HEARTLAND FAMILY SERVICE: IMPROVING ACCESS

The mission of Heartland Family Service (HFS) is to strengthen individuals and families in east central Nebraska and southwest Iowa through education, counseling and support services. HFS offers education, counseling, and support to give people the assistance they need to get back on their feet and look toward a brighter future. Founded in Omaha in 1875, HFS serves 40,000 people annually in twelve counties.

Improving access to treatment is a concern across the nation. According to a state by state breakdown of a 2006 NSDUH study, an estimated 52, 000 Iowa residents were shown to need treatment, but did not receive it in 2004 and 2005. The same study indicates an estimated 238,000 Iowans are deemed to be substance dependent or abusers.

HFS is one of several agencies working with the state of Iowa through the Strengthening Treatment Access and Retention- State Initiative (STAR-SI) grant. The Iowa Department of Public Health (IDPH) selected eight substance abuse treatment providers to participate in the first year of the STAR-SI grant. HFS received funding for this project from October 1, 2006 through September 30, 2007 and continues to be part of the Iowa STAR-SI Learning Collaborative.

CHANGE TEAM MEMBERS

Mary O'Neill, Program Director for Iowa Behavioral Health, a program of HFS, served as Executive Sponsor for the HFS Change Project, and T.J. Gorman, Therapist, was chosen to be the Change Leader. Marilyn Starke, Clinical Supervisor, for Iowa Substance Abuse Treatment Services, and Cheryle Ross, Office Manager for the Iowa Region, were also invited to participate on the Change Team, due to their positions and leadership skills. Other team members volunteered to participate: Lorelle Mueting, Iowa Project Manager Meth Treatment Services, Shannon Mahnke, Substance Abuse Case Manager for the Women and Children's Program, along with Kerry Black and Melissa Adkins both therapists within the substance abuse program. Shannon Mahnke and Lorelle Mueting both served as interim Change Leaders while Ms. Gorman was on an extended leave of absence. The Change Team met on a weekly basis and called on peer mentor, Kevin Gabbert, for support.

Kevin Gabbert completed a walk-through of the HFS substance abuse program and observed areas for improvement, such as wait time for assessment and amount of paperwork. HFS also conducted focus groups with Department of Human Services and the Fourth Judicial Probation Office, our two largest referral sources, requesting feedback about services provided. Both referral sources indicated they would like to see a reduction in wait time for assessment and treatment. In 2007 the longest wait time for assessment was in March, with a wait of 33 days.

HFS has completed Change Projects on increasing retention from assessment to admission, adolescent incentives, and improving retention throughout treatment with the implementation of the Matrix Model. The average length of time for our Change Projects

was one month. IDPH assigned two specific projects to HFS. These projects were to look at state-level system changes. The following information on Plan – Do – Study – Act (PDSA) Cycles 1 and 3 reflects only a small portion of the overall project.

Our first PDSA Cycle was a data validation piece from IDPH. We were asked to verify information from our monthly SARS data. This exercise provided accurate baseline data for a three-month period and also helped us to examine data entry processes within our agency.

Our second PDSA Cycle focused on retention from assessment to admission. In this cycle, counselors asked clients "What could keep you from attending orientation?" at the end of the assessment. Counselors recorded the answers (ranging from "nothing" to "needing daycare," "transportation" or "getting off of work"). This change improved admission: within the first seven days from 37 percent to 50 percent; within the first 14 days from 54 percent to 75 percent, and overall anytime admission from 67 percent to 75 percent.

The third PDSA Cycle involved a file review of paperwork for IDPH. This helped our organization to reduce unnecessary or duplicate paperwork. We decreased paperwork for clients at time of admission by 50 percent.

Our fourth PDSA Cycle focused on improving client retention by testing the Matrix Model of substance abuse treatment (Matrix Institute). After completing the Matrix Institute training, HFS implemented the model for all levels of outpatient substance abuse treatment. Retention rates for groups improved from 40 percent (with our previous group structure) to 69 percent (with Matrix Model group structure).

PDSA Five focused on increasing adolescent retention within groups. This project yielded very little difference in attendance rates and only improved by four percent.

None of the changes we tested reduced wait time for assessment. Our final (sixth) PDSA Cycle was to move from scheduling appointments for substance abuse assessments to conducting walk-in assessments, with a goal to reduce wait time for assessment. The Change Team hypothesized that reducing wait time for assessment could also have a positive impact on decreasing no-show rates for assessment.

WALK-INS REDUCE WAIT TIME TO ASSESSMENT

The first step was to research the NIATx web site and review case studies of other agencies that had made the change to walk-in assessments. Shannon Mahnke (co-change leader for this project) contacted the Center for Drug Free Living in Florida to discuss the process that agency used to make the change to walk-in assessments. Our next step was to establish the average number of assessments done monthly, the number of counselors needed to fulfill the demand, and the number of days to offer walk-in assessments.

We determined that the average number of assessments completed each month was 80 and that we would need to offer walk-ins four days a week, with three to four counselors completing two assessments each day (a schedule detailing the client and staff time for walk-in assessments Monday through Thursday is shown in Table 1). This schedule

allows the client time to complete the necessary paperwork before the counselor begins the assessment, giving counselors 1.5 hours to complete the assessment, with the possibility of seeing two clients if needed. The one exception to the walk-in process is private insurance clients due to scheduling needs for credentialed staff (the majority of HFS clients are sliding fee scale). Private insurance clients may access the walk-in assessment schedule if they agree to pay full fee at the time of assessment.

Central Intake serves as the first point of contact for clients seeking to access services at HFS. Central Intake was involved in this part of the project as their role is to gather intake demographic information. Central Intake stopped scheduling assessments the second week of July 2007, when they began informing clients of the new walk-in schedule. Walk-in assessments began on August 1, 2007. Additional counselors were available for the first three days of assessments, as we expected a large turnout due to not scheduling assessments with July callers. After the first three days of this process, the staff reverted to the pre-determined schedule for counselors.

RESULTS

The first day of walk-in assessments resulted in 17 clients walking in and all 17 clients were assessed. As Table 2 indicates, the number of people who came for assessments was greater the first two and a half weeks, appearing to even out the last two weeks. In August, six clients chose not to wait for the next available counselor on walk-in assessment days. One Medicaid recipient person could not been seen on the same day and had to be rescheduled to see a Medicaid provider.

The average wait time for assessment from January to July 2007 was 22 days. After changing to walk-in assessments, the average wait time decreased to five days (See Figure 1.) Wait time is calculated from the date the client calls HFS to request an assessment to the date they choose to walk-in for the assessment. The client has the option to walk in for an evaluation on Monday, Tuesday, Wednesday, or Thursday. Counselors are available in the office on Friday if a crisis assessment needs to be scheduled.

ADDITIONAL BENEFITS OF REDUCED WAIT TIME

We experienced benefits in other areas as a result of decreasing waiting time. The percentage of people who called intake and actually kept their assessments increased from 19 percent (average from January 2007 to July 2007) to 70 percent in August and 81 percent in September, as noted in Figure 2. It should also be noted that the pre-change data included those who took more than 30 days to attend the assessment. Post-change data does not, as we collected data for only one month.

Another unexpected benefit (Figure 3) was that 93 percent of clients (August 2007 only) were assessed within 14 days of intake versus 56 percent in the pre-change data. The percentage of kept appointments was determined by tallying callers who called intake requesting an assessment from August 1 to August 29 and kept that appointment, versus those who did not.

Yet another unexpected success with this Change Project was in increased payment for service. Pre-change data indicated a 66 percent pay for service while the post-change

data showed that 92 percent of clients paid their fee at the time of service in August and 86 percent in September (See Figures 4 and 5).

Client and referral feedback on the walk-in process has also been positive. As one client commented, “It was so much quicker this time around and the paperwork was great, it only took a few minutes versus the hour that I spent here last time.”

We have developed a database to determine if HFS is remaining on track with wait time, admission status and retention for incoming clients. This database can compare this information for a month or longer and can be pulled at anytime.

CONCLUSION

Improving access to services is a key goal for all treatment agencies: 52,000 Iowans were not able to receive or were unwilling to attend treatment in 2004–2005 (SAMHSA, 2006 National Survey on Drug Use and Health: National Findings). Decreasing wait time to five days improved our show rate to assessments from 19 percent to 86 percent in September 2007. It may be that by decreasing wait time, those who would be ambivalent about services are more likely to attend. The increase in attendance will help to increase revenue for the agency and it appears that when clients are able to come when they choose, they are more likely to pay.

Some areas we will continue to monitor will be program capacity and overall client retention. Several months ago, HFS adopted the Matrix Model of treatment. This model gives guidelines for group size and HFS already had concerns about maintaining fidelity to the model. With an increase in admissions, the group size is most likely to swell over fidelity within a few months. We have increased client retention in groups with the move to Matrix, however with the group sizes being over capacity, this may decrease again.

When first discussing walk-in assessments we considered the possibility of an increase in admissions. However, the success of the change was beyond prediction. We have discussed several options to address the increased flow of clients, including using a satellite location for a Matrix track or hiring additional staff to help manage the influx. HFS will monitor admissions and retention rates to continue to make changes to provide quality care for clients.

The NIATx PDSA model has become part of the culture of quality improvement for the HFS Council Bluffs location, and we are planning to extend this process improvement model beyond substance abuse to other services that we offer.

For further information regarding the implementation or outcomes of this project please contact either: Shannon Mahnke or T.J. Gorman at (712)322-1407.

Table 1
Walk-in Assessment Schedule

	Monday	Tuesday	Wednesday	Thursday	Friday
Client Time	12:30-2:30pm	9:00-11:00am	12:30-2:30pm	9:00-11:00am	No assessments offered
Staff Time	1:00-4:00pm	9:30am-12:30pm	1:00-4:00pm	9:30am-12:30pm	
Number of Counselors	5	3	3	5	

Table 2
Number of Evaluations Completed Per Day in August 2007

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
			1 17 EVALS	2 9 EVALS	3	4
5	6 6 EVLAS 1 LEFT	7 2 EVALS	8 2 EVALS	9 4 EVALS	10	11
12	13 6 EVALS 1 LEFT	14 6 EVALS 1 LEFT	15 4 EVALS 2 LEFT	16 5 EVALS 1 LEFT	17	18
19	20 4 EVALS	21 2 EVALS	22 2 EVALS	23 5 EVALS	24	25
26	27 4 EVALS	28 2 EVALS	29 4 EVALS	30 4 EVALS	31	

Figure 1. Wait time for January 2007 through September 2007

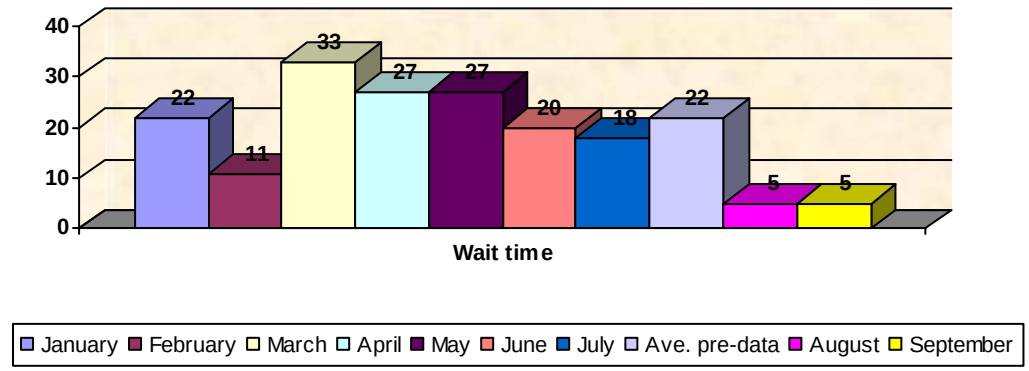


Figure 2. Percentage of clients who kept appointments

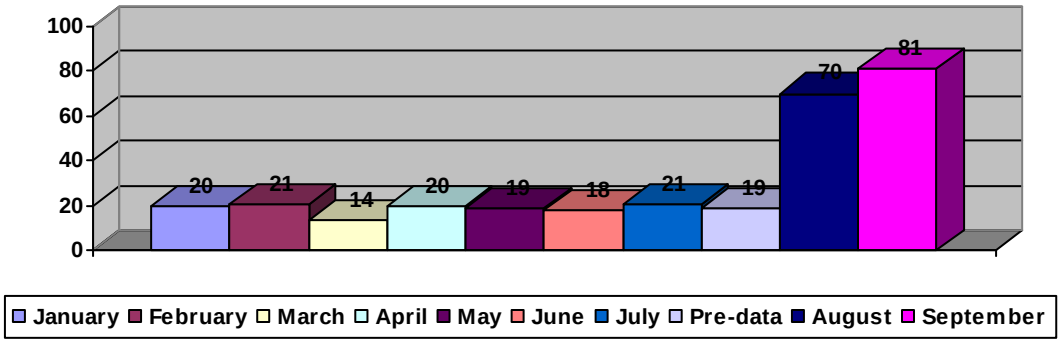


Figure 3. Percentage of clients who kept assessments by number of days after intake

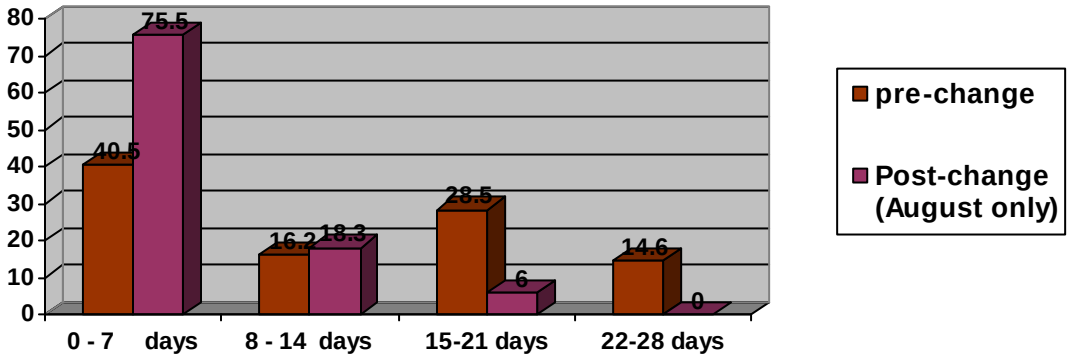


Figure 4. Breakdown of payor sources by month

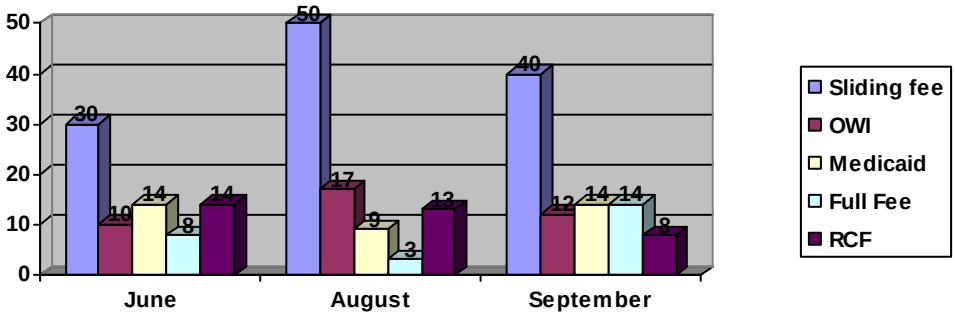
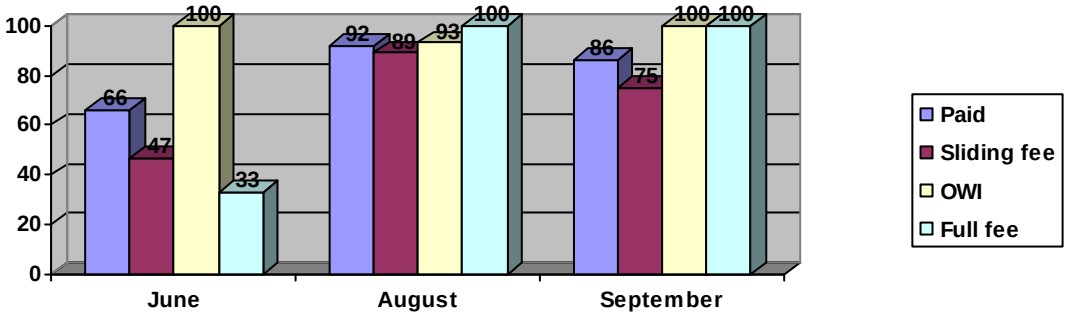


Figure 5. Breakdown by payor source, percent paid



*note: RCF and Medicaid are not included in Figure 5 as RCF clients have no fee for assessment and Medicaid clients do not have fees for services.