Using the Value of Care Equation to Improve Quality – *Why We Measure – GAP/SDA*

Scott Lloyd, President of MTM Services

Senior National Council Consultant & Chief SPQM Data Consultant

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GAP Analysis/SDA – *Why We Measure*

Scott Lloyd

President of MTM Services, Lead SPQM Data Consultant and Senior National Council for Mental Wellbeing Consultant

- 10 years in a private-for-profit industry
- 24 years in the CBHO, CSB, CCBHC environment *(Since 1998)* working with an amazing team of consultants
- Has worked with more than 1,000 organizations in 48 states, Washington, DC, and 2 foreign countries in all service disciplines
- Author or Co/Author of Books on the use of data and costing.
- The data in this presentation is tied to that experience working to help teams make substantive change every day

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Experience –

Improving Quality in the Face of Healthcare Reform

"Working to help organizations deliver the highest quality care possible, while improving the quality of life for those delivering the care!"

- MTM Services' has delivered consultation to over 1,000 providers (MH/SA/DD/Residential) in 49 states, Washington, DC, and 2 foreign countries since 1995.

- **MTM Services' Access Redesign Experience** *(Excluding individual clients)*:
  - 5 National Council Funded Access Redesign grants with 200 organizations across 25 states
  - 10 Statewide efforts with 216 organizations
  - Over 9,000 individualized flow charts created

- Leading CCBHC Set up and/or TA efforts in 5 states

Consultation Team

Scott Lloyd
President

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Jodie Giboney
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David Lloyd
Founder

Jennifer Senechal
Financial Controller / Cost and Revenue Consultant

What Does Access Actually Mean!?

Your Questions…

	Questions
1.	Our initial evaluation time is 3 hours between paperwork and meeting with assessor. is that normal?
2.	How to make this work with the same amount of staff while keeping productivity the same/high.
3.	How can we incorporate mobile crisis services
4.	How to integrate this into a clinic logistically.
5.	Transitioning from historical scheduling to SDA. Realistic process and timeframe; strategies and process. Thanks.
6.	Since I work at a Community Partner organization, I'm interested in how CPs/similar orgs are partnering with CBHCs.
7.	How are clinics collecting vitals for section H, with so many telehealth visits?
8.	Do you leave certain slots open for same day access?
9.	How do other centers successfully provide this model?
10.	How this will impact daily staff processes.
11.	Accessibility Standards
12.	How do you prioritize same day clients with scheduled clients?
13.	What is the biggest obstacle that others have had to overcome when implementing SDA
14.	What standardized access and enrollment criteria is being used to enroll individuals in a CCBHC?
15.	How you are able to meet the access need in a timely manner?
16.	Strategies for SDA
17.	How can a chronically understaffed agency meet the growing caseload requirements with SDA?
18.	About same day access
19.	How to do this during workforce shortages. How does this connect to pre screening.
20.	By what % does SDA reduce unproductive provider time?
21.	Implementation
22.	Details related to staffing and process change from a current schedule based model
23.	interested in learning more about same day access
24.	How much time to give to SDA- for completion of interview? ideas for managing flood/flow post assess if no staff/shortage?
25.	How rural CMHs can provide these services.
26.	How to navigate insurance and documentation challenges for same day care if the client is not an established client
27.	How can companies eliminate the loss of ROI from lack of consumers?
28.	I am curious about referring coaching clients to CCBHCs, so my questions are more about helping CCBHCs have more availability
29.	Effective planning for no-shows
30.	How are same day services different than crisis services.
31.	how do you build the culture that supports this?
32.	Needs Assessment
33.	How to ensure staff remain productive while providing same day access.
34.	What is the national range for PPS 1 rates?
35.	Sustainability of services provided within CCBHC scope
36.	How to effectively staff same day access.?
37.	How can we help commercial insurance providers access SDA for their members?
38.	Ways to implement SDA while staffing appropriately. Has this been done with the pediatric population?
39.	How are CCBHC different from other models?
40.	Considerations of a rural environment across a large geographic area.
41.	How can non-profits focused on mental health advocate for and promote Same Day Access? What does that advocacy look like?
42.	I would like to know processes to become a CCBHC
43.	How to implement the CCBHC model into my programs?
44.	Staffing recommendations
45.	Messaging to Clinicians around SDA
46.	Is there a site where all aspects for CCBHC providers is located?
47.	Benefits of becoming CCBHC, how agencies handle the same day walk in service while maintaining productivity levels for providers
48.	Access - also staffing is a huge issue for us
49.	What are some positive strategies to help in improving SDA?
50.	assisting clients, providers and staff with transitioning to SDA
51.	Staffing impact for SDA
52.	Scheduling logistic ideas
53.	How to provide same day care.
54.	Assisting access
55.	What is the biggest barrier to this being implemented?
56.	Process for becoming ccbhc and benefits.
57.	We are doing SDA in a multi county agency, issues with walk ins/staffing
58.	balancing access with clinical productivity
59.	How this impacts my role as a supervisor for intake clinicians
60.	how others manage same day access when there are more needing to come in than can be safely discharged
61.	What roles do Certified Peer Specialist play in this model?
62.	Information about how the model work, staffing patterns, what is needed from EMR, what data is needed in order to implement.
63.	Sufficient staffing for initial and ongoing services
64.	I would like to understand why an organization moves to a CCBHC and how it can help drive quality in behavioral health care.
65.	What are reasonable show rates for new assessments and how do we improve that?
66.	Seeing the difference in No Shows/late cancels utilizing Same Day appts
67.	how to implement SDA and centralized scheduling without additional staff
68.	How this fits into screening, assessment, LOC and workflow
69.	learn more about SDA process
70.	How has SDA been implemented and how does it effect productivity?
71.	How is unused staff time mitigated?
72.	How to engage staff in change process.
73.	Its all data and how do we succeed.
74.	Just trying to learn the details of CCBHC
75.	strategies in improving same day admissions
76.	How to do same day access for case managers and therapist with their busy schedules.
77.	What pitfalls can we plan for?
78.	How to implement SDA
79.	taking in volume
80.	shorten admission process
81.	staffing patterns with little data;
82.	perceived barriers to same day access and ways to eliminate them.
83.	How to promote same day access when a lobby cannot accommodate walk-in traffic
84.	difficulties getting individuals into treatment after intake due to lack of staffing
85.	Short staff, inability to maintain a provider network adequate to meeting increase in those requesting services. When to refer
86.	Does this work for Psychiatric Appointments?
87.	How do we simplify the intake process to decrease barriers for clients while creating less work for staff?
88.	How to implement a successful SDA program.
89.	Implementation plan and specific processes
90.	What states are establishing CCBHCs for the first time
91.	Just want to understand more about same day access in general.
92.	Is there a work around to Medicaid not allowing SDA?
93.	Same Day Access
94.	How to provider services same day with minimal staff
95.	What are the barriers/down sides to Same Day Access?
96.	How to get there? Steps involved
97.	Same Day Access (SDA)
98.	What level of staffing is needed to implement SDA?
99.	Access to care relationship to satisfaction with services
100.	Overcoming staff shortages with SDA

What Does Access Actually Mean?

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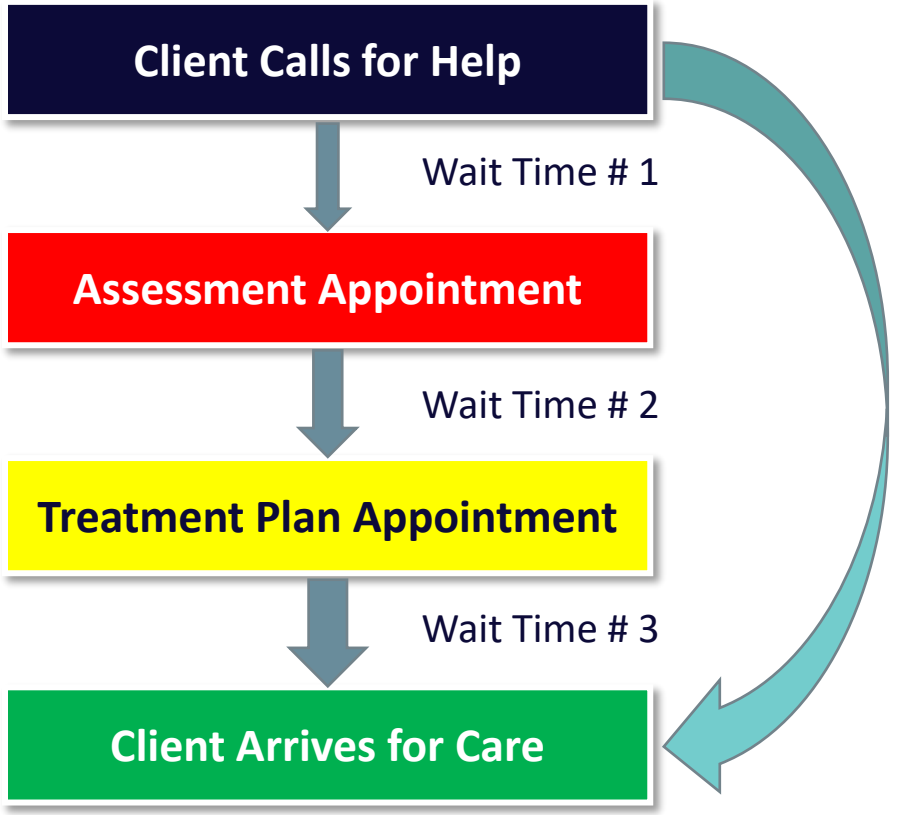
What Does Access Actually Mean!?

How Does Your Organization Define Access to Care!?

Does That Definition Match Your Consumers?!

What Does Access Actually Mean!?

Defining Access…Based upon over 30,000 Access Flows…

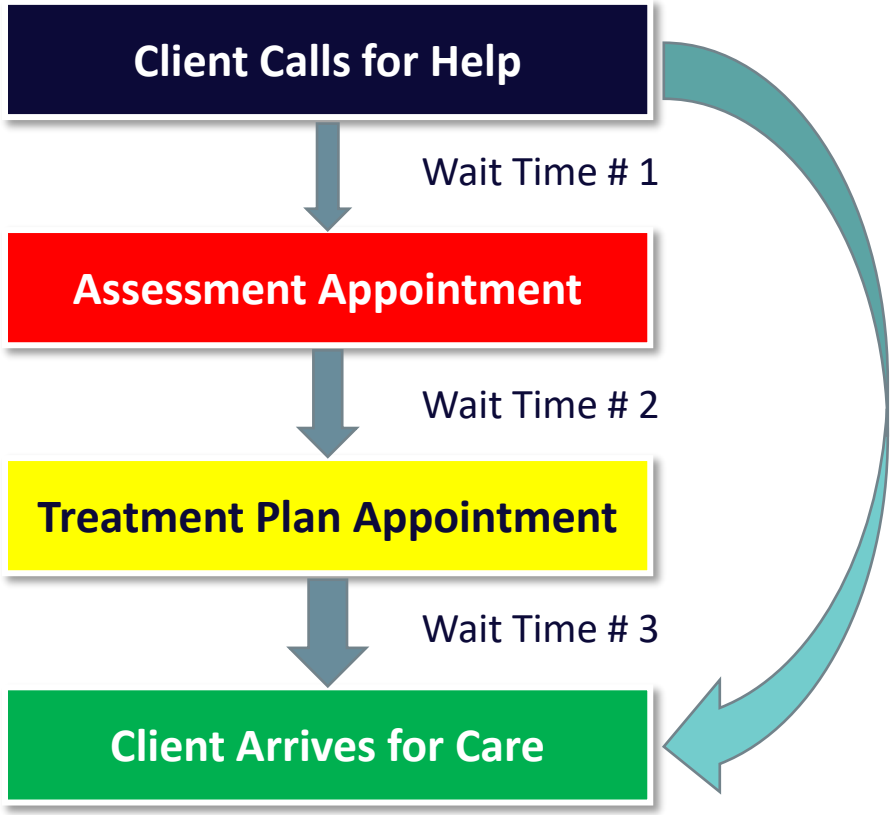


Organizational View -

Client's View -

What Does Access Actually Mean!?

Defining Access…Based upon over 30,000 Access Flows…



Access System Realities -

1. Client vs Agency View.
2. The False Reality of Full.
3. The Impact of Silos.
4. Mission versus Reality.
5. Huge Engagement Opportunity.
6. Clients Voting with their Feet.

Same Day Access Scheduling Defined -

Same Day Access is the process of establishing the appropriate staffing and systems needed to offer a full Diagnostic Assessment with a Therapist on the same day it is requested to all consumers, without a scheduling delay or waitlist. This assessment will be the determinate for what services are clinically appropriate going forward and greatly improves consumer satisfaction and engagement, while also eradicating no shows in the assessment process! MTM has moved more than 900 teams through this process and knows how to tailor it to the specific needs of each organization!

Resetting our Reality…

The #1 Reason that Change Efforts Fail -

Teams come into the change process looking to alter what they are doing now instead of looking at what it will take to actually make a substantive change….

Partial Implementation or Cherry Picking the Change…

The best way to overcome this is to tie to a solid change reason with a solid change target with Data…

Resetting our Reality…

Change ***- (Verb) -*** Alter, vary, modify. To make or become different. **Change** implies making either an essential difference often amounting to a loss of ***original identity*** or a ***substitution of one thing for another***.

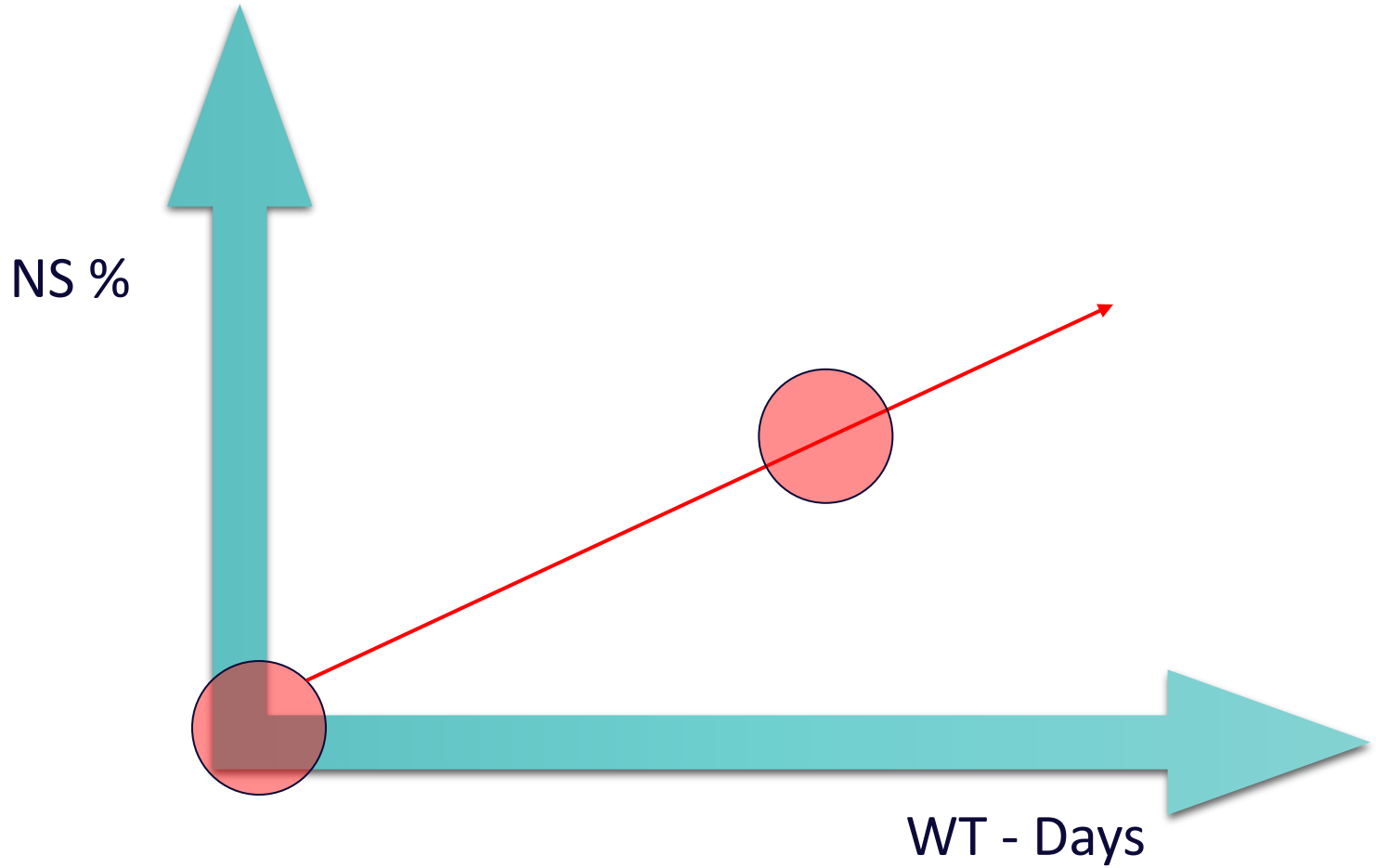
Resetting our Reality…

What has to be overcome …

- *For decades we have set our systems up to what might happen instead of what is happening.*
- *Very often we have set our systems up for what is best for us more than what is best for our consumers.*
- *We have convinced ourselves that talking about a change/going through the motions is as good as actually making a measurable & impactful change.*
- *COVID has magnified the challenges in our systems created by the points above.*
- *A Waitlist is the equivalent of not serving someone.*

What Does Access Actually Mean!?

How did we get to here?!



What Does Access Actually Mean!?

How did we get to here?!

System Noise –

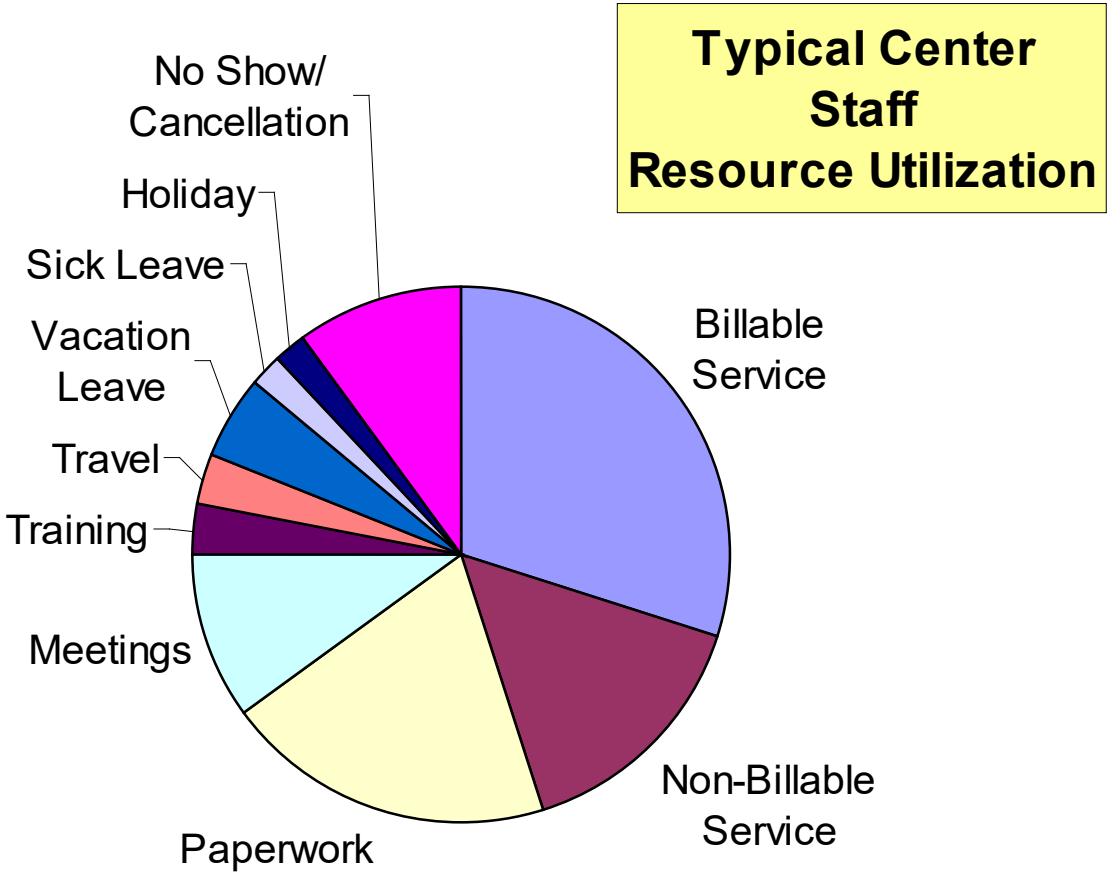
Anything that keeps staff from being able to do the job they want to do:

Helping consumers in need!

More Importantly, what do you do about it!?

What Does Access Actually Mean!?

How did we get to here?!



Substitute Process is Key!

Walk In Intake/Assessments a 0% No Show Model

Your Set Up Steps for Success!

1. Measure your current access reality and set targets (0% No Show Rate, 2nd appt. within 7-10 days).
2. Adjust your Documentation reality (Assessments as close to 60 min as possible.)
3. Determine your Organization's Demand & Optimal Hours of Operation
4. Select Your Staffing / Team Model /Back-Up Contingency Staff
5. Set a Plan to handle your Existing Appointments
6. Choreograph your Wait time
7. Communicate and Go!

What You Need To Change -

Leading Areas of Challenge that Impact –

1. Paperwork – Build your forms to time…
2. No Shows
3. Back Door Challenges
    1. EOC/LOC
    2. No Show Management
4. Staffing –
    1. SDA normally requires fewer staff
    2. Contingency Staffing is crucial

Having The Data to Know for Sure!

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We tried SDA (*or heard of someone else trying it*) and it didn't work!

Were you doing SDA to Fidelity!?

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Top 5 Signs You are Not Maximizing Same Day Access

5 YOU HAVE NO-SHOWS FOR ASSESSMENTS

By definition, Same Day Access utilizes *unscheduled* assessments – clients are seen when they show up and staffing schedules are adjusted to make it work. By not scheduling assessments, organizations eliminate no-shows. Those that continue to schedule assessments **lose clinician productivity and revenue**.

4 CLIENTS WAIT LONGER THAN ONE DAY TO GET AN ASSESSMENT

It is not Same Day Access if they cannot be seen the same day. And if a client has to wait, it **doubles the likelihood they will drop out**. If you really want to get your clients into care, you must offer Same Day Access.

3 THERE'S A LONG LINE OUT THE DOOR

Long lines and **client frustration** can be eliminated by adjusting Same Day Access staffing to meet actual client demand.

2 CLIENTS ARE ROUTINELY TURNED AWAY

Staffing needs to match client demand. Making these adjustments reduces the likelihood that **you will lose that client**.

1 SAYING "FIRST-COME-FIRST-SERVED"

That phrase creates a gold rush mentality and clients assume they will have to fight to get in. Hearing this, **some clients won't even bother to try**. If you design Same Day Access correctly, there is enough access for all.

NOT REALLY PROVIDING SDA? MTM SERVICES CAN HELP • WWW.MTMSERVICES.ORG

Resetting our Reality…

We are going to be a CCBHC and the standard is having a consumer to an Assessment within 7-10 days…..

So why would we do SDA!?

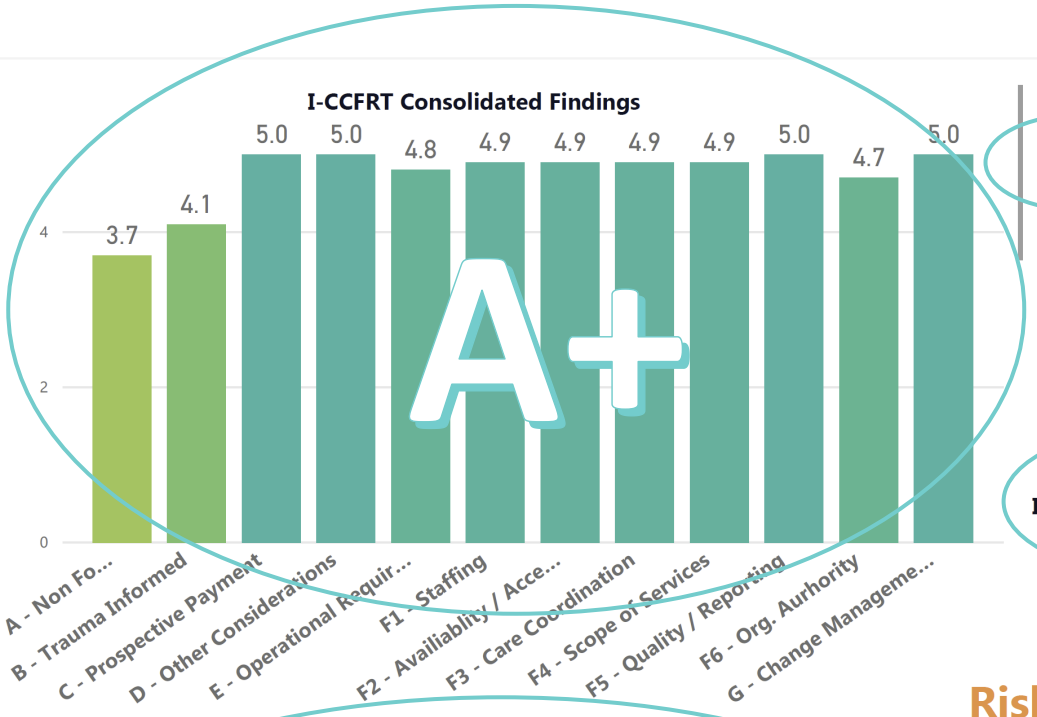
Same Day Access Consultation –

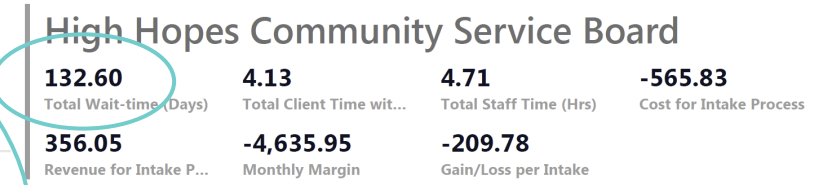
Return on Investment includes:

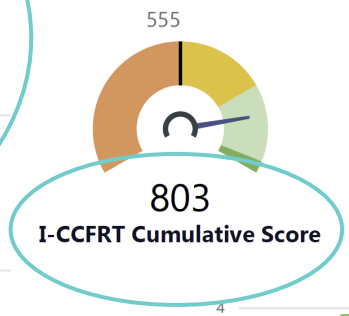
1. An instant increase in client show rates to 100%,
2. An increase in engagement that leads to an increase in outcomes,
3. The ability to see the same amount or more consumers with fewer staff,
4. A wholistic system change that boasts a 97% client approval rating according to client surveys,
5. Addresses important system issues with Episode of Care planning, Collaborative Documentation Training, & No Show and Engagement policies, and
6. Financially, teams see an average of an 8 to 1 return on investment in the first year based upon the efficiencies generated with those savings continuing into the future, and normally additional billings of 5-10% that are generated by the higher show rates and engagement levels.

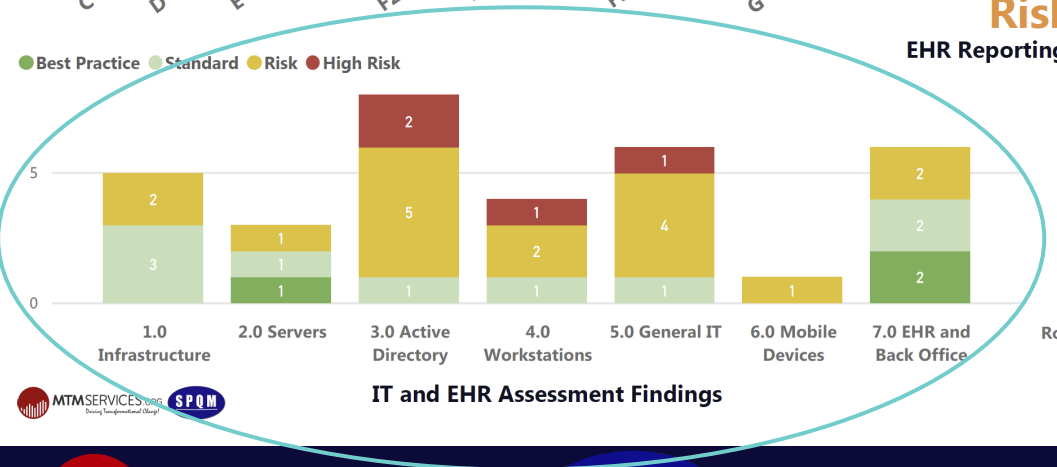
Resetting our Reality…

We Need Accurate Data!

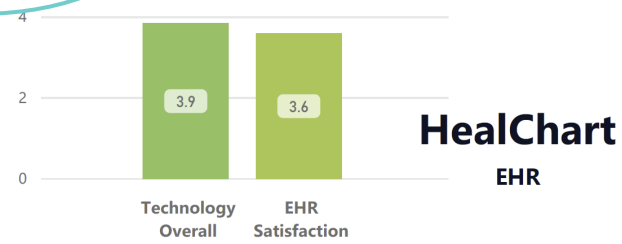




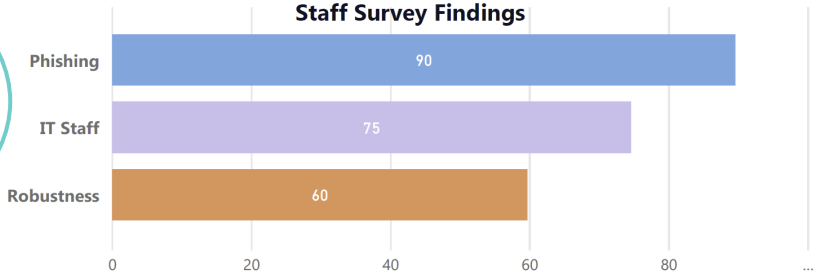




Risk
EHR Reporting Finding

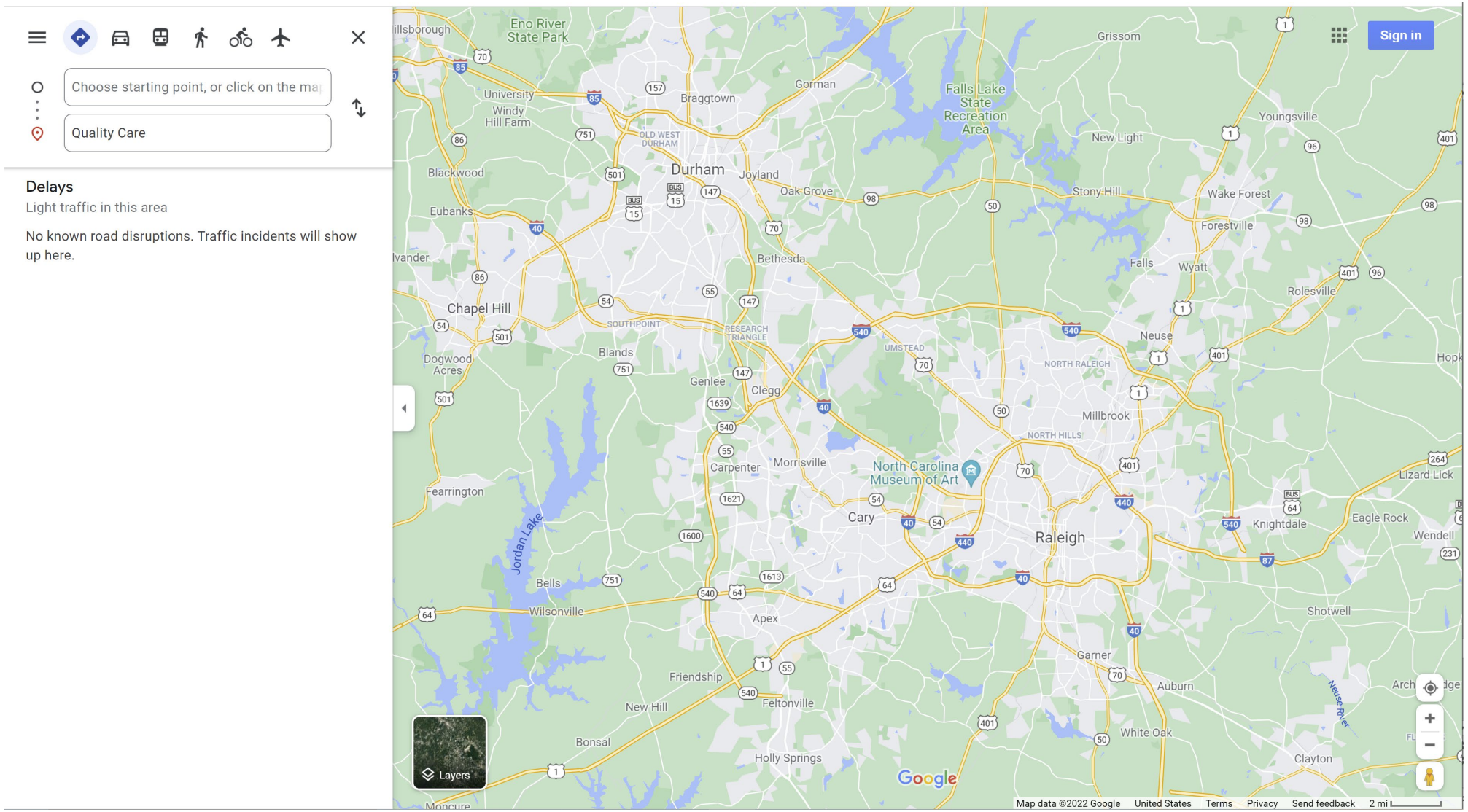


HealChart
EHR

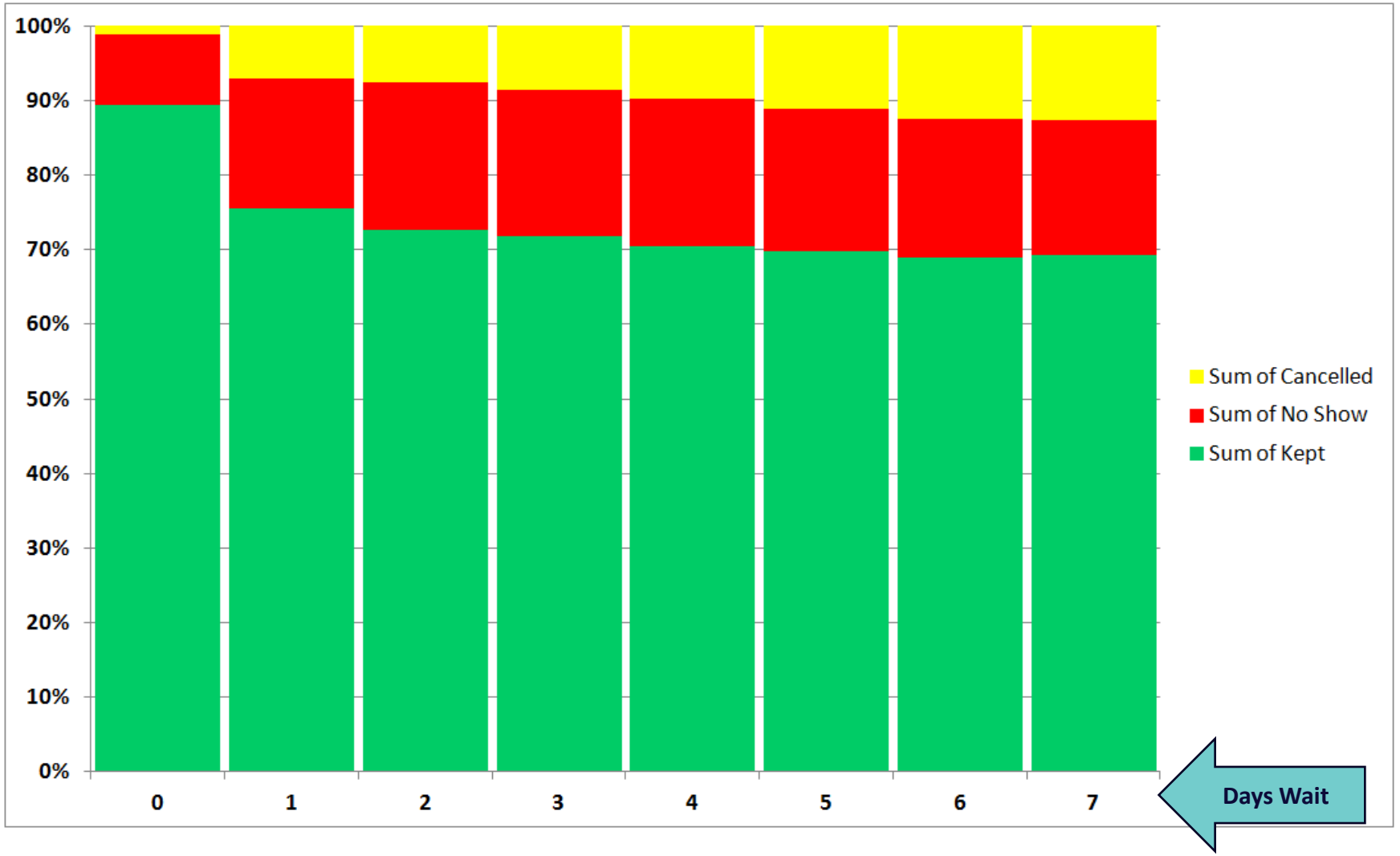


Anecdotal/Self Assessment
vs.
Real Data

You Need to Know Your Starting Point!!

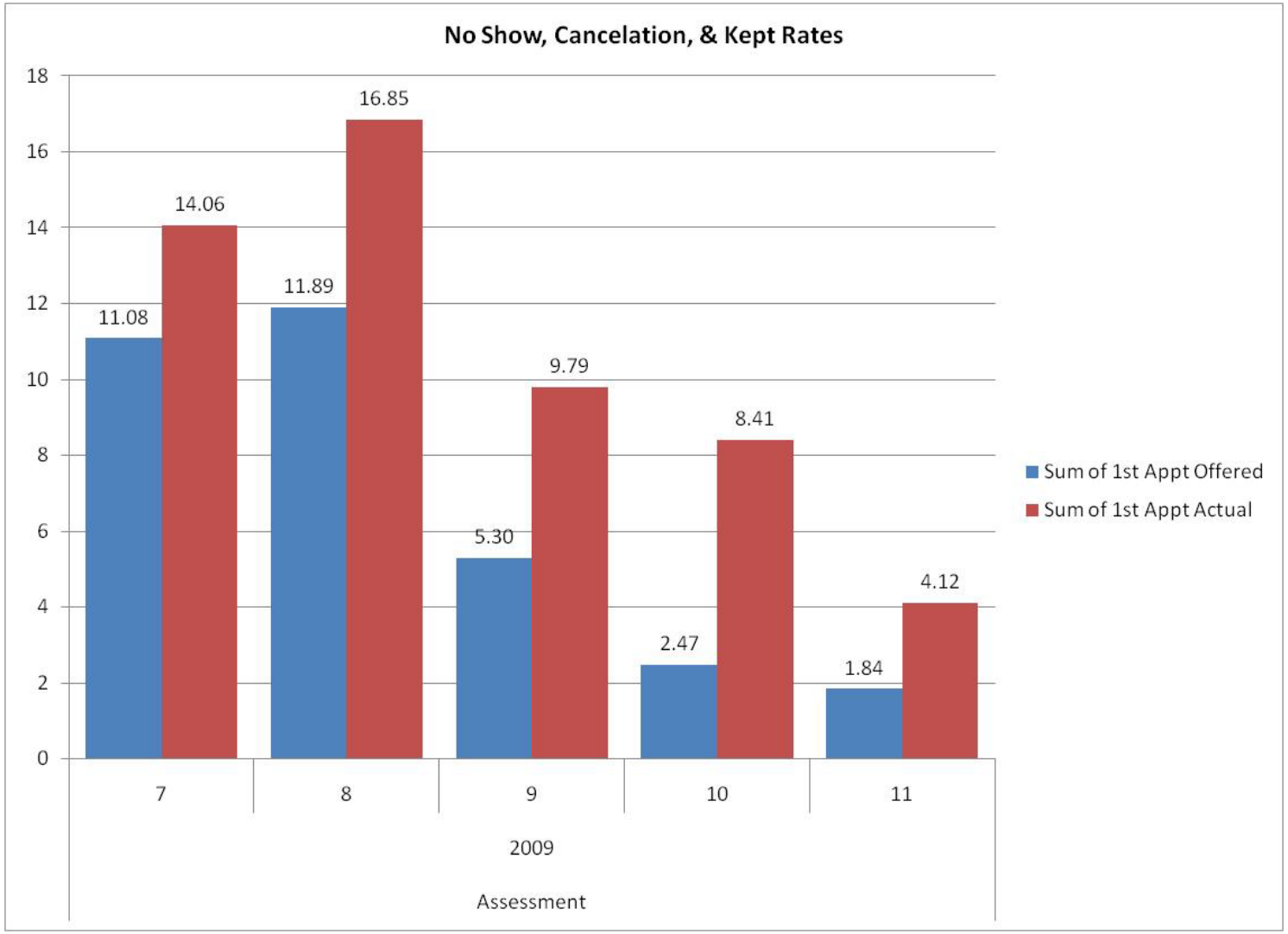


The SDA Difference vs. Scheduling



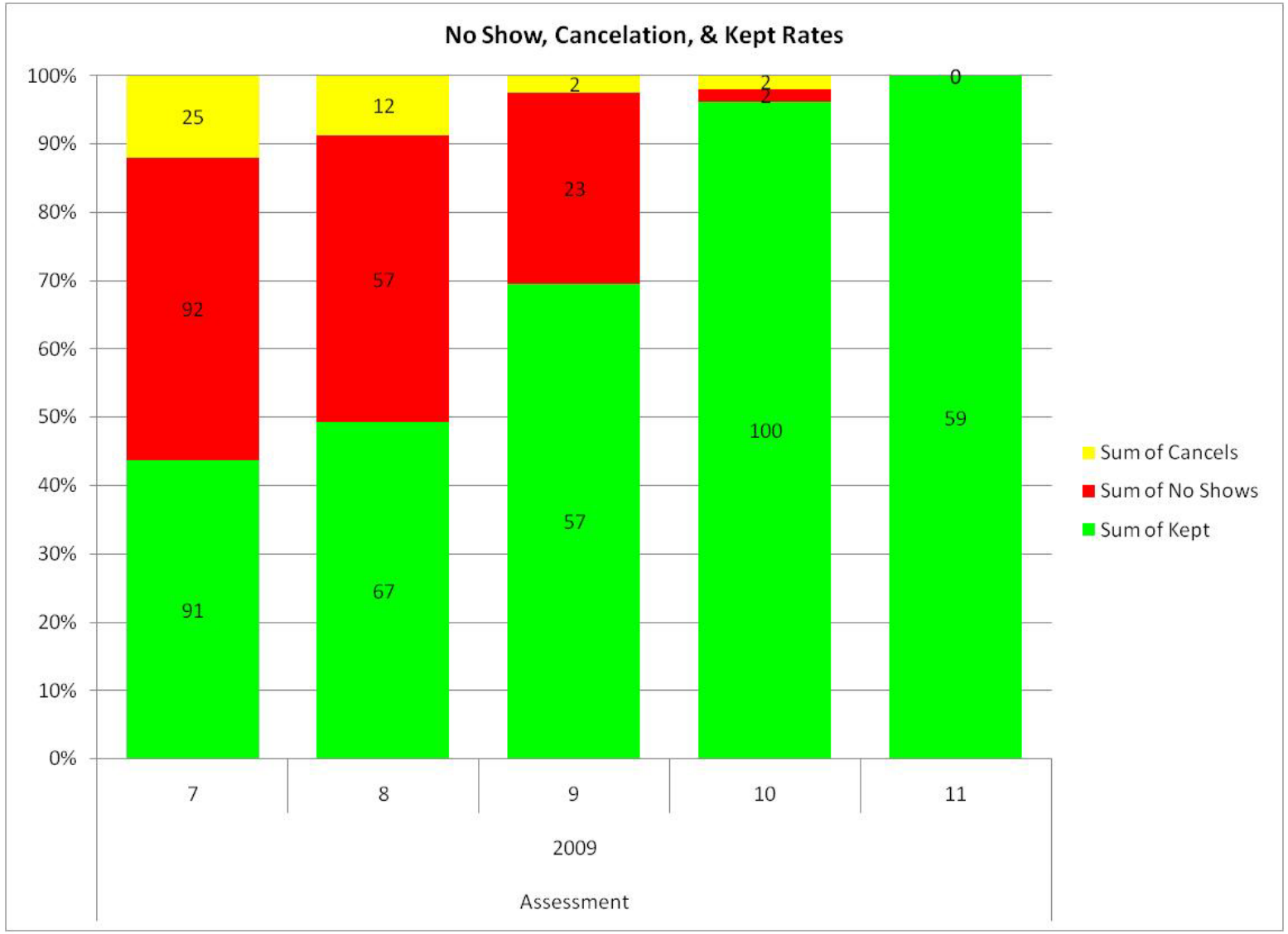
Initial Question - But what if they need to set up transportation!?

The SDA Difference vs. Scheduling



Going Back to the beginning of the SDA program, the change has been solid and shows itself quickly.

The SDA Difference vs. Scheduling



Going Back to the beginning of the SDA program, the change has been solid and shows itself quickly.

The SDA Difference vs. Scheduling

Access Comparison Worksheet				
	Total Staff Time (Hrs)	Total Client Time without Wait-time (Hrs)	Cost for Process	Total Wait-time (Days)
Old Process Averages:	4.94	3.35	($347.20)	45.72
New Process Averages:	3.74	2.85	($265.95)	25.81
Savings:	1.20	0.50	$81.25	19.92
Change %:	24%	15%	23%	44%

Avg. Number of Intakes Per Month	24,349.20
Intake Volume Change %:	10%
Monthly Savings:	$1,676,428.44
Annual Savings:	$20,117,141.29
Average Savings Per Center:	$135,926.63

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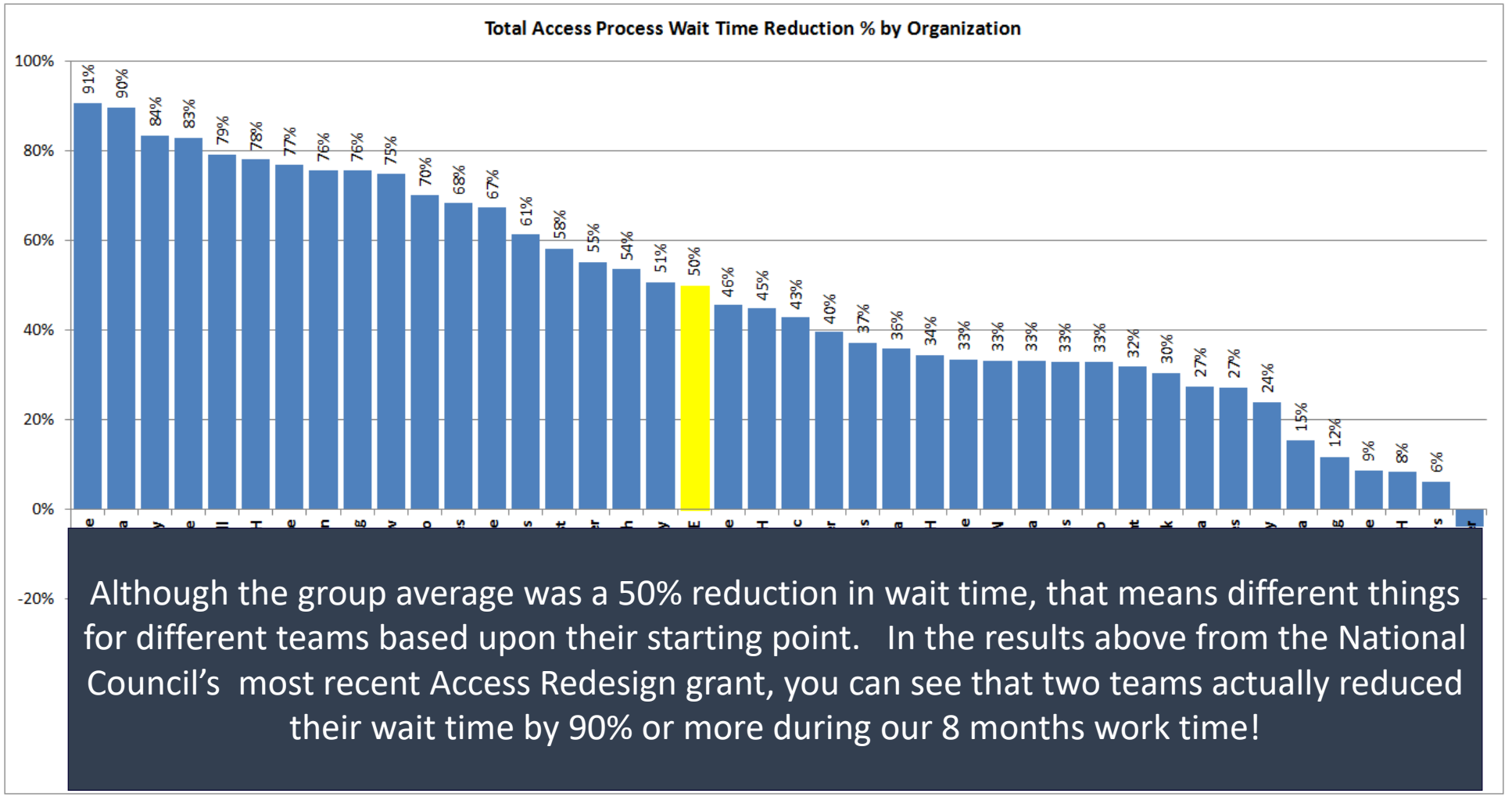
The sample size of this change information is taken from 169 organizations in 25 states.

Average Savings Per Center is based upon Fewer Organizations as some teams did not need to change their staff time, only their wait time

The SDA Difference vs. Scheduling



Although the group average was a 50% reduction in wait time, that means different things for different teams based upon their starting point. In the results above from the National Council's most recent Access Redesign grant, you can see that two teams actually reduced their wait time by 90% or more during our 8 months work time!

Comprehensive Life Resources

Same Day Access Journey

Kathy Hagen, LICSW
Chief Clinical Officer

Challenges

- ✓ Meeting the need- It's a moving target!
- ✓ Losing clients as a result of lack of engagement= increase in no show rates
- ✓ Inefficiencies in workflows- meeting demands of multiple funders; too much paperwork
- ✓ Accepting a major system overhaul was needed

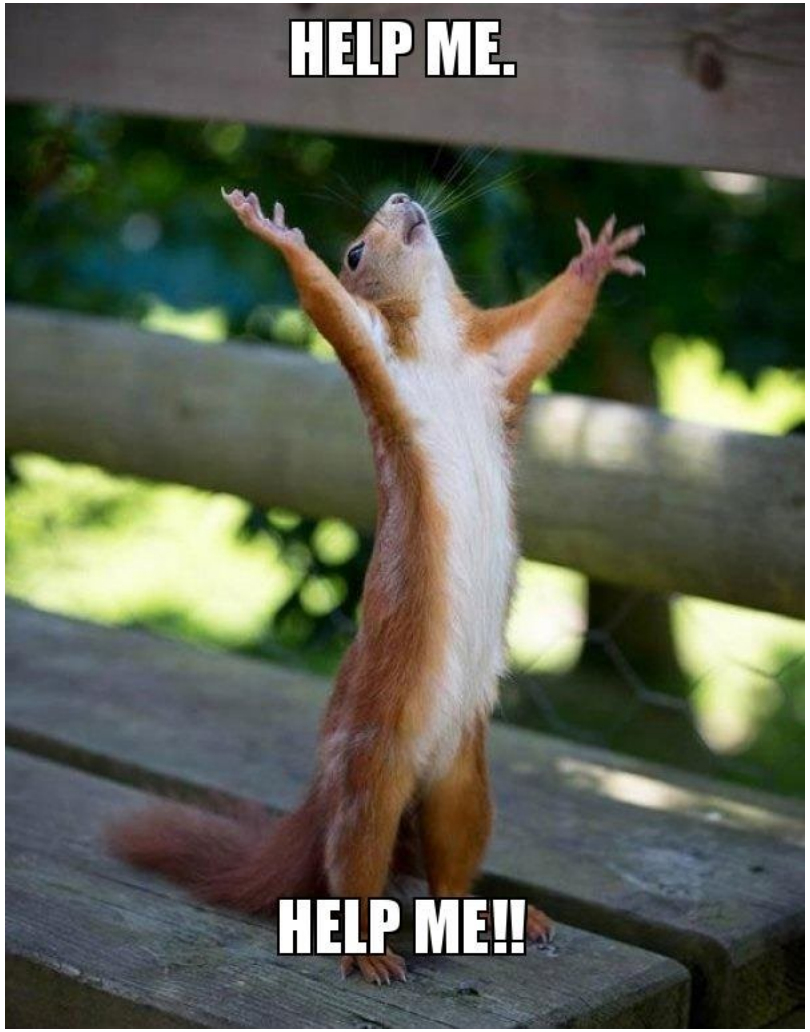
Post Pandemic
Less workforce + More need = DISASTER

Before SDA intervention

Client wait times could be as high as 90 minutes **BEFORE** they saw a staff member

Intakes were taking 90 minutes or more once they started

Reception staff not utilizing scripts in effort to meet need



Clinical staff were doing a lot of non-clinical paperwork

Leadership, staff teams, and clients all felt frustrated with the process and no clear solution

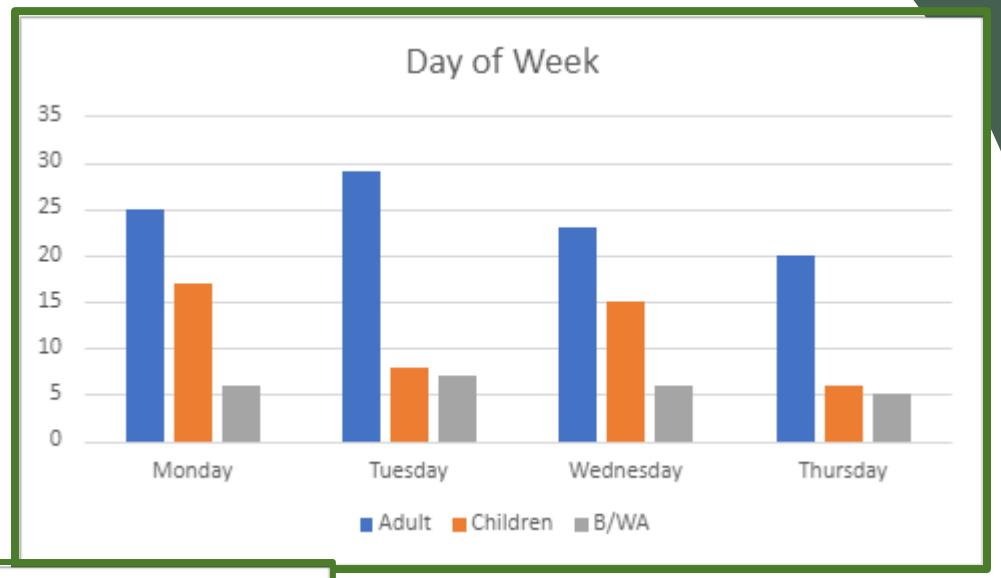
We were defaulting to scheduling intakes when staff were not available

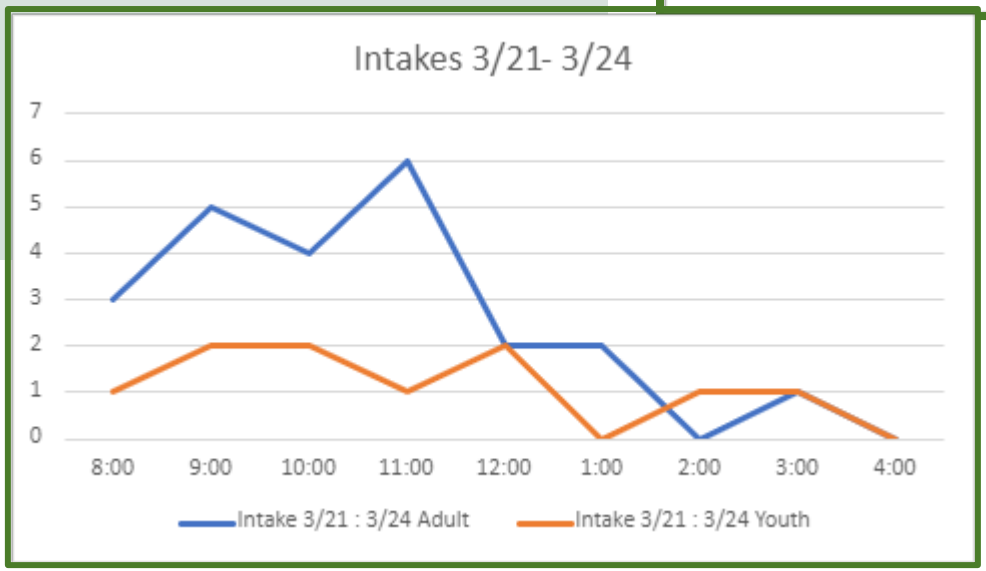
Developing the Plan

- ✓ Hired Consulting- Thank you MTM!
- ✓ Identified a design team
- ✓ Made Changes
- ✓ Evaluated progress- both quantitative and qualitative

Where do we start?

- ✓ What did we believe was the process versus what ***was*** the process- management versus clinical staff team
- ✓ What was the client experience?
- ✓ We needed to adjust our thinking to let data drive decisions not feelings/assumptions
- ✓ We had to learn **HOW** and **WHAT** data to gather

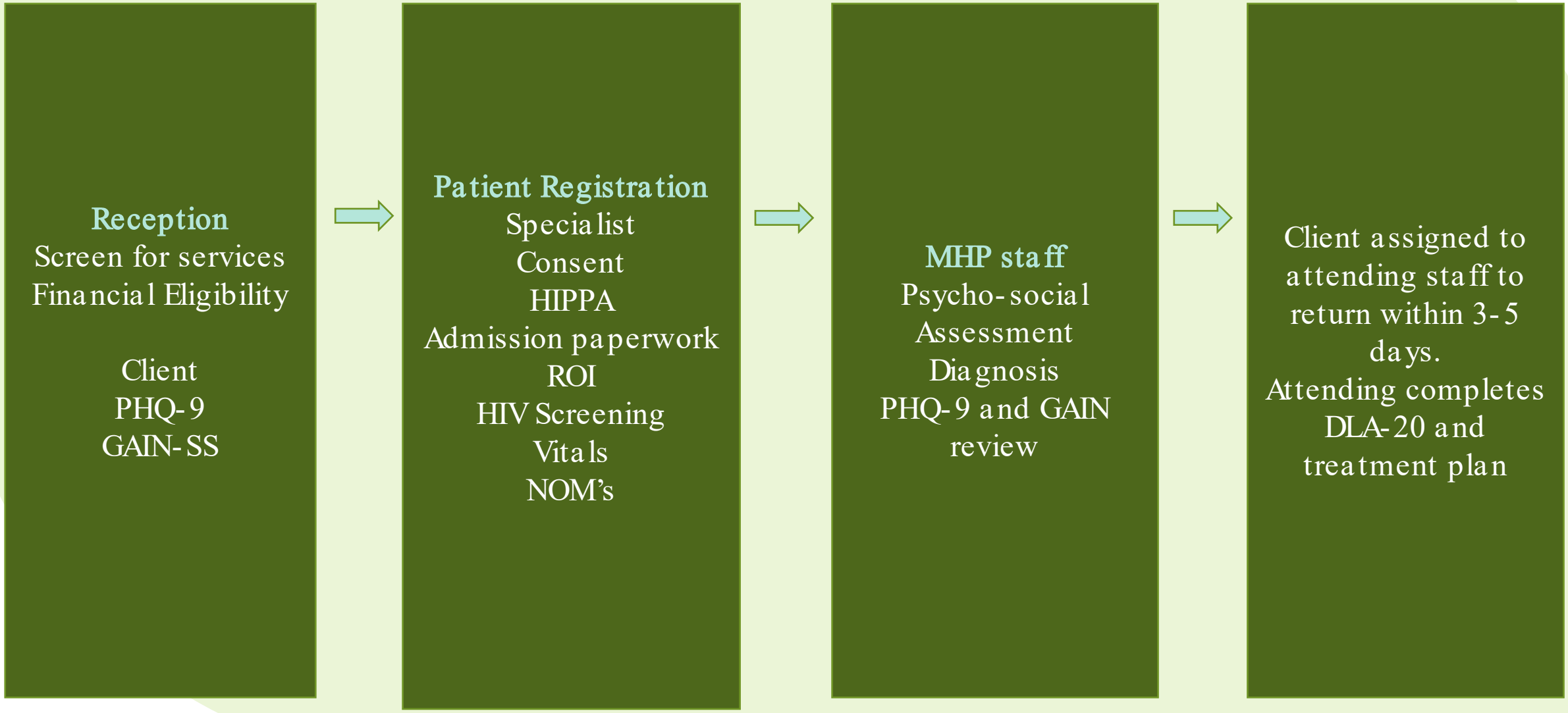




What did the data tell us?

Time and Cost	What was our capacity	Intake days/times
Pre-Session Time = 30 min In-Session Time = 60 min Post-Session Time = 30 min Average cost of ONE intake= $448.00 BUT Average reimbursement = $292.00	We had a minimum of 65 client slots available weekly and a maximum of 96 We averaged about 33-40 intakes/week	We discovered that most youth came in the early morning Adults tended to come mid to early afternoon Very few intakes on Fridays

Change #1- Re-design the workflow to ensure administrative tasks are done by administrative staff and clinical by clinical staff



Challenge # 2- Data Collection

How to collect required data most efficiently…

Who collects it- client/clinical/admin

How- client portal/paper/concurrent

Invested in data mapping which has helped this process!

Challenge #3- Develop a contingency plan

Reception
Screen for services
Financial Eligibility

Client
PHQ-9
GAIN-SS

Patient Registration
Specialist
Consent
HIPPA
Admission paperwork
ROI
HIV Screening
Vitals
NOM's

No MHP available

- Use Psychiatrist "No show" time to complete
- Client wants psychiatric services- schedule this appointment within 1-3 days and assign attending
- Screen for crisis and offer client "fast pass" for assessment next day either in person or telehealth

Challenge # 4- Implement a new No Show policy

This was implemented in August of this year. So far the trend is that NS are declining by 2-3%

COMPREHENSIVE LIFE RESOURCES

Comprehensive Life Resources
No Show Policy

CLR values providing effective and efficient services to everyone we serve. We understand that life can sometimes get in the way of scheduled appointments. If you need to reschedule your appointment, please provide us a minimum of 24 hours' notice. If you cancel or reschedule with less than 24 hours' notice, your appointment will be considered a "no-show."

If you have two or more no-show appointments within 90 days or two consecutive, no-show appointments:

- You must speak with an Engagement Specialist before we will schedule another appointment. The specialist will discuss barriers to attendance and the scheduling plan moving forward.
- Your future scheduling options may be limited to off-peak hours, walk-in services or same-day appointments only.

I have reviewed and understand the no show policy.

_____

- Consumer Legal Name

Next steps…. Keep evaluating

In Sept/Oct 2022 we had 373 slots available for intakes

- ✓ We completed 248 intakes over the two months
- ✓ 185 of those were completed by intake staff
- ✓ 51 utilized contingency planning
- ✓ 12 were completed using prescriber no show time or through medical scheduling

We have only ONE dedicated FTE for intakes- efficiencies created in the system made it possible to maximize clinician "no show" time for new clients!

March to August 2022

- ✓ 51 scheduled intakes
- ✓ 20 walk-outs

NO ONE WAS TURNED AWAY!

Our Learning

Data, Data, Data

Using data challenged our “beliefs” about the process

Be open

We were pushed to consider new ways of business in ways that made us uncomfortable

Keep evaluating

Every change should be evaluated for desired outcome

Thank you

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Thank You

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