Strategies for Minding the Back Door

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MTM SERVICES SPQM

Measure • Transform • Maximize

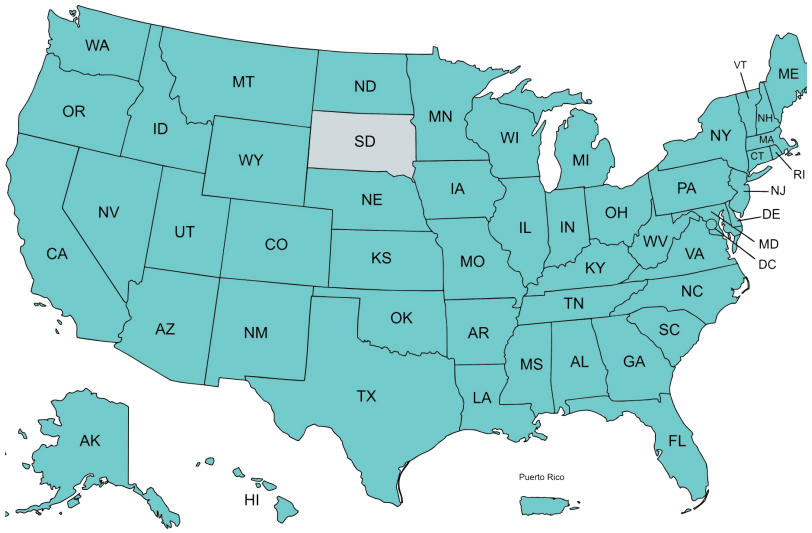
NATIONAL COUNCIL for Mental Wellbeing

PLATINUM PARTNER

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, Puerto Rico, Canada and The Netherlands since 1995.
- Leading CCBHC set up and/or TA efforts in more than 35 states across the country since the program's inception in 2014 (Statewide and Individual Centers).

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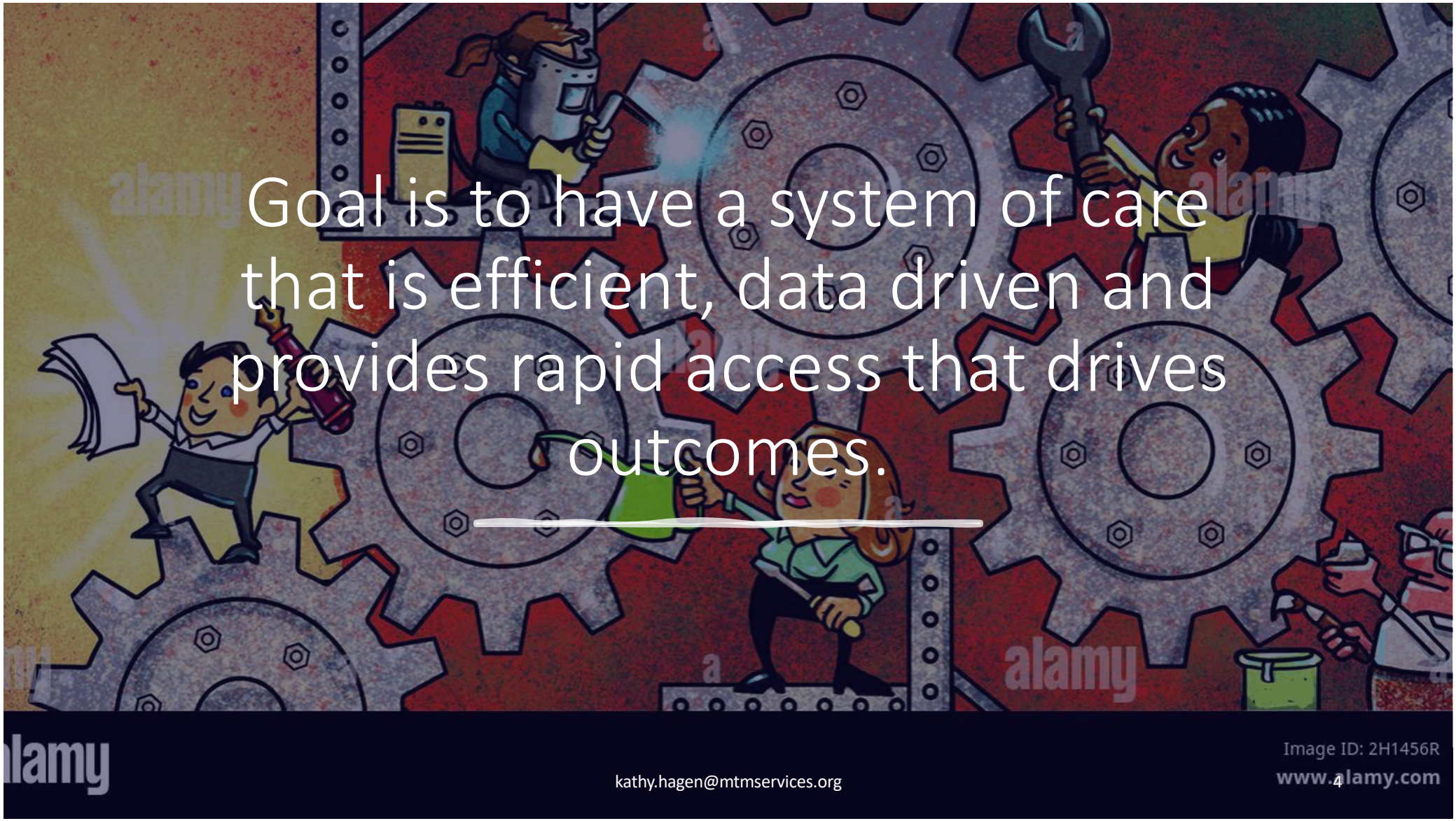
Objectives

- Identify the barriers to moving clients through services.
- Learn about system solutions that can ensure **intentional** movement through an episode of care.
- Learn how to manage psychiatric services more efficiently.


Goal is to have a system of care that is efficient, data driven and provides rapid access that drives outcomes.
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Challenges

- System barriers that drive dis-engagement
- Lack of guidelines for service frequency/depth
- False reality of “full” caseloads
- Accurate data to drive decision-making and change initiatives

Access Re-Design (where do we start?)

- Always with the DATA!
- We have to trust data and use it as our roadmap

What are your no show rates?

Do staff "block" time for paperwork?

What is average length of stay?

What are your outcomes?

How do staff determine service depth and frequency?

Developing a finely tuned system of care…

Rapid, low barrier access to care

Same Day Intakes

Intake to initial = 8 days max

Utilize Levels of Care to provide the right "dose"

Maximize clinical capacity through implementing system efficiencies

Centralized scheduling

Collaborative documentation

AI

EBP Training

Evaluate our Outcomes

We insist on engagement through a strong "no show" policy

When we focus on "chasing" clients who *choose* to not engage in services, we do so at the COST of those seeking services today

Managing “No Shows”

Start with a solid policy that sets the expectation at intake

NO Show Policy Trigger Recommendations:

2- No shows in 90 days

2 -consecutive No shows

3- Cancellations in 90 days

Next Steps:

NO MORE SCHEDULED APPOINTMENTS

Take this out of clinician hands- use another staff or Engagement Specialist

Send a 10-day letter

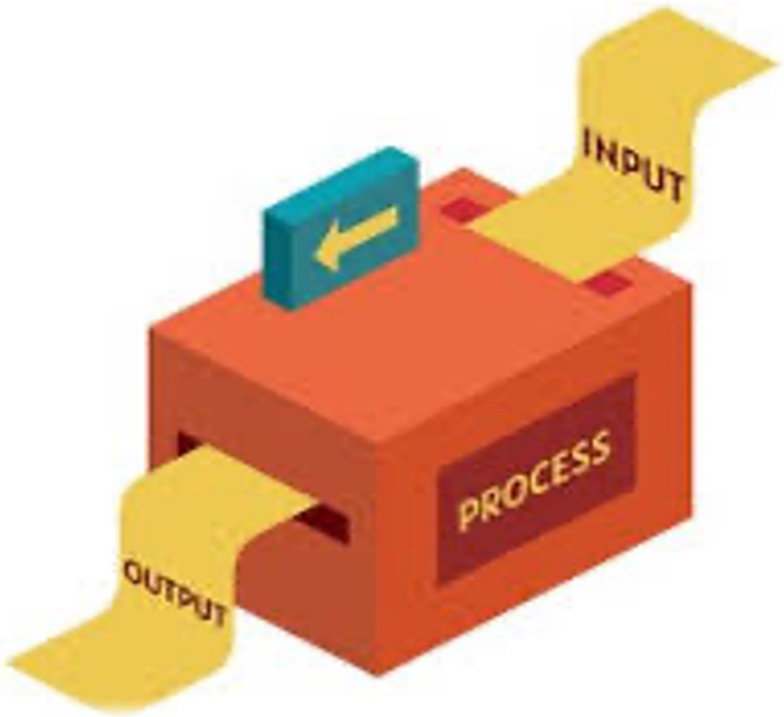
Negotiate temporary scheduling plan or discharge within 30 days

A Strong Engagement Policy = Efficient System of Care

Focusing on engaged clients will increase outcomes

Keep clinicians happy- they want to see clients!

Increase productivity = Revenue

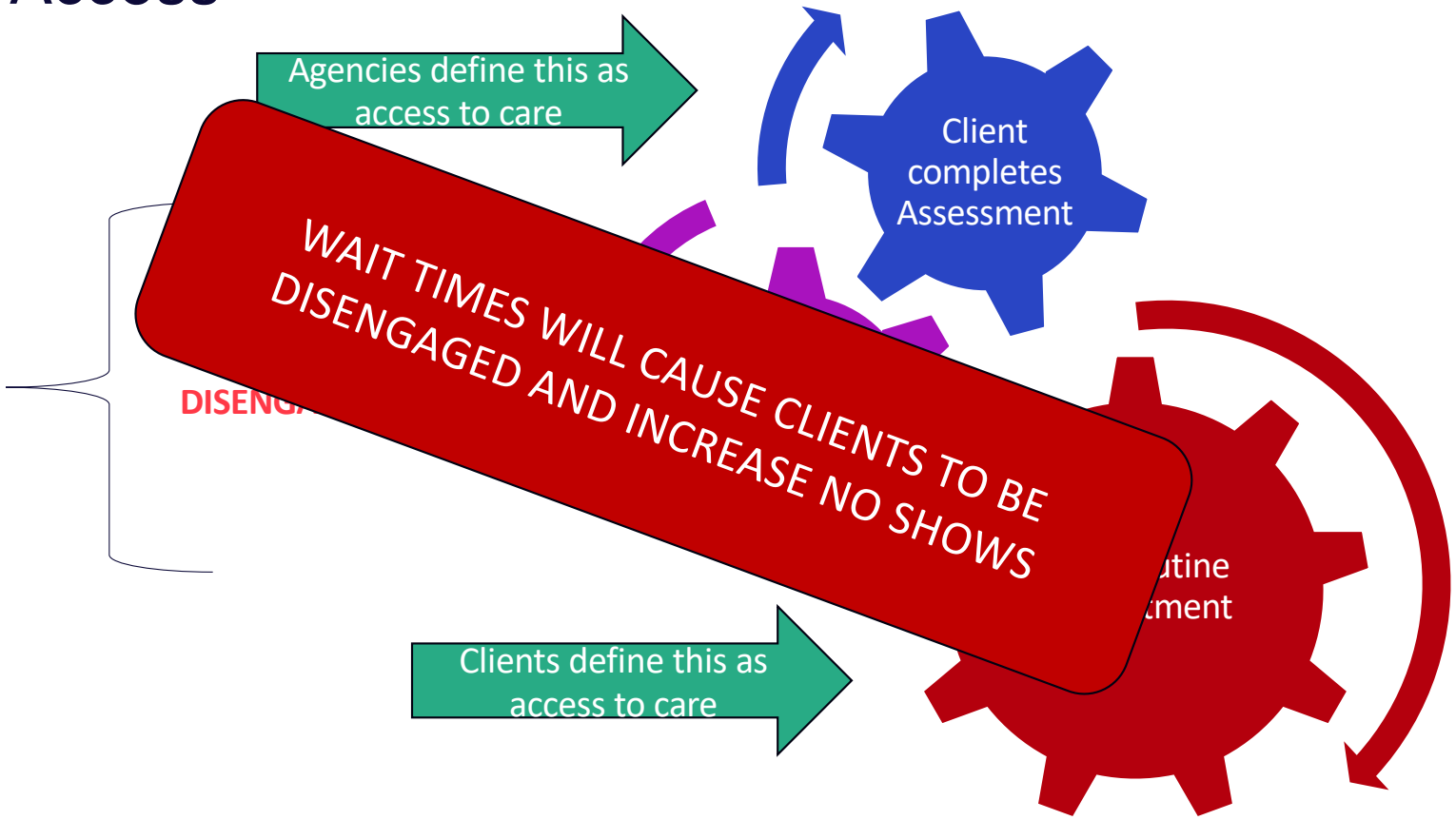


What does ”Access” look like at your agency?

- Can clients enroll in services same day?
- Can they receive an appointment within 8 days of enrollment?
- Can they access psychiatry within 3-5 days of an intake?

If your answer is “NO” to any of those questions, you will struggle with client engagement

Defining Access



Same Day Access- Why?

- ✓ Provides care when clients need it
- ✓ Exceeds CCBHC Requirements
- ✓ Maximizes clinical capacity
- ✓ Better client engagement- 12% average increase in volume
- ✓ 0% No Show rate

Get data on current system

- Who does what and how long does it take

re session

Total cost of intake- $448.00
Total Reimbursement- $292.00

Begin to build the new system

- Ensure clinical staff work top of license
- Data map
- Choregraph the expected workflow
- Build your contingency plan

Use data to establish staff hours and intake days/times

Pre SDA- offered 65-96 intake slots but only averaged 33-40 intakes/week

GO LIVE and Monitor for Outcomes

Same Day Access

Division:	Agency A
Assessment/Clinical Staff Time	
Direct Service Hours Delivered Per FTE Per Day	6
Avg. Direct Service Time Per Intake (Min.)	60
Avg. Length of Post Session Activities (Min.)	0.5
Total Direct Service Intake Time in Hours	1.00
Maximum # Intakes Per Day per FTE	6.00

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Total Post Session Hours	Days Per Week	Days Per Year
0.05	5	260

Total Hours Required	Holidays	Hours Needed/Day (w ps)	Hours Needed/Day (no ps)
6.05	11	0.68	0.67

# of Months		Projected % of Increase			
12	Kept	15%	Scheduled	No Show %	
Total Intakes	145	166.75	250	42%	
Intakes Per Month	12.08	13.90	20.83	8.75	Difference
Intakes Per Day	0.58	0.67	1.00	0.42	
FTEs	0.10	0.11	0.17	0.07	

Clinical Staff Breakdown		FTE
Total FTE needed		0.11
% Telehealth	30.0%	0.03
% Telephonic	50.0%	0.06
% In-office	25.0%	0.03

Common Misapplications of Same Day Access

Offering walk-ins for paperwork and then scheduling the assessment

Offering open access times AND scheduling intakes

Telling clients “First Come, First Service”

What about access to Psychiatry?

Most adult clients want to see the psychiatrist, yet we often put barriers in the way of access due to limited capacity and cost of this care

No shows for these providers is very costly to the agency

What are we teaching clients about managing their own healthcare? Are we embracing recovery-oriented care?

Just In Time Scheduling

March 2025 to May 2025

12% cancellations and no shows

7% just no shows

Operational Hours per Day	Work Days PY
8	208
Billable Hour Standard	
70.0%	
Available Hours Per Year	1,664
Annual Leave / PTO	40
Personal / Holidays / Sick	128
Charting/Paperwork	384
Supervision	72
Travel	0
Scheduling	0
Other Non-Billable Activity	-1
Non-Billable Hours:	4
Billable Hours:	1

	Bill Standa
	11

CPT Codes	# of Events Delivered in Each Level			
Total Events:	298	Must Equal 100%	100%	
90792	37	1.00	12%	37.00
99213	74	0.50	25%	37.00
99214	86	0.50	29%	43.00
99215	27	0.50	9%	13.50
99205	74	1.00	25%	74.00
99204				
0				
0				

service depth

- expect
ents

Recovery
ach clients to be responsible for their healthcare

Developing a finely tuned system of care…

Treat to Target- Levels of Care

Adult Outpatient
Levels of Care

Group Only Services	
This is for individuals who either are transferring out of care or who are medication management only	
Services Allowed	**Service Length**
Group Services	On-going for medication management
	3 months for those graduating

Level 1	
DLA-20 score between 5.1-5.9- Eligible for telehealth	
Average Length of Service- 90 days (about 3 months) or less	
Services Allowed	**Service Length**
Individual Counseling	Maximum of 15 sessions.
Peer Support, Group	Maximum of 4 sessions
Psychiatric Services	Not eligible. Please coordinate with PCP for medication evaluation and management

Level 2	
DLA-20 Score between 4.1-5.0 Score 4.5 or higher eligible for telehealth	
Average Length of Service- 6 months	
Services Allowed	**Service Length**
Counseling- mental health counselor or MHP	Maximum of 24 sessions; **Must provide 1-3 outreach sessions focused on engagement.**
Case Management	Maximum of 12 sessions. Services must include: Connection to primary care, dental, and at least one community resource for support.
Peer Support	Minimum of 1 session and maximum of 10 sessions. This must include orientation to Advanced Directives and WRAP.
Group Services	Minimum of 1 group session
Medication	Allowed if indicated.

- Are we using outcome tools to help clinicians guide treatment and demonstrate outcomes?
- Not every client requires the same level of service. Why do we offer it?
- Utilizing data to drive care- clinicians and clients struggle with discharging

Why Use Levels of Care?

Cost Effective

Maximizes Clinical Capacity

Demonstrates Outcomes

Support to staff especially newer clinicians

Keeps your system of care moving- serve more people

Example Level of Care

Level of Care # 2	SERVICE	AMOUNT	AVERAGE COST
Indicators of Level: • Qualifying DSM 5 Diagnosis • LOCUS Level 2 • DLA-20 4.1- 5.0	**Typical Length of Services: Up to 12 Months** **(Reassessed at program standard contract requirement times)**		
	1. Biopsychosocial Assessment	• Total of one hour	
	2. Crisis Interventions	• As medically necessary	
	3. Care Coordination	• 90 days (frequency by needs and reevaluated at 90 days for continued services)	
	4. Counseling/Psychotherapy	• Individual/Family Therapy: Up to 20 Sessions **AND/OR** • Group: Up to 15 group sessions or based on evidenced based group curriculum requirements	
	5. Medication Services	• As needed and determined by prescriber	
Possible Descriptors: • No recent history of inpatient services • Moderate symptoms, e.g., frequent, moderate depressed mood, insomnia and obsessing, or occasional anxiety attacks, circumstantial speech) • No imminent danger to self or others • Good structure and supports in his/her life • Everyday functioning is moderately impaired, meaning moderate difficulties in more than 1 area of social, work or school functioning • Potential for compliance is good • Acute stabilization may be needed		**Discharge Criteria:** • Stable on meds • Successfully managing medication regime • Means of obtaining meds when discharged • Community integration • Community support • Medical needs addressed • Minimal mild symptoms • Client is goal directed and has made measurable progress with treatment plan goals. • Employed or otherwise consistently engaged (volunteer, etc.) • Client has a good understanding of illness • Family or significant other(s) understand and support the client and illness	

Are you providing team-based care?

- Many consumers entering services present with social determinants of health over true psychotherapy needs are we treating to top of credential?
- How do you hold staff accountable to team-based care? Do you have data and reporting that supports this initiative

Uses for LOC for Leadership

- Analyze the acuity of population served and if their needs are being met with current service delivery models
- Manage community needs vs capacity by using resources and care more efficiently
- Greater knowledge of costs associated with each LOC- this can drive your staffing model
- Prepares you for integrated service arrangement with the broader healthcare system (health homes, MCO's, etc)

Keys to Success

- Identify, remove and/or minimize any barriers that will prevent compliance with LOC
- **Clarify roles of staff**
- Assess and address training needs to ensure technical and core competency expertise
- Provide frequent and honest communication opportunities with staff
- All staff must demonstrate fluency =cultural shift

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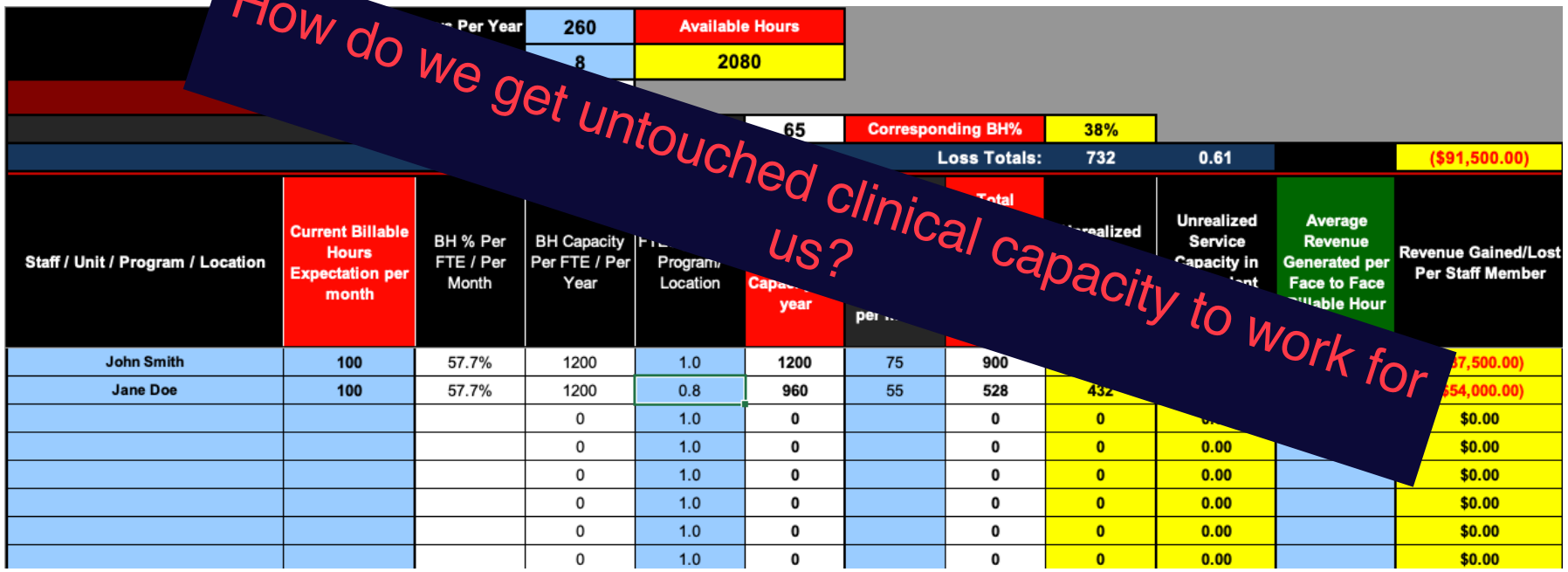
PRODUCTIVITY IS A MEASURE OF HOW WELL OUR SYSTEMS ARE WORKING FOR OUR STAFF TEAMS



			Per Year	260	Available Hours						
				8	2080						
						65	Corresponding BH%	38%			
								Loss Totals:	732	0.61	($91,500.00)
Staff / Unit / Program / Location	Current Billable Hours Expectation per month	BH % Per FTE / Per Month	BH Capacity Per FTE / Per Year	Program/ Location	Capa… year	per …	Total …	…realized	Unrealized Service Capacity in …	Average Revenue Generated per Face to Face …illable Hour	Revenue Gained/Lost Per Staff Member
John Smith	100	57.7%	1200	1.0	1200	75	900				…7,500.00)
Jane Doe	100	57.7%	1200	0.8	960	55	528	432			…54,000.00)
			0	1.0	0		0	0			$0.00
			0	1.0	0		0	0	0.00		$0.00
			0	1.0	0		0	0	0.00		$0.00
			0	1.0	0		0	0	0.00		$0.00
			0	1.0	0		0	0	0.00		$0.00
			0	1.0	0		0	0	0.00		$0.00

How do we get untouched clinical capacity to work for us?

Centralized Scheduling

- Pandemic had many of us shift back to clinicians scheduling
- On average clinicians will spend 100 hours a year scheduling
- We need to have scheduling experts manage the calendar
- Eliminate re-occurring appointments- not client centered and lead to increased no shows

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Collaborative Documentation

- This is NOT concurrent documentation
- It is an evidence-based practice that is shown to increase client engagement
- It works WITH AI
- Clinicians working at home/weekends leads to burnout
- It is a clinical skill that must be taught AND practiced
- We need to not suggest it, but expect it

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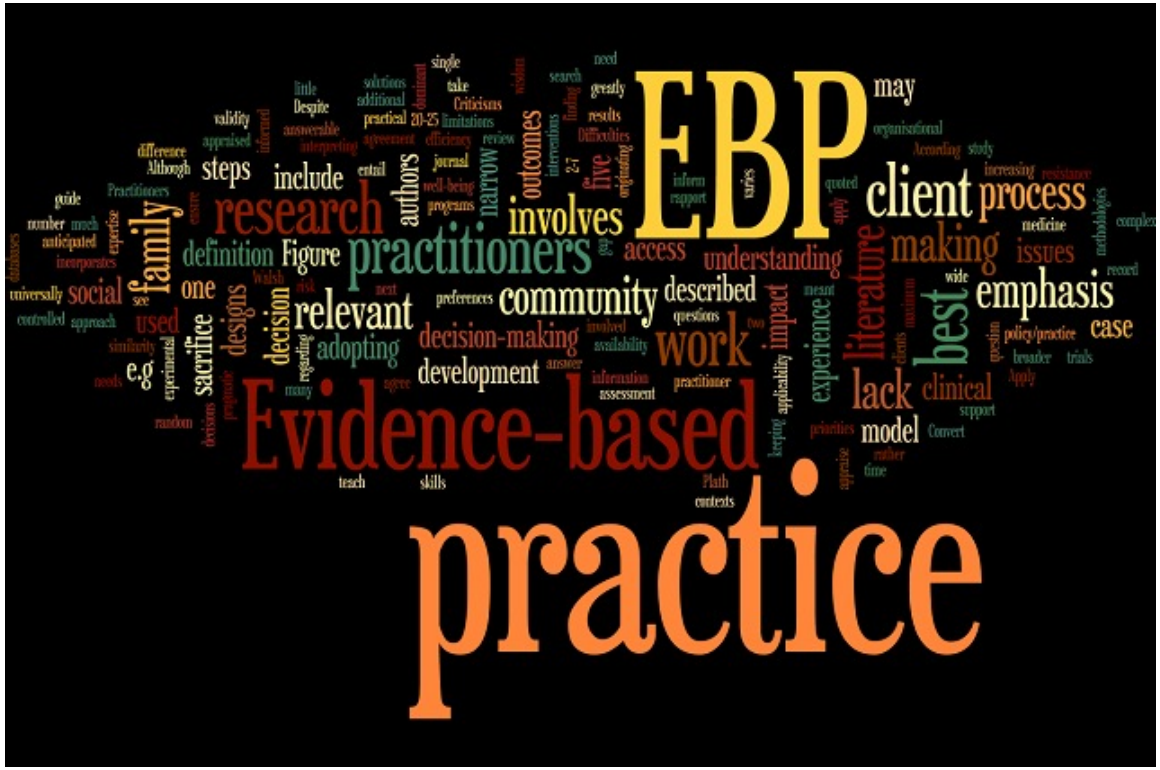
Evidenced Based Practice

Establishes best practices care pathways for new clinicians that will drive outcomes

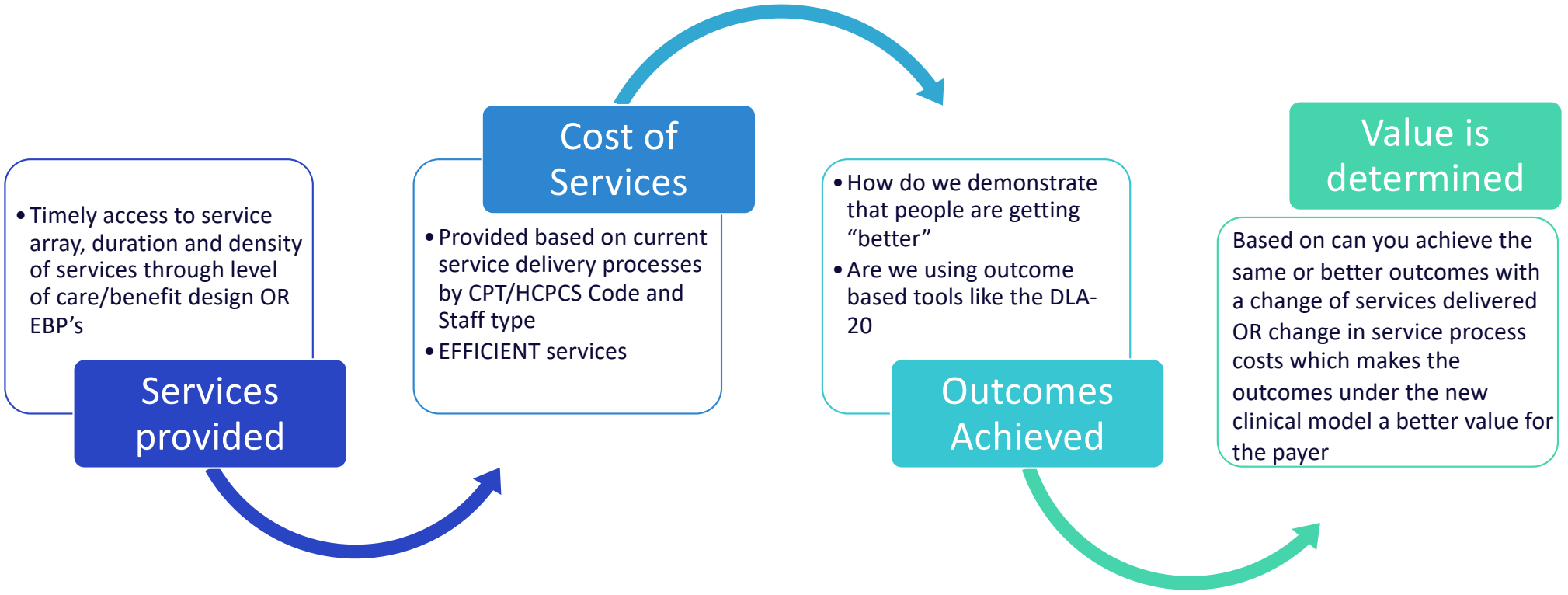
CCBHCs are required to utilize EBP's and demonstrate that staff apply them competently

It's not just for therapists



Developing a finely tuned system of care…

“Value” of Care Equation



What is your outcome tool?

Identify how you will gather the data on client outcomes?

Develop reporting so all levels of leadership can see it?

Build case consultation around outcomes and data

LOCUS

LEVEL OF CARE UTILIZATION SYSTEM
FOR
PSYCHIATRIC AND ADDICTION SERVICES

Adult Version 2010

AMERICAN ASSOCIATION
OF COMMUNITY PSYCHIATRISTS

March 20, 2009

ANSA

FOR NEEDS:

a. No evidence
b. Watchful waiting/prevention
c. Action
d. Immediate/Intensive Action

FOR STRENGTHS:

1.Centerpiece strength
2. Strength that you can use in planning
3. Identified-strength-must be built
4. No strength identified

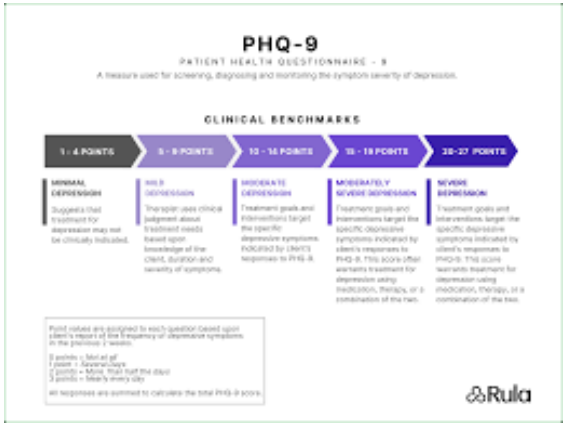
CANS

FOR NEEDS:

0 – No evidence
1 – Watchful waiting/prevention
2 – Action
3 – Immediate/Intensive Action

FOR STRENGTHS:

0 – Centerpiece strength
1 – Strength that you can use in planning
2 – Identified-strength-must be built
3 – No strength identified



Data Driven Decision Making and Sustainability

- Must base any decision in data- move away from “gut” or “feelings” (I know we live in feelings, but not helpful here)
- Learn to trust data and get what you need to diagnose the problem accurately
- This is new, hold each other accountable to this value until it becomes habit
- Are you utilizing a continuous quality improvement lens to inform you when something is NOT working- must correct rapidly

QUESTIONS?

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Thank You

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See our outcomes, resources and more…

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