*EXPERIMENTS IN A COMMUNITY MENTAL HEALTH
CENTER: INCREASING CLIENT PAYMENTS
FOR OUTPATIENT SERVICES*

GERALD T. HANNAH AND TODD R. RISLEY

KANSAS MENTAL HEALTH & RETARDATION SERVICES AND
UNIVERSITY OF KANSAS

Although public health care systems often depend on revenue generated from client payment for services, inadequate agency fee payment systems continue to create substantial administrative problems. The first study examined the effects of implementing a system for producing and maintaining routine client fee payment. The second study was a replication of the first study. The Credit Criterion System was designed to: (a) allow clients to establish intra-agency credit by paying cash for each of the first three visits; and (b) pay for services monthly after credit was established. The system resulted in a baseline collection rate of 20%, compared with the Credit Criterion rate of 96.6%. The Credit Criterion System did not create additional administrative costs and it had no effect on attendance. Thus, the Credit Criterion System appears to be a reasonable set of procedures for allowing clients to meet their financial obligations to an agency.

DESCRIPTORS: administration, community mental health, consumer satisfaction, replication, reliability

During the past few years community mental health centers have been confronted with several complex issues, such as: (a) the accountability of services; (b) the protection of client rights; (c) the de-institutionalization of the chronically mentally ill; and (d) the adequate funding of programs. Public health care systems are maintained to provide services that enhance the social and physical functioning of individuals. Such systems, including community

mental health centers, are typically financed by federal, state, and local governmental funding, and to some extent by fees received from service recipients. However, in recent years, erratic accessibility of federal and state funds has produced program and planning problems for community mental health centers.

Federal funding policies for mental health have changed over the past three decades. Between 1945 and 1961, the thrust of federal policy was toward broad-based financing of research, training, and demonstration programs for direct services in mental health institutions. But in 1963, with the passage of Public Law 88-164 (Mental Health Centers Construction Act), federal policy began to focus on community-based service delivery. This piece of legislation provided the financial incentives for states and communities to develop local community mental health centers. Since then, mental health has become a \$17 billion business (Cooper, 1979). The National Institute of Mental Health (NIMH), between 1963 and 1978, spent over

The Authors express their appreciation to Pat McNees, Tom Sajwaj, Michelle Domash, Steve Roth, Jovi Larson, John Pierce, Terry Curley, and Jack Delaney for their assistance and cooperation in the conduct of these studies. This paper is based in part on a dissertation submitted by the senior author in partial fulfillment of the Ph.D. degree in the Department of Human Development and Family Life at the University of Kansas. We thank the members of the doctoral committee, Montrose M. Wolf, Stephanie B. Stolz, Stephen B. Fawcett, and David G. Born for their valuable assistance and advice. Reprints may be obtained from Gerald T. Hannah, Ph.D., Commissioner, Mental Health and Retardation Services, State Office Building, Topeka, Kansas 66612.

\$1 billion to fund 603 community mental health centers (Weiner, Woy, Sharfstein, & Bass, 1979). However, such heavy reliance on federal and state funds has caused both positive and negative consequences for community mental health centers. Also during this period, the federal government established third-party entitlement reimbursement programs (Title XIX, Title XX, etc.) for providing services to low income individuals. These funds are awarded to community mental health centers as a fee for service and are paid jointly by the federal (66⅔%) and state (33⅓%) governments (Silber, 1974).

Funding policies of the federal government also require state mental health authorities to approve a community mental health center's initial request for funds and expect them to cooperate in financially assisting the community mental health centers thereafter. Consequently, state government funds account for over \$6 billion of services to the mentally ill. In 5 years, from 1971 to 1976, the state's funding share increased from 29% to 40% (Weiner et al., 1979).

The federal government's support for community mental health centers is in the form of an 8-year grant. The funding for nonpoverty centers during this period is based on a declining formula, which is 80% the first year, 65% the second year, 40% the third and fourth years, 35% for the fifth and sixth years, and finally 25% for the seventh and eighth years (Weiner et al., 1979). Each year as federal funds decline, the state government is encouraged to help replace the loss of federal funds.

Community mental health centers have a difficult time in anticipating how much, when, or even if, the state will pick up the difference of the funds that have faded out. Thus, the declining formula of funding causes program instability. Due to federal and state funding uncertainties, community mental health centers are faced with the difficult problem of securing necessary funds to year service demands (Chu & Trotter, 1974; Lohman, 1976). Because community mental health centers have little control over state and federal funding (Harvey, 1973),

their major efforts should be directed toward developing funding systems that are more under direct agency control. A funding source over which most community mental health centers have control is fees paid for services.

In 1963, President Kennedy (*Congressional Record*, 1963) outlined a financial approach for community mental health centers that precluded the denial of services to clients due to an inability to pay, but it also suggested that clients who were able to afford services be charged on their individual ability for payment. The collection of client fees from a community mental health center accounts for approximately 20% (Weiner et al., 1979) of the total funding available for community mental health centers, with a projected goal to be approximately 35% (Mazade, Note 1).

Although the importance of using reliable fee for service collection systems is becoming increasingly obvious, the *Joint Commission on Mental Health and Mental Illness: Report to Congress* (1974), cited numerous agency inadequacies in this area, including: (a) long billing time lags, (b) absence of explicit billing and collection systems, and (c) failures to bill insurance companies due to inadequate records. Mazade, Surles, and Akin (1976) stated that poor eligibility determination, inadequate records, and sloppy accounts often prevent collection of payments. Pope, Geller, and Wilkenson (1975) point out that systematic research on fee payment is almost nonexistent.

If client needs and community mental health center fiscal responsibilities are to be met, it would appear that reasonable fee collection procedures must be developed and validated. The present studies examine the effects of implementing a system for producing and maintaining the routine payment of fees by clients by developing a fee collection system in which clients are required to pay cash for the first three office visits, with the option, in subsequent visits, either to continue paying cash or to pay 50% of the monthly balance until the balance has been paid. The first study was conducted in a com-

munity mental health center in which the first author was the executive director. The second study was replicated in two mental health centers in which the business office staff was trained to implement the fee collection system.

STUDY 1 METHOD

Setting and Participants

The study was conducted in a community mental health center located in middle Tennessee. The center provides community mental health services and various nonclinical community services. The center, with an approximate annual budget of \$600,000, serves an urban catchment area with a population of approximately 100,000. The facility in which the study was conducted contained outpatient services and administrative offices.

The participants of the study were 150 new clients requesting clinical outpatient services, such as individual therapy, marriage counseling, and chemotherapy. The average client was a 28-yr-old white female, married, with 2.1 dependents, and an annual income of \$7,800. Persons were included as participants only if they were classified by the business office as being responsible for paying their own fees. Indigent and third-party paying clients (Medicaid, Medicare, and private insurance) were not included as participants. Client fees, determined by family income, were \$.50-\$50 per visit.

Measurement System

Clients' billing cards were used to gather weekly data for: (a) the percentage of cash paid visits for the first three office visits; (b) the amount of fees charged and collected in cash for the first three office visits; and (c) the percentage of paid visits for fourth visit and subsequent visits.

A fourth measure was client attendance for second and third office appointments. Attendance was determined from the center's client appointment book. The receptionist recorded the letters K (kept), DNS (did not show), or C (cancelled)

for each client listed in the appointment book at the time of the client's appointment.

The fifth measure was derived from a telephone survey which was conducted to detect client's reaction to the Credit Criterion System. The survey was conducted after the client terminated from the center. An administrative staff member randomly called 17 clients who were included in the Credit Criterion System. Each client was asked to answer one question, with a yes or no answer: "Did you feel the policy for paying your fee to be fair?"

The billing cards and appointment book data were routinely recorded by the center's staff. Reliability was assessed in each phase of the study of a second recorder who randomly checked the data recorded from the billing cards and appointment book by the first recorder. Reliability was calculated by dividing the total number of agreements by the total number of agreements plus disagreements and multiplying by 100. The second recorder made a total of 15 checks of the billing cards and had 15 agreements and no disagreements. Reliability for recording fee charge, fee paid, fee not paid, was 100%. The second recorder made 10 checks of the appointment book and had 10 agreements and zero disagreements. Reliability for recording client attendance was 100%. During the telephone survey, the second recorder jointly called with the first recorder five clients who had answered the telephone survey. The recorders had five agreements of the client's responses and no disagreements. Thus, reliability was 100%.

Procedure

A reversal design (Baer, Wolf, & Risley, 1968) was used to evaluate the effects of the procedure. The four phases were: (a) an 8-week baseline phase; (b) a 4-week intervention phase (Credit Criterion System); (c) a return to baseline phase for a 4-week period; and (d) a return to intervention phase for a 4-week period. When a client was started on baseline or Credit Criterion procedures, he or she remained on those procedures throughout the study. Thus, the

phases of the study refer to procedures used with *new clients* during these periods of time.

Baseline

After the first clinical appointment, the business office personnel interviewed each new client to gather financial background information. This information was used to determine the source of fee payment: (a) the client; (b) private insurance company; (c) Medicaid or Medicare; or (d) no source (indigent clients received free services). Also, the business office personnel established an hourly fee rate for each client based on the family's annual income and number of dependents living in the same household.

Business office personnel were responsible for collecting client fees. After each session, therapists instructed clients to take the Service Rendered Form, i.e., a form listing the outpatient service rendered at the visit and the amount of time for the visit, to the business office. The business office staff collected these forms, calculated the client's fee for that visit and recorded it on the client's billing card. If the client immediately paid the fee, it was recorded on the billing card. If the client did not pay the fee, the business office personnel mailed a monthly bill to the client.

Credit Criterion

The Credit Criterion System contained two distinct sets of procedures. The first set of procedures was used for the first three visits. Upon arriving for the first office visit, a new client was given two written policy statements, signed by the Executive Director and the Financial Manager, that described the center's billing policy. Basically, this policy stated that clients could establish center credit by paying cash for each of the first three visits at the time of each visit. At the end of the initial appointment, when the client's fee was being calculated, a business office staff member explained the billing policy and made reference to the written policy statements. Finally, after each visit the client was asked to pay the fee.

Clients who failed to pay at the end of the first visit were given a self-addressed envelope and asked to mail the fee before their next appointment. If the client failed to pay after the second visit, a conference with the business office personnel was held to work out any problems that might be preventing the client from paying the fee. If the client failed to pay for the third visit, the client had a conference with the financial manager. The client had to pay some portion of the fee before another appointment was issued. If the client needed emergency treatment, services were rendered, regardless of the extent of payment.

For clients who paid cash for the first three visits, a second set of procedures was followed for the fourth and subsequent visits. Clients were informed: (a) they could receive a monthly bill or continue paying cash for each visit; (b) at least 50% of the monthly bill should be paid each month; (c) the balance of their bill should be paid in full within 3 months after termination; (d) if unforeseen financial difficulties arose, they should contact the business office to arrange a realistic payment plan; and (e) if they did not meet their financial responsibilities, the matter could be referred to the center's attorney for resolution.

Assessment of Procedures

Reliability was determined by two unobtrusive observers independently monitoring the procedures in baseline and Credit Criterion. Reliability was calculated by dividing the total number of agreements by the total number of agreements plus disagreements and multiplying by 100. On 10 occasions in baseline, the two observers monitored the business office to determine if verbal prompts for payment of fees were given. The observers agreed eight times and disagreed two times that verbal prompting did not occur. Reliability was 80%. The two observers on seven occasions recorded whether or not the receptionist actually gave new clients the policy statement. The observers agreed seven times and had no disagreements; thus, reliability

FIGURE 1

Fig. 1. Percentage of cash paid visits for first three office visits.

was 100%. On 10 occasions during the Credit Criterion phases, the observers monitored the extent of the business office staff verbally prompting the client to pay the fee. The observers agreed 10 times and had no disagreements. Reliability was 100%.

RESULTS

Figure 1 presents the percentage of cash paid visits for new clients' first three office visits over the four conditions. During the baseline periods, the percentage of cash paid visits for their first three office visits averaged 21.8% and 33%. When the Credit Criterion System was employed, the percentage of cash paid visits for the first three office visits increased to an average of 92% and 86.5%.

Figure 2 is a cumulative representation of cash collected (solid lines) and the total collec-

tions that were possible (broken lines) for the first three office visits. During the Credit Criterion System, 97% was collected (\$804.25 of the total \$827.00 charged), whereas during the baseline conditions, only 46.6% was collected (\$558.75 of the total \$1,189.75 charged). Thus, the Credit Criterion System resulted both in more income and in a higher proportion of money collected than during baseline periods.

Figure 3 illustrates the continued increase of fee payment during the Credit Criterion System after the third visit. For the clients in the Credit Criterion System, the average paid visits was 90%, and the average for baseline clients was 44%.

The clients who were in the Credit Criterion System had an average of 97% attendance for second and third office visits and the clients in the baseline condition had an average of 95%.

FIGURE 2

Fig. 2. Cumulative representation of cash collected and charged for the first three office visits.

Thus, the percentage of client's attendance for second and third office visits indicated no significant difference as a function of the Credit Criterion System.

The telephone survey indicated that 100% of the eight clients contacted reported that the Credit Criterion policy was fair. Of the clients called, 53% of the clients randomly chosen could not be reached due to change of address, disconnected telephone service, or client did not answer after three morning and evening telephone calls.

Although one of the Credit Criterion procedures described the withholding of service for nonpayment after the first three visits, no clients were denied services. Two clients were granted services despite the failure to pay for

one of their first three office visits because of potential suicide behavior. Also, one procedure described the center's attorney contacting clients who did not pay their fees; no client failed to pay their fee without making adequate arrangements beforehand.

DISCUSSION

The study demonstrated that the Credit Criterion System increased the amount and proportion of money collected but attendance in the first three visits were unaffected. The credit system not only was effective in increasing the collection of cash, but at termination of services the results from the sampling groups indicated that 90% of clients owed the center no money. The remaining 10% owed an average of \$4.25

FIGURE 3

Fig. 3. Percentage of client payment for fourth and subsequent office visits.

per client. However, only 25% of the baseline clients had a zero balance, and the remaining 75% had a balance of approximately \$10.25 per client. The Credit Criterion System could be evaluated without disrupting the normal routines of the center because the data collected were routinely recorded as a function of the center's daily operating procedures.

STUDY 2

METHOD

Settings and Participants

The study was conducted in the outpatient and administrative facilities of two separate comprehensive community mental health centers located in the western (Center A) and eastern (Center B) sections of Vermont. Both cen-

ters provide mental health, mental retardation, and alcohol/drug services. The centers' staff have undergraduate and advanced degrees. The outpatient services could be described as being of eclectic orientation with varied therapy techniques. Center A has an annual budget of \$1.5 million and is located in an urban community. Center B has an annual budget of \$1.1 million and is located in a rural area. The centers' budgets include both mental retardation and residential services.

The participants were clients receiving outpatient services (adult, alcohol, aftercare, marriage/family, children/youth). Ages of the clients ranged from 14 to 55 years. The average annual income of the participants was \$5,639. There were a total of 325 participants. Persons were included only if they were responsible for

paying their own fees. Thus, indigent and third-party paying clients (Medicaid, Medicare, and private insurance) were not included in the study. Fees were determined by family income.

Measurement

Clients' billing cards were used to gather weekly data for: (a) the percentage of cash paid visits for the first three office visits; (b) the amount of fees charged and collected in cash for the first three office visits; (c) the percentage of paid visits for four through twelve visits; and (d) the amounts of fees charged and collected for visits four through twelve.

Client attendance for the first through the twelfth visit by cohort groups were measured. Attendance was determined from the center's client appointment book at Center A and the therapist's time ticket at Center B (the center did not use a centralized client appointment book). In addition, total intake appointments were recorded for each center covering the period July 1978 through July 1979. These data were gathered from the State Department of Mental Health's computer service.

The eighth measure was consumer feedback derived from a telephone survey of the clients' reactions to the Credit Criterion System. Clients who were included in the Credit Criterion System in Center A were asked permission to call for the purpose of asking if they felt the system was fair. From this group, clients were randomly called after termination from the centers. In Center B, clients in Credit Criterion were called randomly upon termination and were asked the same question regarding the fee payment process as being fair. Clients were not asked permission because the administrative staff felt such a procedure required "too much paperwork." In addition, consumer feedback was conducted randomly with clients not included in the study to see if they felt the fee payment policy was fair. The center is located in the middle section of the state. The center has an annual budget of \$1.6 million. The center's fee collection system is similar to the procedures

described in baseline; that is, the center has no formal procedure for collecting fees except a monthly statement. According to the Vermont Department of Budget and Management, this center's annual client fee (as defined in the study) collection rate was 4% in 1977, and 6% in 1978 (Rollins, Note 2). Baseline data were not be collected.

The data collected from the billing cards, client appointment book, and therapist's time tickets were routinely recorded as a function of the center's daily operating procedures. In each weekly group, reliability was assessed for the recording of the data from the billing cards, appointment book, and therapist's tickets. A second recorder randomly checked the data recorded by the first recorder. Reliability was calculated by dividing the total number of agreements by the total number of agreements plus disagreements and multiplying by 100. The second recorder made a total of 998 checks of the appointment book, therapist's tickets, and billing cards and had 996 agreements and 2 disagreements. Thus, the reliability for recording client appointment data was 99.7%. The second recorder made 1,128 checks of the billing cards and had 1,117 agreements and 11 disagreements. Reliability for recording fee charge, fee paid, and fee not paid was 99%. Reliability was conducted on approximately 30% of total data recorded. The first recorder was informed that his recording would be checked for reliability with the purpose of being more accurate (Kazdin, 1977; Reid, 1970; Taplin & Reid, 1973).

The telephone interviewer in Center A was given three false sets of consumer feedback forms corresponding to "confederates" who were unknown to the interviewer. The reliability of the response recording procedure was calculated by comparing the telephone interviewer's recordings of the confederate's response to the confederate's response. The telephone interviewer knew of the possibility of these reliability checks, but did not know when such checks would take place. Schnelle, Gendrich, McNees, and Hannah

(1979) explained this procedure as a way to avoid the threat to the client that would result if two people continually monitored responses of actual interviews with the telephone interviewer. Results of the three checks showed 100% agreement between the telephone interviewer and the confederate with regard to consumer feedback data. The interviewer in Center B was not checked for reliability because the author did not have access to citizens to serve as confederates.

Procedure

A multiple baseline design (Baer, Wolf, & Risley, 1968) across centers was used to evaluate the effects of the Credit Criterion System which was applied only to new outpatient clients. The baseline phase in Center A continued for 8 weeks and Credit Criterion phase continued for 15 weeks. In Center B, baseline phase occurred for 19 weeks and the Credit Criterion phase occurred for 4 weeks. When a client started on baseline or Credit Criterion procedure, he or she remained on those procedures throughout the study.

Baseline

During the first appointment, a business office staff member in Center A and the client's therapist in Center B interviewed each client to gather financial background information. This information was used to determine the source for fee payment: (a) client; (b) private insurance company; (c) Medicaid or Medicare; or (d) no financial source. Also, the business office personnel or therapist established an hourly fee rate for each client based on the family's annual income and number of dependents living in the same household.

Business office personnel in both centers were responsible for collecting client fees. After each therapy session, clients were not given instructions to pay their fees. The business office staff calculated the client's fee from the therapist's daily time ticket. The ticket listed to client's name, the type of service rendered, and the

amount of time for the visit. The ticket was forwarded to the business office at the end of the day, week, or month. The information from the ticket was used to post the client's billing card for mailing the client's monthly bill. However, if the client immediately paid the fee after the session, it was recorded on the billing card.

Credit Criterion

The Credit Criterion System contained two distinct sets of procedures. The first set of procedures was used for the first three visits. Upon arriving for the first office visit, a new client was given a written policy statement, signed by the Executive Director, that described the center's billing policy. Basically, this policy stated that clients could establish center credit by paying cash for the first three office visits at the time of each visit. At the end of the initial appointment, when the client's fee was being calculated, a business office staff member explained the billing policy and made reference to the written policy statements. Finally, after each visit, the client was asked to pay the fee.

Clients who failed to pay at the end of the first visit were given a self-addressed envelope and asked to mail the fee before the next appointment. If the client failed to pay after the second visit, a conference with the business office personnel was held to work out any problems that might be preventing the client from paying the fee. If the client failed to pay for the third visit, the client had a conference with the financial manager. The client had to pay some portion of the fee before another appointment was issued. If the client needed emergency treatment, services were rendered, regardless of the extent of payment.

For clients who paid cash for the first three visits, a second set of procedures were followed for the fourth and subsequent visits. They were informed: (a) they could receive a monthly bill or continue paying cash for each visit; (b) at least 50% of the monthly bill should be paid each month; (c) the balance of the bill should be paid in full within three months after termi-

nation; (d) if unforeseen financial difficulties arose, they should contact the business office to arrange a realistic payment plan; and (e) if they did not meet their financial responsibilities, the matter could be referred to the center's attorney for resolution.

Assessment of Procedures

To determine observer reliability and the effectiveness of the Credit Criterion System, two observers monitored unobtrusively the procedures in baseline and Credit Criterion. Reliability was calculated by dividing the total number of agreements by the total number of agreements plus disagreements and multiplying by 100. The observers on 10 occasions during the Credit Criterion phase recorded if the business office staff verbally prompted the client to pay the fee. The observers agreed 10 times and had no disagreements that verbal prompting occurred. The

reliability was 100%. The two observers on six occasions observed if the receptionist actually gave new clients in the Credit Criterion phase the policy statement. The observers agreed on all six observations that the receptionist gave a new client the policy statement; thus, the reliability was 100%. During baseline, the observers on five occasions monitored the business office to determine if any form of verbal prompts were given. The reliability that verbal prompting did not occur was 100%.

RESULTS

Figure 4 shows the percentage of cash paid visits for clients' first three office visits during the baseline and Credit Criterion conditions across the two centers. During the baseline periods, the percentage of cash paid visits for Center A averaged 14% and Center B averaged 10%. The percentage of cash paid visits in the

Fig. 4. Percentage of cash paid visits for clients first three office visits.

FIGURE 5

Fig. 5. Percentage of paid visits for clients' fourth through twelfth visit.

Credit Criterion System increased in Center A to an average of 95% and in Center B to an average of 90%.

Figure 5 presents the percentage of paid visits for clients' fourth through twelfth visit during the baseline and Credit Criterion System for both centers. The percent paid during the baseline periods for Center A was an average of 14% whereas Center B had an average of 27%. During the Credit Criterion System, the average percent paid in Center A was 78% and in Center B was 74%.

Figures 6 and 7 are in a cumulative representation of fee collected (solid lines) and fee charged (broken lines) for the first three office visits as shown in Figure 7. In Figure 6, the Credit Criterion System in Center A collected 97% (\$3,071) of the total \$3,168 charged during the first three office visits. During the baseline period of Center A, only 23% was col-

lected (\$507) of the total \$2,206 charged. In Center B, the Credit Criterion System collected 95% (\$768) of the total \$805 charged; whereas during the baseline condition, only 22% was collected (\$1,060) of the total \$4,833 charged. In Figure 7, the Credit Criterion System in Center A during the fourth through twelfth office visit collected 99% (\$4,183) of the total \$4,244 charged and Center B collected 97% (\$1,241) of the total \$1,278 charged. During the baseline periods, Center A collected 14% (\$432) of the total \$3,191 charged and Center B collected 36% (\$2,562) of the total \$7,216 charged. Thus, the Credit Criterion System resulted in a higher proportion of money collected than during baseline periods.

Figure 8 shows the percentage of client's office visits through the twelfth visit for Center A, and Center B is shown in Figure 9. Figure 8 and Figure 9 indicate that the Credit Criterion

Fig. 6. Cumulative representation of fee collected and charged for first three office visits.

clients did not have a negative attitude toward the Credit Criterion procedures. Their percentage of office visits through the "cash paying visits" (visits 1-3) averaged 98% in Center A and averaged 97.6% in Center B, whereas the baseline clients averaged 90.6% in Center A and averaged 92% in Center B. It appears the Credit Criterion clients continue to support the fee payment procedures in visits 4, 5, 6, and 7, which requires at least 50% of the balance. In Center A, Credit Criterion clients' average attendance was 82.7% and Center B was 78.2%, compared with baseline clients in Center A of 50% and Center B of 59.7%.

Figure 10 shows the total monthly intake appointments during the baseline and Credit Criterion System for both centers. In Center A, the Credit Criterion System average monthly in-

take appointments were 93 compared with a baseline of 94. In Center B, the average monthly intake during the Credit Criterion System was 57.2 compared with a baseline of 49.9 per month.

The telephone survey indicated in Center A that 94% of the 16 clients contacted reported that the Credit Criterion policy was fair. In Center B, the survey indicated that 100% of the six clients called felt that the Credit Criterion was fair. The survey with five non-Credit Criterion clients indicated that 100% felt that the center's fee payment policy was fair.

Although one of the Credit Criterion procedures described the withholding of service for nonpayment after the first three visits, no clients were denied services. Also, one procedure described the center's attorney contacting clients

FIGURE 7

Fig. 7. Cumulative representation of fee collected and charged for visits four through twelve.

who did not pay their fees; no client failed to pay their fee without making adequate arrangements beforehand.

DISCUSSION

The results of the study demonstrate that community mental health centers can implement the Credit Criterion System successfully without inhibiting client attendance. Both mental health centers increased the amount and proportion of money collected from their clients. In addition, the Credit Criterion clients continued to support the fee payment procedures beyond the third visit and maintained a higher average attendance than the baseline clients through the eighth visit in Center B, and the tenth visit in Center A. Credit Criterion clients who require more than approximately nine visits have lower average attendance than non-

criterion clients with more than approximately nine visits. These phenomena could have resulted because clients that take their payment of fees seriously tend to require fewer appointments than other clients and terminate successfully (Andre, Kane, & Meyer, 1978).

GENERAL DISCUSSION

The two studies illustrate the positive effects of implementing a system for producing and maintaining the routine payment of fees by clients receiving services from community mental health centers. In all three centers, the percentage of cash paid visits and proportion of money collected increased during the Credit Criterion System. For example, during the Credit Criterion System, the three centers charged \$11,348 and collected \$10,964, resulting in a

FIGURE 8

Fig. 8. Percentage of clients' office visits through the twelfth visit for Center A.

collection rate of 96.6% as compared with the baseline collection rate of 20%.

There were no additional administrative costs for implementing the Credit Criterion System. In each center, regular administrative staff were used, such as billing clerks and receptionists. It is important that at least one member of the business office be designated to prompt and collect the client's fee. In a small center where there is only one business office staff member, one additional staff member could be hired at approximately \$8,500 per year, to prompt and collect fees, establish fee rates, and prepare monthly billing for all cash paying clients while the other staff member concentrates on the preparation of third-party and private insurance billing. In addition to regular administrative staff,

the success of the Credit Criterion System is contingent upon: (a) an up-to-date, adequate sliding fee scale; (b) an explicit billing record system; and (c) immediate completion of a service rendered form by clinical staff after each visit.

Future financial stability for community mental health centers is dependent on the collection of patient fees and third-party funds. For example, if all 10 mental health centers in the State of Vermont used the Credit Criterion System, it would not be unreasonable to expect the 20% collection ration of fiscal year 1978 to increase at least to 70%. As a result, collection of approximately \$500,000 in 1978 would represent \$1.75 million in patient fee revenue by the 10 centers. Patient fees and third-party funding sources would continue to increase at a faster

FIGURE 9

Fig. 9. Percentage of clients' office visits through the twelfth visit for Center B.

rate than other community mental health funds, such as federal funds that reached a peak in fiscal year 1977 and have since declined, and state funds that are projected to rise moderately in fiscal years 1980 and 1981.

Most mental health staff see themselves adhering to a public service image instead of that of a private, nonprofit organization. Although the public service identification is important, it has invariably caused the public and community mental health staff to feel that services must always be free. In the future, financial viability for community mental health centers will rely on their recognition that policies regarding client fee collection should be re-examined.

The studies demonstrate the effectiveness of the procedures for increasing client fee collections in various cultural settings and with different staff sizes. The consumer feedback data suggest that clients feel the fee payment policy was fair and acceptable. The client attendance data indicate the system did not inhibit attendance. The Credit Criterion System is cost efficient to implement and appears to benefit the collection of noncash billing clients.

In light of the fact that federal and state funds for community mental health centers are becoming more unstable and more unreliable, further research should be aimed at developing another funding package for dissemination of a nongovernmental funding system.

FIGURE 10

Fig. 10. Total monthly intake appointments for Center A and Center B.

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Received February 16, 1978

Final acceptance September 16, 1980