respondents reported a low extent of effective planning and facilitation of transitions. Teamwork may also be an area needing improvement, with such items as the usefulness of the client service plan, the clarity of the teams' role, and the consideration of agency's input all receiving low marks from more than 20% of the respondents. The information required for continued authorization of services was also considered unreasonable by more than 20% of the service providers. On the other hand, the same item (information for continued authorization) was also one of only two items receiving positive ratings from more than 50% of the respondents. The teams' responsiveness in emergencies was reported as a strength by the largest proportion of this year's respondents.

For coordinators/supervisors, strengths included approachability, accessibility, responsiveness, professionalism, knowledge of the spectrum of children's services, and their willingness to remain involved and explain decisions. The accessibility and professionalism of coordinators were underscored by comments made by service providers. While willingness to explain decisions received high marks from more than 50% of the respondents, it also received low marks from more than 20%. The importance of coordinators in agencies' treatment of families was also rated low by more than 20% of the service providers. These two issues, in combination with remarks about areas

needing improvement, suggest that a more collaborative attitude could further improve the generally positive relationships between service providers and coordinators/supervisors.

Team leaders were recognized by 50% or more of the respondents for their approachability, professionalism, willingness to remain involved, and expertise. These strengths were reinforced in the remarks made by some of the service providers. However, team leaders received large proportions of low ratings (20% or more) on three issues: accessibility, and willingness to resolve disagreements and explain decisions. Of these, the willingness to resolve disagreements and explain decisions had the most unfavorable pattern of ratings. As with the coordinators/supervisors, concerns in these areas may be related to the service providers' comments about teamwork as an area for improvement.

In general, coordinators/supervisors were perceived more positively than the team leaders, but their strengths and weaknesses were similar. Particular strengths in both groups were professionalism and expertise. An area receiving fewer high ratings was the willingness of either group to resolve disagreements. This was echoed in respondent comments in which teamwork and the definition of roles were identified as central areas needing improvement. On the other hand, two comments identified specific improvements made in the past year in simplifying the process of accessing services and being more available.

THE DCMHS PROVIDER SURVEY: RESPONSIVENESS AND IMPROVEMENTS

The last section of the survey asked respondents about DCMHS' responsiveness to the information gathered in the FY 1998 survey, especially in terms of improving communication. Service providers were asked to answer this section only if they participated in last year's survey. Twenty-three respondents completed the section. Starting with the stem, "In the past year, to what extent, if any," the specific items used to evaluate DCMHS responsiveness to the FY 1998 survey were:

1. Were the concerns and suggestions expressed by providers in last year's survey appropriately addressed?
2. Has quarterly network provider forum meetings improved communication between DCMHS and its provider network?
3. Have highlights in the quarterly NETWORK NEWS publication to providers improved communication between DCMHS and its provider network?
4. Has the information outlined in the DCMHS Provider Manual clarified DCMHS authorization procedures?

As shown in table 7, most of the service providers who responded to this section of the survey were not enthusiastic about DCMHS responsiveness to the survey or the value of

the meeting series and the highlights in the NETWORK NEWS as communication tools. Five (22%) respondents said that DCMHS had been responsive to the issues raised in last year's survey to a high extent, 11 (48%) rated the response as moderate, and 7 (30%) rated it as low. In other words, 18 (78%) of the providers did not see DCMHS has highly responsive to the survey findings. The level of satisfaction between CEOs and PDs differed, with CEOs more positive than PDs about DCMHS' responsiveness. (CEO and PD responses can be found in table H.2.) The pattern of responses was almost the same for the question about quarterly meeting series, with slightly more respondents saying the meetings had improved communication to a low extent than the number giving it a high mark. Again, CEOs were more likely to be positive than PDs about the meeting series. As in the results from last year's survey, the information about authorization procedures in the DCMHS Provider Manual was the item in this section that received high ratings from the largest number of respondents.

Table 7. Responsiveness to Survey – Distribution of Responses

In the past year, to what extent, if any:	Low	Moderate	High	Total
Were the concerns and suggestions expressed by providers in last year's survey appropriately addressed?	7 30%	11 48%	5 22%	23 100%
Has quarterly network provider forum meetings improved communication between DCMHS and its provider network?	6 27%	11 50%	5 23%	22 100%
Have highlights in the quarterly NETWORK NEWS publication to providers improved communication between DCMHS and its provider network?	6 27%	9 41%	7 32%	22 100%
Has the information outlined in the DCMHS Provider Manual clarified DCMHS authorization procedures?	2 9%	6 26%	15 65%	23 100%

Five (4 CEOs and 1 PD) service providers made the following suggestions in response to an open-ended question about how to improve DCMHS responsiveness:

- "The response was statistical. There should have been more human response - like how the statistics will be used to make a child life better."
- "It would be more helpful if the quantitative data was shared with providers."
- "Could we shorten it; they are responsive."
- "Address issues around local clinical teams."
- "Address issues around local teams and providers."

Fifteen service providers responded to an open-ended question about the value of the survey process. For eight of the respondents, the main value of the survey was the opportunity to provide feedback to DCMHS. For example, one respondent wrote, "DCMHS are often inaccessible, unresponsive to questions, and lack follow up for resolution of an issue. Survey process allows DCMHS to receive provider feedback."

Other merits of the survey were internal, as in the case of the provider who wrote, "It facilitated an open discussion of the clinical staff regarding strengths and areas for possible improvement within the DCMHS system." The comments by the two respondents who found no value in the survey were supported by one of the nonrespondents who stated that he or she had not responded to the survey because it was "more paperwork."

Eleven service providers commented on possible changes in the content of future surveys. Two respondents found the survey sufficient as it is, while others recommended topics related to the services that are provided, including the transition between services and the determination of appropriate services, and other DCMHS procedures. These comments are listed in appendix H.

Conclusions

Of the questions about communication tools, only the Provider Manual's clarification of authorization procedures was rated highly by more than 50% of the respondents. In contrast, DCMHS responsiveness to the 1998 survey and the value of the forum meetings and the NETWORK NEWS as communication tools were given low marks by more than 20% of the providers. (As described on page 16, the low marks given to the forum meetings probably reflect the limited target audience for the meetings.) However, eight of the 15 people who commented on the value of the survey said that it was an opportunity to provide feedback to DCMHS. Considerations for future implementations of the survey are (1) shorten it so that it does not become another piece of paperwork, and (2) focus the questions on particular aspects of the services, particularly the transitions from one service to another.

CONCLUSIONS

This section first inventories the DCMHS strengths and areas needing improvement discussed above. Then, general conclusions are drawn about the DCMHS system.

Areas of Strength

As described on page 3, items that received high marks (answers of "to a great extent" plus those of "to a very great" extent) by at least 50% of the respondents were identified as areas of strength. Table 8 lists each of the items that met this criterion. The items are organized by the same categories used to classify the responses to the open-ended comments. Consistency is the only category that was not used, perhaps because there were no survey items that directly addressed consistency. Items in italics are those that also met the criterion for a priority area for improvement (see table 9).

Table 8. Items that were marked high by 50% or more of the service providers

Category	Item
Services	▪ Accessibility of services for clients ▪ Immediacy of response by teams when called with a clinical emergency ▪ *Importance of managed care coordinators in your agency's treatment of families*
Communication	▪ Familiarity with DCMHS mission ▪ Consistency of DCMHS mission with agency's mission ▪ *Extent to which agency is informed about the DCMHS managed care system* ▪ Clarity of the requirements for providing services under agency's contract/provider agreement with DCMHS ▪ Clarity of agency's role as a service provider within the DCMHS managed care system ▪ Extent to which the Provider Network Forum ensures consistent information exchange ▪ *Extent to which the Provider Network Forum identifies topics of discussion that are germane to providers* ▪ Clarity of the authorization procedures in the Provider Manual ▪ Responsiveness of program administrators to questions ▪ Responsiveness of coordinators/supervisors to questions ▪ *Clarity of incident reporting procedures for providers* ▪ Clarity of process for becoming a network provider panel member
Paperwork	▪ *Reasonableness of the clinical information required for continued authorization of services, compared to other managed care systems*
Timeliness	▪ *Payments made within 30 days after bills are submitted*
Teamwork	▪ Reasonableness of DCMHS expectations for agency ▪ Willingness of program administrators to resolve disagreements ▪ Willingness of program administrators to remain involved ▪ Willingness of coordinators/supervisors to remain involved ▪ Willingness of team leaders to remain involved ▪ Willingness of program administrators to explain DCMHS decisions ▪ *Willingness of coordinators/supervisors to explain decisions*

Table 8 (continued)

Category	Item
Professionalism	▪ Professionalism of program administrators ▪ Professionalism of coordinators/supervisors ▪ Professionalism of team leaders
Knowledge/ Technical Assistance	▪ Extent of knowledge of clinical processes by program administrators ▪ Extent of knowledge of administrative processes by program administrators ▪ Extent to which coordinators/supervisors are knowledgeable about the spectrum of children's services in Delaware ▪ Adequacy of the team leaders clinical expertise
Accessibility	▪ Approachability of program administrators ▪ Accessibility/availability of program administrators ▪ Approachability of coordinators/supervisors ▪ Accessibility/availability of coordinators/supervisors ▪ Approachability of team leaders
Procedures	▪ Adequacy of notification for the scheduling of monitoring visits ▪ Objectivity with which monitoring visits are conducted ▪ Fairness of monitoring feedback ▪ Accuracy of monitoring feedback ▪ Fairness of process for becoming a network provider panel member

Priority Areas for Improvement

Throughout the report, the guideline of 20% or more low marks has been used to identify the areas that should be addressed most promptly by DCMHS. (Low marks signify an answer of either "little or no extent" or "some extent.") Table 9 lists each of the items that the 20% or more of the service providers marked low. The items are organized by the same categories used to classify the responses to the open-ended comments. Some categories were not used, specifically, timeliness, consistency, procedures, and knowledge/technical assistance.

Table 9. Items that were marked low by 20% or more of the service providers

Category	Item
Services	▪ Usefulness of the DCMHS Client Service Plan to agency in developing treatment plans ▪ Appropriateness of consideration of agency therapist in decisions made by the Clinical Services Management Team ▪ Effectiveness of transition planning/facilitation at admissions ▪ Effectiveness of transition planning/facilitation at discharge ▪ Effectiveness of transition planning/facilitation to adult services ▪ *Importance of managed care coordinators in your agency's treatment of families*
Communication	▪ *Extent to which agency is informed about the DCMHS managed care system* ▪ *Extent to which the Provider Network Forum identifies topics of discussion that are germane to providers* ▪ Informative feedback from incident reporting ▪ Appropriateness of DCMHS response to concerns and suggestions in last year's survey ▪ Extent to which the quarterly network provider meetings have improved communication between DCMHS and its provider network ▪ Extent to which the highlights in the quarterly NETWORK NEWS have improved communication between DCMHS and its provider network ▪ Clarity of the role of the Clinical Services Management Team
Paperwork	▪ Reasonableness of the amount of paperwork required for DCMHS managed care compared to other managed care systems ▪ Reasonableness of the complexity of paperwork required for DCMHS managed care compared to other managed care systems ▪ *Reasonableness of the clinical information required for continued authorization of services, compared to other managed care systems*

Table 9 (continued)

Category	Item
Teamwork	▪ Adequacy of the opportunities to comment on policy and service delivery/provision procedures ▪ Opportunities for providers to provide input and have an open dialogue at the Provider Network Forum ▪ *Willingness of coordinators/supervisors to explain decisions* ▪ Willingness of the team leaders to resolve disagreements ▪ Willingness of the team leaders to explain DCMHS decisions
Accessibility	▪ Accessibility/availability of team leaders

Conclusions

The two major themes in the responses from the providers were communication and teamwork. Other areas were identified as strengths, such as DCMHS staff in general, the timeliness with which DCMHS pays its bills, and the immediacy of the response of the clinical services management teams when called to an emergency. Other areas needed improvement, such as the timeliness of the authorization procedures, the fairness of the process for becoming a network panel member, and the coverage of specific populations. But communication and teamwork were basic elements underlying many specific issues.

This year communication was as likely to be seen positively as negatively in the responses to the questions about strengths and areas of improvement. The need to continue to improve communication appeared most clearly in the questions about specific issues. As shown above, seven survey questions addressing communication issues, including the clarity of the team role, the utility of the feedback from incident reporting, and the adequacy of the opportunities for providers to comment on policies and procedures, received low ratings from 20% or more of the respondents. In many cases, the program directors were more likely than the CEOs to give low ratings to these items. The quantity and complexity of paperwork, a major aspect of how DCMHS and the providers communicate, also received relatively large proportions (20% or more) of low ratings.

While this picture seems bleak, it was offset by the generally positive assessments of specific staff positions, especially in the areas of professionalism and their knowledge and technical expertise. Many of the respondents perceived the program administrators, coordinators/supervisors, and team leaders as approachable, professional, and knowledgeable. Moreover, some of the comments made by service providers indicated that teamwork was a strength of the DCMHS system. Yet, despite the positive ratings of the people with whom the providers work, weaknesses in the relationship were identified. Specific areas in which the relationship could be improved are the willingness of clinical

services management to work with the providers to resolve disagreements and to explain their decisions. A more collaborative relationship could also be fostered by providing more opportunities for program directors as well as CEOs to participate in the development of policies, procedures, and events like the quarterly meeting series. It is important to develop a sense of teamwork in order to ensure that clients are admitted, treated, and discharged in ways that best support their needs.

To go beyond maintaining the range and quality of current services to children, DCMHS needs to continue developing the successful aspects and improving the consistency of their relationship with service providers. DCMHS also needs to bring renewed attention to communication and teamwork in order to achieve their mission of developing "the potential of this generation and the next through effective treatment for children and their families and collaboration with service providers." Specific improvements that can help achieve the mission include:

- Clarify the role of the clinical services management teams;
- Include the therapists and other service providers in the decisions made about a child's treatment and ensure that decisions that vary from their recommendations are explained;
- Ask service providers how to make the incident reporting feedback more valuable (for some, simply receiving feedback would be an improvement), and then implement their suggestions;
- Provide more opportunities for service providers to participate in the development of policies and procedures and planning for events that will include the whole network;
- Solicit suggestions for how to improve the communication tools, such as the quarterly meeting series, the quarterly publication, and the annual survey, and then use the suggestions to replace or improve the tools;
- Continue efforts to streamline the organization, especially the amount and complexity of the paperwork;
- Support the DCMHS staff who were recognized for their professionalism and expertise; and
- Attend to the concerns about the role of the teams and DCMHS administration more generally in client transitions so that these transitions are smoother for both the client and the service provider.

APPENDICES

APPENDIX A

SURVEY RESPONSE RATE AND NON-RESPONSE

Calculating the Response Rate

Table A.1 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 was necessary because we received three surveys from a single program site. We averaged the responses to the closed-ended questions so that there was a single entry for the three sets of responses. (All comments responding to the open-ended questions were included.) The third 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 average multiple surveys from a single site and multiply single surveys representing multiple responses is to maintain the weight given to each entity on the mailing list. The fourth row identifies our action with the one survey in which the respondent had checked that he or she was unfamiliar with DCMHS and left the other questions blank. After subtracting that response from the total, our final response rate was 70%.

Table A.1. Calculating the Response Rate

	Result of Action		
Action in calculating response rate	**CEO**	**PD**	**Total**
We compiled the surveys we received from the agencies.	24 67%	22 73%	46 70%
We subtracted surveys when more than one was received from a single site.	No action	20 67%	44 67%
We added surveys when a single survey represented the responses from more than one site	25 69%	22 73%	47 71%
We subtracted the response from a service provider who was not familiar with DCMHS.	No action	21 70%	46 70%
Final response rate	**25** **69%**	**21** **70%**	**46** **70%**

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 A

Understanding Nonresponse

Nineteen of the potential respondents did not return a survey at all. These nonrespondents were called to learn how we could improve the response rate for future surveys. Of the 19 nonrespondents:

- 10 (6 CEOs and 4 PDs) could not be reached because they were away from the office or did not return phone calls after three contacts had been made.
- 2 (1 CEO, 1 PD) stated that they were too busy to respond.
- 2 PDs reported that they were unfamiliar with DCMHS and so did not think it was appropriate for them to respond.
- 4 (3 CEOs and 1 PD) never received the survey -- the appropriate respondent could not be identified or the position was open or recently filled with someone who had not received the survey.
- 1 CEO refused to respond because he or she preferred to deal with DCMHS directly.

Nine (14%) of the original 66 sites that were sent surveys are still unaccounted for. However, for at least some of them, scheduling problems (including simple busyness) is a probable explanation. This issue was the explicit reason for not responding given by two other potential respondents, and could also explain the response of the person who preferred to deal with DCMHS directly on specific issues. Ways to ease the burden on the potential respondents include making the survey shorter, providing clearer explanations for why it is worth the service providers' time to fill it out, or both.

The problems with the mailing list that resulted in nonresponse from five potential respondents could be addressed in at least two ways. First, a preliminary letter telling the providers to expect the survey and to identify the appropriate person to respond could be mailed out. Second, instead of using specific names on the CEO labels, the surveys sent to CEOs could be mailed to a generic title (Executive Director) as the program director surveys are. In this way, the survey can be forwarded to the appropriate person within the organization, rather than to the person whose name is on the label who might have left the organization.

The decision not to respond seemed appropriate for those who were not familiar with DCMHS, although ideally the intended respondent would find someone who was sufficiently familiar to answer the questions. In fact, our calls yielded survey responses from two CEOs who had said that they were not familiar enough to respond but, after our call, found other people in their organization who could respond for them. In the future, the option of passing the survey off to someone else in the central organization who deals directly with DCMHS should be described in the cover letter to the CEOs.

In short, the nonresponse is significant enough to warrant continued review of the survey format and content, as well as the actions of administering the survey. While achieving a response rate of 100% is unlikely, further improvements have the potential of further increasing the response rates of future surveys.

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). One respondent did not identify what types of services or service delivery methods they used. All others did, so there were 45 responses to these questions. Note that the service providers were supposed to check as many of the service delivery methods as they used.

Table B.1. Types of Services by Type of Respondent – Distribution of Responses

	Types of Services		
Type of Respondent	**Mental Health**	**Substance Abuse**	**Both**
CEO	12 46%	3 60%	10 71%
PD	14 54%	2 40%	4 29%
TOTAL	**26** **100%**	**5** **100%**	**14** **100%**

Table B.2. Types of Services by Service Delivery Methods – Distribution of Responses for Total

	Types of Services			
Service Delivery Methods	**Mental Health**	**Substance Abuse**	**Both**	**Total**
Crisis	5 63%	0	3 38%	8 100%
Outpatient	6 35%	2 12%	9 53%	17 100%
Intensive Outpatient	5 42%	3 25%	4 33%	12 100%
Wrap-around/Aide	6 75%	1 13%	1 13%	8 100%
Day/Partial Day Treatment	8 57%	3 21%	3 21%	14 100%
Day/Partial Day Hospital	2 40%	0	3 60%	5 100%
Residential	10 53%	1 5%	8 42%	19 100%
Inpatient Psychiatric Hospital	2 40%	0	3 60%	5 100%

APPENDIX B

Table B.3. Types of Services by Service Delivery Methods – Distribution of Responses for CEOs and PDs

Service Delivery Methods	Mental Health Only		Substance Abuse Only		Both		Total	
	CEO	PD	CEO	PD	CEO	PD	CEO	PD
Crisis	2 40%	3 100%	0	0	3 60%	0	5 100%	3 100%
Outpatient	3 27%	3 50%	1 9%	1 17%	7 64%	2 33%	11 100%	6 100%
Intensive Outpatient	2 29%	3 60%	1 14%	2 40%	4 57%	0	7 100%	5 100%
Wrap-around/Aide	3 60%	3 100%	1 20%	0	1 20%	0	5 100%	3 100%
Day/Partial Day Treatment	3 43%	5 71%	1 14%	2 29%	3 43%	0	7 100%	7 100%
Day/Partial Day Hospital	2 40%	14 70%	0	2 10%	3 60%	4 20%	5 100%	20 100%
Residential	7 50%	3 60%	1 7%	0	6 43%	2 40%	14 100%	5 100%
Inpatient Psychiatric Hospital	2 40%	0	0	0	3 60%	0	5 100%	0

APPENDIX C

DCMHS MISSION

This appendix presents the information received in response to the three questions about the DCMHS Mission. The frequency of responses for the total number of service providers answering the two closed ended questions is displayed in table C.1. Table C.2 breaks the total out into CEO and PD responses. Exhibit C.1 lists the two comments made in response to the question asking for comments on the mission.

Table C1. Familiarity and Consistency – Distribution of Responses for Total

To what extent, if at all:	Low	Moderate	High	Total
Are you familiar with the DCMHS mission?	7	13	26	46
	15%	28%	57%	100%
Is the DCMHS mission consistent with the mission of your own agency?	5	5	35	45
	11%	11%	78%	100%

Table C2. Familiarity and Consistency – Distribution of Responses for CEOs and PDs

	Low		Moderate		High		Total	
To what extent, if at all:	CEO	PD	CEO	PD	CEO	PD	CEO	PD
Are you familiar with the DCMHS mission?	6	1	5	8	14	12	25	21
	24%	2%	20%	38%	56%	57%	100%	100%
Is the DCMHS mission consistent with the mission of your own agency?	2	3	4	1	18	17	24	21
	8%	14%	17%	5%	75%	81%	100%	100%

Exhibit C.1. "Please list any additional comments you have about the DCMHS mission:"

Verbatim Responses:
- Process time to engage a person in the system.
- At times the mission implementation becomes unclear as it is interpreted very differently by different team leaders.

SYSTEM PERFORMANCE

This appendix summarizes the response to the closed-ended questions about DCMHS System Performance and provides the full text of the comments prompted by the two open-ended questions.

Summary of Responses to Closed-Ended Questions

Table D.1. System Performance – Distribution of Responses for Total

To what extent, if any, does the DCMHS system:	Low	Moderate	High	Total
Provide access to services for clients?	2 5%	19 43%	23 52%	44 100%
Keep my agency informed about the DCMHS managed care system?	9 20%	11 24%	25 56%	45 100%
Ensure that the amount of paperwork required for DCMHS managed care is reasonable, compared to other managed care systems?	12 26%	21 46%	13 28%	46 100%
Keep the complexity of paperwork required for DCMHS managed care reasonable, compared to other managed care systems?	17 39%	16 36%	11 25%	44 100%
Make payments within 30 days after bills are submitted?	0	13 36%	23 64%	36 100%
Clearly describe the process for provider appeals?	6 14%	19 44%	18 42%	43 100%
Ensure that clients receive appropriate services for the conditions they present?	8 19%	14 33%	21 49%	43 100%

APPENDIX D

Table D.2. System Performance – Distribution of Responses for CEOs and PDs

To what extent, if any, does the DCMHS system:	Low		Moderate		High		Total	
	CEO	PD	CEO	PD	CEO	PD	CEO	PD
Provide access to services for clients?	2 8%	0	10 44%	9 43%	11 48%	12 57%	23 100%	21 100%
Keep my agency informed about the DCMHS managed care system?	2 8%	7 33%	6 25%	5 24%	16 67%	9 43%	24 100%	21 100%
Ensure that the amount of paperwork required for DCMHS managed care is reasonable, compared to other managed care systems?	6 24%	6 29%	11 44%	10 48%	8 32%	5 24%	25 100%	21 100%
Keep the complexity of paperwork required for DCMHS managed care reasonable, compared to other managed care systems?	9 38%	8 40%	9 38%	7 35%	6 25%	5 25%	24 100%	20 100%
Make payments within 30 days after bills are submitted?	0	0	7 39%	6 33%	11 61%	12 67%	18 100%	18 100%
Clearly describe the process for provider appeals?	4 18%	2 10%	9 41%	10 48%	9 41%	9 43%	22 100%	21 100%
Ensure that clients receive appropriate services for the conditions they present?	1 5%	7 33%	10 46%	4 19%	11 50%	10 48%	22 100%	21 100%

Responses to Open-Ended Questions

Twenty-seven respondents provided comments about the strengths of DCMHS system performance. Eleven of these respondents were CEOs and 16 were PDs. Twenty-eight respondents, 13 CEOs and 15 PDs, provided suggestions for the areas in which DCMHS system performance could improve. There are more comments than respondents because some responses identified more than one strength or area for improvement.

Table D.3. System Performance Strengths and Areas for Improvement

Strengths	Areas for Improvement
Services	
– Ability to provide a wide range of services - commitment to provide whatever service is needed. – The DCMHS system offers and manages a wide variety of programs and has been able to maintain many programs as program funded and not fee for services. This allows services to provide intensive services for difficult situations. – Psychiatric services are of high quality as are aides provided with wrap-around services. – Crisis intervention team at Brandywine Program is very strong.	– Also it is difficult for client to move from one level to another level without gaps in service. This is especially true if client is going from more intensive to less intensive. Example: someone in day treatment gets referred to out-patient the day they are being discharged from day treatment. Then it may take a few weeks to get an outpatient appointment (coordinating schedules, etc.). – Accessibility of service is not possible in a timely manner consistent with client's needs. – No services for culturally linguistically diverse populations. – Allow for gradual step down from intensive services. There is a tendency to send clients to routine outpatient when being discharged from inpatient or RTC. Often a step down to Day Treatment or IOP would be more effective/appropriate for a while and then outpatient. – To provide adequate in-state treatment and services that are geared to the assessed needs treatment and otherwise, of the more severely disturbed adolescent. – A gap in service surrounding children with low IQ has adversely affected many children in our service. – Children requiring more intensive treatment are being placed within our program. Inherent conflict of managed care vs. treatment of client. – On several occasions, Day Treatment has been sent children who are not clinically appropriate for our setting. In addition, children are not always clinically grouped in an appropriate way to provide highest level of care. Set up a process where as the hours for meetings involving the aide / therapist / case manager / psychiatrist, ex… the child and family, should not be taken out of the child's authorized hours, but given additional emergency hours.

Table D.3 (continued)

Strengths	Areas for Improvement
Services (cont.)	
	– RTC beds are too rationed + "mental health issues" is too narrowly defined. – Better supports for chronic conditions are needed. – DCMHS has not authorized a higher level of service at our request unless the initial service was provided by DCMHS, thus not recognizing our clinical programs. – There is poor coordination between different levels of service.
Communication	
– Communication with us. – Willingness of most staff to discuss and improve the system. – Contract relationships, responsive. – Communication regarding clinical issues is good . – Good working relationship with local office managing cases. – DCMHS actively communicates needed information to providers in a timely manner. – Team reviews and responses to inquire. – Contract administrator provides both open and regular communication. – Offering information.	– We get no assistance or feedback regarding program performance as compared to other similar programs. – DCMHS services and other state services need a mechanism to communicate and collaborate more effectively. – Informing service providers of criteria for TX, ID. – Communication with us regarding administrative issues affecting clinical issues is inconsistent, with poor follow through except when at a crisis stage. – Communicate to us how we can better negotiate their system and provide quarterly updates regarding organizational structure and changes in the system.
Paperwork	
– Tries to keep paperwork updated to combine 1 or 2 forms together, which makes less forms for clinicians to complete. – The paperwork for the service we provide is minimal. – Paperwork is more manageable than other systems but can be streamlined further. – Changes to forms are explained adequately.	– Appeals write or define process; requiring less paperwork - have DCMHS do chart reviews + not collect /store records. – Paperwork required to refer someone for intensive services is too extensive. – Less paperwork and/or less need for clinical phone time with reviewers. – Paperwork is too cumbersome. Bills due 10 days after close of month with no subsequent bills allowed. – Overwhelming paperwork. – They could reassess the amount of paperwork required and eliminate some of it.

Table D.3 (continued)

Strengths	Areas for Improvement
Timeliness	
– On one occasion recently when an appeal was made, the response was prompt and appropriate.	– We don't usually get a response of approval or denial within 48 hours. – Quicker investigation and intake. – Slow response w/approval. – Provide more feedback regarding case disposition to initial referral sources in a timely manner. – Lengthy delay in applications being accepted for admission by central intake. – Extremely slow process (2-4 weeks) to (a) transfer cases to deep-end managed care teams and (b) make decisions regarding authorization of deep-end services (esp. day treatment).
Consistency	
	– Consistency in decision-making by CSMTs – Local clinical teams are inconsistent.... There appears to be different rules in different counties. Local DCMHS clinical workers occasionally make requests that appear to be contradicting provider's manual.
Teamwork	
– Involvement by coordinators with + providers	– Work with providers closely – respond to provider concerns. – Local clinical teams sometimes ... make decisions without input from provider.
Professionalism	
– Concern about youth care. – Case managers are active with parents of clients. – Concerned about client safety. – Interest. – The contract manger ... appears to be a strong advocate of our program. – Contract manger has been a strong advocate for Day Treatment.	– Local teams could promote professionalism with providers.
Knowledge/Technical Assistance	
– Knowledge of clients; clinical expertise.	
Accessibility	
– The contract manger is readily available.	

APPENDIX D

Table D.3 (continued)

Strengths	Areas for Improvement
Procedures	
– Organized and comprehensive. – Generally, a well organized system. Treatment teams are better organized and coordinated than in past years. – Seeking attaining accreditation. – Quality assurance is a welcome addition. – Re-authorization process has improved. – Ease of operation	Organization – Streamline – Streamline. Admission process to and services. – Complicated – Too much micro-management Contracts – Need more money for services – There has not been a contract increase with our program for over three years now. Referral Process – Problems with families accessing services and with referral process. Gate is very high. – Access /Awareness. Many candidates for CMH services are made aware by the providers. Few are referred directly by DCMHS (in substance abuse services). – We are at the back end of this process and receive referral after they have already met the criteria established by CMH. Other – The appeal process, treat inquiries as such, not as challenges to the "system." – Families should be evaluated by local teams to ensure information is recorded and most effectively utilized
None	
	– Cannot identify any currently

APPENDIX E

ROLE OF THE PROVIDER

This appendix summarizes the information on the role of the provider obtained from closed- and open-ended questions. The closed-ended questions addressed two topics, the role of the provider generally and the DCMHS Provider Network Forum quarterly meeting series. Tables E.1 and E.2 provide the distribution of responses to the questions about the role of the provider, for all respondents and for CEOs and PDs broken out. They are followed by the comments that providers made in response to a question about how DCMHS can assist the providers to provide the best services to Delaware children. Then, table E.3 supplies the distribution of responses to the questions about the Forum for all respondents. The breakout of CEO and PD responses about the Forum can be found in table 3 in the report. Table E.4 has the providers' suggestions for improving the quarterly meeting series. In addition, the responses to a question at the end of the survey about CEU training events are provided in table E.5.

Role of the Provider

Table E.1. Role of the Provider – Distribution of Responses for Total

Questions	Low	Moderate	High	Total
How clear (if at all) are the requirements for providing mental health/substance abuse services under your agency's contract/provider agreement with DCMHS	3 7%	2 5%	38 88%	43 100%
How clear (if at all) is your agency's role as service provider within the DCMHS managed care system?	2 4%	11 24%	33 72%	46 100%
How reasonable (if at all) are DCMHS expectations for your agency?	3 7%	15 33%	28 61%	46 100%
How adequate (if at all) are the opportunities to comment on policy and service delivery/provision procedures?	11 24%	19 42%	15 33%	45 100%

APPENDIX E

Table E.2. Role of the Provider – Distribution of Responses for CEOs and PDs

Questions[a]	Low		Moderate		High		Total	
	CEO	PD	CEO	PD	CEO	PD	CEO	PD
Clarity of requirements under contract/provider agreement	1 4%	2 11%	2 8%	0	21 88%	17 90%	24 100%	19 100%
Clarity of your agency's role	0	2 10%	6 24%	5 24%	19 76%	14 67%	25 100%	21 100%
Reasonableness of expectations	1 4%	2 10%	7 28%	8 38%	17 68%	11 52%	25 100%	21 100%
Adequacy of opportunitites to comment	7 28%	4 20%	9 36%	10 50%	9 36%	6 30%	25 100%	20 100%

[a]For full text of questions, see Table E.1.

Respondent Comments About How DCMHS Can Assist Providers

Twenty-four providers, 12 CEOs and 12 PDs, identified ways that DCMHS can support providers in their efforts to provide the best possible services to the children of Delaware. Because this section asked only for suggestions from the providers, the presentation below does not use a column format. Instead the comments are listed under each of the topics.

Services

- Willingness to see that children at different ages /developmental stages may need different models for treatment: i.e. – providing intensive early interaction to young children may seem expensive at the time but pays off in terms of preventing chronic mental health problems.
- Contract for residential group care is currently under utilized.
- Develop an age appropriate protocol for provider services to young children (i.e. criteria for levels of care) and important discharge + follow up services for continuity of care.
- DCMHS to learn more about services we provide and recognize our clinical programs.
- Assist with appropriate placements for children requiring special services.
- Recognize that residential services are at times a long term component of mental health need.
- Recognize our clinical services and utilize them as part of their system.
- More and more DCMHS seems to be more about statistics, $$ and paperwork. Do not forget about children! Improving a child mental health and quality of life can not always be measured quantitatively.

APPENDIX E

Communication

- Distribute organizational chart with explanation of positions along with phone numbers of CSMT leaders, CSC program administrators.
- Include treatment team leaders in the provider meetings.

Paperwork

- Forms have been simplified over last few years - Thanks!
- Simplify paperwork + case management system.
- Much less paperwork.
- Of the forms still used the formats are all different (order of information, type styles). Standardization would make the process of filling out forms easier.
- Reduce paperwork requirements.
- Streamline applications for treatment. Avoid duplication of paperwork –e.g. – applying for outpatient and submitting. Same + more for other levels of care.

Timeliness

- Be more timely to respond to authorizations.
- Continue to provide timely information on client tx and medical histories.
- Quicker authorization response.
- Provide faster access to services. I have seen providers find mental health aides in less time than DCMHS takes to do the computer work to authorize the service. So, the aide has been verbally authorized and found, but can not start because the computer entries takes too long.
- Expedite process of referral to ensure quick service delivery.
- See #3 [Quicker investigation and intake]

Consistency

- Provide clinical consistency with downstate local teams.

Teamwork

- They are already most helpful, we have worked collaboratively to create solutions to service gaps.
- As a provider in the DCMHS care system it would be helpful for the local Kent and Sussex treatment teams to work collaboratively with providers along with clearly defining roles and boundaries between treatment team works and providers.
- Remain focused on the benefit of the children, promoting … teamwork.
- Providers should not believe (or be threatened) that referrals will not be sent if the provider has clinical disagreements with local team.
- Provider friendly, provider trust to make a decision about our clients.

Professionalism

- Remain focused on the benefit of the children, promoting professionalism....
- Improve professionalism in downstate local teams.

Accessibility

- Within the last years DCMHS has become more accessible, although expectations may change daily.

Procedures

Organization

- Try to minimize redundancy by either having verbal updates on clients or paper updates but not requiring both. Suggest second review on 20% of clients but not on all.
- Share some of its system or forms to unify what is done through out the system. Provide computer links.

Provider Forums

- DCMHS would benefit from having case management staff and their supervisors attend provider network forums.

Other

- Consider contracting directly with labs and pharmacies to access needed lab studies and medication as opposed to providers acting as middleman.
- Secure more funding.

DCMHS Provider Network Forum Quarterly Meeting Series

Table E.3. Provider Network Forum – Distribution of Responses for Total

To what extent, if any, does the DCMHS Provider Network Forum quarterly meeting series:	Low	Moderate	High	Total
Ensure consistent information exchange?	7	11	18	36
	19%	31%	50%	100%
Afford providers an opportunity of input and open dialogue?	11	11	14	36
	31%	31%	39%	100%
Share information in an effective manner?	6	13	17	36
	17%	36%	47%	100%
Identify topics of discussion that are germane to providers?	11	7	18	36
	31%	19%	50%	100%
Improve communication between DCMHS and providers?	7	18	11	36
	19%	50%	31%	100%

The service providers comments on how to improve the DMCHS Network Provider Forum are listed in table E.4. Twenty-three service providers made comments related to the Forum. Fourteen were CEOs and 9 were PDs.

Table E.4. DCMHS Network Provider Forum – Areas for Improvement

Topic	Comments
Communication	– Get out dates + agenda well in advance of meeting. – Agency site has never been invited to Network Provider Forum. – Agencies are notified late if at all of meetings. Agenda for meetings are not clear and often stray from topic. – DCMHS can notify our agency site letting us know in advance when these meetings are going to take place so we can plan to attend. – I have only recently begun to attend these meetings. – Not clear on what quarterly meetings. – Notify us of meetings. – Notify us of the meetings – I have not known about the Forums. – No knowledge. – I am not aware of these meetings in Sussex County and have not attended any.
Format	– Information shared to providers are presented in a format which does not generate involvement by providers. – Smaller groups may facilitate more discussion. – More effective presenters
Topics	– More networking and topics for those who work with diagnostically or culturally diverse clients – More time devoted to topics – Discuss innovative approaches. Use to streamline the process. – More on new research – Review /explanation of all services available to providers who are concentrated with DCMHS. – Topic – the managed care process as practiced by DCMHS, walk through the system.

Table E.4. DCMHS Network Provider Forum (continued)

Topic	Comments
Teamwork	– Perhaps providers should have input into agenda. – See previous note: local representation - i.e. staff of Sussex county/Kent county CMH offices. – Request topics for agenda from providers. – Increase provider interaction; less lecture. – Providers are brought into discussions after decisions are nearly finalized. Thus programming decisions are made without input from clients and without input from providers – the professionals who talk to the clients. Improvement: involve clients and providers in decision-making. – More input from providers on the agenda.
Location	– I do not get to go as site director (agency policy). So, I have no specific comments. Although I have heard that the meetings are almost always in Wilmington area. Someone in Sussex County has to commit a full workday to stand a 2-3 hours meeting due to travel time. – Are there downstate quarterly meetings?

CEU Training Events – Recommendations

Thirteen respondents (9 CEOs and 4 PDs) made suggestions for topics to be covered in future training events. These are listed in table E.5 by topic.

Table E.5. CEU Training Events – Recommendations

Topic	Comments
Younger Children	– Play Therapy!!! Working with younger children. Day long training on topic is best. Multi-topic conferences are more a tease than help. Too many providers try to work with children as "little adults". – Disorders most commonly diagnosed for children. – Developmentally appropriate criteria for providing mental health services to younger children.
Adolescents	– Working with narcissistic /anti-social adolescent. – Research on adolescent growth and development.

APPENDIX E

Table E.5. CEU Training Events (continued)

Topic	Comments
Substance Abuse	– Substance abuse issues in MH treatment; – Alcohol/substance abuse training.
Other Clinical Topics	– Any issues that relate to adolescents, infants and toddlers – Dual diagnosis; pharmacological interventions. – Training on new medications + drug interactions for non-medical people. – Treating the borderline client. – Group work with a small population. – Any clinical topics would be helpful. – Training in specific clinical areas. – An annual providers meeting which highlights clinical work by provider on a particular subject or area
Professionalism	– Ethics, cultural diversity and confidentiality. – Teamwork – Supervision would be helpful to DCMHS and providers (management training). – New forms, new processes tied into when they are to be implemented.

PROVIDER NETWORK ADMINISTRATION

The Provider Network Administration section of the survey had three parts. The first part, about program administrators, asked the service providers to respond only if they had direct experience with one or more program administrators. Thirty-eight to 40 responded. Their answers are summarized in table F.1, and broken out by CEO and PD in table F.2. The second section of the survey focused on quality improvement administrators. Again, service providers were supposed to respond only if they had had experience with people in this position. Table F.3 summarizes the responses of the 23-25 service providers answering this section. The break-down by CEO and PD is provided in the text (table 3). The third section of the survey asked only those familiar with the contracting or monitoring process to respond. The table that summarizes the results across the 17-18 respondents to this section is in the report (table 4). Table F.4 breaks out the reactions of the CEOs and PDs to the contracting and monitoring process. These tables are followed by tables that classify and display the verbatim comments received in response to open-ended questions.

Table F.1. Program Administrators – Distribution of Responses for Total

In your experience, to what extent, if at all, are the DCMHS Program Administrators:	**Low**	**Moderate**	**High**	**Total**
Approachable?	3	3	34	40
	8%	8%	85%	100%
Accessible/available?	2	4	34	40
	5%	10%	85%	100%
Professional in their working relationships?	3	5	32	40
	8%	13%	80%	100%
Responsive to questions?	3	4	33	40
	8%	10%	83%	100%
Willing to resolve disagreements?	2	8	28	38
	5%	21%	74%	100%
Willing to remain involved?	1	7	32	40
	3%	18%	80%	100%
Willing to explain DCMHS decisions?	2	6	31	39
	5%	15%	80%	100%
Knowledgeable about clinical processes?	2	5	33	39
	5%	13%	83%	100%
Knowledgeable about administrative processes?	1	3	36	40
	3%	8%	90%	100%

Table F.2. Program Administrators – Distribution of Responses for CEOs and PDs

In your experience, to what extent, if at all, are the DCMHS Program Administrators:	Low		Moderate		High		Total	
	CEO	PD	CEO	PD	CEO	PD	CEO	PD
Approachable?	1 4%	2 13%	2 8%	1 6%	21 88%	13 81%	24 100%	16 100%
Accessible/available?	0	2 13%	3 13%	1 6%	21 88%	13 81%	24 100%	16 100%
Professional in their working relationships?	1 4%	2 13%	4 17%	1 6%	19 80%	13 81%	24 100%	16 100%
Responsive to questions?	1 4%	2 13%	3 13%	1 6%	20 83%	13 81%	24 100%	16 100%
Willing to resolve disagreements?	1 5%	1 6%	6 27%	2 13%	15 68%	13 81%	22 100%	16 100%
Willing to remain involved?	0	1 6%	5 21%	2 13%	19 79%	13 81%	24 100%	16 100%
Willing to explain DCMHS decisions?	1 4%	1 6%	4 17%	2 13%	18 78%	13 81%	23 100%	16 100%
Knowledgeable about clinical processes?	2 8%	0	3 13%	2 13%	19 80%	14 88%	24 100%	16 100%
Knowledgeable about administrative processes?	1 4%	0	1 4%	2 13%	22 92%	14 88%	24 100%	16 100%

Table F.3. Quality Improvement Administrators – Distribution of Responses for Total

To what extent, if any:	Low	Moderate	High	Total
Is assistance from DCMHS Quality Improvement Administrators … clear?[a]	3 12%	10 40%	12 48%	25 100%
Are incident reporting procedures for providers clear?	1 4%	7 28%	17 68%	25 100%
Is feedback from incident reporting informative?	9 39%	8 35%	6 26%	23 100%

[a]Full text of the question is: Is assistance from DCMHS Quality Improvement Administrators in the interpretation of standards, development of provider standards and records available?

APPENDIX F

Table F.4. Contracting and Monitoring – Distribution of Responses for CEOs and PDs

	Low		Moderate		High		Total	
To what extent if any:	**CEO**	**PD**	**CEO**	**PD**	**CEO**	**PD**	**CEO**	**PD**
Is the DCMHS process for becoming a network provider panel member clear?	1 8%	2 33%	2 17%	1 17%	9 75%	3 50%	12 1005	6 100%
Is the DCMHS process for becoming a network provider panel member fair?	2 18%	2 33%	1 9%	1 17%	8 73%	3 50%	11 100%	6 100%
Is adequate notification provided for the scheduling of monitoring visits?	2 17%	1 17%	2 17%	0	8 67%	5 83%	12 100%	6 100%
Are the monitoring visits conducted in an objective fashion?	1 9%	0	1 9%	1 17%	9 82%	5 83%	11 100%	6 100%
Is monitoring feedback fair?	0	0	3 27%	1 17%	8 73%	5 83%	11 100%	6 100%
Is monitoring feedback accurate?	0	1 17%	3 27%	1 17%	8 73%	4 67%	11 100%	6 100%

Network Administration – Strengths and Areas for Improvement

Table F.5 displays the responses to the general questions about the strengths and areas for improvement in DCMHS provider network administration. Thirteen of the service providers (9 CEOs and 4 PDs) identified strengths of the administration of the provider network. Five CEOs and 5 PDs offered suggestions for improvement. Some respondents identified more than one strength or area for improvement. Responses to the open-ended question about the monitoring process are provided in the report.

Table F.5. Provider Network Administration -- Strengths and Areas for Improvement

Strengths	Areas for Improvement
Communication	
	– Increased communication regarding performance. – Be open to feedback; do not judge provider on one event but overall performance.
Timeliness	
	Contract negotiations - provide drafts sooner.

Table F.5. Provider Network Administration (continued)

Strengths	Areas for Improvement
Consistency	
The people, low turnover rates in personnel - good continuity from year to year.	The divisions within DCMHS are so vast that messages, decisions, information, and policy are inconsistent. Differences in counties of DCMHS (N.C./K./S) are astounding and notably Kent County is led without little regard for procedure and DCMHS policy/manual specifications. *[From response to question for general comments.]*
Teamwork	
	– Utilize input from clients and providers in making programming decisions.
Professionalism	
– Professional, courteous, helpful with technical assistance. – Currently they are very supportive and work toward quality improvement. – Enthusiastic - high expectations for quality. – Professional, committed to developing a successful network.	
Knowledge/Technical Assistance	
– Our contract manger is willing to seek out information when she does not readily have it. – Information flow, technical assistance. – The contract administrators have been extremely helpful in a problem-solving productive manner…. – Clinical expertise help; knowledge of P.I. helpful. – Contract manager always makes an effort to get answers for our questions.	
Accessibility	
– Accessible – Accessibility – Program administration has been cooperative and available. – Our contract manger is very accessible and helpful. – Availability – The contract administrators have been … accessible. – Within the last years DCMHS has become more accessible, although expectations may change daily.	Clinical service administration needs to be accessible after 4:30 in a crisis situation.

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Table F.5. Provider Network Administration (continued)

Strengths	Areas for Improvement
Procedures	
	– Simplify routing of decisions between DCMHS funders. – Stick to your deadlines. If we miss a deadline we get into trouble. If they miss a deadline it "oh well." – It appears the standards for inclusion as a network provider (individual clinician) for non JCAHO organizations are higher than are mandated for JCAHO accredited organization who credential their own staff. – Gain more insight and control over local DCMHS teams. Become aware of local DCMHS action being taken with agencies.
None	
	None at this time.

APPENDIX G

CLINICAL SERVICES MANAGEMENT

The data from questions in the clinical services management section of the survey are provided in this appendix. The first 8 tables summarize the results from the questions about clinical services management teams, transitions, coordinators/supervisors, and team leaders. Table G.9 contains the verbatim comments of the respondents about the strengths and areas needing improvement in clinical services management.

Clinical Services Management Teams

Table G.1. CSM Teams -- Distribution of Responses for Total

Questions	Low	Moderate	High	Total
To what extent (if at all) is the DCMHS Client Service Plan useful to my agency in developing treatment plans?	11 25%	17 39%	16 36%	44 100%
To what extent (if at all) is the role of the Clinical Services Management Team clear??	10 23%	14 32%	20 46%	44 100%
How immediate, if at all, is the response of the DCMHS Clinical Services Management Teams when called with a clinical emergency?	4 10%	10 25%	26 65%	40 100%
How clear (if at all) are the Clinical Services Management authorization procedures?	6 15%	16 39%	19 46%	41 100%
Compared to other managed care systems, how reasonable... is the clinical information required ...for continued authorization of services?[a]	9 22%	9 22%	23 56%	41 100%
To what extent (if at all) do the ...Teams appropriately consider the input of my agency's therapist(s) in making ... decisions? [b]	11 26%	13 30%	19 44%	43 100%

[a]Full text of question: Compared to other managed care systems, how reasonable (if at all) is the clinical information required by the DCMHS Clinical Services Management Team for continued authorization of services?

[b] Full text of question: To what extent (if at all) do the DCMHS Clinical Services Management Teams appropriately consider the input of my agency's therapist(s) in making clinical and discharge decisions?

Table G.2. CSM Teams – Distribution of Responses for CEOs and PDs

Items[b]	Low		Moderate		High		Total	
	CEO	PD	CEO	PD	CEO	PD	CEO	PD
Usefulness of DCMHS Client Service Plan in developing treatment plans	3 13%	8 38%	10 44%	7 33%	10 44%	6 29%	23 100%	21 100%
Clarity of the role of the Clinical Services Management Team	1 4%	9 43%	11 48%	3 14%	11 48%	9 43%	23 100%	21 100%
Immediacy of response when called with a clinical emergency	2 10%	2 11%	6 29%	4 21%	13 62%	13 68%	21 100%	19 100%
Clarity of authorization procedures?	2 10%	4 20%	11 52%	5 25%	8 38%	11 55%	21 100%	20 100%
Reasonable requirements for continued authorization	4 19%	5 25%	4 19%	5 25%	13 62%	10 50%	21 100%	20 100%
Consideration of agency's input	3 14%	8 38%	8 36%	5 24%	11 50%	8 38%	22 100%	21 100%

[b]See table G.1 for complete text of questions.

Clinical Services Transitions

Table G.3. Clinical Services Transitions – Distribution of Responses for Total

To what extent, if any, do the DCMHS Clinical Services Management Teams effectively plan and facilitate client service transitions:	Low	Moderate	High	Total
At admissions?	11 26%	13 30%	19 44%	43 100%
At discharges?	10 23%	15 35%	18 42%	43 100%
During transitions to the adult services system?	9 26%	11 31%	15 43%	35 100%

Table G.4. Clinical Services Transitions – Distribution of Responses for CEOs and PDs

To what extent, if any, do the DCMHS ...Teams effectively plan and facilitate client service transitions?	Low		Moderate		High		Total	
	CEO	PD	CEO	PD	CEO	PD	CEO	PD
At admissions?	1	10	10	3	11	8	22	21
	5%	48%	46%	14%	50%	38%	100%	100%
At discharges?	4	6	10	5	8	10	22	21
	18%	29%	46%	24%	36%	48%	100%	100%
During transitions to the adult services system?	4	5	7	4	7	8	18	17
	22%	29%	39%	24%	39%	47%	100%	100%

Clinical Services Coordinators/Supervisors

Table G.5. Coordinators/Supervisors – Distribution of Responses for Total

In your clinical staff's experience, to what extent, if any, are the DCMHS Clinical Services Coordinators/Supervisors:	Low	Moderate	High	Total
Approachable?	4	9	31	44
	9%	21%	71%	100%
Accessible/Available?	6	9	29	44
	14%	21%	66%	100%
Professional in their working relationships?	5	9	30	44
	11%	21%	68%	100%
Responsive to questions?	4	12	27	43
	9%	28%	63%	100%
Willing to resolve disagreements?	8	15	20	43
	19%	35%	47%	100%
Willing to remain involved?	3	11	29	43
	7%	26%	67%	100%
Willing to explain DCMHS decisions?	10	8	25	43
	23%	19%	58%	100%
Knowledgeable about the spectrum of children's services in Delaware?	4	9	30	43
	9%	21%	70%	100%
How important (if at all) is the role of the DCMHS managed care coordinators in your agency's treatment of families?	11	9	21	41
	27%	22%	51%	100%

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Table G.6. Coordinators/Supervisors – Distribution of Responses for CEOs and PDs

In your clinical staff's experience, to what extent, if any, are the DCMHS Clinical Services Coordinators/ Supervisors:	Low		Moderate		High		Total	
	CEO	PD	CEO	PD	CEO	PD	CEO	PD
Approachable?	1 4%	3 14%	6 26%	3 14%	16 70%	15 71%	23 100%	21 100%
Accessible/Available?	2 9%	4 19%	4 17%	5 24%	17 74%	12 57%	23 100%	21 100%
Professional in their working relationships?	1 4%	4 19%	4 17%	5 24%	18 78%	12 57%	23 100%	21 100%
Responsive to questions?	0	4 19%	6 27%	6 29%	16 73%	11 52%	22 100%	21 100%
Willing to resolve disagreements?	1 5%	7 33%	10 46%	5 24%	11 50%	9 43%	22 100%	21 100%
Willing to remain involved?	0	3 14%	5 23%	6 29%	17 77%	12 57%	22 100%	21 100%
Willing to explain DCMHS decisions?	2 9%	8 38%	6 27%	2 10%	14 64%	11 52%	22 100%	21 100%
Knowledgeable about the spectrum of children's services in Delaware?	0	4 19%	4 18%	5 24%	18 82%	12 57%	22 100%	21 100%
How important (if at all) is the role of the DCMHS managed care coordinators in your agency's treatment of families?	5 24%	6 30%	6 29%	3 15%	10 48%	11 55%	21 100%	20 100%

Clinical Services Management Team Leaders

Table G.7. Team Leaders – Distribution of Responses for Total

In your clinical staff's experience, to what extent, if any, are the DCMHS Clinical Services Team Leaders:	Low	Moderate	High	Total
Approachable?	8	11	23	42
	19%	26%	55%	100%
Accessible/Available?	9	13	20	42
	21%	31%	48%	100%
Professional in their working relationships?	5	12	25	42
	12%	29%	60%	100%
Responsive to questions?	8	14	20	42
	19%	33%	48%	100%
Willing to resolve disagreements?	14	9	19	42
	33%	21%	45%	100%
Willing to remain involved?	8	13	21	42
	19%	31%	50%	100%
Willing to explain DCMHS decisions?	12	11	19	42
	29%	26%	45%	100%
Have adequate clinical expertise?	7	9	26	42
	17%	21%	62%	100%

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Table G.8. Team Leaders – Distribution of Responses for CEOs and PDs

In your clinical staff's experience, to what extent, if any, are the DCMHS Clinical Services Team Leaders:	Low		Moderate		High		Total	
	CEO	PD	CEO	PD	CEO	PD	CEO	PD
Approachable?	3 14%	5 24%	5 24%	6 29%	13 62%	10 48%	21 100%	21 100%
Accessible/Available?	2 10%	7 33%	8 38%	5 24%	11 52$	9 43%	21 100%	21 100%
Professional in their working relationships?	2 10%	3 14%	6 29%	6 29%	13 62%	12 57%	21 100%	21 100%
Responsive to questions?	2 10%	6 29%	7 33%	7 33%	12 57%	8 38%	21 100%	21 100%
Willing to resolve disagreements?	5 24%	9 43%	6 29%	3 14%	10 48%	9 43%	21 100%	21 100%
Willing to remain involved?	2 10%	6 29%	6 29%	7 33%	13 62%	8 38%	21 100%	21 100%
Willing to explain DCMHS decisions?	3 14%	9 43%	7 33%	4 19%	11 52%	8 38%	21 100%	21 100%
Have adequate clinical expertise?	3 14%	4 19%	4 19%	5 24%	14 67%	12 57%	21 100%	21 100%

Respondent Comments About Clinical Services Management

Nineteen of the survey respondents identified strengths of DCMHS Clinical Services Management. Of the 19, 12 were CEOs and 7 were PDs. Slightly more respondents identified areas where DCMHS Clinical Services Management could improve. Twenty-two service providers (12 CEOs and 10 PDs) replied to the question about improvements. The comments made about strengths and areas needing improvement are provided in table G.9.

Table G.9. Clinical Services Management – Strengths and Areas for Improvement

Strengths	Areas for Improvement
Services	
Have seen great improvement in recent years in simplifying the process of accessing services. Some services seem more readily available.	– Identify services and funding streams for clients who may turn 18 while in RTC and at that point lose funding. Introduction and planning would enable additional funding to be obtained to avoid discharge. – Adult mental health services need to be in process 6 months or more prior to age 18 as our clients are most often on their own at age 18. – Responding to needs of clients who have chronic mental health issues – i.e., sometimes an RTC is needed for long term support, not short term acute issues. – Supports are not authorized when the child begins to deteriorate, only as child de[ampensates?] to a serious extent. – Facilitate day care arrangements faster.
Communication	
	– Admission, discharge, and transitions are not effectively communicated to providers – Many extra calls required reporting to them. They could call directly and let the therapist to the treatment. – Provide complete data at the time of referral, especially medical information. – Communication with providers regarding admission/discharge.
Paperwork	
	– Diminish paperwork and phone consults. – For outpatient services sessions are frequently authorized month to month requiring frequent reauthorization requests (paperwork). – Decrease in paperwork.
Timeliness	
	– Respond faster - DCMHS deadlines are frequently missed - resulting in delays in services. – Timelessness [sic] … need[s] improvement.

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Table G.9. Clinical Services Management (continued)

Strengths	Areas for Improvement
Consistency	
	– Greater consistency between teams. – Consistency – Professionalism and teamwork is inconsistent among case managers. – CMH needs to look at low census in Kent County across provider setting last year + assess whether team leader style/ interpretation a major factor.
Teamwork	
– Willingness to work as partner to develop creative service plans. – Georgetown office clinical service team members become actively involved within the treatment process by keeping current on treatment status. – Their participation in the treatment planning is positive and very helpful.	– Be more open to provider when client disruptive in area of TX and other support services are needed. – Since CSMTs make decisions based on "paper review", greater weight should be given to providers' decision-making in clinical + discharge issues. – The treatment team leaders in Kent and Sussex counties need to work in a collaborative manner and be more aware of contract obligations of providers. – Rather than just asking for information on a client CMHS should act as a team with providers. – Agency site works directly with clients and families enrolled in program. DCMHS/CSM should take our recommendations for treatment in consideration when they have to make clinical decision regarding clients or family. – Increase involvement with clients, particularly to increase client's role in treatment planning. – Consider provider input. – It would be extremely helpful for local treatment teams and providers to work collaboratively as staff has reported this relationship feels inflexible and one-sided. Both groups should support each other in working with many difficult situations. It may be helpful to meet on quarterly basis with local teams.

Table G.9. Clinical Services Management (continued)

Strengths	Areas for Improvement
Role Definition	
	– There are times when the CSMTs get very involved in the management of treatment, seemingly confusing role of consulting /manager vs. direct supervision of case. – More clarification of the CSM expectations – Role definition. – Clearer expectations + role definitions (these vary from county to county). – Our understanding is that supervisors and team leaders are the same.
Professionalism	
– Dedicated coordinators (most but not all). – Additionally, members have been strong advocates for supplementary services that seek to enhance/support existing services. Team members, excellent advocates, became involved with families. – Professional; concerned about client well being; appear to make decision based on treatment needs rather than financial considerations. – The Clinical Coordinators /Supervisors are … very willing to work hard for children. – Certain case managers are professional. – Some case managers work diligently to ensure client treatment is the best it can be.	– Professionalism. – Local case managers are inconsistent in their clinical levels and professionalism ranging from excellent to poor. I would suggest that supervisors attend meetings periodically with case managers. I would also suggest case managers be monitored regularly on the amount of contacts made with providers. – Many staff report team leaders being unprofessional and punitive. Also threatening to not refer clients unless their recommendations are followed. This has created a lack of trust and greatly affected working relationships. – The teams … at times seem condescending when discussing clinical issues, other agencies within the state, and programmatic issues.
Knowledge/Technical Assistance	
– Knowledge - clinical + service availability. – Clinical expertise of team leaders. – Know the resources. Keeps knowledgeable of progress in case. – Clinical expertise of most of the CSMT leaders. – Some have a range of clinical expertise. – Certain case managers …have clinical knowledge. – Knowledgeable people.	– Stronger knowledge base in substance abuse and its impact on adolescent functioning. – It would be beneficial in the teams had more experience with this specific service [residential mental health]. – CSMTs should understand the impact of long-term placement in a restrictive setting in children.

Table G.7. Clinical Services Management (continued)

Strengths	Areas for Improvement
Accessibility	
– When you can get hold of them, they will take the time to consult and review concerns – The monthly meetings with team leaders. The diversity of the team leaders and willingness to look into substance abuse issues – Accessibility – Accessible, approachable. – Very approachable and responsive. – The Clinical Coordinators /Supervisors are accessible to staff – They have more made themselves more available for formal discussions. – They are local. – They are located within each county.	– Availability … needs improvement. – The teams are not always approachable …. – To hold client meetings at the provider location as opposed to taking so much time to meet at CMH.
Procedures	
	– Accept crisis applications as beginning part of the regular application for out patient services as information already in system. – Discharge planning with other agencies … need[s] improvement. – Clients are sent to program to be admitted, sometimes with no contract with provider from DCMHS. Program walk-ins are too common to function effectively.

APPENDIX H

PROVIDER SURVEY AND OTHER COMMUNICATION TOOLS

The data on effectiveness of different communication tools are presented in this appendix. First, tables displaying summaries of the responses are provided. After the tables, the comments made in response to two open-ended questions are listed.

Table H.1. Communication Tools – Distribution of Responses for Total

In the past year, to what extent, if any:	Low	Moderate	High	Total
Were the concerns and suggestions expressed by providers in last year's survey appropriately addressed?	7 30%	11 48%	5 22%	23 100%
Has quarterly network provider forum meetings improved communication between DCMHS and its provider network?	6 27%	11 50%	5 23%	22 100%
Have highlights in the quarterly NETWORK NEWS publication to providers improved communication between DCMHS and its provider network?	6 27%	9 41%	7 32%	22 100%
Has the information outlined in the DCMHS Provider Manual clarified DCMHS authorization procedures?	2 9%	6 26%	15 65%	23 100%

Table H.2. Communication Tools – Distribution of Responses for CEOs and PDs

In the past year, to what extent, if any: [a]	Low		Moderate		High		Total	
	CEO	PD	CEO	PD	CEO	PD	CEO	PD
Concerns and suggestions appropriately addressed?	2 17%	5 46%	6 50%	5 46%	4 33%	1 9%	12 100%	11 100%
Communication improved by forum meetings?	1 9%	5 46%	6 55%	5 46%	4 36%	1 9%	11 100%	11 100%
Communication improved by NETWORK NEWS?	3 27%	3 27%	4 36%	5 46%	4 36%	3 27%	11 100%	11 100%
Authorization procedures clarified by DCMHS Provider Manual?	1 8%	1 9%	4 33%	2 18%	7 58%	8 73%	12 100%	11 100%

[a]See table H.1 for complete text of questions.

Respondent Comments on the Service Provider Survey

The first open-ended question about the survey asked, "How could DCMHS' responsiveness to the FY '98 survey be improved?" The responses to this question are included in the report. This section of the appendix first presents respondent answers to the survey question about the value of the provider survey to the service providers. The next question asked what additional topics would be important to include in future surveys. The responses are provided below.

Value of Provider Survey

Seventeen respondents commented to the question, "In what ways, if any, has the provider survey process been of value to your organization? Of these 10 were CEOs and seven were PDs. However only 11 identified ways in which the survey had been of use to them. Of the other six, three said that the survey either had no value, stating:

- No significant value.
- Not really of much value. Sometimes one gets the message that the process is more important for compliance purpose than really improving services and the lives of children.
- We are out of state – much does not apply.

The other three could not identify a use, two stating that this was the first survey they had completed and one writing, "not sure," in response to the question. The comments identifying how the survey had been valuable are listed below.

Communication

- It allows providers to express some concerns that might be also concerns of other providers. I also think that it allows DCMHS to know that they do a good job, which they might not hear otherwise.
- This is the only opportunity I have been afforded to give input into the process.
- DCMHS are often inaccessible, unresponsive to questions, and lack follow up for resolution of an issue. Survey process allows DCMHS to receive provider feedback.
- Allows feedback in a confidential forum.
- It has not been productive in the past; however the confidentiality of this information will allow for more productive information.
- Confidentiality has enabled an accurate response and a sense of being heard.
- Gives a chance to voice comments and concerns.
- An opportunity to share feedback and see trends or areas of concerns.

Other

- Process requires the agency to define its needs.
- Able to compare services with similar providers.

- It facilitated an open discussion of the clinical staff regarding strengths and areas for possible improvement within the DCMHS system.

Topics for Future Surveys

Eight service providers identified potential topics for future surveys. An additional three responded to the question about what topics should be included in the future by stating that none are needed, because either the "survey appears comprehensive," or the survey is "ok as is," or "none specific." Of the 11 respondents commenting on this question, 8 were CEOs and 3 were PDs. The potential topics are listed below.

Services

- More on transitions between levels of services. Many clients need to go up or down in levels ... the transitions need work.
- What services could DCMHS provide to us to facilitate more qualitative services to our clients? It makes it difficult to answer accurately with the grouping identified.
- How are emergency services determined, what role does the staff-providing emergency services play with the staff of the referring agency?
- Managed care, how are services determined?
- Adequacy of services provided.

Procedures

- Accessing medical tx for out of state providers
- The budgeting process, result of UR. QI and other information managed care collects.
- Time frames for which DCMHS provides agencies with final decision on clinical services coordinator level.

Case Managers

- Please add a section for the case managers.
- Evaluation of case managers on treatment teams.