ACTION Campaign II Webinar (August 20, 2009): Questions and Answers

Questions answered by Andrew Quanbeck, NIATx

Question: Our wait for intakes hasn't been too bad (yet), but our wait for ongoing appointments after the intake appointment has been terrible. What experience have people had with walk-in systems for ALL service contacts?

Answer: A couple of possible suggestions. First…if they don't do it already, intake staff should work with clinicians to develop schedules for group/individual appointments, and then (once schedules have been created) intake staff should have the ability to schedule directly into clinician schedules. Second, if you can incorporate more groups into your treatment planning (especially in the early stages), it can help. The same type of bottleneck usually seen at intake can be created if the first treatment is a scheduled individual therapy session. Some counselors feel strongly about this approach (and I don't claim to know much about clinical matters… but the little evidence I have seen seems to indicate that group therapy is as effective as individual therapy). You have to weigh the client's well being during the long period of waiting for an appointment, when he/she is receiving no help at all.

Question: I currently work in a NTP and the process described in the presentation today, is our "normal". If you look at a hospital emergency room, they utilize a "triage" system, which can easily be utilized in an outpatient treatment center.

Answer: I agree that we should treat requests for addiction treatment as emergent.

Question: Region 8 OAD experienced significant problems going to a walk in assessment. However, it has proven quite successful. This indicates a resistance to change, even though change proved beneficial.

Answer: Resistance is common. The best approach, I believe, is to appeal to staff members ethic of client service and involve staff in the process of change by forming Change Teams and using NIATx tools such as the walkthrough, nominal group technique, PDSA change cycles, etc.

Question: In one of our outpatient clinics, we developed an intake team to staff and be available during working hrs (day/evening) to be available for walk-ins.

Answer: Good idea.

Question: How do you handle walk-in appointments in very small offices, e.g. 1 or 2 counselors who may have group or individual session scheduled throughout the day?

Answer: This is a tough one because smaller organizations generally have less in the way of "slack" resources to call upon…. however, I think the same ideas/principles apply in this case; make sure everyone on staff is trained to do intakes and try to handle intakes whenever time permits. Other ideas welcome are welcome on this topic from smaller programs that have gone to walk-ins.

Question: SO, we are only "not scheduling" consumers, we are still scheduling clinicians. That results in loss of productivity for those clinicians and for clinic overall, right? 8 clinician hours "scheduled" as available for intake each day, with maybe only 1 or 2 appointments per day.

Answer: Intake staff needs to be *available* to do intakes, but not *scheduled* to do them. It is a subtle difference because we are very schedule-oriented in general. If we schedule intake times for clinicians, we haven't really changed anything and have missed the point…randomness is still at play and will blow the system up. Organizational flexibility is the key- being able to rapidly respond to fluctuations in intake demand.

Question: We are interested in reducing our wait time for services in our outpatient mental health program, but we don't have the treatment capacity to enroll everyone who calls for an appointment. How could we use walk-in intakes without being overwhelmed with more clients than we can appropriately serve? We've been triaging clients based on their risk-rather than scheduling appointments on a first come first serve basis.

Answer: This is a dilemma that many agencies have faced. Without better understanding your organization, it is hard to give direct advice but here are a couple of "food for thought" items: first, how are you defining treatment capacity? Are you using caseload as a measure? If so, caseload (in my opinion) is a notoriously bad measure of treatment capacity. I have seen agencies with caseloads in the 100s per counselor who are very unproductive (nobody ever shows up, and are not discharged on a timely basis). Second, there is sometimes a leap of faith involved with going to walk-ins. If you go to walk-ins (which will eliminate waiting time and no-shows, good for clients), you may be able to request more funding to handle the increase in admissions you will see. Generally you have to make the change and demonstrate results to justify funding increases (i.e., don't wait for someone to give you the money in advance). The challenge is handling the increased census with current resources, which can often be done with other process improvements.

Question: Related to limited bed space in residential in programs that have set lengths of stay, for example 21 days, would it effectively alleviate the waiting list if the residential programs would go to a process of moving consumers out sooner based on actual progress/needs in treatment, instead of keeping everyone the same period of time?

Answer: In theory, it sounds like that would help shorten the waiting list. But as you note, there may be clinical concerns that I don't feel qualified to address.

Question: We currently do walk in assessments. We do have DCFS referrals that can be transported a certain time. We do schedule those who have a specific transportation time. These numbers are limited. We are currently working on increasing accessibility of staff to help with assessments. We have an assessment team, but we will be adding a few counselors to help out.

Answer: Thanks for sharing.

Question: Negative response from staff initially; much improved now. We were scheduling appts. 6 weeks in advance prior to walk-in intakes. One of the positives is that we moved the intake unit (we call it Assessment Center) away from the clinics and rehab facilities, which allowed more intense treatment at these facilities. To allow for the increase in intakes, we added a treatment team of case managers to complete treatment plans, which ensures folks get to the right group. This has worked really well. The negativity of staff included one staff going on FMLA and one staff transferred to another clinic.

Answer: Another example of a team approach to handling increased intakes- the team approach is critical. Nobody can do this alone- it is an organizational process change that needs to involve everyone.

Question: Regarding residential programs, a possible solutions is to get clients into some kind of OP treatment while waiting for a bed - may require getting them into local OP program, as often clients travel far away for residential treatment.

Answer: Good suggestion- interim services at a lower level of care are better than no service at all.

Question: We often schedule more than 800 Intakes/month: How do you suggest we implement a walk-in system to accommodate that volume?

Answer: Good news and bad news. Good news is that being a large agency doesn't change any of the underlying dynamics presented today, so the principles of organizational flexibility, teamwork, and cross training still apply. Bad news is that it is often harder to implement significant process changes in larger organizations (at least quickly). I would suggest pilot testing walk-ins on a small scale, collecting data and showing results, learning from your experience, and then spreading on a larger scale.