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Numbers Don’t Exaggerate

Using Quantitative Data to Improve Access to Intensive Outpatient Services

Where hope begins.

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First things first:

Who is here today?

- Therapists?
- Coordinators?
- Program Directors?
- Administrative Directors?
- Board members?
- QI/QA?

Why are you here?

- Because you LOVE data?
- To improve Access?
- Ideas for IOP services?
- To engage staff in change?
- Any others?

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Once upon a time, at a community mental health center not so far away…

From:	To:
• Peer • Supportive supervisor • A small part of a bigger team	• Boss • Unknown supervisor • A team in itself

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Youth and Family Intensive Services

- Substance Abuse IOP/ MRT
- Day Reporting Center
- Intensive In Home
- Functional Family Therapy
- **180 Program (MH IOP)**

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The Work Flow:

- Level I
- Risk Assessment
- Safety Plan
- Assign groups

- Level II assessment
- CCAR
- Diagnosis

The Dilemma

My Boss

"The screen makes the workflow too long for the intensive level of care. It's a barrier to starting IOP level of treatment in a reasonable time frame"

My Team

"In the screen, we do a thorough risk assessment and a high quality safety plan which increases safety and decreases liability. We also use time during the intake to build rapport which increases engagement. It is VERY important and we like the system the way it is."

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Me

"Does the workflow need to change? How do I build a relationship with my team while pleasing my boss?"

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Things I believe to be true…

- My boss and my team BOTH care about providing quality treatment
- My boss and my team have different opinions for what that looks like.

We start with opinions and observations

Opinions inform what data should be gathered

Data provides direction for programming

- My therapists (and probably most of yours) don't care much for data

Hospital referrals CBHC.xlsx

The Secret Studies

Neither side had any data to support their claim so I quietly began gathering data of my own in order to make an informed decision. Support staff and I collected 4 months of data to answer the question:

Should we change our intake process?

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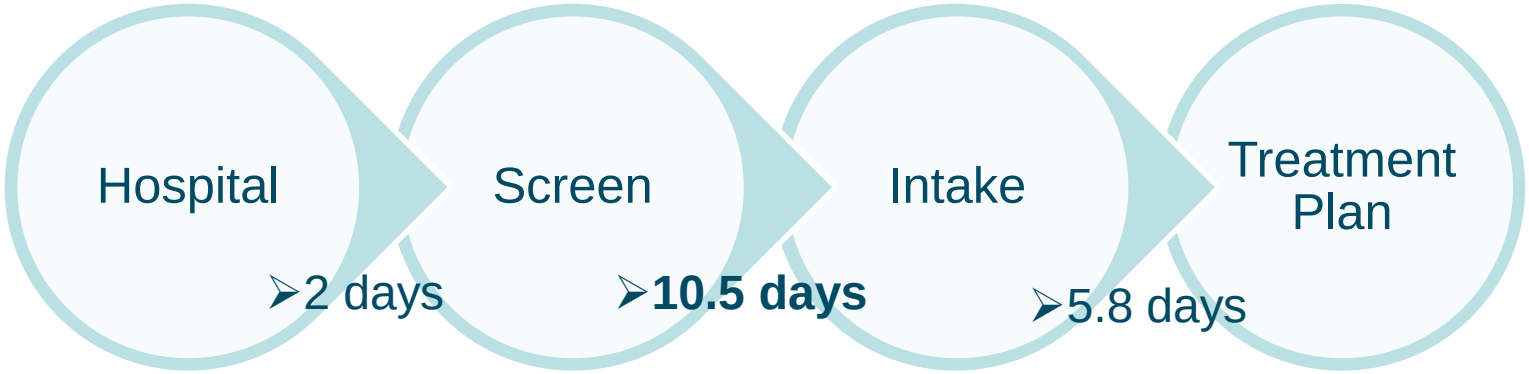
Results:



Average number of days between Hospital Discharge and 1st non assessment Appointment:

18.31 Days!

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Improving the process for greater efficiency:

Now engaged, staff were took the lead on finding a solution:

Original Screen

- Risk Assessment
- Safety plan

Combining Screen and Intake

- Risk assessment became part of intake
- If family has hospital Safety plan, complete intake and treatment plan only. If family does not, do Safety plan

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With our current access trends, how do we make sure all clients are seen in a reasonable amount of time?

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	No shows	Appts. Kept	Appt. offered
Average initial appts/week:	2.29	5.29	7.59
Max in a week:	6	11	15
Mode (most often):	2	5	8
Rate:	30.23%	69.77%	

We need a plan that would

- ❑Offer around 8 Intake slots per week
- ❑Assume that about 2-3 would no show
- ❑Avoid putting extra stressors on already busy therapists
- ❑User friendly for support staff
- ❑Have the ability to provide up to 15 appts if needed

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Use Open Calendar Space

Pros

- Avoids putting extra stress on therapists

Cons

- Not enough intake slots offered
- Does not account for no shows
- Hard for supports staff to find space

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Each of the 3 therapists offer 3 appts per week

Pros

- 9 slots offered
- Therapists could choose when apts are offered to fit in their schedule

Cons

- May be hard on Support staff to search out random appt times
- Doesn't account for no snows and unproductive time
- Doesn't account for super busy weeks

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Same day access (2/day)

Pros

- Enough appts offered (10)
- Simple for support staff
- Same day access

Cons

- Doesn't account for no shows
- More apts offered than data indicates could lead to non-productive time

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Mini Intake Clinic- 2+2+2=9

Day	Mon	Tues	Wed	Thurs	Fri
Primary	T1		T2		T3
Secondary	T2		T3		T1
Back up	C or D		C or D		C or D

If more than 9 referrals came in a week, Support staff reached out to therapist

Primary: appt scheduled and an appt show
Secondary: appt scheduled but not as likely to show
Back up: could have an appt scheduled and unlikely to show

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Mini Intake Clinic (2+2+2=9)

We need a plan that would

- ✓Offer around 8 Intake slots per week
- ✓Assume that about 2-3 would no show
- ✓Avoid putting extra stressors on already busy therapists
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Conversation with QA

1. QI double checked my numbers
2. Talked through the project and asked helpful questions
3. We made decision to go from “days” to “business days”
4. Made much prettier graphs
5. Helped me set goals
   - Goal 1: Clients complete Intake within 2 business days of hospital discharge (Goal=60%)
   - Goal 2: Clients do first non-assessment appointment within 7 business days of hospital discharge
   - Goal 3: 100% of initial appts offered within 2 business days of hospital discharge

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The results…

Measurement	Before	After	Goal
Days between Hospital release and intake	*9.31	3.40	2
Percentage of initial appts. offered within 2 days	46.2%	81.8%	100%
Percentage of intakes completed within 1 day	2.9%	26%	NA
Percentage of intakes completed within 2 days	11.4%	56%	60%
Percentage of Clients engaging in 1 non-assessment visit	55.3%	71.2%	NA
Days between release and 1st non-assessment appt.	*16.96	11.27	7

*Numbers differ from Original data set to reflect change from “days” to “business days”.

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Issues:	Solutions:

Getting used to a new system	• Change Management:
	  • Being open to feedback; even negative
	  • Validating concerns and fears of all staff while still moving project forward.

Hospitals not informing us of discharge	• Developed a closer working relationship with hospital liaison • Accept that this will happen and do the best we can
Most releases occur on Fridays	• Adjusted schedule to be Mon-Tues-Thurs

Unintended Positive Consequences:

- Free up Coordinator time to focus on other projects
- Staff engagement-All clinicians and support staff unanimously preferred the new system.
- Collaboratively changing program gave me a better connection with my team.
- Data collection method lead to Support staff education and training. Questions that came up lead to collaborative problem solving.

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Takeaways

1. Its easy to differ in opinions, Its hard to argue with solid data
2. Therapist engagement improves with collaboration: Figure out the direction and give team space and freedom to figure out the HOW.
3. Don’t be afraid to question the status quo.
4. Instead of asking “How do I please others?” ask, “what makes sense for my team? My agency? My community?” Others will be pleased with results.
5. If your QI department is awesome like mine, use it!
6. This is what worked for my team, follow the data that works for yours

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Thank you for your time

Any Questions?

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