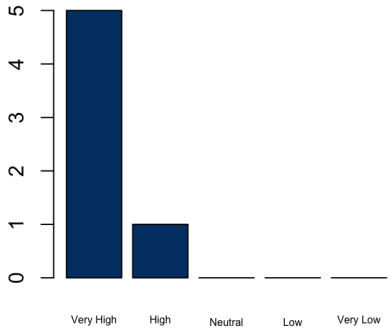
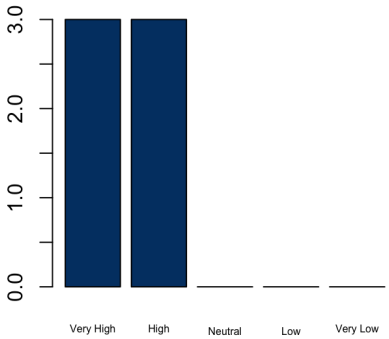
TeamTime Report #3 - Team Vision: Stronger Together!

MTL Menu

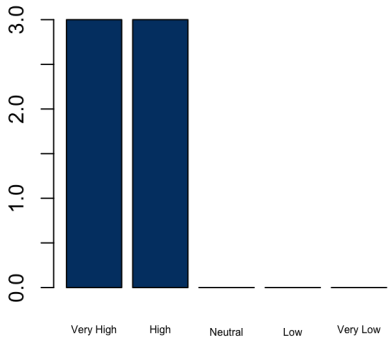
Schedule - How to manage team schedules (i.e. clinics/grids) to meet patients needs.



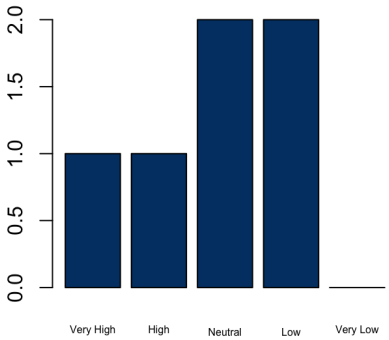
New patients - How to get new patients in care, while meeting existing patients needs.



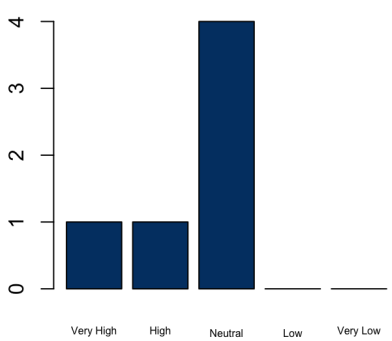
Return to clinic - How return to clinic orders free free us to get patients to the right treatment at the right time.



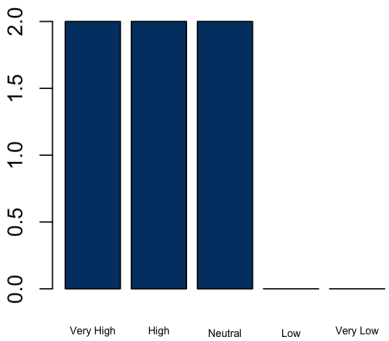
Overwork - How overbooking or overworking increases patient no shows.



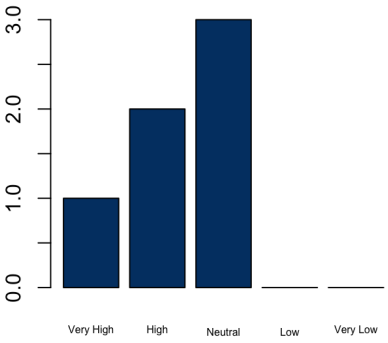
Psychotherapy - How to improve team psychotherapy and patients' patterns of engagement.



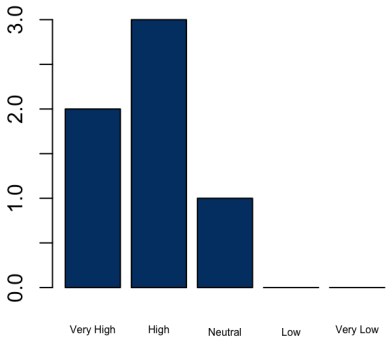
Evidence-based Psychotherapy - How to improve evidence-based psychotherapy in our team.



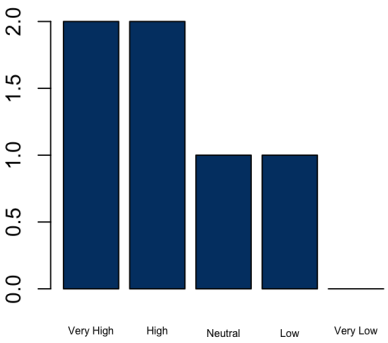
Evidence-based Pharmacotherapy - How to improve evidence-based pharmacotherapy in our team.



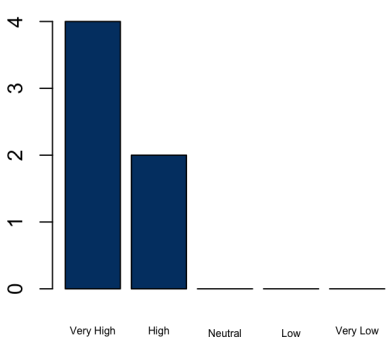
Referrals - How to manage referrals to our team and services (e.g. meds, therapy, group) within our team.



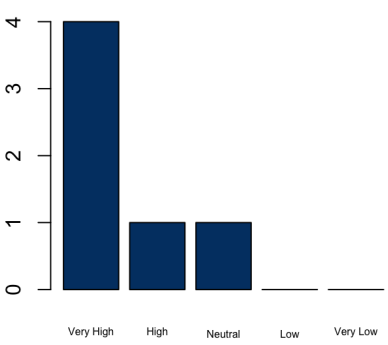
Mix of services - How our patients engage in our teams mix of services.



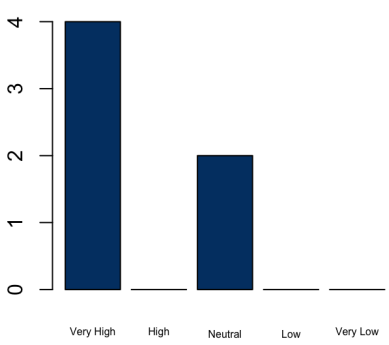
Improvement - Which improvements will have the best effects across our mix of services?

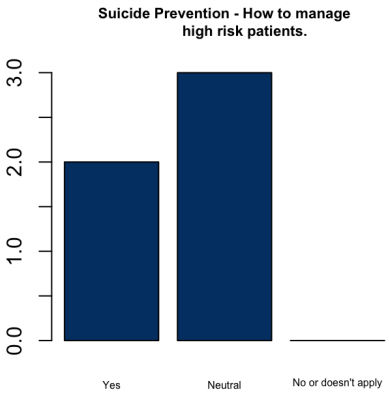


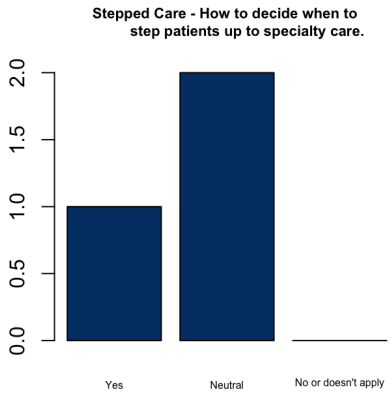
Burnout - How to reduce provider burnout and improve patient satisfaction with care.

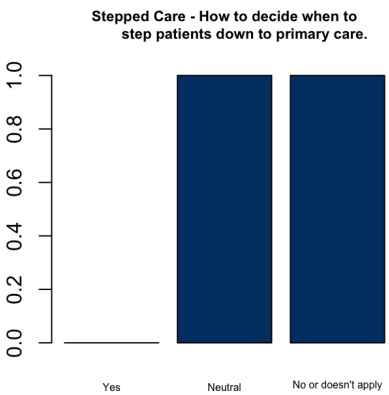


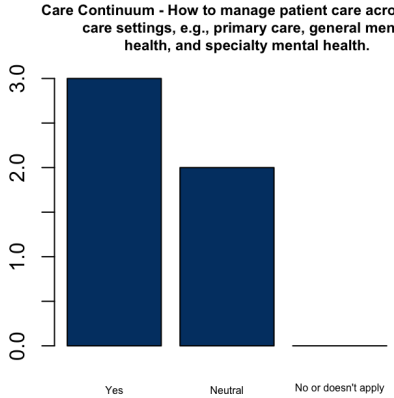
Staffing - How to improve team care with our existing staff mix.

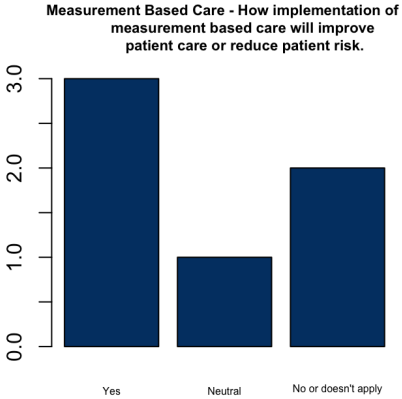


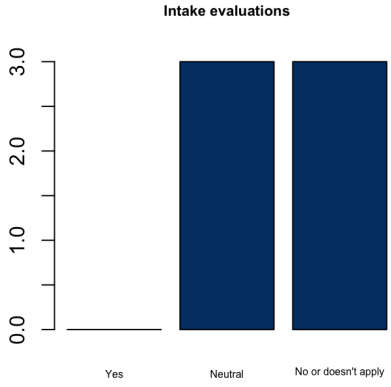

Suicide Prevention - How to manage high risk patients.
0.0
1.0
2.0
3.0
Yes
Neutral
No or doesn't apply

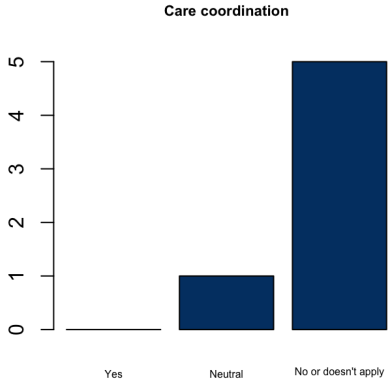

Stepped Care - How to decide when to step patients up to specialty care.
0.0
0.5
1.0
1.5
2.0
Yes
Neutral
No or doesn't apply

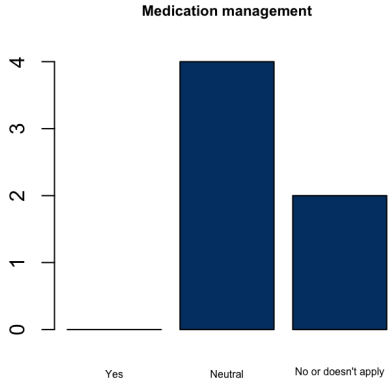

Stepped Care - How to decide when to step patients down to primary care.
0.0
0.2
0.4
0.6
0.8
1.0
Yes
Neutral
No or doesn't apply


Care Continuum - How to manage patient care across care settings, e.g., primary care, general mental health, and specialty mental health.
0.0
1.0
2.0
3.0
Yes
Neutral
No or doesn't apply

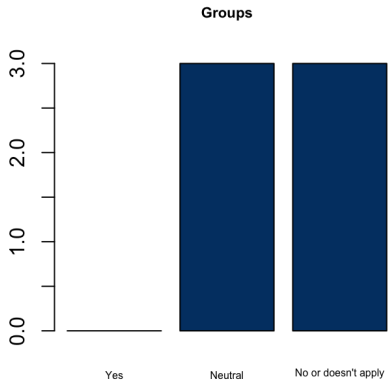

Measurement Based Care - How implementation of measurement based care will improve patient care or reduce patient risk.
0.0
1.0
2.0
3.0
Yes
Neutral
No or doesn't apply


Intake evaluations
0.0
1.0
2.0
3.0
Yes
Neutral
No or doesn't apply


Care coordination
0
1
2
3
4
5
Yes
Neutral
No or doesn't apply


Medication management
0
1
2
3
4
Yes
Neutral
No or doesn't apply


Psychotherapy
0
1
2
3
4
Yes
Neutral
No or doesn't apply


Groups
0.0
1.0
2.0
3.0
Yes
Neutral
No or doesn't apply

Team Data Table - Aggregate Module

Aggregate Table without definition (similar to the UI)

Team Data

New Patient Start Rate (mean)	165.9	0.0	0.0	0.0
Appointment Supply (median) (Psy)	560.0			
Appointment Supply (median) (EBPsy)	3.0			
Appointment Supply (median) (CC)	177.0			
Appointment Supply (median) (MM)	226.0			
Appointment Supply (median) (Adjunctive)	207.0			
Appointment Supply (median) (Group)	21.0			
Appointment Supply (median) (Intake)	191.0			
Appointment Supply (median) (Total)	1385			

	True Missed Appointments %	Return Visit Interval (median)	Engagement Duration (median)(wks)	Service Proportions from Team Data
Psy	0.25	10.00	90.00	0.32
EBPsy	0.21	1.00	15.00	0.03
CC	0.26	12.00	68.00	0.27
MM	0.25	15.00	98.00	0.31
Adjunctive	0.25	10.00	76.00	0.37
Group	0.25	2.00	29.00	0.08

Aggregate Table Definition

Team Data: Aggregate Table Concept Definition

Concept	Definition
New Patient Start Rate (mean)	An estimate of the number of patients starting a new service with the team per week, calculated from a cohort of patients seen over one year in this team who have never had an visit of that type with this team before. (pts/wk)
Appointment Supply (median)	An estimate of the weekly hours available with this team for each service. The estimate is calculated using the volume of visits for each service with this team over one year. (appt/wk)
True Missed Appointment %	The proportion of appointments for each service with this team that no-showed or were cancelled after the appointment was supposed to have happened. (pct)
Return Visit Interval (median)	The median return-to-clinic visit interval by encounter type bin with this team, calculated from the number of visits per patient over their entire engagement time. (wks)
Median Engagement	The median number of weeks that patients stay engaged with this team, receiving visits according to team data. The visits can be with any member of the team. This engagement time represents a patient's entire engagement across treatment episodes, regardless of gaps in service. (wks)
Service Proportions from Team Data	The proportion of patients who receive visits for each service with this team. Note that the percentages sum to more than one, because patients may engage in multiple services concurrently. (pct)

Sim UI Experiments - Aggregate Module

Team Experimental Design

Experiment	Our Question	Our Hypothesis	Our Findings	Our Decisions
Base Case	We are struggling with psychotherapy because we have so many patients and they're spread out far (coming in once a month or so, aka "RVI"), what happened if they came in for concentrated episodes of psychotherapy (RVI+Engagement Duration) we expect they would get better faster, and not be engaged for as long, which in the longer term would free up more slots for new patients. But, leadership is worried that will reduce access for new patients. If we opened up more groups, would adding more groups and having more slots in groups, would it reduce patients waiting for individual therapy (appointment supply). It seems like when we have more groups, it seems like they are cycling through multiple groups ("group to group to group"). Wonder what the impact of that is. This is related to the issue of when are patients stable enough to step down to primary care. Also, wonder if we need all of the adjunctive services we offer.	If we made no changes, pts would be seen longer than optimal, but less frequently than we like, and we'd have fewer appts available than we like.	If we make no new decisions in our team, the hours for the services will remain the same over the next two years.	We expect they would get better faster, and not be engaged for as long, which in the longer term would free up more slots for new patients.

Experiment 1	We are struggling with psychotherapy because we have so many patients and they're spread out far (coming in once a month or so, aka "RVI"), what happened if they came in for concentrated episodes of psychotherapy (RVI+Engagement Duration) we expect they would get better faster, and not be engaged for as long, which in the longer term would free up more slots for new patients. But, leadership is worried that will reduce access for new patients. If we opened up more groups, would adding more groups and having more slots in groups, would it reduce patients waiting for individual therapy (appointment supply). It seems like when we have more groups, it seems like they are cycling through multiple groups ("group to group to group"). Wonder what the impact of that is. This is related to the issue of when are patients stable enough to step down to primary care. Also, wonder if we need all of the adjunctive services we offer.	If we reduce RVI to 1 week, and engagement duration to 16 weeks, then we expect they would get better faster, and not be engaged for as long, which in the longer term would free up more slots for new patients. However, we expect that wait times will go up in the short term.	Long term effect on work pressure is good but short term difficult; small increase in patients waiting to start services initially, then it will drop for a time, then after a year it will increase to levels higher than current status;	May want to think about adjusting service proportions (for the purpose of the model, consideration of referral to particular services within the team); will need to hold on true treatment discharge; may consider adjusting appointment supply (grids); consider additional use of/referral to groups

Experiment 2	We are struggling with psychotherapy because we have so many patients and they're spread out far (coming in once a month or so, aka "RVI"), what happened if they came in for concentrated episodes of psychotherapy (RVI+Engagement Duration) we expect they would get better faster, and not be engaged for as long, which in the longer term would free up more slots for new patients. But, leadership is worried that will reduce access for new patients. If we opened up more groups, would adding more groups and having more slots in groups, would it reduce patients waiting for individual therapy (appointment supply). It seems like when we have more groups, it seems like they are cycling through multiple groups ("group to group to group"). Wonder what the impact of that is. This is related to the issue of when are patients stable enough to step down to primary care. Also, wonder if we need all of the adjunctive services we offer.	If we run our base case in balanced mode, patients would utilize group treatments more often and we would reduce the team's reliance on the adjunctive services.	If we make no new decisions in our team, the hours for the services will remain the same over the next two years. If we use a balanced mode and compare to BC, patients waiting for adjunctive services do not change/doesn't get worse over 2 years ; when looking at patients waiting for group, the number of patients waiting doesn't get better.	We expect they would get better faster, and not be engaged for as long, which in the longer term would free up more slots for new patients. We decided to combine an increase in group psychotherapy referrals (using balanced case number of approx 15-16) with a decrease in RVI to psychotherapy (to 1) and a decrease in length to psychotherapy to 16 weeks.
Experiment 3	We are struggling with psychotherapy because we have so many patients and they're spread out far (coming in once a month or so, aka "RVI"), what happened if they came in for concentrated episodes of psychotherapy	We expect wait times for psychotherapy to decrease to align with a more evidence-based pattern of care and new patient access to psychotherapy to increase.	Number of patients waiting to start a service decreases and stays low when reducing percentage referred to individual psychotherapy from 32% to 12% AND increasing referrals to	Evaluate grids and group availability to determine if it is possible to increase referrals to group psychotherapy ensure the availability of 20 hours of groups psychotherapy per week across all providers on the team. This will allow for the team

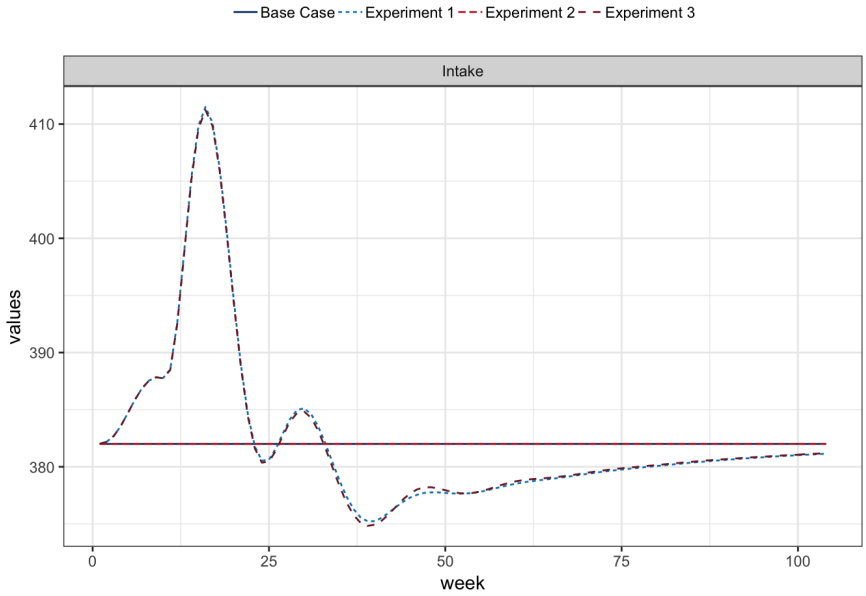
	(RVI+Engagement Duration) we expect they would get better faster, and not be engaged for as long, which in the longer term would free up more slots for new patients. But, leadership is worried that will reduce access for new patients. If we opened up more groups, would adding more groups and having more slots in groups, would it reduce patients waiting for individual therapy (appointment supply). It seems like when we have more groups, it seems like they are cycling through multiple groups ("group to group to group"). Wonder what the impact of that is. This is related to the issue of when are patients stable enough to step down to primary care. Also, wonder if we need all of the adjunctive services we offer.. In this experiment we are asking if reducing the number of people referred to psychotherapy to ~12%, increasing the number referred to groups to ~15%, decreasing the RVI to 1 week for psychotherapy; and decreasing the length of engagement to 16 weeks for psychotherapy will result in more access to services and more concentrated episodes of psychotherapy.	groups psychotherapy from 8% to 15% while also transitioning to an ebp model of care relying on weekly treatment for 16 weeks.	to start at least 20 patients per week in a course of evidence based psychotherapy. We will begin a process of talking with the team about the value of group treatment and discuss the overall approach to treatment that is embodied by the team. The team will meet at least monthly to explore team data to monitor impact of changes made. The team will establish a weekly huddle to foster consensus building in implementing cultural/operational changes.

Changes to Model Parameters Relative to Base Case

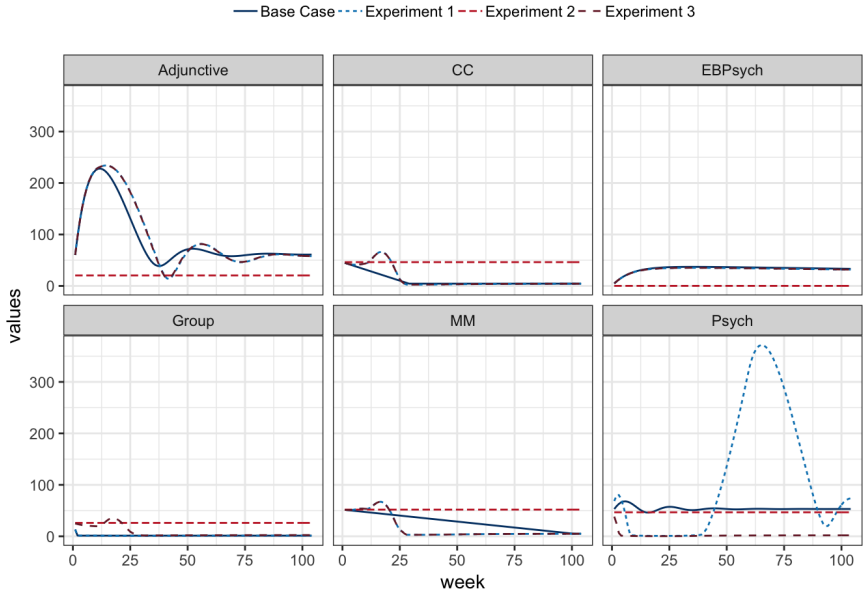
Experiment	Variable	values
Experiment 1	Psych - Return Visit Interval	1.00
Experiment 1	Psych - Engagement Duration	16.00
Experiment 2	Service Proportions From Team Data	0.00
Experiment 3	Psych - Return Visit Interval	1.00
Experiment 3	Psych - Engagement Duration	16.00
Experiment 3	Psych - Service Proportions from Team Data	0.12
Experiment 3	Group - Service Proportions from Team Data	0.15

Team Graphs

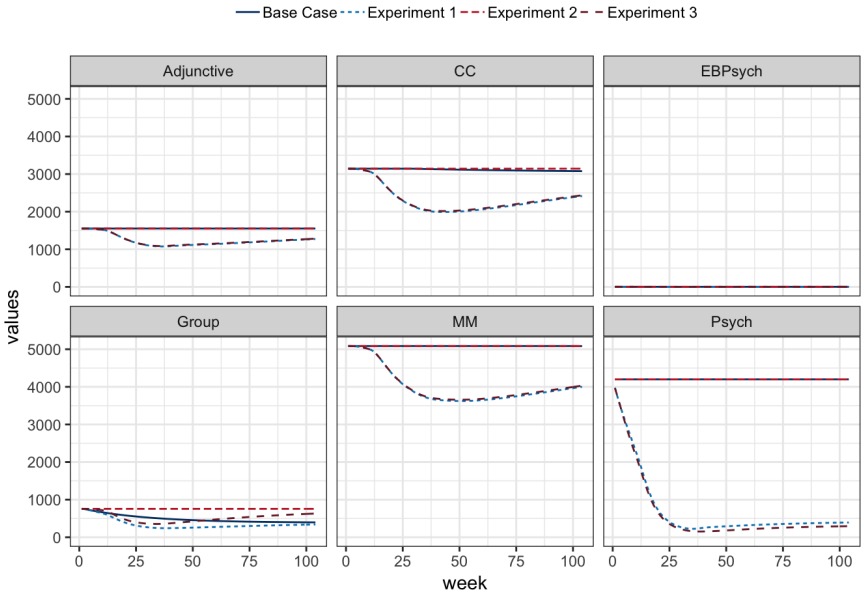
Compare Services: Patients Waiting for Intake Evaluation



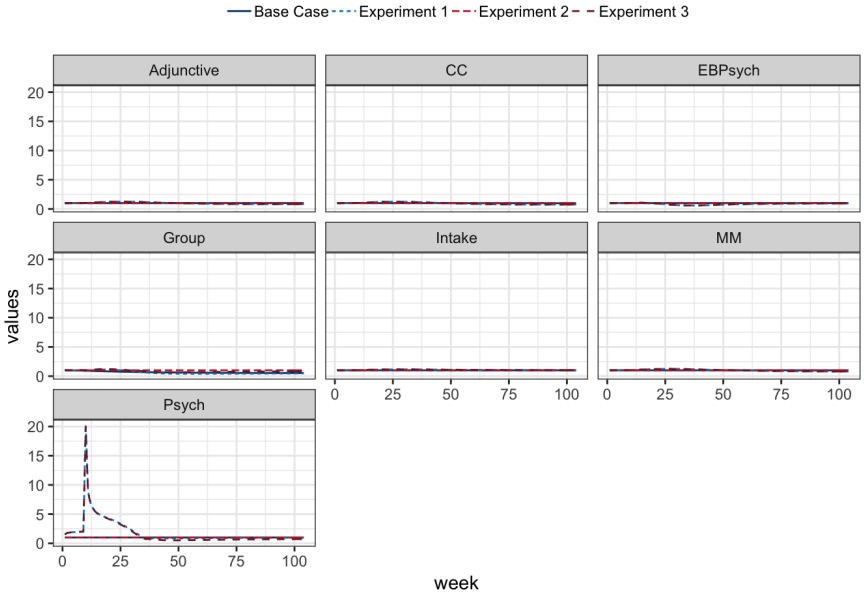
Compare Services: Patients Waiting to Start a Service



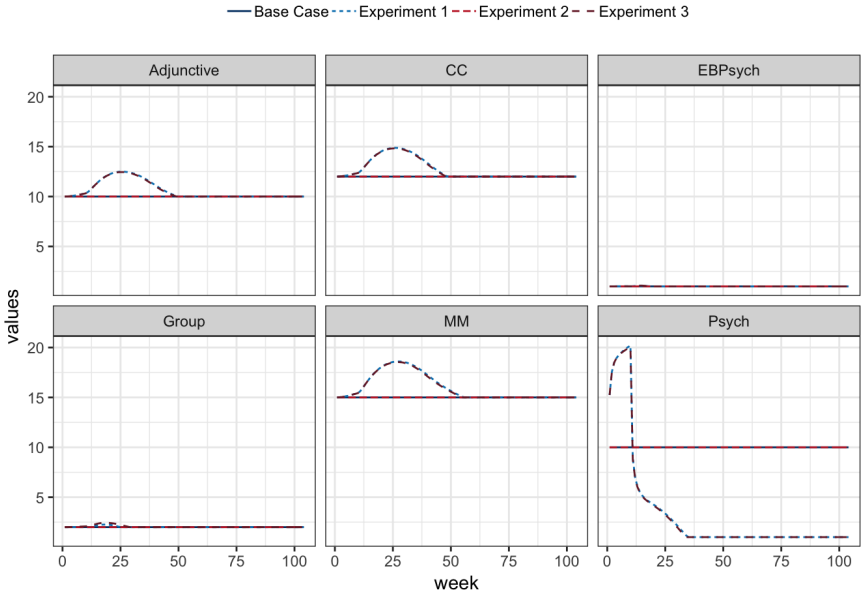
Compare Services: Patients in Service



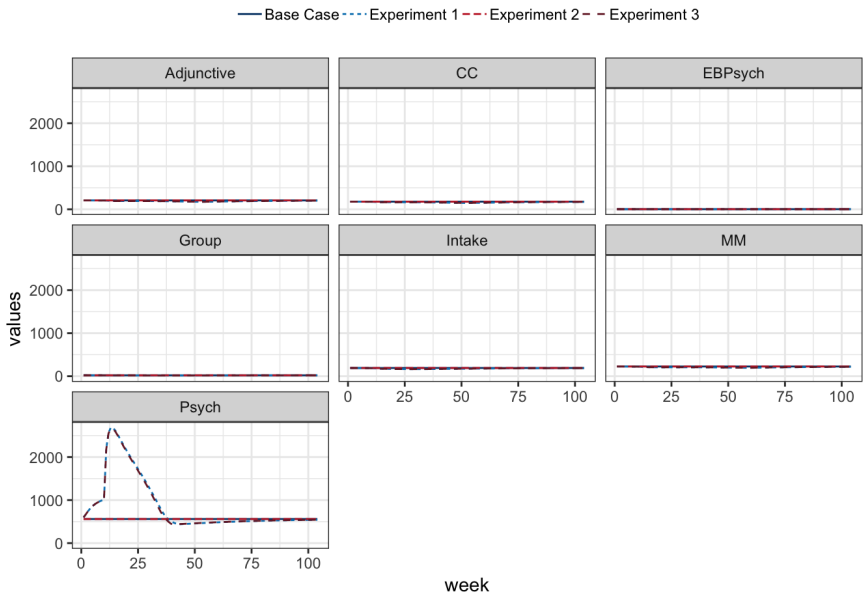
Compare Services: Work Pressure



Compare Services: Actual Return Visit Interval



Compare Services: Actual Hours Available for Service



P-Charts

Individual Location Data

Example Site from Menlo Park