

Sustaining Open Access

Annie Jensen LCSW

Clinical Consultant, MTM Services

Annie.Jensen@mtmservices.org

Healthcare Reform Context

Under an Accountable Care Organization Model the **Value** of Behavioral Health Services will depend upon our ability to:

1. Be Accessible (Fast Access to all Needed Services)
2. Be Efficient (Provide high Quality Services at Lowest Possible Cost)
3. Electronic Health Record capacity to connect with other providers
4. Focus on Episodic Care Needs/Bundled Payments
5. Produce Outcomes!
 - Engaged Clients and Natural Support Network
 - Help Clients Self Manage Their Wellness and Recovery
 - Greatly Reduce Need for Disruptive/ High Cost Services

Access to Treatment As a Customer Service Focus...

- **No Show Management**
- **Centralized Scheduling**
- **Levels of Care Guidelines**

Practice Management Efficiencies

- The primary challenge facing almost every healthcare provider is having adequate service delivery capacity to support timely and effective access to treatment.
- In an era of integrated healthcare reform, access to treatment is even more critical.
- The historical three levels of access to care challenges have been Primary Access, Secondary Access, and Tertiary Access.

Three Levels of Access to Care

- **Primary Access-** Wait time from the initial call/walk in for routine help to the face to face initial intake/ assessment
 - Same Day Access
- **Secondary Access-** Wait time from the initial face to face assessment to the next appointment with treating clinician
- **Tertiary Access-** Wait time from the intake/assessment date to an initial appointment for psychiatric services

Intake/Diagnostic Assessment Model Can Contribute to No Shows/Cancellation Rates

- Wait time from initial contact and Intake/Diagnostic Assessment date has impact which is usually exacerbated by long intake processes and high no show/ cancellation rates for intakes.
- Multiple face-to-face Intakes/ Diagnostic Assessment sessions exacerbate No Show/Cancellation Levels.
- When we ask questions, the clients indicated they are helping US, when we listen, they indicate we are helping THEM.

No Show Management

We must change our behavior shifting from having a schedule to managing a schedule

Poll Results based on 628 Registrants for the NC LIVE Webinar on Enhanced Revenue Presented by David Lloyd, MTM Services on December 15, 2009

1. From the Clinician's perspective, are the caseloads in your organization "full at this time?"

Yes 70% No 30%

2. Do you know the cost and days of wait for your organization's first call to treatment plan completion process?

Yes 41% No 59%

3. Indicate the no show/cancellation percentage last quarter in your organization for the intake/assessment appointments:

a. 0 to 19% = 20%

b. 20 to 30%= 42%

c. 40 to 59% = 16%

d. Not aware of percentage = 22%

4. Indicate the no show/ cancellation percentage last quarter in your organization for Individual therapy appointments

A. 0 to 19% =25%

B. 20 to 39% = 49%

C. Not aware of the percentage=26%

How Much Capacity is Lost in No Shows?

- What is your organization's no show rate for return appointments?
- How much additional capacity would you have if your organization's no show rate was below 10% for all return appointments for all services types?
- How much additional capacity would you have if your organization was able to successfully backfill 90% of all cancelled appointments?

Recommended No Show Types and Definitions

- **“No Show”** – Consumer did not call or did not cancel scheduled appointment for services greater than 24 hours.
- **“Cancellation – Rescheduled”** - Consumer called and cancelled appointment for service more than 24 hours before appointment, the client was rescheduled at a later time.
- **“No Show – Not Rescheduled”** - Consumer called and cancelled appointment for service less than 24 hours before appointment, the client did not want to be rescheduled at a later time
- **“Provider Cancelled”** – Clinician cancelled appointment.

Responding to Missed Appointments

- **After each missed appointment:** The service provider discusses reasons for missed appointment with the individual and plans remedies with them to prevent further missed appointments. This conversation and the agreed-upon remedies are documented in an episode log.
- **Policy Triggers:**
 - **When a individual's rate of no-show/late cancellation exceeds 20% or 2 Events over a 90-day period:,**
 - **Two consecutive no-show/late cancellations, or**
 - **Rate of cancellation exceeds 30% or 3 Events over a 90-day period: No further routine appointments are scheduled for the family.** The service provider arranges for a “**10-day letter**” to be sent, advising the individual that unless they contact the provider within 10 days to discuss reasons for missed appointments and negotiate an **alternative scheduling plan**, we will assume they are no longer interested in further services and will close their case.

Barriers Assessment

Barriers Assessment

Date Consumers Name

Are these services important to your recovery? Explain?

What are the two most important goals that you would like to achieve while participating in services?

1.
2.

Do you have any concerns about the services you are receiving? Explain

What are the main barriers to scheduling or attending appointments?

- Medicaid Transportation
- Personal Transportation
- Child Care
- Conflicting appointments
- Unable to pay co-pay
- Other :

What are the specific actions steps that will be taken to address the identified barriers to treatment?

Estimated date that barriers will be addressed and appointments can resume?

Consumer Signature Date

Provider Signature Date

Options for Alternative Scheduling

- Scheduling appointments during off-peak hours only;
- No Show Group;
- Walk-In Clinic;
- Seeing the provider during their established personal walk-in hours;
- Same-day appointments
- Terminating services.

Reducing Exposure to Failed Appointments

- Contract with clients for **limited number of service contacts or limited duration of service** – i.e., 6 service contacts or 90 days – when developing their ISP.
- Schedule **shorter service contacts** of 15 or 30 minutes for individuals who are stabilizing and may benefit from a quick check-in vs a more involved intervention.
- **Negotiate the next appointment** – when ending an appointment, ask individuals if they are able and willing to meet again and how soon, rather than automatically scheduling another session for “same time next week.”
- **Maintain a “back-fill” list** of clients who could be contacted on short notice to take an appointment time freed-up by a cancellation.
- **Promote group services** as a valuable and less-expensive alternative to continued individual and family sessions.

Centralized Scheduling

- The average staff member will spend 100 hours a year managing his or her schedule.
- The key concept is that schedules belong to the organization, not the provider.
- Organizations must hold staff and consumers accountable for appointments.

Centralized Scheduling

- A staff scheduling template is built for a 90 day period. This template includes the clinicians availability and unavailability to provide clinical services during that time.
- Staff schedules should be blocked for supervision, team meetings, lunch and dinner breaks, holidays and trainings. Non emergency time off would be granted as long as consumers are not scheduled.
- The staffing template should include sufficient appointments each day to absorb each staff's no-show/cancellation rate and meet sustainability for production standards.

Centralized Scheduling

- Providing the ability to determine clinical capacity at any time and support “just in time” service delivery
- Completing the functions of scheduling new and return appointments
- Managing all backfilling of open appointment times
- Completing confirmation phone calls
- Providing consumers with an available contact person to coordinate their scheduling needs.

Levels of Care

- Level of Functioning is best determined by assessing functional impairments in daily living activities based on symptoms, behaviors, developmental stage, cognitive abilities, and emotional abilities. Must be able to demonstrate medical necessity and functional impairments.
- Level of Care includes the scope of evidence based interventions including frequency and intensity.
- Length of Stay is the recommended length of time an individual can receive the services linked to each level of care.

Utilization Management

Levels of Functioning (LOF)

Require specific

Levels of Care (LOC)

Tied to

Length of Stay (LOS)

- Provide services that appropriately match the assessed needs of consumers to help them achieve optimal functioning.
- Review frequently to ensure progress toward outcomes

Levels of Care

- Establish baseline measurement for consumers symptoms, behavior, and skill deficits and document how these impact consumers functioning is the basis for developing service/ recovery plans
- Standardized assessment tools and/or local or state mandated tools (ASI, LOCUS, CAFAS, DLA-20, etc.) used in conjunction with an initial assessment helps establish baseline functioning and helps justify continued medical necessity.
- Once the appropriate level of needed medical necessity is assessed the consumer can be placed in the appropriate level of care.

Levels of Care

- Each level of care would include:
 - Indicator of the level of care that include the admission criteria for that level of care
 - Descriptors of functional impairments to meet the level of care
 - Length of Service which is typically a range of estimated length of treatment
 - Types of Services offered in that level of care (menu of services)
 - Episode of Care including the frequency of each service type
 - Add on Services
 - Measureable Discharge Criteria

Levels of Care

Level of Care # 4	Service Recommended 2-5 years	Amount	Add-Ons
Indicators of Level: <ul style="list-style-type: none"> Primary DSM-5 of: Schizophrenia; Major Depressive Disorders; Bipolar Disorders; Other Psychotic Disorders; or Schizoaffective Disorder. <u>And</u> DLA-20 >2.5 and < 4.0 or mGAF 25 – 40 ICD10 4th digit severity modifier = 3 OR DSMV Diagnosis of Moderate to severe Substance Use Disorder (>=4 symptoms) ASAM PPC-2R Level I OR Co-Occurring DSM-V Diagnoses (Mental illness & Substance abuse/dependence) ASAM PPC-2R Level I 	1. Diagnosis/Assessment	<ul style="list-style-type: none"> Maximum of 4 contacts per episode of need 	<ul style="list-style-type: none"> Mental Health Education & Referral
	1. Crisis Interventions	<ul style="list-style-type: none"> As needed, no maximum 	<ul style="list-style-type: none"> Hotline Services
	1. Counseling/Psychotherapy:	<ul style="list-style-type: none"> Up to 12 Individual Sessions per episode of need Up to 12 group sessions per episode of need 	<ul style="list-style-type: none"> AA/NA Support Groups
	1. Medication/Somatic Services	<ul style="list-style-type: none"> Psychiatric Evaluation within 2 weeks of admission. Minimum of 1 contact a month with Medical Staff, until stable on meds 	<ul style="list-style-type: none">
Additional/Optional Service Eligibility: <ol style="list-style-type: none"> Severe Levels in at least 7 of the 20 Daily Living Activities (DLA-20©) OR 3 of the 10 Multnomah Community Assessment Scale categories OR ___ of Colorado CCAR or -__ Fla. FFARS or ___ for LOCUS Client willingness to participate in services as documented on TX Plan 	1. Comprehensive Community Support Services (CCSS):	<ul style="list-style-type: none"> Staff must offer an average of three face-to-face contacts per week per consumer and one contact per week to consumer's supports The frequency of contacts with an individual consumer at any one time will depend on the needs and preferences of the individual consumer. 	<ul style="list-style-type: none"> Peer support Supported Employment - at least 1 visit per month Supported Housing - at least 4 visits per month Respite or close family supervision
	1. Psychosocial Rehabilitation Services (PSR)	<ul style="list-style-type: none"> Integrated Model Program Individual Classes 	<ul style="list-style-type: none"> Drop-in Program
Possible descriptors:		Transition Criteria:	
<ul style="list-style-type: none"> Potential for harm to self or others if not managed well Recent hospitalizations Co-occurring medical or substance abuse which could be life threatening Compliance is poor, inconsistent Everyday functioning is significantly impaired 	<ul style="list-style-type: none"> Frequent crisis management needed If not with ACT or intensive programming on a weekly basis, the client is at risk Intractable symptoms No supports or very limited No structure without BHC High use of psychiatric emergency services during the past 18 months 	<ul style="list-style-type: none"> Reduced Level Of Need when criteria are met. Admission for Psychiatric Inpatient Treatment for six months with no imminent discharge date 	<ul style="list-style-type: none"> Placed in a nursing home with no imminent discharge date Incarceration with no imminent release date

Thank You

- Questions?
- Feedback?
- Additional Resources?

Annie Jensen LCSW

MTM Consultant

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