Part B, Lesson 1 of Module 301, Course 5A.

Anticipated Barriers to Network Coordination

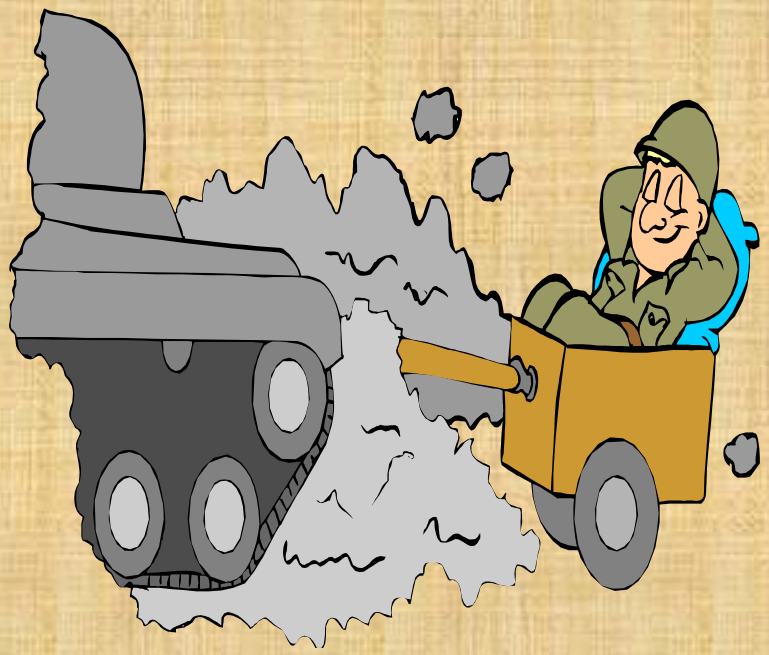
Like we said – it has its challenges! Like what?

- **Senior staff and board leadership – or practice partners – who don't want to give up power and control through a strategic collaboration or expanded partnership**
- **Fear of needing to come 'out of the box' – clinging to 'tradition.'**
- **Fear of losing 'the gold' through forming a partnership or collaboration with others, having to share clients and contracts**

Anticipated Barriers, cont. . . .

- **Paranoia – jealously – mistrust of motives of other agencies**
- **Suspicion of other partners' pursuit of their own goals, in addition to network goals**
- **Fear of being out-done by network partners or collaborators – losing the limelight in a particular niche of service delivery**

Anticipated Barriers, cont. . . .



- **Less productive partners:**

Resentment can fester when one or more network partners fails to 'do its share' in regard to assigned tasks or shared activities.

New Partnerships Prompt Innovative Links Between Unlikely Parties

- **Two or more State agencies as partners**
- **For-profit MCOs partnering with trade associations (CMHCs) and other not-for-profit providers and 'private provider' networks**
- **CD/SA education and prevention providers, partnering with CD/SA treatment providers – how often did you see THAT, in the past?**
- **Not-for-profit agencies partnering with other not-for-profits, and perhaps even with for-profits – forming provider managed networks**
- **Advocacy groups partnering with treatment**

But make sure that your ethics MATCH!

The Rules of Strategic Partnering and Agency Collaboration

- **Expect and give commitment to each other's well being – and this goes beyond avoidance of professional pirating of clients. True strategic partnerships are stronger than interagency coordination.**

Choose partners or collaborators for more than politics – do you 'fit'? Do you share a common set of ethics?

The Rules . . .

- **Formalize all decision making techniques – no 'off the cuff' decisions allowed – include review & modification workgroups.**
- **Formalize the 'rules' of partnership, such as 'it's fine to pursue a contract on your own – but just tell us about it up front.'**
- **Forget courtesy 'on-paper-only' collaborations which have no real function. It's meaningless, and is eventually seen for what it is by the community and contractors.**

This is sounding a lot like Big Business. Is that what we are saying here? Yes.

- **Prompts strategic partnerships between providers, and even between providers and MCOs**

  ↳ **just like big business!**

- **Has survivors and quitters**

  ↳ **just like big business!**

- **Comes out of the box to compete and stay viable**

  ↳ **just like big business!**

The time is now!

Think Like the 'Big Guys' and 'Smart Women' at Amazon. And Apple. And Google.

- **Move from 'Mom & Pop non-profit' to a corporate management philosophy**
- **Secure strategic alliances - merge & grow**
- **Capture a corner of the market - become a "niche" leader**

- **Focus Board of Directors upon leadership, vision, and strategic thinking – versus operations**
- **Prepare for a potential need to change Board composition, and even internal management**

In other words, if you are not already ‘there’, become a business!

- **Learn to recognize where CD and SA practices are ripe for “business-ization”**
  - **Recognize that your survival depends upon it, and make a decision about survival**
- **Start to think like Microsoft; allow yourself to say “If this was Microsoft, would I do it this way?”**
  - **New Business Thinking has a place in your organization, and is the key to survival in the new age!**

Re-Design . . .

And don't buy the old mantra that says that behavioral health providers should be limited to 18-20 hours of face-to-face (billable) intervention, weekly. This is perhaps one of the major hurdles we encounter with 'old guard' agency clinicians, when we must switch from the 'regular monthly check' from the State or other fixed contracts, to a 'fee-for-services-delivered' system. NOTE: Private practitioners have long ago dispelled the notion that providers will 'burn out' with more than 20 direct service hours. However, consider compensating program staff for increased productivity through workplace flexibility and incentive programs.

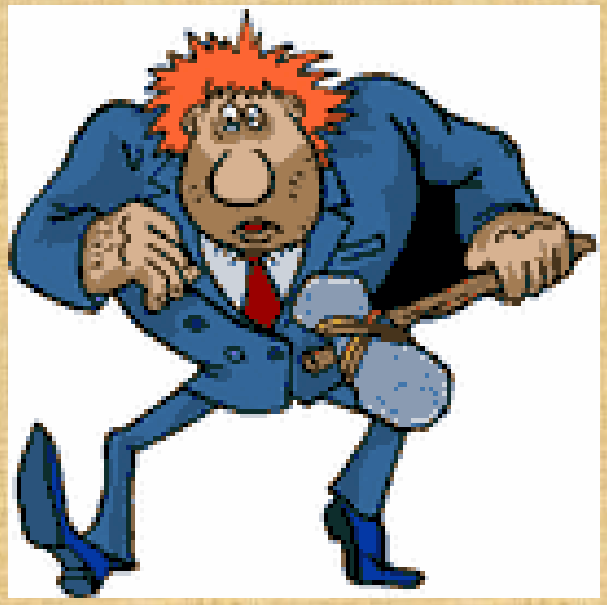
BUT WHAT ABOUT PROGRAMS? Will we need shifts in program design? Yes! Program design must come 'out of the box' to be successful in managed care!

What new 'out-of-the-box' programmatic shifts are worth considering, in order to be successful in managed care? This depends in part upon . . .

- **the provider's own professional biases and beliefs**
- **the 'culture' of the provider's agency or practice (e.g., flexibility vs. rigidity, play-it-safe vs. trying a new direction).**

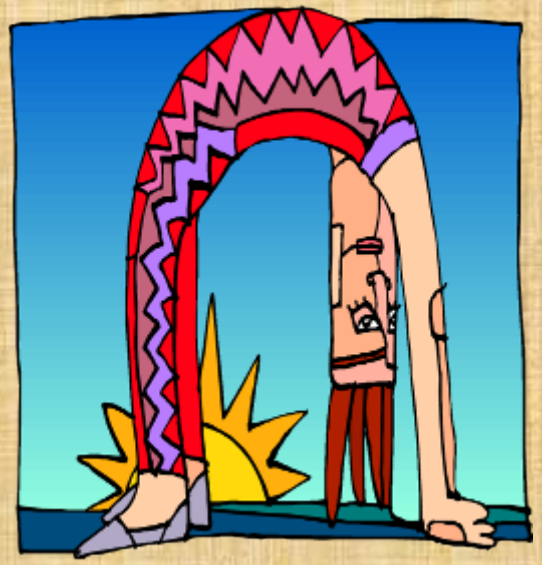
Are you willing to examine your current beliefs about treatment, and about documentation in client records? Open to new ideas that managed care brings to the front?

Flexibility! You may have to set some of your historical beliefs about how to deliver treatment on the back burner.



Stone age thinking leads to stone age clinical performance!

A change-up of your historical approach to programming and practice may be CRUCIAL, if you are to compete and grow in this new healthcare environment. There is no room for 'but we have always done it this way!' Even for those who have moved beyond 'old guard' programming, there may be some surprises in store for you in terms of new twists in managed care programming – although you may actually teach the MCO a thing or two.



Are you the FLEXIBLE type – willing to look at NEW, alternative ways of delivering and documenting treatment? This is important because MCOs make daily decisions about WHICH treatment and HOW MUCH of that treatment is 'Medically Necessary' for enrollees – AND THESE DECISIONS MAY CONTRADICT HOW TREATMENT HAS ALWAYS BEEN PROVIDED. This is particularly true for Chemical Dependency services and for treatment of persons with less-than-severe Mental Health disorders (such as non-psychotic depressive episodes and anxiety disorders) – who may receive limited treatment after assessment.

Check out Course 5B – Where The Rubber Meets The Road! We expand on various ways that providers can deliver services creatively under a managed care contract – and also look at numerous issues and problems that can arise in any managed care contract or treatment situation.

All of which brings adjustment issues in the workplace, which must be resolved.

Like conflicts in . . .

- **Perspectives**
- **Priorities**
- **Values**
- **Image**
- **Corporate Culture**

- **Conflict of perspectives between 'old guard' and 'new system' staff – it may be a 'traditions' thing.**

- **Introduction of managed care 'bottom-line oriented' culture – management and line staff may see money and budgets differently.**

- **Increased emphasis on 'image', credentials, and professional presentation – a 'values' and 'priorities' thing.**

(Re)Training, Culling, New Hiring Practices . . .

(Re)Training, culling, and some new hiring approaches are often necessary in agencies and group practices, in order to get the right staff who can rise to the occasion. And, Board of Director education is critical in not-for-profit agencies and networks!

A CD Issue Related to Care Management Decisions

Special Notes . . . to be remembered as we work through this and all courses offered for Managed Care: Standardized 'Level of Care' protocols (such as those CARE MANAGEMENT criteria typically used by the Managed Care Companies) are believed by many to result in questionable clinical outcomes for chemically dependent consumers. Reason: These protocols may not adequately accommodate the CD population's inherent tendency to relapse repeatedly while they are on the road to recovery. What to do here? Encourage your state and Managed Care company to engage in good Quality Management studies of outcomes for CD patients! And for your most relapse-prone clients – especially those who recycling in and out of detox frequently – ask for a 'Case Rate', where you can make treatment decisions more freely – where you 'hold the cards'.

And also . . . The Concerns of the National Alliance for the Mentally Ill (NAMI) About The 'Cost Control' Element

The National Alliance for the Mentally Ill (NAMI) has consistently expressed concerns that the emphasis will be placed upon the element of COST CONTROLS instead of upon the element of CARE. And of course, the State legislatures typically are most concerned about the element of COST, as their primary reason for implementing a managed care model. Their concerns were most recently expressed in 'Grading the States 2006: A Report on America's Health Care System for Serious Mental Illness.' This statement and others like it were made in this year's 2006 NAMI *Report*: "Managed care models sometimes turn into managed cost models."

Concerns of NAMI . . .

And further, NAMI reflects the thought that managed care companies' corporate emphasis upon *profit* may result in harm to the delivery system. For example, one comment made in the 2006 report is that too often " . . . people's needs are sacrificed in favor of private profit incentives." If you have a desire to review what NAMI has to say about YOUR state's status and 'grade' check out NAMI's report card for each state .

Human Services Programs Are Often Led by People With Passion

- **Recognize the biases**
- **Build on the strengths**
- **Be open to new ideas, even if initially painful.**
- **Balance passion with good management**
- **Practice good recovery principles from a MANAGEMENT point of view. Recognize that not everything will be accomplished in one day, but that consistency and ultimate attention to your reality situation is CRITICAL TO PROGRAMMATIC OR PRACTICE SURVIVAL.**

It's a new day. Rise to the occasion.

In the next and last lesson of Module 301, Course 5A, we will provide information on some of the heavier clinical and programmatic changes we are called to make under managed care – changes that impact how we deliver care and how we document it. Such changes are oftentimes difficult or impossible for a provider to accept – and so it's important to deal with these directly. So let's move forward!

Congratulations!

You have completed Lesson 1 of Module 301, Course 5A. You may complete the short quiz for this lesson, either now or later, by simply closing this page. You will see your list of Study Guides and Quizzes displayed in the previously opened window. Click on Quiz 1, Module 301.

You can take each quiz as many times as you want, until you pass it. There is no penalty for failing a test and you may retake it immediately.

To move on to the second (and LAST) lesson of Module 301, simply close this page. You will see your list of Study Guides and Quizzes displayed in the previously opened window. Click on Lesson 2, Module 301. Or, you may return to the site and your home personalized home page at any time to resume the Module.