Just In Time (JIT) Scheduling –
To a Medical Provider in 3 Days

Presented by:
Scott Lloyd, President

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 800 providers (MH/SA/DD/Residential) in 46 states, Washington, DC, and 2 foreign countries since 1995.

- **MTM Services’ Access Redesign Experience (Excluding individual clients):**
  - 5 National Council Funded Access Redesign grants with 200 organizations across 25 states
  - 7 Statewide efforts with 176 organizations
  - Over 5,000 individualized flow charts created
  - Leading CCBHC Set up and/or TA efforts in 5 states

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What questions do you want answered by attending this webinar?

1. How do you deal with Client No-Shows when utilizing JIT scheduling?
2. Best way to implement this system maintaining quality of care and preventing physician burnout.
3. Doesn’t SDA and JIT scheduling conflict with current CMS policies that prevents payment for same-day visits within a grp practice
4. How can we as the sole clinic with one practice( Part time) make this work?
5. How can you shorten times without more psychiatrist time and higher contract dollars ( to pay for it)?
6. How do you do this when the timeline does not allow for obtaining records from other/past provider?
7. How do you get prescriber ‘buy in’ / How to get buy in from the MDs and NPs
8. How does just in time scheduling improve access to care?
9. How effective is JIT in a clinic with low income clients whose phones are frequently out of service or have changed numbers
10. How the schedule is managed for JIT
11. How to implement JIT scheduling models with contractual Clinic M.D.’s
12. How to operationalize at our individual site? who besides the prescribers can be included in JIT Scheduling? why not clinician?
13. How to prescribe meds without doing complete assessment on client.
14. Use of telepsych and extenders in Just in Time
15. What are some strategies to overcome client’s resistance to the JIT model?
16. What staffing ratios, service delivery time frames do you recommend for Just-In-Time Prescriber scheduling.
17. Which CCBHC’s or CMHC’s are using this effectively?
**“Value” of Care Equation**

1. **Services provided** – Timely access to clinical and medical services, service array, duration, and density of services through Level of Care/Benefit Design Criteria and/or EBPs that focuses on population based service needs

2. **Cost of services** provided based on current service delivery processes by CPT/HCPCS code and staff type

3. **Outcomes achieved** (i.e., how do we demonstrate that people are getting “better” such as with the DLA-20 Activities of Daily Living)

4. **Value is determined** based on can you achieve the same or better outcomes with a change of services delivered or change in service process costs which makes the outcomes under the new clinical model a better value for the payer.

**The “Values” that Organizations Need…**

- Organizations have an excellent opportunity to be helpful partners in the new integrated healthcare system *if* they can display the following specific values:
  1. **Be Accessible** (Provide fast access to all needed services).
  2. **Be Efficient** (Provide high quality services at lowest possible cost).
  3. **Be Connected** (Have the ability to share core clinical information electronically).
  4. **Be Accountable** (Produce information about the clinical outcomes achieved).
  5. **Be Resilient** (Have ability or willingness to use alternative payment arrangements).
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The False Reality of Full!

“We’re hoping you’ll lead us on a journey of transformation without requiring any real changes.”

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Does it Make Sense !?

Life’s Reminders…
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Does it Make Sense !?

- Average Access Entry Time is 31 / 48 Days (48 is if you include Psychiatric Evaluations as a possible first appointment).
- 98% of the organizations we work with are understaffed in their support departments (Can’t get a live person on the phone).
- Teams are still utilizing assessments that take hours of time to complete including in session and post session time.
- Teams are utilizing EMRs that don’t work.
- Teams have staff members continually not attaining their productivity standards.
- Consumers continue to miss appointments, while we have caseloads that are too full to take on new clients....

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Does it Make Sense !?

Standard Answer, “We’ve Talked About That!”
Talking About it is No Longer Good Enough....
It Never Really Was...
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Does it Make Sense !?

Why we Just Talk...
1. Staff are Exhausted!
2. Staff will get upset!
3. We don’t want staff to leave!
4. We have always done it this way!
5. It is our system’s/state’s/MCO’s/consultant’s/Trump’s fault!
6. Our Managers/I am exhausted.....
7. **We don’t have the data to know for sure.**

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Dysfunctionality Defined -

Dysfunction in the CBHO arena can be seen when organizations start to become stymied in their change processes. Occasionally teams can even find themselves completely incapable of making operational decisions due to the behavior of staff that keeps them from moving forward. This behavior is normally emotionally driven, pattern based, and therefore predictable. Despite how predictable it is, over time we accommodate it, which allows it to become ingrained and very challenging to move beyond it.
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*Does it Make Sense!*

*What to Do About it...*

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**The False Reality of Full!**

- **Data is the Key!**
  - What data do you need and how do you get it?
  - What is the best way to Present it to staff?
  - Without data, teams set up to their exceptions.
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The False Reality of Full!

Team members with differing opinions, but neither side has data to back their points is a key roadblock to successful changes!

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The False Reality of Full!

The Client’s Definition of Access

Client Calls for Help → Wait Time # 1
Assessment Appointment → Wait Time # 2
Treatment Planning Appointment → Wait Time # 3
Client Arrives for an Open Session

Just in Time Prescriber Scheduling Defined -

This process allows teams to move a consumer from their diagnostic assessment to a psychiatric evaluation within 3 to 5 calendar days, greatly increasing engagement and reducing no shows and cancellations.

This move improves that consumer's experience and the staff member's quality of life by removing obstacles like non-billable med call-ins that generate high levels of frustration.
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The False Reality of Full!

How did We Get to Here?

System Noise –
Anything that keeps staff from being able to do the job they want to do: Helping consumers in need!

Areas of System Noise

1. Dealing with consumers angry about the wait
2. Dealing with poorly laid out documentation.
3. Poorly functioning EMR/EHR
4. Dealing with No Shows/Late Cancellations
   1. Medication Call Ins
   2. Rescheduling/Crisis Events
   3. Direct Service Production Hits
5. Naturally Occurring vs. Structured Downtime
How We Arrived Here...

Typical Center Staff Resource Utilization

- No Show/Cancellation
- Holiday
- Sick Leave
- Vacation Leave
- Travel
- Training
- Meetings
- Paperwork

Billable Service
Non-Billable Service

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What we do About it!

- Collaborative Documentation
  - Documentation Redesign
- Same Day Access
  - JIT Prescriber Scheduling
- No Show Management
- Utilization Review/Utilization Management
  - Episode of Care (EOC) / Level of Care (LOC)

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Scott C. Lloyd, President
Rosecrance Berry Campus
Rockford, IL
Open Access Case Study

Richard Jaconette M.D.
Child/Adolescent Psychiatrist

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The False Reality of Full!

Dr. Jaconette: Med Monitoring and Evaluation Events Prior to Open Access
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The Crux of the Problem – We make Consumers Guess!

Where will you be in 30-90 Days at 2:15!? 

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Decision Time...

More of the same, or make a change?

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Biggest Obstacle To Implementation

• **Anxiety** -- Within the:
  – Doctor
  – Consumers / Consumer’s Family
  – Front Office Staff
  – Other Clinicians
  – Administration
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Key Factors for Success!

1. No Medical Provider Appointments are Scheduled more than 3 to 5 days out.

2. No More Calling in Med Requests, the consumer must be seen face to face for a script.

3. No more rescheduling no show events, they have to go to the no show clinic (NSNAP).

Results

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Customer Satisfaction

<table>
<thead>
<tr>
<th>Question</th>
<th>Percentage that agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>I received services in a reasonable amount of time from the time I walked in today</td>
<td>89.5%</td>
</tr>
<tr>
<td>I was treated with courtesy and respect today</td>
<td>96.5%</td>
</tr>
<tr>
<td>I was educated about any medication ordered for me</td>
<td>97.2%</td>
</tr>
<tr>
<td>I was educated about any follow up treatment ordered for me</td>
<td>98.4%</td>
</tr>
<tr>
<td>I am in charge of my plan and it clearly reflects what I want and need to achieve</td>
<td>96.6%</td>
</tr>
<tr>
<td>I would recommend ______ to a friend or family member</td>
<td>97.5%</td>
</tr>
</tbody>
</table>

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Where would you have gone without our services?

<table>
<thead>
<tr>
<th></th>
<th>Gone to an urgent care center</th>
<th>Gone to another agency to get services today</th>
<th>Gone to my primary care physician</th>
<th>Gone to the hospital emergency department</th>
<th>Not gotten services anywhere</th>
<th>Waited weeks/months to get services from another company</th>
</tr>
</thead>
<tbody>
<tr>
<td>July</td>
<td>5%</td>
<td>13%</td>
<td>9%</td>
<td>27%</td>
<td>25%</td>
<td>21%</td>
</tr>
<tr>
<td>August</td>
<td>5%</td>
<td>6%</td>
<td>11%</td>
<td>27%</td>
<td>33%</td>
<td>18%</td>
</tr>
<tr>
<td>September</td>
<td>3%</td>
<td>14%</td>
<td>12%</td>
<td>26%</td>
<td>30%</td>
<td>15%</td>
</tr>
<tr>
<td>October</td>
<td>4%</td>
<td>14%</td>
<td>10%</td>
<td>25%</td>
<td>31%</td>
<td>16%</td>
</tr>
</tbody>
</table>

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**JIT first 90 days Review –**

**Billable Hours:**
Providers totaled 925 billable hours for the period July to September 2014.
Providers totaled 1,062 billable hours for the period November 2014 to January 2015.

An overall 15% in hours /A 4 hour a day increase

**Billable Dollars:**
Providers totaled $146,421 for the period July to September 2014.
Providers totaled $199,066.80 for the period November 2014 to January 2015.

An overall 36% increase in dollars. / A $1,144.36 per day increase.

*** Percentage of billable hours verses total hours increased for an average of 48.6 % to 61%
from the July to September 2014 period to the November 2014 period to January 2015 period.

*** These daily averages are based on actual hours during these periods. We had 64 billable days
in the July to Sept 2014 period and 58 during the November 2014 to January 2015 period.

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