Responding to an Increased Demand for Services: Options for Building Capacity

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Use of Clinical Triage in the University Mental Health Service

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Key Elements of Triage System

• Clinically based decision making
• Customer friendly orientation
• Ease of use
• Maximize efficiency
• Promotion of clinical discussion
THE PROCESS

• New director joins staff 6/95
• Individual meetings with all staff: near unanimity as to deficiency with current intake system
• Reaching consensus among staff
• Addressing resistance to change
• Proposal issued for discussion
• Staff mandate for change
• Multidisciplinary workgroup

WORKGROUP PHASE

• Active meetings begin
• Review of data-intakes, urgent care, on-call
• Triage protocols developed
• Levels of care
• Forms and documentation
• Specialized referrals
• Change in team model
• Presentation to staff
• Staff suggestions integrated
IMPLEMENTATION

• Program piloted 11/13-21/96
• Modifications made post-pilot
• Full implementation spring semester, 1997

RESULTS

• All new referrals offered clinical triage appointment same day
• Urgent slots available, offered directly during triage
• Urgent care walk-in clinic experiences immediate decline.
  • Spring semester, 1996 (old system): 184 visits
  • Spring semester, 1997 (new system): 39 visits
  • Spring semester, 1998: 12 visits
  • Summer 1998: eliminated
Results (cont.)

- Clinical matching takes place within intake teams
- High degree of satisfaction noted in community:
  - consistent feedback from UMASS community about improved access
  - Pt satisfaction survey 12/97 found 96.8% overall satisfaction with our services.
- Hiring of senior clinician, expert in crisis and triage, to take primary role in daily clinical triage.

DIFFICULTIES

- With increased access, increased flow
- Staff stress
- Possible increase in acuity
- Managing shifting demands
ONGOING PROCESS

• Workgroup has periodic meetings
• Refinements continue to be made