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SPQM

Effective Strategies to Address Workforce Shortages

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Nothing to disclose

Learning Objectives

- Review Centralized Scheduling, Just-in-Time Medical Provider Scheduling and EBPs needed to support implementation
- Explain how these strategies maximize existing clinical capacity
- Review effective implementation considerations, decisions and approaches

BH Workforce Economics

- Turnover – 33% annual Turnover (Behavioral Health Business Report) compared to Hospital Rates of 19.5%
  - Cost of Turnover is severely impacting a system with low margins
  - Lose growth potential for the organization – developing the leaders of tomorrow
- Salary does matter
  - BH lags other sectors – including other healthcare sectors
  - Rates are not rising to meet increased staffing cost – will VBC/PPS make a difference?
  - Benefits may not be inline with other employers – fewer holidays, 24/7 coverage, limiting PTO use because of required overtime/call out coverage

BH Workforce Potential Strengths

- Mission Driven … Meeting client needs leads to Staff Engagement and Commitment
- Leadership Styles … Commit to Continuous Transformational Change
  - Hire for and Develop Emotional intelligence
  - Engage staff at all levels in change initiatives
  - Remove Silos and build medical/clinical/business teams that value and support each other … increase efficiency … increase productivity … increase wages
- Prepare for VBC/PPS Models … salary increases require systems and staff to be nimble, *effective* and *efficient*
- Be Flexible … Telecommuting, Four-day work weeks, Flexible PTO
- Prevent Work Creep … support your staff by promoting a healthy work/life balance

Critical Concepts

- Why are we doing this … meet the needs of clients … create a environment where people want to work …maintain financial sustainability!
- CBHCs are *Group Practices* … not individual private practices … consistent practices *mitigate risk* and support *efficient* and *effective* care
  - Protocols, Care Pathways, Workflows, Schedules are designed and implemented by the organization … not Individual Service Providers
  - Individual Provider input is valued … but decisions are based on measurable EBPs, and client and organizational needs … staff must adhere to established protocols
- *Productivity* means increased access to *high quality* care … all departments need to work together to ensure the system makes is easy for clients to be seen and for clinicians and medical providers to deliver care
- *Transformational Change* is disruptive and uncomfortable … but ultimately leads to improved care, improved workforce satisfaction and increased retention of staff who are committed to the mission of the organization

Building Capacity in your System

- Hold the System (Workflows, Care Pathways), *Tools* and all Staff Accountable
  - Do your Workflows support the work of medical, clinical and business activities?
  - Do your Care Pathways promote Measurement Driven, Team Base Care?
  - Do your Workflows support efficient activity in all sectors?
  - Do your tools support efficient service delivery?
  - Are you capturing all revenue sources?
- Engage in Transformational Change Initiatives to improve how your system operates
  - Centralized Scheduling
  - JIT Medical Service Delivery
  - E/M Assessment Standardization and Concurrent/Collaborative Documentation
  - Use of Measurement Tools

Centralized Scheduling

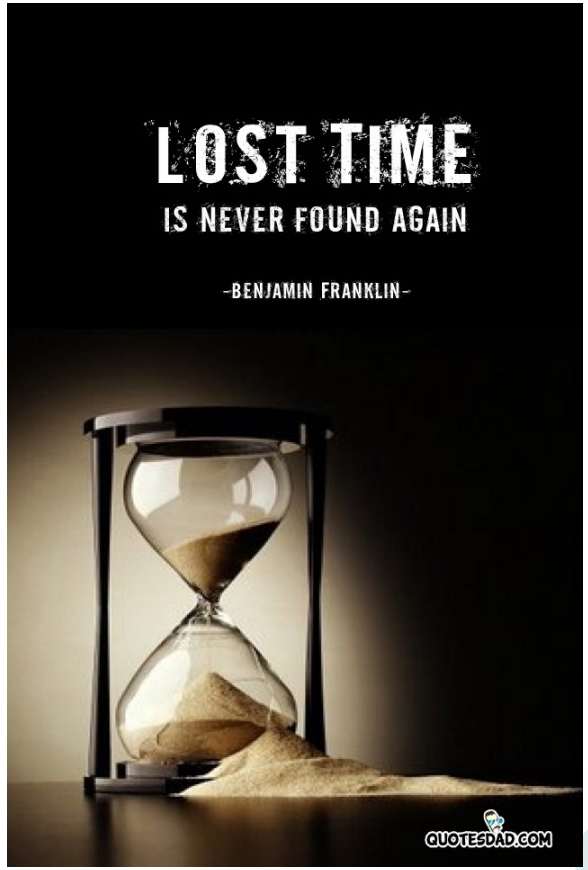
- A Client-Focused Practice Management Tool
  - Promotes Rapid Response to Client Scheduling Needs
  - Makes Efficient Use of Valuable Human Resources
  - Reduces No Shows
  - Allows access to all available clinical capacity at any given moment

BECAUSE

- Support Staff – NOT Clinicians – Schedule All Appointments
  - Scheduling is A BUSINESS FUNCTION not a Therapeutic Intervention
  - Staff should be empowered to perform tasks within their area of expertise

Why Centralized Scheduling?

- Clients deserve a quick response to scheduling requests – clinicians simply cannot supply that level of customer service
- Clinicians lose 2-3 hours per week of service provision due to scheduling functions and scheduling failures
- With Centralized Scheduling, your organization could see more clients without adding any additional staff!



Why Centralized Scheduling?

- Typically, CS more than pays for itself in increased clinician productivity.

Cost benefit of the use of Centralized Scheduling

Office Staff FTEs	Hours lost (weekly) to scheduling functions	Total agency hours lost (weekly)
24	2.5	60

Agency-Wide

Billable hours lost to scheduling (weekly)	Average Reimbursement per billable hour	Potential Revenue Lost due to unbillable scheduling (daily)
60	$75.06	$4,504

Potential Revenue Lost due to unbillable scheduling (Monthly)
$18,014

Potential Revenue Lost due to unbillable scheduling (Annually)
$216,173

Essential Elements of Centralized Scheduling

- All scheduling is managed by support staff; Clinicians have *Read-Only Access* to their schedule.
- Scheduling staff are aware of all available clinician time and resources as part of the *Group Practice Model*
- Clinical time is scheduled using *"Just in Time"* Principles
- Make *Confirmation* – not Reminder - *Contact* 48 hours in advance reducing no shows and maximizing clinical capacity:

"You have an appointment with _____ on _____ at _____.

Do you still plan to see _____ or would it be better if we reschedule you?"

- Scheduling staff *can Backfill* 90% of all cancelled appointments by maintaining a will call list for all clinicians

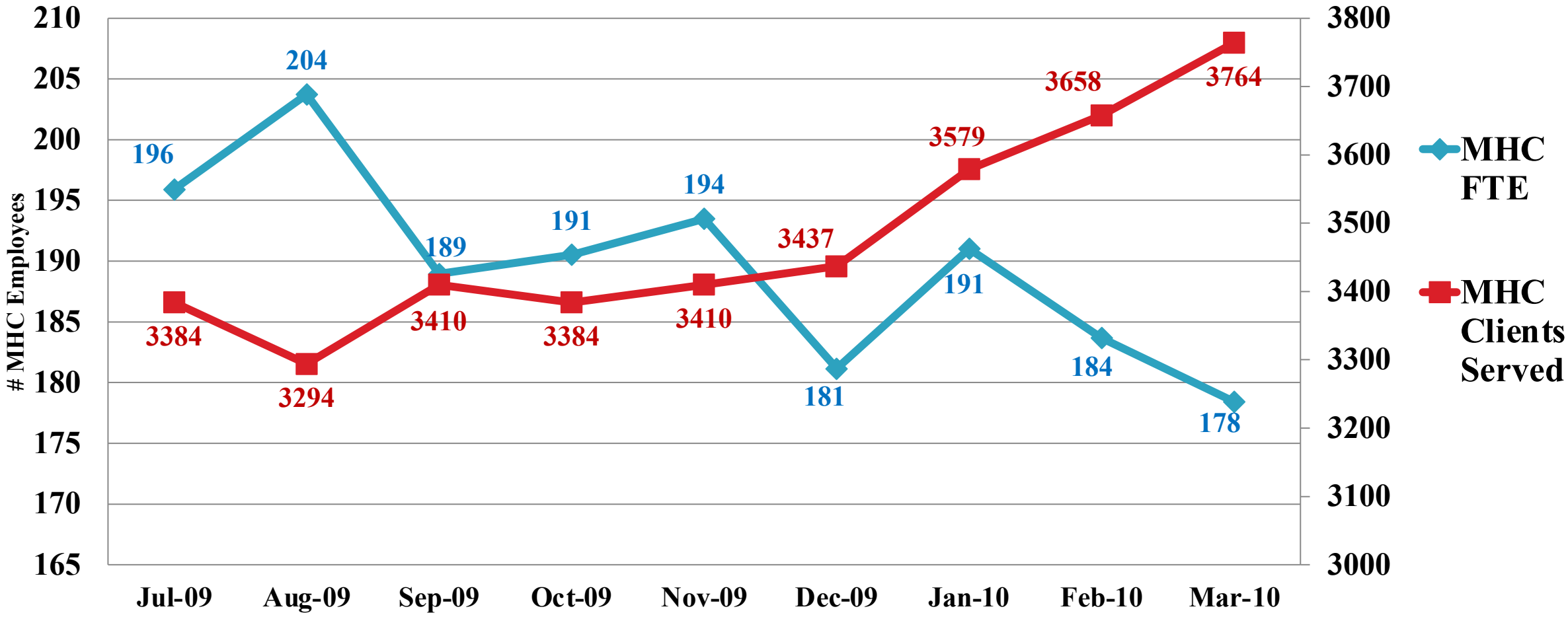
Steps to Implementing Centralized Scheduling

- Calculate level of Scheduling Support Needed
- Create Scheduling Templates
  - 8 appointments per day, minimum (assuming a “therapeutic hour”)
  - No scheduled paperwork hours or days. Clinicians should be doing *Collaborative Documentation.*
  - No staff meetings longer than 1-hour
  - Schedule 30-minute appointments for clients who have completed 75 percent of their Episode of Care.
- Create Protocols for Allowable Standing Appointments
  - Supervision, Training, Multidisciplinary Treatment Teams, Staff Meetings, Meals
  - Establish Schedule two months in advance
- Create Backfill Processes
- Identify Relevant KPIs to Monitor Scheduling Practices
  - 90% Backfill Rate for Cancelled Appointments
  - SDA Support
- Restrict Scheduling Authority

Backfill Practices

- Identify how to create a Backfill Process using Shared Drives, EHR Processes or other IT Resource
  - Automatic Systems – not email based
  - Schedulers need easy and rapid access to system
  - Create Policies and Procedures to promote appropriate use of this resource
- Schedulers are responsible for identifying and filling open appointment slots
  - Add clients to the Backfill list who could not get their preferred day/time
  - Fill with Same Day Access Overflow
  - Updating Biopsychosocial Assessments
- Each Clinician identifies clients who should be placed on their Backfill List
  - Based on LOC Needs and current Treatment Plan or ISP
    - Benefit from Additional Session
    - Need a sooner appointment
  - Consistent with Counseling Strategy – CBT, ACT, Solution Focused, EMDR
  - List should be reviewed and updated weekly

Colorado West Persons Served per Full Time Equivalent Staff



Just In Time (JIT) Medical Provider Scheduling

- Appointments are not scheduled when a client leaves their appointment … they are made when the client needs to return
  - When they are running out of Medication
  - If they are having side effects
  - When Symptoms or Circumstances change
  - Follows LOC Treatment Plan model
- Clients call to make an appointment and are scheduled within 3-5 days
  - Rapid access when client is motivated to be seen
  - Clients make appointments that work with schedule today … not months in advance

Why JIT

- What is your Kept Rate?
  - Averages around 70% … meaning 30% of your provider time is spent not seeing clients
- How long does someone wait for an initial evaluation?
  - New Evaluations on average have a lower kept rate … those needed help are not getting it
- How long does someone wait to be seen if an appointment is cancelled or they no show?
  - Time and energy is spent sending bridge prescriptions rather than providing care

Essential Elements of JIT

- Appointments are scheduled within 3-5 days of a request to be seen
- No More Bridge Prescriptions - Bridge Prescriptions are not a medical best practice
- No Show events do not lead to a rescheduled regularly appointment
  - Referred to the “No Show Needs an Appointment” Clinic or NSNAP
  - Brief engagement to assess safety and refill medication for no more than 30 days
  - Nursing visit or provider visit … and not guaranteed to see assigned provider
- Staff must follow the workflows and policies developed for implementation of JIT as part of the agency *Group Practice*
- Make sure you have adequate capacity to support a truly full schedule – 80% of provider time will be spent seeing clients

Steps to Implementing JIT

- Identify Implementation Team and Create a Timeline
  - Implementation Team – multi-departmental with senior leadership support
  - Four to five months time frame with weekly goals
- Critical Tasks
  - Determine Capacity needs – Providers, Call Center
  - Establish Scheduling Template
    - Scheduled Appointments/Wave Blocks
    - Walk-in Blocks
    - NSNAP
    - Administrative Time
  - Communication Plan
    - Department – Agency – Client – Community
    - FAQ – Client Letters – Scripts
    - Engage other Departments and Programming as part of your communication process
  - Trouble Shooting Concerns
    - Transportation
    - Schedule filling up too quickly

NSNAP – Bridge Appointments

- Replace Bridge Prescription with Bridge Appointments
- Brief, focused encounter - Provider (99213) or Nursing (99211)
  - Safety
  - Medication Effectiveness
  - Side Effects
- No Change in Medications
- Motivational Encounter – Importance of seeing provider as scheduled
- No guarantee of seeing regular provider – Adequate Supply Until Next Appointment (5-30 days)
- Establish policies to avoid misuse

JIT Evidence Based Outcomes

- Increased Access and Decreased Wait times
  - Seeing clients on their timeframe and within the *Group Practice* Framework
  - Positive Impact on HEDIS Measures
- Increased Capacity and Productivity
  - Kept rate becomes 90% or higher … number of clients seen increases without increasing your staff
- Increased Compliance due to increased engagement in treatment
  - Decrease need for Crisis Care and Improve Clinical Outcomes
- Stronger Provider-Client Partnership
  - Focus on Client Strength and Resilience rather than Deficit Based

Complementary Practices

- Increased Access to Care – addresses *Efficiency of Service Delivery*
  - Centralized Scheduling
  - JIT
  - SDA
- Building a Team Based System – everyone working within their area of expertise – addresses *Effectiveness of Care*
  - Stratified Delivery of Care
  - LOC Practices
    - Frequency of contact
    - Measurement based – reflects *Quality of Care*

Level of Care (LOC) Treatment Planning

- Measurement Based Tools
  - Symptom Based – PHQ9, GAD 7, PDSS-SR, PCL, BPRS, PANSS 6, C-SSRS, Vanderbilt
  - SUD – AUDIT, CAGE, BAM
  - Functional – WHO-DAS, DLA 20
- Protocols and Care Pathways drive LOC Placement and treatment planning – addressing *Compliance* and decreasing enterprise risk
  - Monitor Effectiveness … changing interventions based on response to care
  - Established consistent practices based on current symptoms, behaviors and functionality
  - Frequency of appointments … weekly to every 6 months

Documentation Practices

- E/M – 2021 Standards
  - AMA/CMS made more efficient to promote increased engagement, making patient care more important than paperwork
  - Establishing Medical Necessity by documenting Medically Appropriate Evaluation Elements
  - Billing based on Complexity and Medical Decision Making, not time or Number of Elements Reviewed
- Concurrent/Collaborative Documentation
  - Documentation During Appointment with client Input whenever possible
  - Multidisciplinary Documents – Team Based Care

Don’t Blink – Stay the Course!

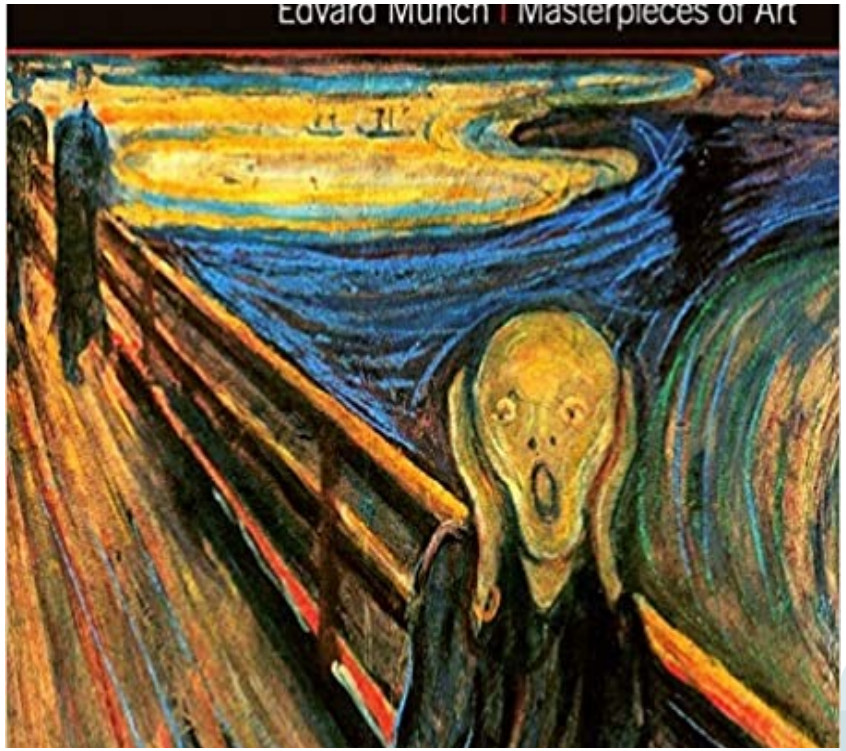
Change causes stress and resistance

Make sure you focus on WHY

Keep messaging consistent

Brainstorm solutions as a Team … but make sure the solutions maintain fidelity to the model

BREATHE!



Final Thoughts

Transformational Change is Disruptive Change

Disruptive changes require Engagement and Acceptance to Succeed

Engagement requires honest Communication and Team Building

Team Building requires commitment to creating a system of excellence, valuing different perspectives … and accepting that data needs to drive decision making

Q&A

Resources

- Team Based Care Monograph - National Council for Mental Wellbeing
- Leadership that Gets Results – Daniel Goleman, HBR March-April 2020

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