Sustaining Open Access

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Access to Treatment As a Customer Service Focus…

- 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
  - 3 to 5 days - no longer than 7 days after intake assessment.

- **Tertiary Access** - Wait time from the intake/assessment date to an initial appointment for psychiatric services
  - 3 to 5 days - no longer than 7 days after intake assessment.
Practice Management Efficiencies

- No Show Management
- Centralized Scheduling
- Collaborative Documentation
- Levels of Care Guidelines
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?
Steps to Effective No Show Management

- Identify Appointment Types
  - National Standard for appointment types:
    - Appointment Kept
    - No Show
    - Appointment Cancelled by Consumer
    - Appointment Cancelled by Staff

- Develop Definitions for all Appointment Types
  - No show = Consumer either misses the appointment without notifying the organization or provides less than 24 hours notice.
  - Appointment cancelled by consumer = Consumer notifies the organization at least 24 hours in advance they can not attend their appointment.
Steps to Effective No Show Management

- Develop and implement consumer no show standards
  - No shows exceeds 20% or 2 events in a 90 day period
  - Two consecutive no shows or
  - Rate of cancellation exceeds 30% or 3 events in a 90 day period.

- Develop and implement provider kept appointments standards
  - Provider kept appointment rate will average 90% during last 3 month time period

- Develop tracking and reporting tool
Responding to Missed Service Appointments

- After each missed appointment the service provider discusses reasons for missed appointment and identifies any barriers to treatment.

- Alternative scheduling plan if:
  - no shows exceeds 20% or 2 events in a 90 day period
  - Two consecutive no shows or
  - Rate of cancellation exceeds 30% or 3 events in a 90 day period.
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
Alternative Scheduling Plans

- Schedule appointments during off peak hours only
- No Show Group
- Walk In Clinic
- Same Day Appointments initiated by the consumer calling to check availability for that day
- Medication Clinic
Shifting from Having a Schedule to Managing a Schedule

**Having a Schedule Model**
- Schedule Out
- Assume Attendance
- Let No Show Occur
- Carry No Show Consumers in Caseload

**Managing a Schedule Model**
- Negotiate Next Appointment
- Call and ask for commitment
- Back fill appointments at a rate of 90%
- Appropriately Transfer/Discharge Consumers
Measurement of Case Loads

- Measurement of specific caseload members no showing/cancelling is a critical part of the ability to reduce rates.
- Use that information in clinical staffings and supervision in order to change our behavior.
- Need agency protocol for when staff are to begin taking action on no show/cancellation challenge that is case specific.
Practice Management Efficiencies

- No Show Management
- Centralized Scheduling
- Collaborative Documentation
- Levels of Care Guidelines
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

- When implementing centralized scheduling there are certain components that should be integrated into policies and protocols.
- The staffing template should include sufficient appointments each day to absorb each staff’s no-show/cancellation rate and meet sustainability for production standards.
- Other items to include in the policy:
  - Timeframe required for submitting changes to schedule
  - Who approves changes to schedules
  - How are changes communicated to centralized scheduling staff
  - Who has access to schedules and can make changes
Centralized Scheduling Templates

- 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.
Centralized Scheduling Templates

- Clinicians provide their supervisor with the 90 days scheduling template for approval. Once approved the schedule for months one and two are open for scheduling and month three is in the scheduling system but not open to schedule. On the first day of month two, months two and three are open. Month four is in the system but not open for scheduling.

- By having two months live in the system and one inactive the clinician has some flexibility if needed to get approval to change the schedule before consumers are scheduled.
Centralized Schedulers are Responsible for

- 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.
Practice Management Efficiencies

- No Show Management
- Centralized Scheduling
- Collaborative Documentation
- Levels of Care Guidelines
Collaborative Documentation

- Originally welcomed by organizations primarily as a way to recapture the clinical capacity being lost by clinical providers sitting in their offices completing documentation.

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- The process has evolved to become a valuable clinical tool with a number of significant benefits.
Collaborative Documentation

- Collaborative Documentation is the process of documenting all core clinical processes directly into the official medical record with the individual served present.
- It is a collaborative and information sharing process where the individual served has full awareness of what is being documented and can clarify issues and ask questions.
- Collaborative Documentation simply provides transparency and psycho-educational opportunities, and allows individuals served to contribute their perspectives and more fully participate in their care.
Benefits to Collaborative Documentation

- Engagement and Involvement of Individuals Served
- Clinical Value of Treatment Plans
- Support for Session Structure and Outcome Focus
- Improved Recall
- Clarification of Information
- Support for Compliance-Medical Necessity
- Documentation Timeliness and Accuracy
- Efficiency and Improved Quality of Work Life
Practice Management Efficiencies

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Focus on Functioning

New focus, new ACA law 1/2014:

- State and federal funding agencies have changed laws and standards that affect funding for services you provide.
- Establish **medical necessity**
- Make **rehabilitation** your treatment goal and your outcomes measurable.
- Both requirements can be addressed if you focus on assessed needs:
  - Having the right tools makes it easier.
  - Measure Impact of Symptom Severity on ADLs: Mild, Moderate, Serious, Severe, Extremely Severe
  - Tie assessed needs to objectives!
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.
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

- The benefit design outlines specific services based on the functional needs of the individual in care.
- Individual organizations can develop their admission and discharge criteria for levels of care and further incorporate the benefits and services available that would assist individuals in their recovery.
- Levels of care with specific benefits or services and length of stay can be monitored through an enhanced utilization management structure that can define practice variance patterns and outliers in the level of care criteria.
Thank You

• QUESTIONS?
• FEEDBACK?

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