Outpatient Services:
Improving Client Wait Times, No Show Rates, and Related Systems

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Abstract: This case proves that ongoing improvement that focuses on client access to care can yield tremendous results that are beneficial to consumers, an organization, and a system of care. Improving work processes in CAB's outpatient program helped improve both revenues and client services. To achieve these results, CAB successfully employed key elements of process improvement: choosing a skilled change leader who provided external expertise, clearly defining the problem(s), involving staff and customers, and pilot testing change.

The Aim

CAB's Outpatient services grew 150% in a ten year period from serving 6, 419 clients in 1990 to over 10,469 clients in 2001. (Graph 1: Outpatient Services, Number of Clients Served). This growth lagged behind the overall growth of the agency which experienced a 620% growth in overall revenue (from $3 million to $18.6 million) in the same period and a 540% increase in its bed capacity (101 to 547) in the same period. (Graph 2 CAB's Revenue and Graph 3 CAB's Bed Capacity). Outpatient services continued to sustain monthly losses equal to monthly budgeted expenses. This loss had a detrimental impact on staff moral and on customer service. Yet because CAB's mission touted a full continuum of care, executive management and the Board was committed to keeping and improving the function of this program. The Darwin project provided the platform for organizational improvement. The broad improvement aims were to improve both revenues and client services through reengineering of the delivery of services.

When this improvement project began, the focus was on improving revenues, not on improving access to care; yet, as the problems in outpatient services were examined and re-defined by the improvement team, access to services became the focus. When access was improved, volume of service increased to make positive impact on revenues.

The Improvement Team and Change Leader

From the beginning, executive management was clear that an external change agent was necessary to reengineer services and improve revenues. Outpatient services had a history of resistance to change. Program management often enabled inefficient processes to continue, despite disadvantages to clients. For example, a case disposition system was in place to triage clients to the most appropriate clinician and level of care. Historically and ideally, this system was designed to maximize care. In reality, the case disposition process caused a 2-week wait period from when a client received an intake to when he/she was assigned a clinician and could begin treatment. But because the system was designed on clinically sound principles, staff and management were resistant to change. Case disposition represents only one service process that needed improvement, and, although staff intuitively knew that change was needed to improve program services, they often could not identify what the primary problems were and how they might be solved. Understanding when and how to use appropriate external resources is a key indicator for successful change: management at CAB was fortunate to understand and apply this principle to the improvement of Outpatient Services.

CAB chose an external consultant, Maureen Sullivan, to lead the change initiative. The consultant had a set of characteristics that pre-qualified her success. She had significant first-hand experience in behavioral health care management specific to substance abuse treatment. Additionally, she had worked with CAB Health & Recovery Services in the past yielding knowledge of the organization, its staff and its history; and finally, the executive director was confident in her skill set.

The improvement team was comprised of program staff and a brand new Director of Ambulatory Services, Derek Moore, who came on board just prior to the improvement initiative. The previous director left to pursue other career opportunities creating a window of opportunity for new leadership

and resulting program change. Maureen Sullivan and Derek Moore acted as a leadership team, involving staff as much as possible in identifying problems, choosing solutions, and piloting changes.

Define the Problem & Involve the Customer

So what was causing poor revenue generation in the program and what processes needed fixing? To find out, the consultant recommended involving the primary customers--clients and staff. Involving customers is a key indicator for successful change initiatives. The first task was to look to the front door. How do clients access services? The consultant completed a step by step walk through of the outpatient admission process from a client's perspective. She assessed, for example, how clients hear about CAB, how they request services, how long it takes from a request for service to be scheduled to an intake, how long it takes to receive a first appointment, and what the details are of each step—including staffs' roles and attention to customer service. The consultant also reviewed billing system data, including reasons for fatal claims and reasons for poor collection of fees. The combined findings painted the needed improvement picture that pointed to delayed access and poor billing processes.

- There was a 2-week delay for intake
- There was an additional 2-week wait for the start of treatment due to the case disposition process mentioned above.
- There was a no-show rate for initial intake at 30% and at 50% for the start of treatment following the 2-week delay.
- No appointments were available Friday afternoons and minimal weekend and evening sessions were available
- The directory assistance phone number was not a live number and therefore was never answered even though it rang
- 27% of services were denied because of no prior authorization
- Only 40% of co-pay or self-pay fees were collected appropriately

To further elicit first-hand customer perspective, the consultant implemented a client survey. In addition, to assess what improvements clients most wanted in the intake process, the program director personally interviewed clients asking "*What would make your first appointment experience better*?" Clients interviewed highlighted three needs:

1. To have a clean and respectable waiting area in which a client was not asked to share personal information.
2. To access service faster (over 70% of client responses indicated the wait was too long for an intake and for an initial treatment appointment). Most clients had a real fear of relapse and a fear of significant loss, such as child custody and employment. For substance abuse clients seeking immediate help, a two-week wait time is too long.
3. To have access to multiple services, such as a physician and other health care providers. Clients believed they would get only counseling services specific to substance abuse at CAB.

In addition to a client survey, a staff satisfaction survey was implemented. Results indicated that communication between staff and between management and staff was a problem. Knowing this, the program director met individually with staff and conducted more in-depth staff interviews. The personal approach helped begin to address communication barriers by helping staff feel more comfortable talking with their new director. Staff survey and interviews also showed that staff felt considerably "stressed" and "overworked" largely because of inefficient and non-supporting systems. The authorization system was cumbersome, there was no scheduled office space for clinicians to provide private counseling,

(clinicians would walk around the facility with the client following looking for an available room), and medical record documentation was duplicative and time consuming.

Client and staff survey results were shared and acknowledged by all in weekly staff meetings newly instituted by the director. Consensus was that services to clients could improve and that, with guidance and teamwork, staff would be able to implement change. In fact, staff would *benefit* from change. After all, staff is experienced clinicians who have direct involvement in business processes. In short, the change leader and program director acted as cheerleader and coach and helped the organization view staff as part of the solution, not part of the problem.

Creating a sense of urgency for action is an initial step in any organizational change process and often the mark of a good change leader. In this case, staff was highly motivated to improve client wait time: they understood the fear of relapse and fear of loss clients reported and wanted to improve client access to services. Not so attractive was the directive from the CEO and CFO to improve revenue performance, but, because of the data, staff begun to see the need to improve the scheduling, authorization, and billing processes.

Fortunately for CAB, the consultant's experience is that all business areas (clinical, financial, and administrative) are interdependent systems and that system modifications in one area directly impact the others. Because of this, the consultant looked at more than access to services and billing systems: other areas assessed included type and number of clinical services, adequate staffing, staff roles and responsibilities, scheduling of services, reimbursement rates, physical space, and medical record systems. With all the data on hand, the broad aim of reengineering client services and improving revenues broke down into five problem areas that needed fixing:

- Poor access to service, including times from initial call to first appointment
- Poor billing processes, including authorization and subsequent authorization of services
- Poor scheduling of staff and services, including staff availability for intake appointments and time and number of groups offered.
- Sub-standard physical environment conducive to treatment needs of clients and working needs of staff.
- Poor communication with staff, including lack of involvement in decision-making.

The Solutions

So what was done to fix all this? The consultant, adept as a change leader, worked to break down each problem into manageable components. This was critical to staff understanding why, how and where in the process changes needed to be made. Multiple changes were made to have a significant impact on each problem. It is an example of wave after wave of rapid improvement that yields some outstanding results.

1. Improving Access

To impact access to services and scheduling, phone lines were changed, case disposition was eliminated, the intake process was re-reorganized, weekend and evening group times were added, and scheduling was computerized. For example, when calling the directory assistance number, all calls now go to an intake coordinator who is trained to answer questions about all outpatient services. In the past inquiry calls would be forwarded to each outpatient program (outpatient, intensive outpatient, women's services, court services, etc.) and the clinician from that program would schedule an intake. Often these program inquiry calls would end up in an individual voice-mail box yielding no monitoring or accountability for response time. It is assumed that an unknown portion was not responded to.

Once a call is received, the intake coordinator now immediately assesses the client's need and determines which program is most appropriate for that client based on initial pre-screening information. The client gets immediate feedback on when the next scheduled group or appropriate service is offered and then is scheduled for an intake within 2.5 days of making the call. In the past, it could be up to 2 weeks before a person would receive a return call and be scheduled for an intake.

In addition, to speed up scheduling, the existing billing system was used to provide a computerized scheduling of appointments. In the past, clinicians managed their own schedules and determined when they could provide intakes. Now, with a computerized scheduling system and set clinical productivity expectations, intakes could be scheduled by one person at the time of client inquiry. This was a huge change from having individual program clinicians schedule intakes.

To decrease time between the initial call and an intake appointment, the outpatient clinic needed to be able to handle an increased volume of intakes that resulted from the above improvements. A fee for service clinician was hired to function as an "intake clinician." This clinician now provides the majority of intake appointments for outpatient services. Before the change, outpatient services completed approximately 30 to 40 intakes per month. Now, after the change, the volume ranges from 100 to 160 per month. It is important to note that this improvement happened over an 18 month timeframe. The program manager set short-term realistic goals for number of intakes and when they were achieved, staff were motivated to keep reaching for the next goal. For example, intakes increased from 30 to 50 within a 2.5 month period. After initial success, the rate of increase grew. At 3.5 months a goal of 60 intakes per month was achieved. At 4.5 months a goal of 75 intakes per month was achieved and so on, until the existing volume of 100 per month on average was achieved.

To eliminate the 2 week wait time between intake and first treatment appointment, the team case disposition system was dismantled. On a daily basis, the program manager now reviews and approves the disposition decision made by the intake clinician. This actually gives staff more time to focus on direct billable service and clinical care. Upon daily review, any mis-triaged clients are reassigned to appropriate care within 24 hours (prior to receiving service) and errors are reviewed regularly with the intake staff as on-going training and corrective action. The program manager reports that 75% of treatment services are now delivered on the same day a client receives an intake appointment. The remaining 25% receive services within 2 days.

To address client concerns about confidentiality, a separate office space was allocated for intake appointments.

The program manager reports that in a recent 2003 client satisfaction survey, 80% of clients report being satisfied with the existing intake process, compared to 70% being dissatisfied in 2000.

2. Billing Processes & Generation of Revenue

To impact increased revenue generation and collection, physical space was re-engineered to mirror a private pay physician's office with a client window specific for billing. In the past, in part due to the design of the physical space, clients could walked in and go to group without paying their co-pay at the front desk. Sometimes, clients would attend the wrong group. To prevent this, the program implemented a locked door and buzzer system and a new service sheet. Now, when a client enters the front office, he/she is required to pick up a service sheet at the front desk, pay all co-fees, and update any insurance information. The client is then "buzzed in" to the clinical area, attends the scheduled service, and

provides the sheet to the clinician. The clinician verifies that the client is in the right group, and verifies attendance and service rendered by signing and returning the billing sheet to the billing supervisor. This improvement was pilot tested and modified based on staff feedback. Staff felt the buzzer was too intrusive to the therapeutic environment, and subsequently, the buzzer was removed while the locked door concept remained in place to ensure clients interacted with the front office. Another component under current consideration for modification is that clients have reported feeling uncomfortable with the privacy of the service sheet. Because the sheets are computer-generated, the clinical diagnosis prints out on the sheet. Clients do not like seeing their problems so blatantly defined. Staff are investigating a way to change this, while keeping the rest of the system in tact. Now 90 % of co-pays are collected and clients show up at and receive the right service.

In addition to improving the physical space of the front office, an experienced billing coordinator was hired who had comprehensive experience with the billing system that CAB used. This was not a new position, but a new hire. With skilled staff, the program took on the role of entering billing information at the program site. This is a decentralized billing model that gave more control and accountability to staff at the program level. Previously, all billing sheets were forwarded to CAB's corporate, centralized billing office for entering and posting. To ensure the process worked smoothly when moved on-site, collaboration between clinical and billing staff was necessary. A simple improvement such as revising billing sheets and placing them in a location accessible to the clinicians helped billing staff get accurate and timely information.

The authorization system was also over-hauled yielding a decrease in non-reimbursable care and an increase in average reimbursement rates. At the time of assessment, the program did not have Point of Service equipment to verify insurance coverage at time of scheduling (prior to receipt of services.) The equipment was purchased and training provided. With better use of computerized scheduling, reports are now generated to monitor number of visits by service type and pay source, flagging the need for subsequent authorization when services are extended or changed. Finally, a list of payors and authorized clinicians was developed for immediate reference upon intake to insure that services were delivered by appropriate staff and to ensure that they were billable.

A standing work group was created to oversee these changes in billing processes and ensure sustainability of improvements. The work group is comprised of clinicians, the program billing coordinator, and the corporate billing supervisor. The cross-functional team helps create an understanding of the need and function of the system (buy in to change) from two very different operational perspectives.

3. No Show Rates-Maximizing Services Delivered

Industry literature supports the on-going challenge of managing adherence to appointments. At CAB, similar to other outpatient programs, no show rates were high. To reduce no show waits, reminder calls were instituted. Research shows that reminders within 48 hours of a schedule appointment increased adherence to attendance. The computerized scheduling made making no show calls an organized task for the front office staff. The duty was assigned to the evening staff, when volume was lower and when most clients are home and most likely to receive a call. No show rates for intake appointments decreased by 27% after reminder calls were implemented. The program director also reports that 23% more clients follow up on their initial treatment appointment after intake.

With fewer barriers to access, decreased no-show rates, and the addition of more groups and evening hours, volume increased which directly increased the ability to generate revenue.

4. Environment Conducive to Treatment

An environment conducive to treatment is one that ensures comfortable, respectful, welcoming, and private space in which both clients and staff can thrive. To achieve this, outpatient services embarked on a renovation of physical space to increase private counseling and work space. A separate space for clients to answer confidential information was added to the front office to ensure privacy. This was in direct response to the information from the client survey. New paint, new carpeting, client art work, and magazines were added to create a warm and welcoming environment. Maureen Sullivan leveraged her expertise as an external resource to get management of the organization to agree to a $40,000 capital expenditure for facility improvements. Management agreed to the renovation because the short-term, rapid successes, (demonstrated by increased intake volume, decreased no-show rates, and an upward trend in revenues), forecast a favorable financial future for the program. Throughout this change process, the change leader acted as an effective communicator and business partner by proactively positioning necessary changes with staff and management. She elicited strong support along the way.

5. Improving Staff Satisfaction and Communication

The renovation of the physical space, the elimination of the time-intensive case disposition system, the institution of weekly staff meetings, and on-going training all helped improve staff satisfaction. Additionally, involving staff directly in the improvement process created a sense of team, owner-ship and pride within the outpatient staff.

While there was an increase in volume of services delivered, there was a reduction of 1.75 FTE's. The consultant and program manager worked hard to re-design job responsibilities of existing positions to match needed functions within the program. The billing coordinator position mentioned above is an example of this. The approach was to recognize and invest in existing staff.

In spite of a conscious, concerted effort to involve staff in the change process and to directly address their concerns, a 25% attrition of existing personnel occurred within the first six months of the change initiative. This 25% represents a portion of individuals who were neither comfortable nor able to adapt to such rapid change. After this attrition occurred, the program manager now happily reports very low staff turn-over rates. After the first six months, staff turn-over decreased to 7%. It is currently less than 3%.The right people are performing the necessary job responsibilities and are satisfied with their work environment. Although there is no formal data on improved staff satisfaction, the program director believes that retention of the existing workforce is a good indicator of staff satisfaction.

Ongoing Continuous Improvement

In a good process improvement project, solutions are implemented, tested, and modified to be the most effective and the best fit for the organization and customers. In this case, solutions were piloted and revised several times. For example, intake hours were increased so quickly that there were initially not enough clinicians to handle the load. This drove the need for better scheduling and re-design of job responsibilities. As mentioned above, the client check-in process with the buzzer and billing sheets changed more than once based on client and staff feedback.

Billing operations were redesigned several times and continue to be an on-going improvement focus. For example, in spite of the improved performance in revenue generation and collection, a corporate decision was made approximately 18 months after implementation to move the data entry and posting of claims back to the central, corporate office. This executive decision was based on continued monthly

fluctuation of revenue. Although overall improvement had been made with decentralized billing, consistency was not achieved and the CFO wanted more direct control. Finally, the attempt at using the billing software for scheduling was abandon after 18 months of trial.

The lesson the organization learned was that software is designed with specific functionality, and although the billing system had a scheduling component, it was cumbersome and not user-friendly. It was a good billing system, not a good scheduling system. Scheduling is now done manually. What was sustained were the process improvements in performing the scheduling with a central intake coordinator. The manual system works. It supports client access to care achieving a minimal 2.5 day wait-time and it supports the current monthly volume of intakes.

Outcomes in Summary

This project represents a comprehensive improvement of outpatient services. Although the reason management initiated the improvement project was to improve revenue, what the organization learned was that access to care is what drives successful operations. By managing access, there are improvements in related systems, (clinical, administrative, and fiscal).

Listed below is a summary of outcomes achieved.

<u>Improved Access</u>

- There is a maximum 48 hour wait for intakes
- Walk in appointments are now available
- No-show rates decreased by 27%
- Expanded evening hours, Saturday hours and psychopharmacology hours are available

<u>Improved Volume</u>

- Intakes increased from 27 per month for to 95 per month with hiring of intake clinician
- Clinical productivity increased from 24 to 28 clients per clinician per week
- Group average daily census increased from 6.4 to 8.2
- Monthly service units increased from 514 to 721 per month

<u>Improved Revenues</u>

- Only 9% of services are denied by insurance companies for no authorization
- 90% of co pays are collected
- Reimbursement per service increased by 17%

<u>Improved Staff Morale</u>

- Turnover decreased from 25% to 3.0%
- There was scheduled office space and improved environment for treatment
- There was improved access without improved staff cost. Administrative FTE's decreased by 1.75. Existing staff was re-deployed to other job position or other job functions.

Conclusion

Clearly, improving work processes in CAB's outpatient program helped improve both revenues and client services. To achieve these results, CAB successfully employed key elements of process

improvement: choosing a skilled change leader who provided external expertise, clearly defining the problem(s), involving staff and customers, and pilot testing change.

Of all the lessons learned from this case, one that is important to recognize is that access to care is an on-going challenge. External influences such as changes in state funding, changes in payors, and changes in reimbursement rates are largely outside of a single organization's control and these external influences directly impact what community services are available and who is eligible to receive them. In turn, an organization is challenged to remain flexible, to adapt to these changes by supporting an organizational environment that is not static but encourages on-going, continuous improvement. This case has proven that on-going improvement that focuses on client access to care can yield tremendous results that are beneficial to consumers, an organization, and a system of care.

Chart 1
Outpatient
Services: Number
Of Clients Served

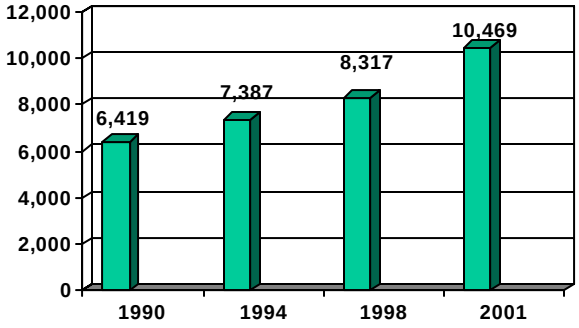

Chart 2
CAB's
Total
Revenue

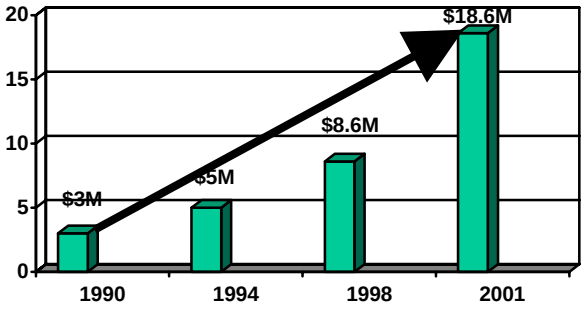

Chart 3
CAB's
Beds Capacity

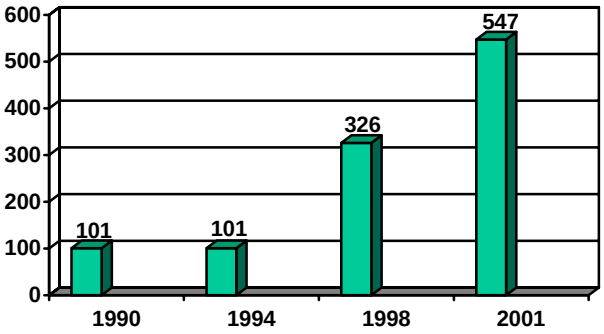

Chart 4
CAB's
Workforce
Growth--
Number of
Employees