

# **Division of Child Mental Health Services**

## **Service Provider Survey**

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## SERVICE PROVIDER SURVEY, FY 1998

### 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 of the FY 1998 provider survey results reports the major findings and areas for improvement from each section of the survey. (For information on sampling procedures, response rates, and survey administration, see pages 1 - 2.)

#### DCMHS MISSION AND VALUES

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##### Findings

Service providers were less likely to report familiarity with the DCMHS mission in 1998 than they were in 1997. Specifically, in 1997, 95% of the service providers responding to the survey reported familiarity, while in 1998, only 70% reported familiarity. One possible explanation for this is the recent revision of the mission. In responses to open-ended questions, collaboration was the most commonly mentioned strength in the new DCMHS mission, but some comments indicated the need for leadership from DCMHS to ensure that collaboration occurred in practice, as well as in the philosophy. (See pages 4 - 6 for details.)

##### Areas for Improvement

The findings indicate that leadership is required from DCMHS in applying the concepts identified in the mission and values. Specific suggestions included:

- Supporting the implementation of innovative programs and services,
- Providing a structure for effective collaboration,
- Increasing the scope of services,
- Demonstrating sensitivity to cultural and ethnic differences, and
- Strengthening accountability.

#### DCMHS SYSTEM PERFORMANCE

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##### Findings

Respondents were generally satisfied with the access and appropriateness of the services provided through the DCMHS system. More than 80% of the respondents gave favorable responses to those items. At the same time, however, 39% of the respondents disagreed that "clients receive appropriate client care management." In the responses to open-ended questions, respondents identified communication and concern for clients as particular strengths of the system. However, communication also emerged as a weak point in both quantitative and qualitative responses. For example, the amount and complexity of paperwork received a large proportion of negative responses (8 respondents, or 29%). (Details can be found on pages 6 - 10.)

### **Areas for Improvement**

Communication, which includes paperwork, appears to be the major concern about the performance of the DCMHS system. According to the responses, communication could be improved by:

- Providing more information about the DCMHS managed care system,
- Clarifying the provider appeals process,
- Reducing paperwork (see p. 10 for specific recommendations),
- Increasing consistency across individual personnel, local offices, and provider manual, and
- Increasing coordination with other divisions of the Department of Services for Children, Youth and Their Families.

## **ROLE OF THE PROVIDER IN THE DCMHS MANAGED BEHAVIORAL HEALTH SYSTEM**

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### **Findings**

Overall, respondents were very aware of expectations and requirements in the role of provider. (See figure 5 for details.) However, one in four respondents stated that they were not given adequate opportunity to comment on policy and service delivery/provision procedures. When asked about strengths of the provider role, the respondents tended to comment on the strengths of their agency, including the quality of services they provided, the quality of their staff, and their communication with DCMHS. Similarly, some of the areas for improvement identified were specific to the individual agencies (such as expansion of services). The areas in which DCMHS needs to improve focused on communication and paperwork. (For more information, see the discussion on pages 10 – 13.)

### **Areas for Improvement**

The respondents indicated that communication between DCMHS and the providers could be improved by:

- Clarifying the providers' accountability responsibilities to different DCMHS components,
- Continuing the process of identifying systems concerns,
- Improving coordination and communication between wraparound service and primary clinical providers, and
- Improving the timeliness of paperwork.

## **PROVIDER NETWORK ADMINISTRATION**

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### **Findings**

Respondents' experience with the DCMHS Program Administrators was generally positive. All but one of the items received favorable responses from more than 68% of the service providers responding to the survey. The only item receiving a lower percentage of "agree" responses referred to the incident reporting feedback, which had a high proportion (29%) of "don't know" responses. A majority of the respondents having direct experience with the contracting or monitoring processes gave favorable responses about the clarity or appropriateness of the processes. (The "agree" responses ranged from a high of 82% agreeing with the objectivity of the monitoring visits to a low of 53% agreeing to the items about the

clarity and fairness of the awards process.) In responses to the open-ended questions, the service providers emphasized the monitoring process, with three of the six strengths identified in this section focusing on the monitoring process. The other three strengths were accessibility, the RFP process, and one specific staff member. Despite the strengths, communication was again identified as a concern. (For details, please see pages 13 – 18.)

### **Areas for Improvement**

The responses of the service providers indicate that communication could be improved by:

- Clarifying the awards process and making it more objective,
- Reducing the time that elapses between monitoring visits and provision of feedback based on the visit,
- Making feedback from incident reporting more informative (Note: Those providing intensive outpatient services were much more satisfied with feedback than the other service providers.),
- Revising forms to ensure consistency with service providers other paperwork processes,
- Respecting service providers in deliberations by treatment teams, and
- Reducing inconsistencies between the central and local offices.

## **CLINICAL SERVICES MANAGEMENT**

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### **Findings for Coordinators/Supervisors**

Clinical Services Coordinators received generally high approval from the survey respondents. Over 22 (79%) of the service providers who responded to the survey agreed with statements about the coordinators' accessibility, responsiveness, involvement, ability to explain decisions, and knowledge. The items receiving the highest proportion of favorable responses (89%) were those addressing the accessibility and responsiveness of the Coordinators/Supervisors. The items receiving the lowest proportion of favorable responses were those addressing the usefulness of the service plan and the clarity of the role of the Clinical Services Management Team, with 19 or 68% of the service providers agreeing. (See pages 18 – 20 for details.)

### **Areas for Improvement for Clinical Services Coordinators and Supervisors**

The overall picture of the management by the Coordinators and Supervisors is positive, but clinical services management could be further strengthened by:

- Making the service plan more useful to the provider agencies, and
- Clarifying the coordinators'/supervisors' role.

### **Findings for Clinical Services Team Leaders**

The pattern of responses to the questions about Team Leaders was similar to, although rated slightly lower than, those for the Coordinators/Supervisors. The proportion of service providers agreeing to positive statements about the Team Leaders ranged from a high of 86% agreeing with the item about the accessibility of Team Leaders to a low of 61% for the item about Team Leaders' resolution of disagreements. (See pages 20 – 21 for details.)

### **Areas for Improvement for Team Leaders**

While the responses were generally favorable, management by the Team Leaders could be further improved by:

- Increasing skills and practice in resolving disagreements and explaining decisions,
- Increasing the clinical sophistication of team leaders.

### **General Findings**

Looking at clinical services management in general, more than half the service providers who returned the survey responded positively to items about the coordinators' role in treatment, the response rates to emergencies, the clarity and reasonableness of the authorization procedures, and the planning and facilitation of transitions (except the transition to adult services which was not applicable to many of the service providers). The favorable responses ranged from 68 % agreement that the agency therapist's input was considered to 54 % agreement that discharge planning and facilitation was effectively planned. (The item about planning and facilitating transitions to adult services was agreed to by only 21 %, but 57 % indicated that they either did not know or the item was not applicable.) Looking at the data from the other direction, the items receiving the most negative responses were (1) clarity of the authorization procedures (36 % disagreement); (2) importance of the coordinators' role in treatment (29 % disagreement); (3) reasonableness of the information required for continued authorization (29 % disagreement); and (4) effectiveness of DCMHS discharge planning and facilitation (29 % disagreement). Compared to other parts of the survey, the responses to items in this section of the survey were more likely to vary by the type of services provided by the respondents. For example, crisis service providers were generally more satisfied with clinical services management than all providers. In responses to open-ended questions, strengths of clinical services management included the quality of the people involved, the focus on clients, the accessibility of the teams, and the coordination of services. However, some of these same areas appeared in the suggestions for improvements. (See pages 21 – 25 for details.)

### **General Areas for Improvement**

Three themes emerged from the service providers' responses to both closed- and open-ended questions in this section: (1) inconsistencies across different clinical management teams and between DCMHS central office and local staff; (2) complexity and appropriateness of management procedures; and (3) communication. The responses suggest the following improvements:

Inconsistencies in clinical services management could be addressed by:

- Using similar decision making procedures across the different management teams (e.g., for determining length of stay), and
- Improving skills in local teams (e.g., in making referrals).

Management procedures could be improved by:

- Simplifying and clarifying paperwork requirements, especially for initial authorizations and reauthorizations,
- Seeking more feedback on appropriateness of clinical information required for continued authorization (some find it unreasonable) and making appropriate changes, and
- Seeking more feedback on discharge planning and facilitation and making appropriate changes.

Communication could be improved by:

- Increasing coordination between DCMHS and other divisions within the Department of Services for Children, Youth and Their Families,
- Increasing face to face contact with clients and other participants,
- Using service providers' expertise and documentation of case in making decisions.

## **THE DCMHS PROVIDER SURVEY: RESPONSIVENESS AND IMPROVEMENTS**

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### **Findings**

A majority of respondents to this section of the survey (53%) indicated satisfaction with DCMHS' response to issues raised in last year's survey. In particular, efforts to improve communication between DCMHS and its providers were appreciated, with the clarification of the authorization procedures in the Provider Manual and the annual meeting receiving the largest proportions of agreement (76% for the Provider Manual and 70% for the annual meeting). In describing the value of the survey, respondents emphasized the value of knowing that DCMHS is committed to obtaining feedback. In addition, internal uses of the provider survey process were identified. (See pages 26 – 28 for details.)

### **Areas for Improvement**

The respondents also provided recommendations for improving the survey by:

- Expanding the scale to 5 points,
- Asking for frequency or extent instead of agreement,
- Including questions about the quality of services for clients or survey clients directly,
- Including questions about coordination of services within the Department of Children, Youth and Their Families, and
- Asking more questions about the functioning of local teams.

## **CONCLUSIONS**

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In many ways the news from the service providers who responded to the FY 1998 survey is good. For example, the value of collaboration stated in the new mission statement was shared by the service providers; service providers recognized DCMHS's improvements in communication and concern for clients; and accessibility, responsiveness, and knowledge characterized clinical services management.

Despite the many positive responses about DCMHS system performance in FY 1998, many areas where improvements are still needed were also identified. In particular, communication continued to be a major concern for the service providers. Looking across the comments made in different sections, the major communications needs appear to be:

- Providing more or clearer information about (1) the DCMHS managed care system, (2) the provider appeals process, (3) providers' accountability responsibilities to different DCMHS components, (4) the awards process, and (5) the coordinators role;
- Reducing and simplifying paperwork required of service providers;
- Providing quick feedback based on visits and reports and quickly completing paperwork required of DCMHS;
- Increasing consistency across different sources of information (individual personnel, local offices, provider manual, central office);
- Coordinating (1) with other divisions of the Department of Services for Children, Youth and Their Families, and (2) across different kinds of services; and
- Respecting and using service providers' expertise and documentation of case in making decisions.

Continued progress on these fronts could bring even more positive feedback in response to next year's survey than was received this year.

# SERVICE PROVIDER SURVEY, FY 1998

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## Division of Child Mental Health Services

### Service Provider Survey, FY 1998

#### INTRODUCTION

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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 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 asking service providers how the DCMHS system is working and how it could be improved.

In the FY 1997 survey, a majority of the service providers that responded were satisfied with their relationship to DCMHS. Most respondents also expressed satisfaction with the transition to a Public Managed Care Organization. The concern raised most frequently dealt with communication issues. Some respondents also reported that their organization's place in the DCMHS continuum was unclear. As this report discusses, some of these issues are still concerns for the service providers. However, many strengths of the DCMHS system are also identified.

#### *Survey Content and Administration*

Although the FY 1998 survey was altered slightly from the FY 1997 survey in order to reflect changes in program and policy, it covers many of the same topics. The survey begins by asking service providers to identify the services (that is, crisis, outpatient, residential, and so on) and type of service (mental health and/or substance abuse services) they offer. Then, specific questions are organized into 6 sections: (1) DCMHS Mission and Values, (2) DCMHS System Performance, (3) Role of Provider in the DCMHS Managed Behavioral Health Care System, (4) Provider Network Administration, (5) Clinical Services Management, (6) DCMHS Responsiveness to FY 97 Provider Survey. Each of these sections use both closed-ended and open-ended questions to fully explore the responses of the contracting agencies. For closed-ended questions, a four point Likert-like scale (Strongly Agree  $\leftrightarrow$  Strongly Disagree) was employed with additional choices of "don't know" and "not applicable." At the end of each of the 6 sections, respondents are asked open-ended questions about the strengths of DCMHS and the areas in which DCMHS could improve. The final section of the survey asked service providers a set of open-ended questions about how the survey process and any other aspect of DCMHS could be improved.

The 1998 Service Provider Survey was conducted by DCMHS in June 1998, with data analysis and reporting by researchers at the University of Delaware. This year, surveys were given to both agency Chief Executive Officers and the program directors of the individual sites where services are delivered. In previous years, only the Chief Executive Officers were surveyed. Seventy-six surveys were distributed to administrators and staff at thirty-five organizations in the network. A total of twenty-eight surveys were returned from the original set of seventy-six distributed, representing a 36.8% response rate in FY 1998. In addition, a 29<sup>th</sup> person who had received the survey sent a message indicating that the service provider had not worked with any

clients through DCMHS in FY 1998 and so could not respond to the survey. Including this person in the calculation of response rate raises the rate to 38.2%.

The FY 1998 response rate compares unfavorably to the FY 1997 survey which had a response rate of 60.6% (20 surveys returned from 33 distributed). However, the discrepancy can be explained by DCMHS' attempt in 1998 to reach a larger portion of the service providers' staff who work with the DCMHS system. In addition, in both 1997 and 1998 surveys, responses were submitted anonymously, so following up with non-respondents was not an option.

### *Limitations of the Data*

The anonymity of the data is a critical feature of the survey since it allows respondents to answer honestly without fear of being identified. However, it limits the survey in two ways. First, as noted above, it is impossible to follow up with non-respondents when there is no way to identify which providers did not respond. Thus, the survey has a low response rate. Second, since respondents and non-respondents cannot be compared, it is not possible to determine whether the respondents are representative of all service providers in the DCMHS system. Thus, the findings reported below must be interpreted as describing the experiences of the survey respondents only, not of the service providers in general. Despite these limitations, the information is still useful. Examination of the data indicates that DCMHS heard from both satisfied and dissatisfied providers, thus the data can be said to represent the likely range of responses.

### *Organization of the Report*

In this report, the survey findings are presented in sections corresponding to those in the survey itself. The first section describes the respondents in terms of the type of services and specific services provided. The second section reports the responses to questions about DCMHS Mission and Values. This is followed by the presentation of data from the DCMHS System Performance, Role of the Provider in the DCMHS System, Provider Network Administration, and Clinical Services Management sections of the survey. Then, the seventh section describes respondents' assessment of DCMHS Responsiveness to last year's survey. The last section of the survey consisted of three 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. Wherever these comments appear, they are followed by a note to indicate that they were not written in response to the specific area but were prompted by the more general questions at the end of the survey. Instead of focusing on those comments in its final section, the report concludes by looking across the different survey sections for common areas of strength and concern in the DCMHS system.

Both tables and figures are used to display the data. You will see that the responses to closed-ended questions have been collapsed into agree, disagree, don't know, and other (which includes not applicable and missing) to facilitate interpretation. Open-ended comments are included in both the text and tables. Those comments coming from the last questions on the survey are noted as such. The only place where the full text of each comment is not included is the section on Mission and Values, where most comments were 1 or 2 words. The data are not presented by provider type (that is, Mental Health Services, Substance Abuse Services, both) due to the small number of respondents. However, where pertinent, discussion in the text

identifies how responses varied by the specific service offered (such as wrap-around, crisis, residential, etc.).

## TYPE OF SERVICES PROVIDED

The following three figures show services offered by type of provider for all of the respondents. A total of twenty-four providers stated that they offer Mental Health Services. Of these, sixteen offer Mental Health Services only and eight offer both Mental Health and Substance Abuse Services. A total of eleven surveys came from agencies that provide Substance Abuse Services. As previously stated, eight providers offer both services, therefore three agencies that responded provide only Substance Abuse services. One survey was not identified as coming from an agency providing either Substance Abuse services or Mental Health services and so, is not graphed.

**Services Offered by Mental Health Service Providers**

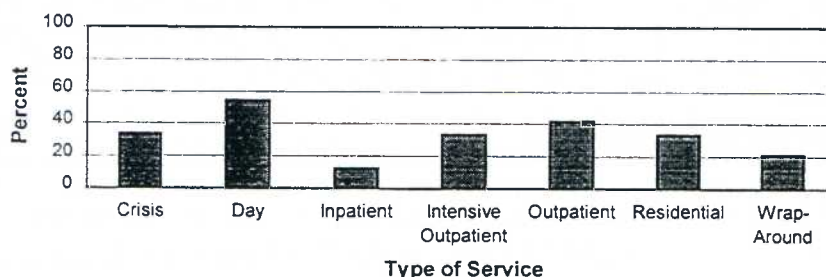


Figure 1. Type of Services Offered by Mental Health Service Providers, n=24

**Services Offered by Substance Abuse Service Providers**

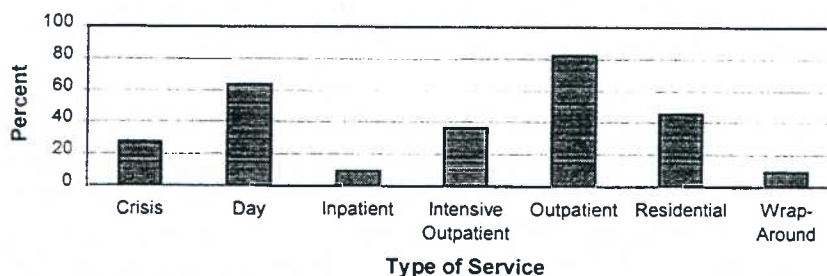
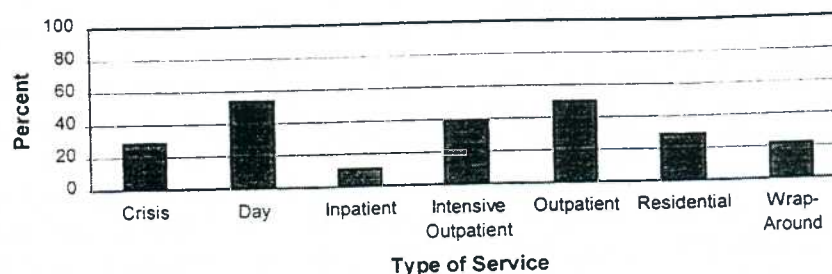


Figure 2. Type of Services Offered by Substance Abuse Service Providers, n=11

### Services Offered by Providers of Both Mental Health Services and Substance Abuse Services



**Figure 3.** Type of Services Offered by Mental Health and Substance Abuse Service Providers, n=8

Outpatient and day services are the major emphasis, with Mental Health Service providers more likely to report offering day services, and Substance Abuse Service providers more likely to report offering outpatient services. The most rarely offered services in all three categories were wrap-around and inpatient, but Mental Health Service providers reported offering wrap-around more often than Substance Abuse Service providers did.

### DCMHS MISSION AND VALUES

The Division of Child Mental Health Services' mission is to "develop the potential of this generation and the next through effective treatment for children and their families and collaboration with service partners." Both this mission statement and the Division's core values were updated prior to the distribution of the 1998 provider survey. The survey first asked respondents about their familiarity with the mission and values. Then respondents were asked to identify specific strengths of and areas of improvement for the mission and values.

#### *Familiarity with Mission and Values*

The specific items measuring provider familiarity with DCMHS mission and values are:

1. I am familiar with the recent changes made to the DCMHS' mission.
2. I am familiar with the recent changes made to the DCMHS' core values.
3. I feel that DCMHS' core values are consistent with my own agency's values.

Figure 4 describes the responses to these questions. Comparing these results to those of FY 1997, the 1998 respondents are not as familiar with DCMHS' stated mission and values as the respondents to the 1997 survey. While 95% of the service providers stated that they were familiar with the mission and values last year, results show that recognition has dropped to 70% in 1998. The recent update of the mission and values statements may account for the drop in the providers' recognition of the mission and values.

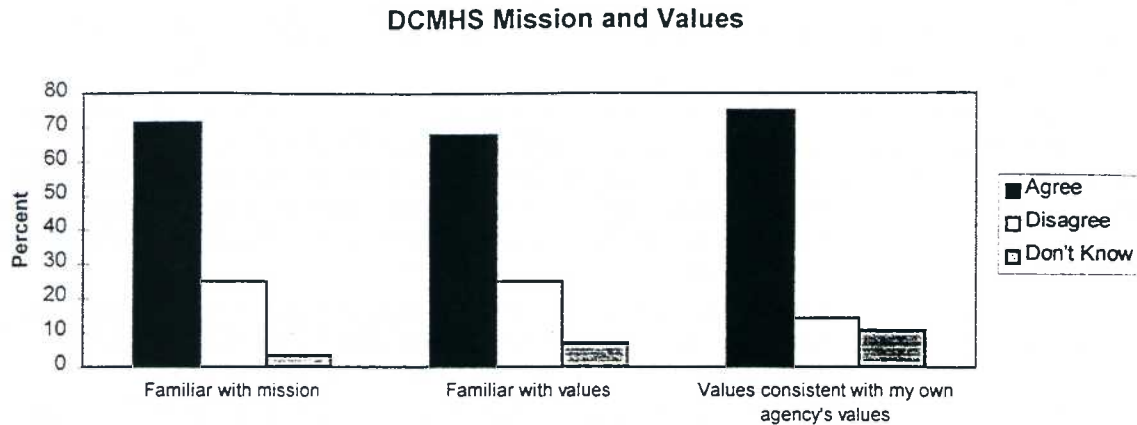


Figure 4. DCMHS Mission and Values: Distribution of Responses

#### *Strengths and Areas for Improvement*

The section on DCMHS Mission and Values closed with two open-ended questions, the first asking about specific strengths of the mission and values and the second asking respondents to identify how the mission and values could be improved. Sixteen providers responded to the first question, some identifying more than one strength, while one wrote "none." Among the strengths identified, collaboration was the most commonly mentioned strength, with five respondents naming it. Three strengths were identified by two respondents each: family focus, treatment effectiveness, and clinical necessity as the basis for care rather than benefit limits. The remaining strengths identified were each mentioned by only one respondent. They are:

- Integration of mental health and substance abuse services
- Accountability
- Accessibility, continuum of services
- Commitment to public/private partnerships
- Clinical services management teams
- Improving array of services
- Cost efficient
- Problem-relevant programming
- JCAHO accreditation
- Succinctly stated values, specific yet inclusive

The providers who responded to the survey also had several suggestions for how the DCMHS mission and values could be improved. Fifteen people responded to the question about improvements, with responses ranging from "I have no concerns about this area" to "Improvement would be effected through application of the philosophical statements." As shown in the table on page 6, major issues seemed to be the leadership of DCMHS and the scope of services provided by the system.

Table 1  
Suggestions for Improvements in DCMHS Mission and Values Classified by Focus of Suggestion (n=13)

Focus	Suggestions for Improvement
Leadership	<ul style="list-style-type: none"> <li>- Leadership by design and by example in identifying needs, advocating for resources fairly, supporting the implementation of innovative programs and services, and providing a structure for effective collaboration among providers and divisions.</li> <li>- Greater leadership in addressing the statewide need for child psychiatric treatment that demonstrates the strength noted in #4 [Commitment to public/private partnerships and collaboration].</li> <li>- Improvement would be effected through application of the philosophical statements.</li> </ul>
Scope of services	<ul style="list-style-type: none"> <li>- Have full array of services for children in state borders; improve clinical management teams review of service needs.</li> <li>- Increase scope of services available in Delaware</li> <li>- Providing appropriate Mental Health services in all areas to children in Delaware</li> <li>- Mission statement should clarify effective treatment- there is no mention that services need to be age/developmentally appropriate. This is very important when dealing with children. <i>[comment from concluding question]</i></li> <li>- Again, the issues most relevant to my service center around availability/accessibility of services downstate, the structure and process of communication among providers who share responsibility for services, and the design/implementation of new services. <i>[comment from concluding question]</i></li> </ul>
Collaboration	<ul style="list-style-type: none"> <li>- Collaboration: treatment teams modes of operation seem inconsistent.</li> <li>- Integration of MH w/substance abuse; collaboration are slow;</li> </ul>
Client focus	<ul style="list-style-type: none"> <li>- Cultural sensitivity/ethnic sensitivity.</li> <li>- Stronger direct connection to clients.</li> <li>- I would love to see DCMHS focus more specifically on concerns relevant to the African American family and community. Community-family meetings where food and music are present would do much to change the image of CMH and increase references to service providers. <i>[comment from concluding question]</i></li> </ul>
Accountability of DCMHS	<ul style="list-style-type: none"> <li>- Accountability of DCMHS is weak.</li> </ul>
Wording of mission and values	<ul style="list-style-type: none"> <li>- Mission statement doesn't mention mental health/SA. By only using the word "treatment" you could just as well be talking about dental, medical, housing, etc. The values- are they values for the organization or values for services?</li> <li>- Mission is vague.</li> <li>- Values statement is unclear; growth for whom? (agency or client?) Also values statements that are a list of words doesn't explain much about your philosophy. Short statements might be better. <i>[comment from concluding question]</i></li> </ul>
Awareness of DCMHS mission and values	<ul style="list-style-type: none"> <li>- Until this survey was distributed we had never seen the mission statement or values.</li> </ul>

### **Mission & Values: Conclusions**

*Compared to last year, a smaller proportion of respondents were familiar with DCMHS Mission and Values. The inclusion of "collaboration" in the Mission was the most commonly mentioned strength, although respondents noted that collaboration and other statements in the Mission need to be implemented in practice, not just stated. In addition to suggestions for the wording and emphasis of the Mission and Values statement, respondents also recommended that DCMHS demonstrate more leadership in some areas and increase the type and availability of services.*

## **DCMHS SYSTEM PERFORMANCE**

The system performance section of the survey was designed to better understand how providers view DCMHS as compared with other managed care organizations. Questions addressed access to service, 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.

### ***System Performance Measures***

Specific items measuring the performance of DCMHS as a Managed Care Organization are:

1. I think the DCMHS managed care system improves access to service for clients.
2. I think DCMHS has kept my agency informed about the DCMHS managed care system.
3. I believe under DCMHS managed care, clients receive appropriate:
  - a. services for the conditions they present.
  - b. client care management that makes receiving services easier.
4. I think the amount of paperwork required for DCMHS managed care is reasonable (as compared to other managed care systems).
5. I think the complexity of paperwork required for DCMHS managed care is reasonable (as compared to other managed care systems).
6. Based on my experience, payments are made within 30 days after bills are submitted.
7. I am familiar with DCMHS' policy for provider appeals and have a clear understanding of the process.

As shown in Table 2, respondents were generally satisfied with the performance of the DCMHS system. However, some concern about communication issues surfaced. Only one-half of the respondents stated familiarity with and understanding of the provider appeals process. One third stated that the process was unclear. Communication is also the focus when 1 in 4 disagree with the statement "I think DCMHS has kept my agency informed about the DCMHS managed care system." "Not in a planned, educational, proactive way," was the comment written next to the statement by one of the respondents to explain his or her disagreement. The amount and complexity of the DCMHS paperwork was described as less reasonable than that of other managed care systems by 1 in 4 of the respondents. Paperwork, being one of the major ways of delivering information, is also a component of communication.

Table 2  
DCMHS System Performance: Distribution of Responses (n=28)

System Performance Measures	Agree	Disagree	Don't Know	Other <sup>a</sup>
1. Access to service for clients	24 85.7%	2 7.2%	1 3.6%	1 3.6%
2. Agency kept informed	21 75.0%	7 25.0%	0 0%	0 0%
3. a) Clients receive appropriate services	23 82.2%	4 14.3%	0 0%	1 3.6%
3. b) Clients receive appropriate client care management	15 53.6%	11 39.2%	1 3.6%	1 3.6%
4. Amount of paperwork	19 67.9%	8 28.6%	1 3.6%	0 0%
5. Complexity of paperwork	18 64.3%	8 28.6%	1 3.6%	1 3.6%
6. Payments are timely	16 57.2%	0 0%	8 28.6%	4 14.3%
7. Familiarity/understanding of appeals	14 50.0%	13 32.1%	4 14.3%	1 3.6%
a. Other refers to those respondents who skipped the item or checked it as not applicable.				

In addition to communication concerns, client care management also received lower numbers of "agree" responses compared to the other items. While a majority of respondents believe clients receive appropriate services under DCMHS managed care, 2 in 5 say clients do not get appropriate client care management which would make receiving services easier. Overall, providers offering wrap-around services were not as satisfied with access, services, and care management for clients as providers offering other services. There was no major differences across types of services on the other items.

### *Strengths and Areas for Improvement*

The first open-ended question about DCMHS system performance asked providers to "list specific strengths regarding DCMHS system performance." Almost all of the 15 respondents to this question who identified strengths were very positive. However one provider answered the question "none," indicating that there were no strengths of DCMHS system performance. As shown in table 3, the other 14 providers identified aspects of communication and concern for clients as major strengths of the DCMHS system.

Table 3

Strengths of DCMHS System Performance Classified by Focus of Strength (n = 14)

Focus	Strengths
Communication, (accessibility, responsiveness)	<ul style="list-style-type: none"> <li>- DCMHS staff more responsive than in past</li> <li>- Contract manager, communication, easy transition between levels of care.</li> <li>- DCMHS kept my agency informed of the many changes</li> <li>- Relatively responsive (timely)</li> <li>- Open, willing to share and involve with service.</li> <li>- Responsive to provider concerns</li> <li>- Team is easily accessed.</li> <li>- Provider manual</li> </ul>
Concern for Clients	<ul style="list-style-type: none"> <li>- Responsive to client needs.</li> <li>- Team is sensitive to client's needs</li> <li>- DCMHS is very concerned about patient care and continuity.</li> <li>- Tracking cases and involvement in discharge planning</li> <li>- Provide reasonable length of stay in order for treatment to be effective; case managers are knowledgeable of case</li> <li>- The way the DCMHS system operates, it keeps those approving services very knowledgeable about the client's functioning.</li> </ul>
DCMHS staff	<ul style="list-style-type: none"> <li>- The conscientiousness of the individual CSC's and CSS's.</li> </ul>
Payments	<ul style="list-style-type: none"> <li>- Timely payments.</li> </ul>

Almost every respondent who identified a strength of DCMHS system performance also had an area in which they would like to see improvements. Fourteen providers responded to the question asking respondents to "list specific areas for improvement regarding DCMHS system performance." Only one of these respondents did not also describe a strength. The responses ranged from no improvements needed ("I have not had any problem with the system.") to improvements were needed "in all areas." The other suggestions, provided in the table 4, focus primarily on the cumbersome paperwork and inconsistency across some areas of the DCMHS system.

#### System Performance: Conclusions

*Respondents were generally satisfied with the performance of the DCMHS system. Specific strengths included improvements in communication and the concern for clients demonstrated by DCMHS personnel. Despite the positive evidence for DCMHS' communication with service providers, communication is also an area identified as needing improvement. In particular, improvements were suggested in (1) the provider appeals process, (2) the consistency and amount of information provided to the providers, and (3) the amount and complexity of the paperwork. Better coordination across Divisions within the Department of Services for Children, Youth and Their Families was also recommended, as well as additional training and clarification of the roles of DCMHS personnel.*

Table 4  
Suggestions for Improvements in DCMHS System Performance Classified by Focus of Suggestion (n = 12)

Focus	Suggestions for Improvements
Communication	<ul style="list-style-type: none"> <li>- Providing more information on cases</li> <li>- Would like more specific written information in the provider manual re: case managers responsibilities for family contact beyond admissions, DCMHS role, attitudes, and procedures for addressing inter-departmental concerns (i.e. DFS), more specific than I'm aware of now. . [<i>comment from concluding question</i>]</li> <li>- Streamline data collection; electronic communication to reduce telephone tag. [<i>comment from concluding question</i>]</li> </ul>
Communication - Paperwork	<ul style="list-style-type: none"> <li>- Limit repetitive and elaborate paperwork</li> <li>- Front end paperwork is too cumbersome esp. with the very tight time frames.</li> <li>- Reduction of paperwork I.e. monthly progress reports, requests for extension of Tx in addition to Tx plan (redundant).</li> <li>- Paperwork is excessive.</li> </ul>
Communication - Inconsistency	<ul style="list-style-type: none"> <li>- Inconsistency at local offices level.</li> <li>- Variations in what is in provider manual versus expectations of local staff; don't think any provider would want to pursue an appeal and risk/jeopardize need for local positive rapport. Period of time between reauthorizations not clear; varies from worker to worker, one review to the next, and from county to county. Written vs. telephone requests vary also.</li> <li>- Would like more specific written information in the provider manual re: case managers responsibilities for family contact beyond admissions, DCMHS role, attitudes, and procedures for addressing inter-departmental concerns (i.e. DFS), more specific than I'm aware of now. [<i>comment from concluding question</i>]</li> <li>- Inconsistencies between DCMHS's personnel as to best/acceptable course of action in a given situation</li> </ul>
Intra- and Inter-agency coordination	<ul style="list-style-type: none"> <li>- Improved relationship between CMH, DFS, and YRS would improve services to families.</li> <li>- A structure/procedure to improve transitions and coordination of services both within DCMHS and between DCMHS and other family service systems, especially DFS and DYRS. Consolidation of planning/implementation among the divisions of DSCYF; sharing of resources</li> </ul>
Roles and Qualifications for Roles	<ul style="list-style-type: none"> <li>- Case managers need to be more empowered in the decision-making process with regard to length of stay and changes in interventions</li> <li>- It would help if those making decisions about clients' service were familiar with the intent of the program for which we are contracted and with the clinical issues relevant and specific to AOD (alcohol/other drug) in adolescents and their families.</li> <li>- I think the role of DCMHS concerning specific treatment interventions would be very helpful, especially regarding the use of medication. [<i>comment from concluding question</i>]</li> <li>- Training for providers AND team leaders regarding addiction/AOD issues. [<i>comment from concluding question</i>]</li> </ul>

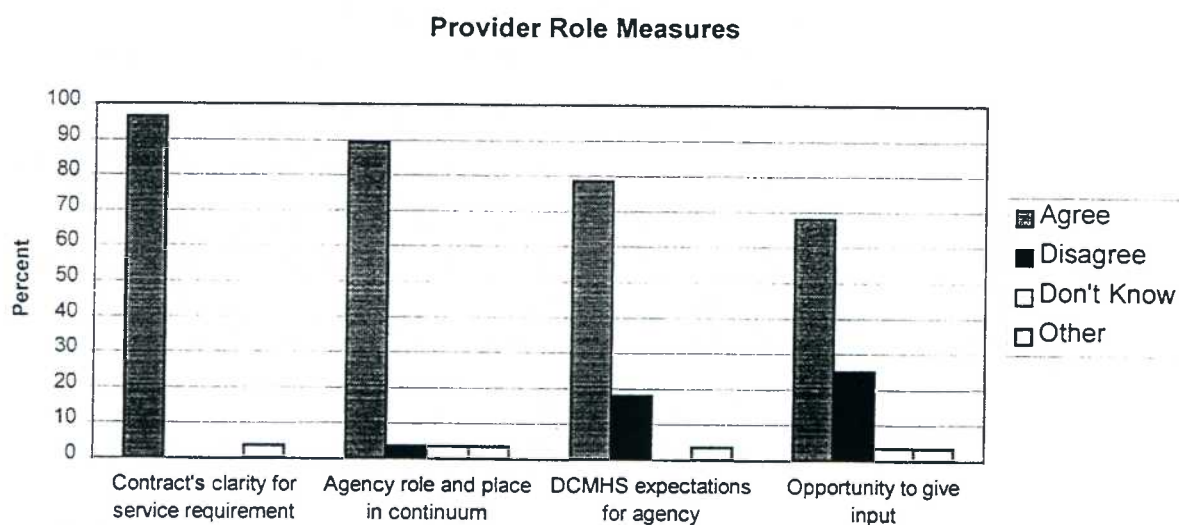
## ROLE OF PROVIDER IN THE DCMHS MANAGED BEHAVIORAL HEALTH CARE SYSTEM

The next section of the survey focused on the role of the provider in the DCMHS managed behavioral health care system. Questions in this section addressed such issues as requirements for providing services, understanding of providers' place in the continuum, DCMHS expectations, and opportunity for provider input.

### *Role of the Provider*

Figure 5 summarizes the responses to the closed-ended items about the role of the service provider. (Table A1 in the appendix provides the details for the figure.) The specific statements that respondents reacted to are:

1. I think the requirements for providing mental health/substance abuse services under my agency's contract/provider agreement with DCMHS are clear.
2. I understand my agency's role as a service provider and how I fit into the DCMHS managed care system.
3. I think DCMHS has reasonable expectations for my agency.
4. I am given adequate opportunity to comment on policy and service delivery/provision procedures.



**Figure 5. Role of DCMHS Providers: Distribution of Responses**

Overall, respondents are very aware of expectations and requirements in the role of provider, although one provider wrote, "abrupt changes have been noted," next to the questions about understanding how they fit into the managed care system. Despite the generally positive responses to this question, one in four respondents stated that they were not given adequate opportunity to comment on policy and service delivery/provision procedures. In addition, one respondent wrote, "not prior to implementation," next to the question about providing input, indicating that while the opportunity to comment may be available, it comes too late.

### *Strengths and Areas for Improvement*

In response to the open-ended question asking service providers to identify strengths, 15 of the 28 survey respondents listed specific strengths related to the quality of their staff and services. In addition, some of the respondents noted how they kept up their part of the relationship with DCMHS by communicating well with both DCMHS and their staff about DCMHS. The provider's comments are listed in table 5.

Table 5

Strengths of the Role of the Provider Classified by Focus of Strength (n = 15)

Focus	Strengths
Quality of services	<ul style="list-style-type: none"><li>- Ability and opportunity to provide a continuum of non-residential mental health services.</li><li>- Strong clinical supervision, leadership,</li><li>- Continuum of services, strong CQI programs</li><li>- Objective and separate perspective on system functioning; a home/family/community systems approach to treatment.</li><li>- Provide good clinical service</li><li>- Provide high quality- age appropriate services.</li><li>- Provide high quality integration of service for the dept.</li></ul>
Quality of staff	<ul style="list-style-type: none"><li>- Amount of time our workers spend with clients "on the front line" provides the system with insights into client's actual ability to function in the community.</li><li>- Staff is experienced and trained; provide high quality service.</li><li>- [Service Provider's] clinical teams are well experienced and well qualified in provision of services to particularly challenging adolescent populations- I.e. the dually diagnosed, the juvenile justice involved youth, etc.</li><li>- Strong advocacy for our clients and their families; expertise in mental health and AOD; psychiatric consultant who is sensitive to AOD issues.</li></ul>
Communication with DCMHS	<ul style="list-style-type: none"><li>- Attend meetings, promptly educate staff re: changing requirements, comply with contract standards, willing to provide feedback.</li><li>- Good communication, good follow-up</li><li>- I feel part of the team of professionals providing services to clients, and also feel like my professional opinions are valued.</li><li>- We are very pleased to work with systems and coordinate care with multiple agencies.</li><li>- Clear expectations/respect for clinical expertise.</li></ul>
Access to services	<ul style="list-style-type: none"><li>- Easy and quick access to services</li></ul>

Four of the 15 service providers who responded to the previous question about strengths of the provider's role did not answer the question about areas of improvement for the role. Of the 11 who did respond, many identified areas of improvement related to the strengths. For example, while the quality of services provided was identified as a strength, comments about areas of improvement included plans for further development of services. Similarly, while the service providers who commented see themselves as successful communicators, they would like to see

improvements in other aspects of communication and collaboration. Table 6 presents their suggestions.

Table 6

Suggestions for Improvements in the Role of Provider Classified by Focus of Suggestion  
(n=11)

Focus	Suggestions for Improvements
Services provided	<ul style="list-style-type: none"> <li>- We would like to expand services to include therapy services for a more cohesive approach to clients.</li> <li>- Continued openness to service delivery changes/demands.</li> <li>- Increased opportunities to address referral services</li> <li>- In the coming year, we will be identifying and affiliating with more Delaware community based providers in order to ensure better continuity of care. We plan to separate our young adults (18-20) from our younger population and further individualize their care.</li> </ul>
Communication & Collaboration	<ul style="list-style-type: none"> <li>- Continue to identify systems concerns in a constructive manner;</li> <li>- Need for clarification concerning accountability to the various components of DCMHS.</li> <li>- Interaction with TCPC with regard to the use of crisis bed.</li> <li>- Improve coordination of services/communication between wraparound service and primary clinical providers the former is meant to support, with more clearly defined roles and a structure in place (to guide the process) which is universally accessible.</li> <li>- We look forward to stronger collaboration as indicated in mission and values statement.</li> </ul>
Communication - Paperwork	<ul style="list-style-type: none"> <li>- There have been several times when I was unable to receive needed paperwork in timely manner.</li> <li>- Ensure all paperwork is completed in the prescribed time frame.</li> </ul>
JCAHO	<ul style="list-style-type: none"> <li>- Need to develop policies and procedures to comply with JCAHO requirements</li> </ul>

#### **Role of the Provider: Conclusions**

*Most of the respondents described themselves as aware of expectations and requirements in the role of provider and identified their communication with DCMHS and the quality of their services and staff as strengths. However, DCMHS communication problems were identified again. Specific concerns include the opportunity for providers to comment on policy and service delivery/provision procedure, the need for better coordination of services and collaboration, and the timeliness of paperwork that is the responsibility of DCMHS.*

#### **PROVIDER NETWORK ADMINISTRATION**

The following presentation of the data from the survey items on the administration of the provider network is divided into three sections. First, the information about the providers' experiences with DCMHS program administrators is discussed. This section also addresses procedures and feedback from incident reporting. The second section deals with the network

provider panel, the award processes, and the monitoring visits. The final section presents the comments made about the strengths of and areas for improvement in the network administration.

### *Provider Experience with DCMHS Program Administrators*

The survey first posed the following items about the experiences that service providers had with the DCMHS program administrators to the respondents for their agreement or disagreement:

1. Based on my experience, the DCMHS Program Administrators are:
  - a. approachable
  - b. accessible/available
  - c. professional in their working relationships
  - d. helpful in response to questions
  - e. willing to resolve disagreements
  - f. willing to remain involved
  - g. willing to explain decisions
  - h. knowledgeable about clinical processes
  - i. knowledgeable about administrative processes
2. Based on my experience, assistance from program administrators is available to help in the development of provider standards and records.
3. I think incident reporting procedures for providers are clear.
4. I think feedback from incident reporting is informative.

As shown in table 7, respondents indicated that their experience with the DCMHS Program Administrators has generally been positive. Underlining the overall positive reaction, one respondent wrote, "Excellent!" in the margins to the items about program administrators. However, once again, communication is an issue, specifically regarding feedback from incident reporting. Less than half of the respondents indicated such feedback to be informative. Moreover, three respondents wrote marginal comments related to incident reporting. These comments are:

- "problems re: DFS reporting—who is accountable to whom?" (next to question 3);
- "no feedback, assume no news is good news" (next to the question 4); and
- "Have never received feedback from DCMHS re: incident report summaries turned in" (next to question 4).

It is interesting to note that when broken down by type of service, those providing intensive outpatient services were much more satisfied with feedback than all providers combined (90.9% for intensive outpatient versus 42.9% for all). Providers offering intensive outpatient services were also more satisfied with the assistance received from program administrators.

Table 7

Provider Network Administration: Distribution of Responses to Questions 1 - 4 (n=28)

Network Administration Measures	Agree	Disagree	Don't Know	Other <sup>a</sup>
1a. Approachable administrators	26 92.3%	0 0%	1 3.6%	1 3.6%
1b. Accessible administrators	24 85.7%	2 7.1%	1 3.6%	1 3.6%
1c. Professional administrators	25 89.3%	0 0%	2 7.1%	1 3.6%
1d. Helpful administrators	26 92.8%	1 3.6%	0 0%	1 3.6%
1e. Administrators resolve disagreements	23 82.1%	2 7.1%	2 7.1%	1 3.6%
1f. Administrators remain involved	25 89.3%	1 3.6%	1 3.6%	1 3.6%
1g. Administrators explain decisions	25 89.3%	1 3.6%	1 3.6%	1 3.6%
1h. Clinically knowledgeable administrators	22 78.6%	2 7.1%	3 10.7%	1 3.6%
1i. Administratively knowledgeable administrators	27 96.4%	0 0%	0 0%	1 3.6%
2. Assistance available	19 67.9%	3 10.7%	3 10.7%	3 10.7%
3. Clear incident reporting procedures	19 67.8%	5 17.8%	2 7.1%	2 7.1%
4. Informative incident reporting feedback	12 42.9%	6 21.5%	8 28.6%	2 7.1%
a. Other refers to those respondents who either skipped the item or checked it as not applicable.				

*Experience with Contracting or Monitoring Process*

The second half 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 of the twenty-eight respondents answered this section.

Questions posed here were:

5. I think the DCMHS process for becoming a network provider panel member is clear.
6. I think the concepts and objectives in solicitations to provide services as part of a network panel are clear.
7. I think provider conferences, related to the DCMHS network solicitation process, answer questions and help me with the proposal preparation.
8. I think the award processes are clear.
9. I think the award processes are fair.
10. I think monitoring visits are conducted in an objective fashion.
11. I think monitoring feedback is accurate and fair.

The responses to these questions are summarized in table 8 and discussed further below.

Table 8  
Network Administration: Distribution of Responses to Questions 5 - 11 (n=17)

Network Administration Measures	Agree	Disagree	Don't Know	Other <sup>a</sup>
5. Process to become panel member	13 76.5%	1 5.9%	2 11.8%	1 5.9%
6. Service provision as a panel member	12 70.6%	0 0%	4 23.5%	1 5.9%
7. Conferences help prepare proposals	11 64.7%	1 5.9%	3 17.6%	2 11.8%
8. Award process is clear	9 52.9%	3 17.6%	4 23.5%	1 5.9%
9. Award process is fair	9 52.9%	3 17.6%	4 23.5%	1 5.9%
10. Monitoring visits are objective	14 82.4%	1 5.9%	0 0%	2 11.8%
11. Monitoring feedback is accurate/fair	13 76.5%	1 5.9%	1 5.9%	2 11.8%

a. Other refers to those respondents who either skipped the item or checked it as not applicable.

Two conclusions can be drawn from the above table. First, among those that are familiar with the process addressed in the question (such as, becoming a panel member, monitoring visits, etc.), the majority of respondents agreed that these processes were clear or otherwise appropriate. However, for most of these questions 3 (18%) or more respondents indicated that they either did not know about the process or considered it not applicable. The exception is question 10, asking about the objectivity of the monitoring process: Only 2 (12%) respondents identified the question as not applicable and none checked "don't know."

The second conclusion is that, while conforming to the overall conclusion provided above, the awards process needs improvement in its clarity and objectivity. Although 9 respondents (53%) agreed that the award processes were clear and fair, 7 (41%) either disagreed or did not know.

#### *Strengths and Areas for Improvement*

Perhaps because the open-ended questions followed a set of items that were answered only by a subset of the survey respondents, fewer service providers answered the open-ended questions about strengths of and areas for improvement in the provider network administration than answered similar questions in other portions of the survey. The six comments about strengths are listed in table 9. Three of the six strengths identified center on the monitoring process; access, the RFP process, and a specific staff person are the other three strengths identified.

Table 9

Strengths of Provider Network Administration Classified by Focus of Strength (n=6)

Focus	Strengths
Monitoring	<ul style="list-style-type: none"> <li>- Helpful to now know the monitoring standards and rating criteria.</li> <li>- I am unfamiliar with the process except for the monitoring visits. The monitoring last year was very helpful because we received immediate feedback.</li> <li>- The monitoring of sites is objective and helpful.</li> </ul>
Access	<ul style="list-style-type: none"> <li>- Excellent access, answers are usually helpful.</li> </ul>
Staff	<ul style="list-style-type: none"> <li>- Janet is knowledgeable clinically and most willing to provide feedback and assistance.</li> </ul>
RFP process	<ul style="list-style-type: none"> <li>- RFP process clear and effective.</li> </ul>

Table 10 provides the specific comments about areas for improvement. Here, as in the strengths, only 6 service providers responded. However, the two sets of respondents are not exactly the same: One person reporting a strength did not give a suggestion; and one person suggesting an improvement, did not give a strength.

Table 10

Suggestions for Improvements in the Role of Provider Classified by Focus of Suggestion (n=6)

Focus	Suggestions for Improvements
Monitoring	<ul style="list-style-type: none"> <li>- Entirely too long between monitoring visits and written feedback. Would like to see a process clearly defined for responding/taking issue with findings (not an appeal).</li> <li>- Provide written feedback from monitoring visits</li> </ul>
Coordination - Paperwork	<ul style="list-style-type: none"> <li>- Very little effort to integrate your paperwork requirements with existing provider paperwork process. Forms are inconsistent in how they ask for information (different order on each form) and that increases paperwork time.</li> </ul>
Collaboration	<ul style="list-style-type: none"> <li>- I wish our position and information as a provider with direct client contact was honored and at least considered by treatment team.</li> </ul>
Communication	<ul style="list-style-type: none"> <li>- Bid and award process is not clear in terms of agency performance versus other factors.</li> </ul>
Inconsistency	<ul style="list-style-type: none"> <li>- Inconsistency between central office and local offices.</li> </ul>

Although one respondent identified the timeliness of the feedback from monitoring visits as a strength of the administration of the network, two service providers identified the gap between monitoring visits and the feedback from the visit as an area that needs improvement. This discrepancy seems to underscore another area of improvement identified by a service provider, the inconsistency across different components of DCMHS.

### **Provider Network Administration: Conclusions**

*The majority of respondents were positive about their experience with the DCMHS Program Administrators and the clarity and appropriateness of the contracting and monitoring processes. Specific strengths included the dissemination of the monitoring standards and criteria, the monitoring feedback, the RFP process, and the access to network administrators. Once again, however, weaknesses are found in communication. In particular, concerns focused on the feedback from incident reporting, the clarity and objectives of the awards process, the gap between monitoring visits and the feedback from the visit, and the inconsistency across different components of DCMHS.*

## **CLINICAL SERVICES MANAGEMENT**

The overall focus of this section of the report is clinical services management. The clinical services management survey questions were designed to probe how clinical staff in the agencies view their relationship with DCMHS. Respondents were asked to solicit input from clinical staff members and then to respond based on their direct experience. The information from these questions is presented below in 4 parts. The first three parts present data from closed-ended questions on the experiences of the clinical staff with: (1) DCMHS Clinical Services Management, especially the Coordinators/Supervisors, (2) the Clinical Services Management Team Leaders, and (3) the Clinical Services Management Team's response rate in emergency situations, authorization procedures, and discharge decisions and options.

### ***DCMHS Clinical Services Management – Coordinators/Supervisors***

The questions that related to DCMHS Coordinators/Supervisors are.

1. My clinical staff perceive that the DCMHS Service Plan is useful to my agency in developing treatment plans.
2. My clinical staff feel the role of the Clinical Services Management Team is clear.
3. Based on my clinical staff's experience, the DCMHS Clinical Services Coordinators/Supervisors are:
  - a. accessible.
  - b. responsive to questions.
  - c. willing to resolve disagreements.
  - d. willing to remain involved.
  - e. willing to explain decisions.
  - f. knowledgeable about the spectrum of children's services in DE.

As shown in table 11, there was generally high rates of agreement with these items. However, one in four of the service providers responding to the survey disagreed with the statements about the usefulness of the service plan and the clarity of the role of the Clinical Services Management Teams. In addition, one respondent wrote, "we don't get them [service plans] consistently" next to question 1.

Table 11

Clinical Services Management: Distribution of Responses to Questions 1 - 3 (n=28)

Clinical Services Management Measures	Agree	Disagree	Don't Know	Other <sup>a</sup>
1. Usefulness of service plan	19 67.9%	7 25.0%	0 0%	2 7.1%
2. Role of Clinical Services Management Team	19 67.9%	8 28.6%	0 0%	1 3.6%
3a. Coordinators are accessible	25 89.3%	2 7.1%	0 0%	1 3.6%
3b. Coordinators are responsive	25 89.3%	2 7.1%	0 0%	1 3.6%
3c. Coordinators resolve disagreements	20 71.4%	6 21.5%	0 0%	2 7.1%
3d. Coordinators remain involved	23 82.1%	3 10.7%	1 3.6%	1 3.6%
3e. Coordinators explain decisions	23 82.2%	3 10.7%	1 3.6%	1 3.6%
3f. Coordinators are knowledgeable	24 85.7%	3 10.7%	0 0%	1 3.6%
a. Other refers to those respondents who either skipped the item or checked it as not applicable.				

Figure 6 displays the high rates of agreement with statements about Coordinators' accessibility, responsiveness, involvement, ability to explain decisions, and knowledge. Over 22 (79%) of the responding service providers agreed with these items, with accessibility and responsiveness receiving the highest ratings (25, or 89%, of the 28 respondents). On the other hand, Coordinators received less high ratings for the item 3c, "Coordinators resolve disagreements." While 20 (71%) service providers agreed with the item, one in five of the respondents disagreed. One of the service providers commented on the inconsistency across Coordinators, writing, "some are much better than others; [Coordinator's name] is terrific!" in the margin.

#### Clinical Services Coordinators/Supervisors:

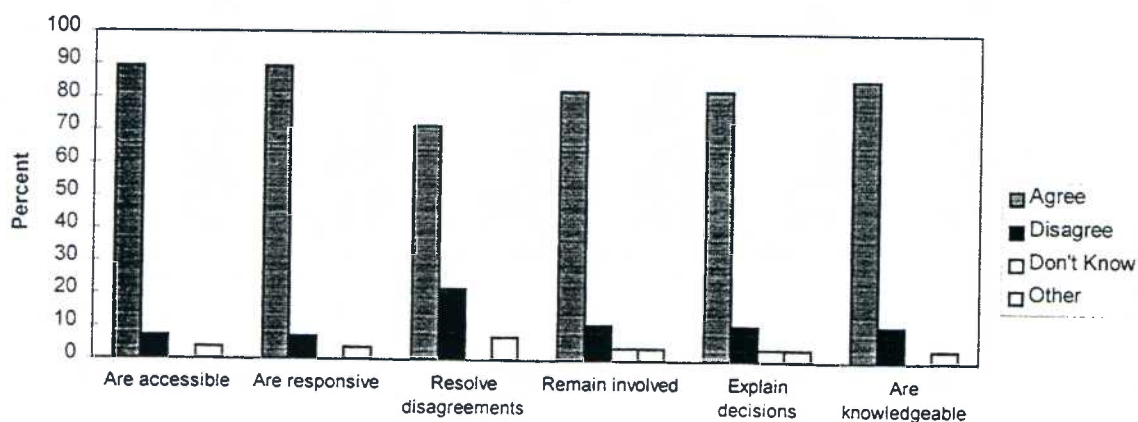


Figure 6. Qualities of Clinical Services Coordinators/Supervisors: Distribution of Responses

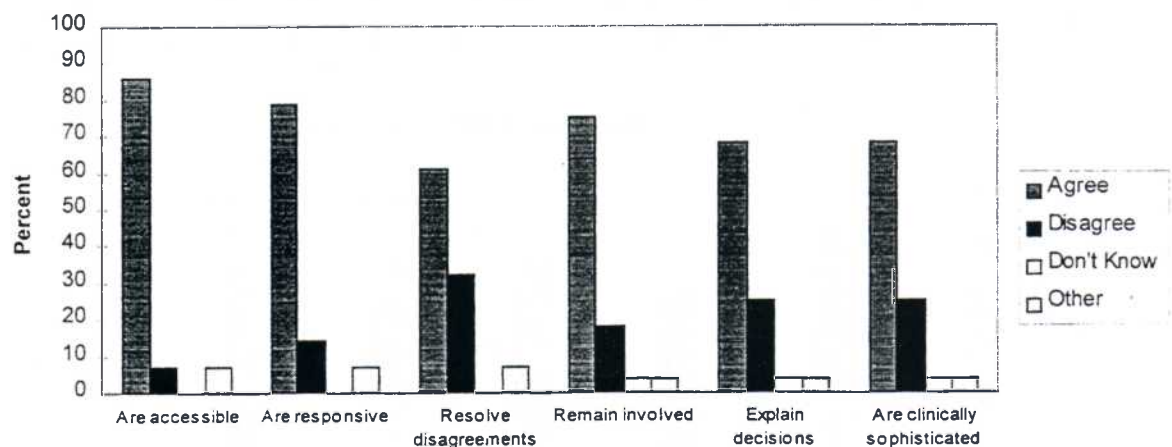
### *DCMHS Clinical Services Management – Team Leaders*

The next set of survey items focus on the performance of the Team Leaders. These are the same as the items about the performance of the Coordinators, with the exception of item f, which is “knowledgeable about . . . children’s services” for the Coordinators, and “clinically sophisticated” for the Team Leaders. The specific items are:

4. Based on my clinical staff’s experience, the DCMHS Clinical Services Management Team Leaders are:
  - a. accessible
  - b. responsive to questions
  - c. willing to resolve disagreements
  - d. willing to remain involved
  - e. willing to explain decisions
  - f. clinically sophisticated

The pattern of responses to the items about Team Leaders is similar to those for the Coordinators/Supervisors. In both cases, the majority of the respondents agreed with the statements. However, the results for the Team Leaders are slightly less favorable than those for Coordinators/Supervisors. As shown in figure 7, only the items about the responsiveness and accessibility of the Team Leaders were agreed to by more than 22 (79%) of the respondents. While more than half of the respondents also agreed that Team Leaders resolved disagreements, explained decisions, and were clinically sophisticated, 25% or more disagreed with these statements. (The complete data for the figure is displayed in table A2 in appendix A.)

**Clinical Services Team Leaders:**



**Figure 7. Qualities of Clinical Services Team Leaders: Distribution of Responses (n=28)**

## DCMHS Clinical Services Management – Management Teams

The third set of questions under Clinical Services Management asked about the Management Teams. The specific items were:

5. My clinical staff think the DCMHS managed care coordinators play an important role in my agency's treatment of families.
6. My clinical staff find that the DCMHS Clinical Services Management Teams respond immediately if called with a clinical emergency.
7. My clinical staff find the Clinical Services Management authorization procedures clear.
8. My clinical staff think the clinical information required by the DCMHS Clinical Services Management Team for continued authorization of services is reasonable (as compared to other managed care systems).
9. My clinical staff find that the DCMHS Clinical Services Management Teams consider the input of my agency's therapist(s) in making clinical and discharge decisions.
10. My clinical staff find that the DCMHS Clinical Services Management Teams effectively plan and facilitate client service transitions:
  - a. admissions
  - b. discharges
  - c. transitions to the adult services system

More than half of the service providers responded favorably to the items, with the exception of the item on the transition to adult services in which over 50% responded with "don't know," "not applicable," or by skipping the item. (See table 12 below.) Also in response to the adult services items, one respondent wrote, "Mr. [Name] only CJMT worker who trans. client to adult services." Looking at the "Disagree" column, the item that stands out is about the clarity of authorization procedures. Slightly more than one in three of the service providers responding to the survey found the clarity of the authorization procedures problematic.

Table 12  
Clinical Services Management: Distribution of Responses to Questions 5 - 10 (n=28)

Clinical Services Management Measures	Agree	Disagree	Don't Know	Other <sup>a</sup>
5. Coordinators' role in treatment	18 64.3%	8 28.6%	1 3.6%	1 3.6%
6. Teams' response rate with emergencies	18 64.3%	6 21.4%	3 10.7%	1 3.6%
7. Clarity of authorization procedures	16 57.1%	10 35.7%	1 3.6%	1 3.6%
8. Information required for continued authorization	18 64.3%	8 28.5%	0 0%	2 7.1%
9. Agency's therapist(s) input considered	19 67.8%	3 10.7%	2 7.1%	4 14.3%
10a. Admission planning/facilitation	20 71.5%	4 14.3%	2 7.1%	2 7.1%
10b. Discharge planning/facilitation	15 53.6%	8 28.6%	3 10.7%	2 7.1%
10c. Plan/facilitate transition to adult services	6 21.4%	6 21.4%	7 25.0%	9 32.2%
a. Other refers to those respondents who either skipped the item or checked it as not applicable.				

While the majority of the respondents are positive about most of the items, the agreement rates in this section have a lower maximum than those for the sections on Coordinators/Supervisors. Specifically, agreement rates for the items about the Management Teams ranged a low of 54% (for planning and facilitation of discharges) to a high of 72% (for planning and facilitation of admissions). In contrast, the sections on Coordinators/Supervisors and Team Leaders both had more than one item receiving agreement rates above 80%. So, overall, a smaller proportion of the service providers are favorable about the Management Teams than about the Coordinators or the Team Leaders.

Considering the close-ended responses to questions 1 – 11 as a group, providers of some services have different patterns of responses. In particular, providers of crisis services were generally more satisfied with clinical services management than other providers. Those providers who offer day services found the clinical services teams more responsive and reported more frequently that coordinators played an important role in the treatment of families. On the other hand, compared to all other providers, smaller proportions of providers of outpatient services and providers of wrap-around services were satisfied with the amount of clinical information required for continued authorization of services.

### *Strengths and Areas for Improvement*

Of the 15 service providers who responded to the question asking respondents to list specific strengths in the area of clinical services management, one respondent wrote "none" while a second provider wrote, "Our concerns (clinical) seem not to be considered, so this is difficult to address." (This respondent noted that the lack of consideration for their concerns had occurred recently, since around the end of 1997.) However, as detailed in table 13, the remaining 13 service providers identified strengths in the areas of the quality of the people involved in clinical services management, the focus on clients, the accessibility of the teams, and coordination of services.

Table 13  
Strengths of Clinical Services Management Classified by Focus of Strength (n=13)

Focus	Strengths
Quality of staff	<ul style="list-style-type: none"> <li>- CCSC's are the strength of the system.</li> <li>- Clinical expertise of leaders</li> <li>- Have become skilled in NCC at making appropriate referrals for treatment.</li> <li>- I feel the clinical services staff being involved in our treatment planning is very important and lends itself to more comprehensive services.</li> </ul>
Focus on clients	<ul style="list-style-type: none"> <li>- Consideration of youth in treatment; appropriate involvement in case</li> <li>- Oriented toward least restrictive. Client needs seem to be placed ahead of financial considerations.</li> <li>- Responsive, have clients best interests at heart.</li> <li>- Willing to discuss cases</li> </ul>
Coordination/ Collaboration	<ul style="list-style-type: none"> <li>- Coordination of services between the treatment team and BP are in general good.</li> <li>- DCMHS is very clear with their expectations of treatment and are collaborative with our facility in decision making.</li> </ul>
Access	<ul style="list-style-type: none"> <li>- Easy access to management teams; realistic approach to families; effectively utilize information given to them regarding clinical issues.</li> <li>- Easy access.</li> <li>- The clinical service managers are accessible and have a strong understanding of client needs.</li> </ul>

In the space provided for service providers to identify areas in which DCMHS could improve their clinical services management, one respondents gave a global answer, simply writing "in all areas." In the comments made by the other 14 respondents to this question, the inconsistent quality across different teams and team leaders was a major issue. (See table 14 for specific comments.) Other concerns included the lack of face-to-face contact with clients, the complexity of the paperwork, communication, and coordination. Note that two of the three comments about paperwork relate specifically to the authorization process which was also flagged as a concern in the responses to the closed-ended questions.

Table 14

Suggestions for Improvements in DCMHS Clinical Services Management Classified by Focus of Suggestion (n=14)

Focus	Suggestions for Improvements
Communication - Consistency	<ul style="list-style-type: none"> <li>- Inconsistent, responses not always timely; sometimes become too involved in clinical activity/enmeshed with family/less responsive to provider recommendations. Attempt to control some clinical activities I.e. worker assignment, educational placement, DFS reports/complaints</li> <li>- The biggest difficulty is the wide variety in decision making procedures between different management teams.</li> <li>- There needs to be more consistency across teams as to procedures for determining length of stay.</li> <li>- Wide variation in team leaders decision making and working relations with providers</li> <li>- Improving Kent and Sussex county teams ability to make appropriate referrals to our services</li> <li>- For the most part, the team is very responsive. There have been situations when I was unable to reach a worker for several days.</li> </ul>
Communication - Decision-Making	<ul style="list-style-type: none"> <li>- Provide staff for periodic face to face meeting with youth.</li> <li>- For many clients, the CSMT's authorize or don't authorize services based on a review of a paper trail, rather than their own assessment. Thus decisions are prone to being affected by (a) biases for or against certain professionals and (b) professionals' varying talent at adequately representing client needs in a manner consistent with CMH criteria for services.</li> <li>- More face to face meetings with all agencies/individuals involved on team</li> <li>- Communication/input from the providers to team leaders is poor; decisions for continued authorization by team leaders do not appear to reflect reliable data, can be bureaucratic and autocratic and not based on provider input.</li> <li>- We, as clinicians, would like to participate with DCMHS in following the progress of discharged patients for six months following the discharge date. If an intervention is needed in order to prevent relapse or crisis, our clinicians could assist the DCMHS. <i>[comment from concluding question]</i></li> </ul>
Communication - Paperwork	<ul style="list-style-type: none"> <li>- Simplify paperwork requirements.</li> <li>- Quantity of info and paperwork, as well as restricted time frame for initial authorizations is overwhelming</li> <li>- More efficient authorization/reauthorization of clients</li> </ul>
Coordination	<ul style="list-style-type: none"> <li>- Greater coordination between divisions (CMH, DFS, YRS).</li> <li>- Teamwork, professional demeanor, need for a program liaison at local office, collaboration of various providers</li> </ul>

### **Clinical Services Management: Conclusions**

*According to a large proportion of respondents, both Coordinators and Team Leaders are accessible and responsive. While 1 in 4 (25%) rated Coordinators and Team Leaders as inaccessible last year, only 1 in 14 (7%) of the respondents rated Coordinators and Team Leaders as inaccessible this year, representing a dramatic improvement. The open-ended comments about strengths underscore this improvement. Specific strengths were identified in the areas of the quality of the people involved in clinical services management, the focus on clients, the accessibility of the teams, and coordination of services. On the other hand, concerns centered on (1) the complexity of the paperwork (specifically on the need for clarification of the Clinical Services Management authorization procedure), (2) inconsistency across different teams and team leaders, (3) the inclusiveness of the decision-making process, and (4) the basis of support for decisions. Respondents identified these as areas in clinical services management that need improvement.*

## **THE DCMHS PROVIDER SURVEY: RESPONSIVENESS AND IMPROVEMENTS**

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The last section of the survey asked respondents about DCMHS' responsiveness to the information gathered in the FY 1997 survey, requesting specific feedback on the annual provider meeting, the quarterly NETWORK NEWS publication, and the voice mail system. In addition, respondents were asked about how to improve the FY 1999 survey. The results are presented below in two parts. The first part describes the responses to questions about DCMHS's response to last year's survey. The second part provides comments about changes that could be made to next year's survey.

### ***Appropriateness of DCMHS Response to the FY 1997 Survey Results***

Service providers were asked to answer this section only if they participated in last year's survey. Seventeen of the twenty-eight respondents completed the section. The specific items used to measure DCMHS's responsiveness to the FY 1997 results of the survey are:

1. I think DCMHS provided appropriate responses to concerns and suggestions expressed by providers in last year's survey.
2. I think better communication between DCMHS and its providers is a result of the following DCMHS initiatives implemented in the past year
  - a. annual provider meeting
  - b. quarterly NETWORK NEWS publication to provider
  - c. voice mail system
3. I think the information outlined in the DCMHS Provider Manual clarified DCMHS authorization procedures.

As shown in table 15, a majority of respondents indicated satisfaction with DCMHS' response to issues raised in last year's survey. In particular, efforts to improve communication between DCMHS and its providers were appreciated, with the annual meeting receiving the highest degree of agreement (12 respondents, 70%) among the communication items. There was also a high rate of agreement (13 respondents, 76%) about how the Provider Manual clarified the authorization procedures. However, there were a number of "don't know" and "not applicable" responses and skipped items in this section of the survey.

Table 15

DCMHS Responsiveness to FY 1998 Provider Survey: Distribution of Responses (n=17)

Responsiveness to FY 97 Survey	Agree	Disagree	Don't Know	Other <sup>a</sup>
1. Appropriate responses provided	9 53.0%	0 0%	5 29.4%	3 17.6%
2a. Communication improved by meeting	12 70.5%	2 11.8%	2 11.8%	1 5.9%
2b. Communication improved by Network News	10 58.9%	2 11.8%	3 17.6%	2 11.8%
2c. Communication improved by voice mail	10 58.9%	2 11.8%	1 5.9%	4 23.5%
3. Information clarified authorization procedures	13 76.5%	2 11.8%	0 0%	2 11.8%
a. Other refers to those respondents who either skipped the item or checked it as not applicable.				

The survey also asked questions specifically about the Service Provider Survey as a means of communication between providers and DCMHS. In response to an open-ended question about the value of the provider survey process, respondents emphasized the importance of DCMHS' commitment to obtaining feedback. In addition, a couple of respondents identified internal uses of the process. The specific comments were:

- Further opportunity to internally identify needs; further opportunity to provide feedback.
- General communication within the program and also between division and program.
- Helps provide quality assurance, method of feedback to DCMHS.
- It is nice to see a system actively invested in getting feedback from those providing direct care services. This openness facilitates a running dialogue that will positively impact patient care.
- Opportunity to empower staff/local managers to reflect/give DCMHS needed input that is anonymous.
- Provide opportunity to evaluate department's skills and operations.
- This is my first time filling out the survey. I believe the concept is a valuable tool, especially if changes are made as needed.
- To be able to identify better communication and improved networking.
- We could see other's impressions.

Responding to the question "How could DCMHS' responsiveness to the FY '97 survey be improved?" one service provider mentioned "more frequent meetings," while a second requested "reduction of paperwork."

### *Suggestions for Future Surveys*

Twelve service providers commented on possible changes in both content and format of future surveys. Three of the twelve suggested format changes, recommending expanding the scale to 5 points and/or asking for frequency or extent to which specific items occurred or were accomplished (as opposed to Agree-Disagree). In commenting on the content of the survey, one respondent wrote, "I think most areas were covered in this survey," while others recommended addressing issues of coordination and the quality of services for clients. Another suggestion was to survey the consumers of the services for their feedback. Specific comments made about changes to the content of the survey are provided in Table 16.

Table 16

Suggestions for Changes to Future Service Provider Surveys Classified by Focus of Suggestion  
(n = 10)

Focus	Suggestions for Changes
Coordination	<ul style="list-style-type: none"> <li>- Address coordination of services among three divisions</li> <li>- DCMH's relationship with other divisions- DFS, YRS, etc.</li> <li>- Inter-provider communication/collaboration; multi systems issues e.g. multiple MH providers; multiple DSCYF providers.</li> </ul>
Feedback from consumers	<ul style="list-style-type: none"> <li>- Feedback from consumers.</li> <li>- Survey the clients and families</li> <li>- Would like to know if a similar survey goes out to parents and if providers might get feedback re: section V [Clinical Services Management].</li> </ul>
Quality of services	<ul style="list-style-type: none"> <li>- Ask more questions about quality of services for clients. After all, that is why DCMHS exists.</li> </ul>
Other issues	<ul style="list-style-type: none"> <li>- Availability of training.</li> <li>- More specific areas around functioning of local teams.</li> <li>- Staffing patterns throughout the network e.g. administrative/CYMT vs Direct clinical</li> </ul>

#### **Responsiveness to Survey: Conclusions**

*A majority of respondents indicated satisfaction with DCMHS' response to issues raised in last year's survey. In particular, the efforts to improve communication between DCMHS and its providers and the clarification of the authorization procedures were appreciated. Suggestions for improving the survey included adding items on the quality of services and the coordination of DCMHS with other DSCYF Divisions, and seeking feedback from clients as well as service providers.*

## CONCLUSIONS

In many ways the news from the service providers who responded to the FY 1998 survey is good. Not only were there generally more respondents agreeing than disagreeing with the survey items about DCMHS performance, but also some overall conclusions about the specific areas of value can be drawn. These areas include:

- the inclusion of collaboration in the new mission statement;
- DCMHS's improvements in communication and concern for clients; and
- the accessibility, responsiveness, and knowledge of clinical services management.

Despite the many positive responses about DCMHS system performance, many areas where improvements are still needed were also identified. In particular, communication continues to be a major concern for the service providers. Looking across the comments made in different sections, communication could be improved by:

- providing more or clearer information about (1) the DCMHS managed care system, (2) the provider appeals process, (3) providers' accountability responsibilities to different DCMHS components, (4) the awards process, and (5) the coordinators role;
- reducing and simplifying paperwork required of service providers;
- providing quick feedback based on visits and reports;
- quickly completing paperwork that service providers need from DCMHS;
- increasing consistency across different sources of information (individual personnel, local offices, provider manual, central office);
- coordinating (1) with other divisions of the Department of Services for Children, Youth and Their Families, and (2) across different kinds of services; and
- respecting and using service providers' expertise and documentation of case in making decisions.

Continued progress on these fronts could improve services and bring even more positive feedback in response to next year's survey than was received this year.

## DATA TABLES

This appendix provides the data that support two of the figures in the text. Table A1 presents the information underlying figure 5 (on page 11) about the Role of the Provider. Table A2 displays the data for the DCMHS Clinical Services Management section about Team Leaders (figure 7 on page 20).

Table A1

Role of Provider in the DCMHS Managed Behavioral Health Care System: Distribution of Responses (n=28)

<b>Provider Role Measures</b>	<b>Agree</b>	<b>Disagree</b>	<b>Don't Know</b>	<b>Other<sup>a</sup></b>
1. Contract's clarity for service requirement	27 96.4%	0 0%	0 0%	1 3.6%
2. Agency role and place in continuum	25 89.3%	1 3.6%	1 3.6%	1 3.6%
3. DCMHS expectations for agency	22 78.6%	5 17.9%	1 0%	1 3.6%
4. Opportunity to give input	19 67.9%	7 25.0%	1 3.6%	1 3.6%
a. Other refers to those respondents who skipped the item or checked it as not applicable.				

Table A2

Clinical Services Management: Distribution of Responses to Questions about Team Leaders (n=28)

<b>Clinical Services Management Measures</b>	<b>Agree</b>	<b>Disagree</b>	<b>Don't Know</b>	<b>Other<sup>a</sup></b>
4a. Team Leaders are accessible	24 85.7%	2 7.2%	0 0%	2 7.1%
4b. Team Leaders are responsive	22 78.6%	4 14.3%	0 0%	2 7.1%
4c. Team Leaders resolve disagreements	17 60.8%	9 32.1%	0 0%	2 7.1%
4d. Team Leaders remain involved	21 75.0%	5 17.9%	1 3.6%	1 3.6%
4e. Team Leaders explain decisions	19 67.9%	7 25.0%	1 3.6%	1 3.6%
4f. Team Leaders are clinically sophisticated	19 67.9%	7 25.0%	1 3.6%	1 3.6%
a. Other refers to those respondents who either skipped the item or checked it as not applicable.				



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