DAYMARK Recovery Services, Inc.
STUDY: Elements of Success in a 501c-3 spin off under NC Reform

Sandra Forquer, Ph.D.
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A major qualification to become a Local Management Entity (LME) in the North Carolina Behavioral Health System in 2003 required public entities to divest their previously operated and managed behavioral services. In order to provide continuity of care for consumers, and to address concerns of stakeholders, several LMEs decided to develop "spin off" 501.3C entities to take over operations of the Community Mental Health Centers "in place". In 2004, PBH, the local management entity for the Cabarrus, Davidson, Rowan, Stanly and Union county region, developed a single 501c3 agency to assume operations of five Community Mental Health Centers in its five county region.

Statewide, four 501c-3 spin offs were established. To date, two of the four LME spin off 501c-3s have folded. In contrast to these now defunct spin-off 501c-3 entities, DAYMARK Recovery Services is currently operating successfully and a key provider resource for PBH. This study is designed to document the process and key decisions underlying this new service delivery strategy for North Carolina. A second goal of this study is to provide a written history of a successful spin off. The intent is to produce a useful document to serve as a resource for other entities attempting to successfully migrate services currently operated by public agencies to a private not-for-profit entity. It should be noted that PBH chose to spin off a new agency rather than transferring services to existing agencies. This decision was based on:

1. The absence of any comparable private agencies that provided emergency services, licensed professionals and medical services. The majority of the pre-existing providers for LMEs were DD providers and Child Mental Health providers.
2. The desire to maintain continuity of care through the transition and beyond. The largest numbers of consumers were served in the Community Mental Health Centers (approximately 17,000). Continuity of care for consumers could be ensured if consumers could be served at the same location with the same services with the same staff). Most of these sites are also co-located with DSS/Health Departments and are within walking distance of highly penetrated areas and/or public transportation routes.
3. The offering of employment opportunities to former LME staff that were direct service providers in the five Community Mental Health Centers (over 200 staff) as a means of continuing, not disrupting, therapeutic alliances. The vision was to retain former staff to keep a viable and professional work force of medical and licensed professionals who had therapeutic relationships with the population served.

Based on the PBH 2003 Local Business Plan, the Department of Health and Human Services designated PBH as a comprehensive demonstration site for state reform. As a demonstration site, PBH was granted flexibility in management of state funds and federal block grants, as well as the direct management of state psychiatric hospital funding. This included rate setting, provider selection and contracting, and service authorization and payment. PBH was also exempted from the requirement to use the state's reporting system, called IPRS (Integrated

Payment and Reporting System). In addition, the PBH LME was successfully granted a 1915 b/c concurrent waiver in 2004, which began operating in April 2005. The 1915 b waiver is a managed care waiver and as such provided PBH the following flexibility in system management:

1. The opportunity to determine the size and scope of the provider network, including the ability to "close" the network.
2. All provider interactions are directly with PBH:
    a. Providers enroll directly with PBH rather than the state's Medicaid vendor;
    b. Providers request and receive authorizations directly from PBH;
    c. Providers bill PBH directly and are paid by PBH (no state vendor involvement in this process).
3. Direct enrollment of consumers;
4. Ability to set both State and Medicaid rates;
5. Receipt of complete Medicaid enrollment data file from the state Medicaid data base (not available to other LMEs)

The demonstration status of PBH allowed the PBH LME/DAYMARK relationship some important exemptions not available to the other LMEs. These included:

1. The ability of PBH to "grant" fund DAYMARK by making payments in one-twelfths for both Medicaid and state funding (thus providing important cash flow during the start up phase of a new entity).
2. DAYMARK enrollment directly with PBH allowed for immediate billing and reporting opportunities for both state and Medicaid services. There were no delays waiting for provider numbers for staff.
3.
    4.

The case study presented below is organized into five sections:

1. **Identification of similarities and differences between DAYMARK Recovery Services, Inc. and the spin-offs that failed on key issues**
2. **Comparison of key data points for first full year of operations to the second full year**
3. **Lessons learned**
4. **Continuing developmental issues between DAYMARK and the PBH LME: financial solvency going forward and recommendations**
5. **New vision for the service model for a community mental health center**

1. Identification of Similarities and Differences between DAYMARK Recovery Services, Inc. and the Failed Spin-Offs on Key Issues:

Leadership Stability:

Leadership at both the PBH LME and the spin off agency has remained constant through the transition. The spin off leadership is comprised of former Area Program Administrators that also had a history of service provision and a developing relationship. The PBH LME leadership, both its CEO and COO, have remained constant through the transition, building on existing relationships

established in the community. The LME CEO also brought to the table considerable managed care experience and knowledge of the IS functionality required to conduct business in this new business environment for community mental health centers. Their familiarity with North Carolina statues and requirements, Medicaid waivers, and history with the service system in general were all major elements of creating a successful spin off. The CEO of DAYMARK had served as a former area program director as well, bringing to the table an important experiential base in the North Carolina environment. In contrast, the now defunct spin-offs saw marked change in top leadership during the same period. In one case the CEO retired and his second in command also left the system; in the other, the area director and CFO changed. The latter was a key player in the State and LME and his departure left a significant vacuum. Both new area directors for the areas in which the spin off 501c3s are now defunct came from out of state and faced a difficult learning curve from the outset. As well, the 501c3 spin off directors in those instances were from out of state and/or private systems and did not have familiarity with the nuances of the North Carolina public system.

PBH also employed key DAYMARK management staff for six months prior to the "go live" date for DAYMARK to allow time for planning and preparation. Additionally PBH used its resources to develop prototype budgets, procedures, salary plans and other basic operational guides to assist DAYMARK in its initial operations.

Information Systems:

First and foremost, DAYMARK credits their survival to Piedmont Behavioral Health's early recognition of the need to provide the spin-off with a complete information system that was designed with the necessary service provider functionality for them to manage their services and meet reporting requirements. PBH through its advance preparation provided DAYMARK with a "ready" data system with the following characteristics:

- Real-time data
- Statistical analyses capability
- Full clinical system that could be constituted into an electronic medical record
- Ability to track staff productivity
- Ownership and control of IS system
- Freedom to build in efficiencies independently of the LME as the spin off matured

In addition, PBH recruited and hired an accomplished CMHC systems analyst to direct the Information Systems Department for the PBH spin-off. When the spin-off went live, PBH transferred the Director and two experienced information systems analysts to DAYMARK as part of the set up of the spin off. PBH fostered collaboration between the 501c-3 and the LME to solve data questions and align service definitions.

In contrast, the now defunct spin-offs used hosted IS systems with functionality defined by the sponsoring LMEs. Screens available to the spin-off were selected by the LMEs, thus screening access to all information. Additionally, one of the spin-offs was charged $27,000 a month for IS services since they were not owners of the system. The IS function was further complicated by the need for the 501c3's to maintain their "side" of the system, requiring two sets of IS staff and expenditures associated with staffing two systems. Another barrier to their success was that they were unable to generate their own reports and thus not able to challenge or offer data to correct any of the LME produced data. This put them at a distinct disadvantage from DAYMARK who both owned and controlled their IS system as part of the original contract agreement with PBH and had the capability to produce its own reports that often provided an opportunity for reconciliation between the spin-off and the PBH LME on critical performance measures.

IPRS Billing System (State Reporting):

As part of the waiver, the PBH LME was exempted from use of the State's new IPRS Billing System. This billing system requires providers to attach a target population designation to each service claim (there are up to 48 Target Populations currently in place). Unlike the other LMEs, none of the PBH providers had to report encounters or submit claims based on IPRS target populations. IPRS was designed to provide claims payment and denial information to a single entity. It was not designed for reform wherein the LME was not the direct provider of services. There was no provision to identify encounters by sub-providers so that the LME could sort remittance advice information by provider and transfer this data back to provider agencies. The non-waiver LMEs could neither sort data by agency nor provide agencies with critical denial of payment information, resulting in severe cash flow problems. The staff resources required to complete the extensive paperwork requirements had not been anticipated, nor were they part of the compensation arrangement between the LMEs and the spin-offs. Both defunct spin-offs had to hire extra staff to sort data by specific program as this capability had not been programmed into the IPRS functionality.

Additionally, the IPRS system may have inadvertently contributed to an over utilization of the Community Support Medicaid service. The system as currently designed allows the LME to bill under a group number for Community Support Services whereas providers such as DAYMARK must have individual numbers for each clinician; thus focusing on the Community Support services allows providers to avoid the lengthy process of applying for individual provider numbers. One of the unintended consequences of this IPRS feature is that it tends to discourage the provision of services provided by licensed professionals (which required separate provider numbers from the state) including medical and crises services and encourage the potential overuse of Community Support Services, which are primarily staffed by Bachelor's level and paraprofessional staff, and for which no individual staff provider numbers are required. Both types of services are needed in a service system if it is to meet the needs of its population effectively.

Individual Staff Enrollment Requirements:

During this time period, the state Medicaid agency initiated a new requirement that required that each staff provider within an agency have a unique billing number. Because DAYMARK Recovery Services did not bill through the state Medicaid vendor, but directly through PBH, it had a distinct advantage compared to the other spin-offs. DAYMARK was further advantaged in that it used only three provider numbers to bill to PBH, those numbers reflecting different programs. The other 501c-3 spin off provider agencies were required to obtain individual provider numbers from the State for each clinician. This process often took up to three months to complete, resulting in a multitude of claims payment denials from the LME related to this issue alone. Cash flow and cash balance issues were unintended consequences of this problem.

Care Model Adaptations to Reflect Reform Agenda: The "Advanced Access Model"

The State's reform agenda embraced the following components:

1. Separation of service management from service provision
2. Consistent and easy access to care for consumers
3. Consumer empowerment and involvement in system management
4. Evidence based and best practice models of care

As part of comprehensive planning for crisis services across the PBH counties, PBH wanted to add an "urgent care" service that would ensure that people in crisis or with urgent needs could be seen on the day they presented, instead of waiting for appointments, or accessing the emergency system. As part of this plan, DAYMARK Recovery Services transformed their clinical model from an office-based appointment model to an "Advanced Access" walk-in model that embraced the preferences of the population served, providing the right dose of care at the right time. Core features of the Advanced Access model include:

1. Walk in assessment and treatment available from 8 am until 8 pm making urgent, emergent and routine performance measure time frames for consumers fall within standards 100% of the time unless otherwise chosen by the consumer.
2. Credentialed Staff availability to conduct emergency evaluation and need for crisis intervention (detoxification, facility based crisis, psychiatric hospitalization) from 8 am until 8 pm
3. Appointment availability for consumers seen overnight by the emergency on-call system that require next day intervention (important for hospital diversion).
4. Access for consumers discharged from psychiatric hospitals to receive follow up appointments and medications, including samples if need be, within five days of discharge from the hospital.
5. Psychiatry back up support for licensed clinicians.

Psychiatric on-call consultation is available to DAYMARK clinical staff 24 hours per day and 7 days per week. Although normally handled by nursing staff, a consumer can speak directly to a doctor during normal business hours if need be regarding medication problems or a crisis. After normal business hours the on call clinician normally may consult with the psychiatrist, but the consumer may also speak to the psychiatrist if indicated. DAYMARK Recovery Services will add Mobile Crisis to its service array in March 2007, at which time both a supervising licensed clinician and a psychiatrist are available 24 hours per day, seven days per week in order to field questions or see the consumer face to face if indicated.

A second adaptation of the traditional care delivery model has been scheduling psychiatrist time to take people off of involuntary commitment status in a timely manner prior to a formal hospital admission.

1. DAYMARK staffs its centers with LCSWs who can provide a first evaluation (required by North Carolina Involuntary Commitment statutes) and serve as the first line of response 8am-8pm for people in crisis.
2. DAYMARK MDs get involved when possible but if they are booked or not scheduled they provide a consultative service to staff. DRS also uses its clinical management staff,(both Ph.D.s) to fill in when coverage gets thin for days off, illness, etc.
3. This staffing pattern has provided some success in reducing the number of involuntary commitments (IVCs). Even when an IVC must be honored, DAYMARK is able to evaluate the entire case and place the person in a clinic in 2-4 hours vs. 4-8 hours in the emergency rooms.

A third adaptation has been the expansion of telemedicine to cover crisis evaluations, routine appointments and advanced access by DAYMARK psychiatrists. This expansion was possible due to the availability of electronic medical records and the connectivity that DAYMARK has been able to establish among its five locations in the PBH area and three locations within the Centerpoint LME area.

Telemedicine affords DAYMARK the opportunity to pool medical resources of 14.3 MDs and

provide better access to care across eight counties without having to hire more psychiatrists. It is anticipated that DAYMARK will increase its child psychiatry time a total of 0.8 FTEs in two PBH counties without hiring an additional child psychiatrist but using existing capacity already located in one county. It is also anticipated that DAYMARK will be able to provide crisis appointments affording patients an opportunity to start medications immediately at the onset of crisis with telemedicine because of improved access to medical care at the time of crisis.

In contrast, one of the now defunct spin-offs kept its appointment driven office-based model. The other did provide a walk-in emergency clinic that dispensed medication but did not provide an array of services including crisis management.

One of the spin-offs invested in Community Support and hired paraprofessionals but provided no crisis services.

Claims Payment Models:

The PBH LME initiated a capitation payment model for its safety net provider from program inception, January 2004, through September, 2006. The intention was to provide a buffer zone through start up and early implementation phases of the DAYMARK clinical model. Each month DAYMARK received a 1/12th payment. DAYMARK subsequently submitted encounter claims to PBH to document services that were provided and for reconciliation purposes. Since October 1, 2006 DAYMARK has moved to a Fee for Service model of payment. Recent enhancements to the PBH IS system have supported this shift. The PBH IS system is fully functioning with HIPAA compliant transaction sets, accepting 837 (claims) and responding with 835's (response to claims). In addition, it can accept and respond to electronic authorization requests through a data transfer arrangement that was written specifically to support the volume of DAYMARK authorizations. This data transfer arrangement is an extremely cost effective arrangement for DAYMARK, as it requires only minimal staff time to request authorizations. In comparison, the process of requesting authorizations from ValueOptions, the state's UM vendor, was described as very time consuming for DAYMARK clinicians working in another LME, and had the same impact on the two defunct spin off's.

Neither of the LMEs supporting either of the now defunct spin-offs had IS systems with these capabilities.

Rate Setting:

Because of their demonstration status and Medicaid waivers, PBH has the ability to set reimbursement rates. In July 2005, the state Medicaid agency reduced outpatient rates by 25%. PBH did not implement this rate reduction. Both the LMEs managing the other spin-offs had no ability to set rates or in any way offset the impact of this reduction for their spin offs. For the other spin offs, this rate reduction impacted cash flow, ability to meet payroll, and ability to invest in new and necessary infrastructure.

Rent and IS Leasing Arrangements between the LMEs and the 501c-3s:

One of the spin-offs had previously experienced no rent as they were located in County office space free of charge. Under the new LME arrangement, the spin-off was required to pay rent and was charged $27,000/month for the use of the LME IS system.

In contrast, DAYMARK pays CPHS a reasonable fee for rent in both Stokes and Forsyth. In Davidson County DAYMARK pays only utilities as it is a county building and an in-kind contribution.

The PBH community mental health centers were located in county space as well. PBH paid rental fees that ranged from free, to nominal to excessive. DAYMARK negotiated similar arrangements with the counties. In the case where excessive rent was charged by the county, PBH subsidized this arrangement for DAYMARK, so that the rent was comparable to the other counties. This was important because the locations were known to consumers and community stakeholders and maintaining the locations during the system transition was essential for continuity of care for consumers.

4.Comparison of key data points from Year One to Year Two of DAYMARK Operations:

Data as identified below was reviewed and compared from the first full year of operations, to the second full year.

Item	**04-05**	**05-06***
Budgets: Budgeted Revenue Actual Revenue Actual Expenses Profit/loss	 $12,951,987 $10,619,476 $10,777,127 $ (157,651)	 $13,131,319 $12,780,150 $13,304,711 $(524,561)
Administrative overhead %	9.9%	10.8%
Medical Loss Ratio	1.02	1.05
Services provided (continuum of services offered)	PBH: Routine Assessment Emergency Assessment Forensic Assessment Medical Services Outpatient Therapy Day treatment for kids	PBH: Routine Assessment Emergency Assessment Forensic Assessment Medical Services Outpatient Therapy Day treatment for kids Diagnostic Assessment Facility Based Crisis (12/06 Mobile Crisis (3/07) CPHS: All the same PBH Services but also Community support and Partial Hospital for adults Mobile crisis No facility based crisis or child day treatment
Utilization of services within the continuum: look at any changes in utilization	For 3 years utilization consistent for child and adult illnesses. Case support/ assertive outreach (non-billable) trended down since opening.	Slight increase in provision of medical services, decrease in SA services
Diagnostic Categories of Persons Served: ADHD Adjustment Disorders Anxiety Disorders	 615 641 1317 1204	 740 715 1278

Item	04-05	05-06*
Clinical Attention Conduct Disorders Mood Disorders Oppositional Defiant Schizo./other Psychotic Substance Related Total Served:	358 4198 570 1125 3752 16,310	812 344 4716 557 1086 3984 16,103
Org structure	Start up PBH prototype	Decrease in 1 FTE in management in every center.
Administrative supports (types of staff: records, QM, IS etc)	Start up PBH prototype	Same, slight increase in support for data entry during trial and error system of PBH information system
[redacted]Productivity Standard	56.25% direct service billable hours	56.25% direct service billable hours
Turnover rates among professionals	Not available specific to 04-05	Union and Cabarrus Center have turned over 100% since inception, others no less 40% and routine turnover is around 40% monthly
Satisfaction data	Consumer satisfaction is good to very good. Staff satisfaction is fair to not so good. Primary issues are salaries and benefit packages.	Same
Additional contracts- when added	None	CPHS- August 22, 2005 During this period, DRS decided against a contract with Neuse Center (Newbern NC) catchment area due fiscal concerns.

*2005 budget figures for DAYMARK are PBH specific; for 2006 they include both PBH and Centerpoint dollars.

4. Lessons Learned:

Major lessons learned include:

1. Having a written agreement in place prior to initially going "live" is mandatory. It establishes the roles and responsibilities of each entity to the people served and to each other, set the performance standards and establish the "rules of engagement".
2. The development of cash flow projections for each year of service for the first five years is critical to the success of the spin-off.
3. The "ownership" and direct control of a provider information system designed to support operations of enrollment, electronic medical records, client tracking, billing, accounts receivable, productivity management, as well performance data for real time management of consumer services and expected receipts was essential. The information

system plus the capability of the DAYMARK information systems department to *use* the data and turn it into information, has enabled DAYMARK to develop a data driven management strategy.

4. In addition, the ability of a spin off to meet State reporting and LME reporting requirements is a fundamental building block of such an arrangement because this upstream reporting is essential for LME accountability to the state. However, the spin-off needs to be able to collect its own information, produce reports to measure programmatic and fiscal outcomes and to enter into reconciliation discussions with the LME.
5. Waiver provisions are essential to developing a healthy spin off. The ability of PBH to set rates, allow providers to bill directly to the PBH LME, and for PBH to authorize care all facilitated the successful 501c3 spin off because PBH was able to customize and adjust its system in response to local conditions. PBH was able to manage its state funds flexibly in ways that ensured continuity of care for indigent populations.
6. The ability of PBH to control their local network under the 1915 b managed care waiver also allowed them to manage the size of their network in a way that allowed the development of other providers to ensure choice of community mental health providers (which was NOT available before the waiver), but also allowed PBH to manage the number of providers to allow its providers to have adequate market share. This further supported the viability of DAYMARK.
7. Mutual commitment to the project based on the realization by both PBH and DAYMARK that the stability of the community system of care depended on the viability of DAYMARK to continue to function as a Community Mental Health Center and Safety Net Provider. Additionally, PBH required its providers of community mental health services to see both Medicaid and indigent populations. A large percentage of DAYMARK clients are indigent.
8. Stability of leadership prior to the transition, during and post-implementation allows for the development of critical relationships through which to negotiate emerging issues. Specifically, the recent shift of the PBH-DAYMARK relationship from a capitated model to a FFS model relied heavily on the nature of those relationships, the presence of trust, and "good faith" that areas requiring further clarity, re-evaluation or enhancement could be effectively addressed at the table.
9. The waiver also allowed for creative systems redesign. The "Advanced Access" model developed between the 501c-3 spin off and the PBH LME is the centerpiece of this reform. The ability to allow walk-ins where core emergency services and medical services can be accessed 12 hours a day vs. the standard model of appointment for screening followed by calendar scheduling of subsequent appointments has been very successful in increasing penetration rates and diverting potential inpatient admissions. This function is highly integrated with the PBH LME's Access and Emergency response system, where tracking of consumers in need of crisis or urgent intervention is monitored.
10. The introduction of mobile crisis 24/7 services in March 2007 will be the second hallmark of this reform effort. Meeting people where they are, providing the necessary supports and helping them get started on a recovery journey are all within reach of this partnership. With the addition of Mobile Crisis Services, DAYMARK will have a full range of crisis supports that include: advanced access, daytime and evening emergency response to the local Hospital Emergency Departments, a 16 bed crisis facility, and an outreach Mobile Crisis team that will respond across the five counties. Again, this is highly integrated with the PBH LME's management of consumers in crisis.

4. Continuing Developmental Issues between DAYMARK and the PBH LME:

The recent shift to Fee for Service in October 2006 from a capitated model was motivated by the need for greater accountability. The shift underscored the need for the PBH LME to be fully prepared to change some operational functions to successfully move from a capitated model using shadow claims to a real-time reimbursement model based on authorizations. The authorization process required major modification to work effectively in the new FFS environment. Additionally, cash flow issues encountered by the other defunct safety net providers needed to be addressed in a timely manner using "rules of engagement" that facilitated rapid resolution of outstanding billing issues including how to bill psychiatrists' time, testing the authorization process before it went live, developing reimbursement strategies for prevention services, especially on the substance abuse side, and policies that simplified accessing categorical funding to serve persons in need.

The largest potential threat is that this move to a FFS system may create some of the same cash flow problems for DAYMARK experienced by the other spin offs early in their development. A recent DAYMARK audit report underscores the vulnerability to the same pitfalls experienced by previous 501c3s as part of the North Carolina reform effort. Claims denials, COB issues and reconciliation between claims and authorizations require immediate attention.

A review of the authorization protocols by a local Clinical Advisory Committee chaired by the LME Medical Director and including the clinical director from DAYMARK is recommended as an immediate next step. A major problem with the current authorization system is that a large number of the treatment plans are developed by an entity other than DAYMARK. This is an issue that must be addressed immediately if the move to FFS is to be successful. Obtaining the necessary signatures, negotiating what is in the best interest of the client in terms of treatment alternatives is currently completed by non-clinical staff (under the NC Community Support Service). Claims denials and authorization issues are often a result of this complex process. The recommendation is to simplify this as much as possible as quickly as possible.

The PBH LME is encouraged to exercise its rate setting authority to correct any rates that are not aligned with unit cost-both direct and indirect costs. Rate setting must be sensitive to market value; it is also a major means of addressing high turnover rates and the ripple effect of continuously training new staff etc.

Another major recommendation for the LME is to begin to monitor DAYMARK's Medical Loss Ratios (MLR) on at least a monthly basis. Based on the numbers in the table above, the MLR for DAYMARK is above 1, signaling a need for serious concern about DAYMARK's fiscal stability as noted in their recent audit. A Medical Loss Ratio consists of two calculations: actual cost of clinical services for a given time frame + administrative costs. Given the deficit reported above, DRS clinical costs currently approximate over 90% of the budget with administrative expenses averaging about 10%, creating a >1 MLR. A reasonable goal for DRS and the LME to work toward together would be a clinical spend of around 82-85% of the budget, maintenance of administrative spend at or below 10% and revenue over expenses of 5-8%.
The revenue over expense represents the dollars available for reinvestment in the continuum of services to accomplish two goals: higher penetration of population served at reduced cost. Right now, given the deficit, the high turnover rates, and the inability to bill community support, the ability to focus on reinvestment strategies is elusive.

The conversion from a capitated reimbursement model to a FFS reimbursement system for DAYMARK is a major undertaking. A major lesson learned by PBH and its safety net provider,

DAYMARK, is that it would have been advisable to run both systems in parallel for a period of time rather than "throwing the switch" as part of the conversion.

A final recommendation for consideration is the examination of achieving some economies of scale between Piedmont Behavioral Health and Centerpoint LMEs in their current contracting with DAYMARK. One area that appears ripe for such discussion is the sharing of psychiatric resources via telemedicine. The three entities are encouraged to explore possible synergies in this area.

5. New Vision for the Service Model for a Community Mental Health Center

A major service design innovation developed by the LME and its spin off DAYMARK Recovery Services is the Advanced Access model. The availability of walk-in appointments from 8 a.m. to 8 p.m. daily to address crisis and emergent situations addresses many of the issues that have plagued service delivery systems for years. The characteristics of populations served in communities tend not to lend themselves to an appointment only service model. Clients often have transportation issues, inability to take time off from a job during the day, child care issues etc. that make appointment keeping a challenge at best. The Advanced Access model as described above is a major innovation in moving toward providing services at the right time in the right dose, avoiding many of the pitfalls of more traditional treatment models.

As a result of information derived from this analysis of DAYMARK and the PBH system of care at large, PBH is planning a Community Mental Healthcare model that integrates clinical and support services into one cohesive team through its model for Comprehensive Community Providers (CCP's). PBH has four CCP providers, however DAYMARK is the largest of these by far. The clinical model envisioned includes changes in the array of services so that both clinical and support services will be provided by the CCP. Clinical accountability will be assigned to the CCPs that includes outcomes such as hospital utilization, and life outcomes such as housing, employment, etc. CCP responsibilities will include first responder role, development and monitoring of the person centered plan, and collaboration with other PBH Network Providers. See the chapter: *Network Design of the PBH 2007 Local Business Plan* for details on this model.

DAYMARK Recovery Services, Inc. and PBH are to be credited with excellent planning and foresight in using the managed care opportunity to restructure basic service delivery models. The addition of 24/7 mobile services in March, 2007 will increase their responsiveness and contribute to reductions in the use of high end services such as inpatient use and emergency room visits.

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Attachment I:	**LME 501c-3 Spin Off Comparison Chart.** Illustrates the flexibility available to PBH in its support of DAYMARK Recovery Services due to its waivered status, as well as differences in PBH planning and support activities, and the positive impact of leadership stability.
Attachment II:	**Minutes from Information Systems Planning Meeting.** Illustrates the level of detail involved in collaborative planning and ongoing monitoring of the DAYMARK start up.
Attachment III:	**Advanced Access Data.** First month of activities following the initiation of Advanced Access at DAYMARK Recovery Services, Inc.
Attachment IV:	**Productivity Comparison of Spin Off and old public Community Mental Health Center model**. Three years of actual productivity data compared to public centers. Although during the last year of operations of the PBH mental health centers, there was a great deal of staff turnover that was reflected in productivity; DAYMARK has also been impacted by high turnover rates for licensed therapists.