White Paper

Data-Driven Decision Making:

Managing the Challenges of a Children's Behavioral Healthcare Practice

By: Michael Gordon, Ph.D.
Upstate Medical University, Syracuse, NY

Clinic Directors nationwide are struggling to cope with unprecedented funding cuts. Demands to see more clients with fewer resources mount daily. How can your services survive against what can seem like insurmountable odds?

The answer, or at least a big part of it, can be found in changes you can implement based on data about your clinic operation. Improving efficiency has to be based on solid information, not on a consultant's fixed notions about what practices will optimize productivity. Data-driven decisions about how to manage your operations offer the best hope for meaningful changes.

Here is an example of how hard data can make a difference: In our clinic, we were able to collect information on what variables best predicted whether a child client got better, worse, or stayed the same over the course of treatment. We wanted to know what factors might predict outcome so we could institute processes that maximized our chances of providing effective care. For example, if it were to be determined that maternal depression was a significant predictor of a child's treatment outcome, a mother's psychiatric history would become a prime area for diagnostic inquiry and perhaps clinical management. Likewise, a finding that the distance between home and clinic was a predictive factor might pave the way for establishing more satellite clinics or perhaps home-based services.

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A systematic analysis of outcome predictors could also have a substantial impact on how we assigned and supervised cases. To avoid staff burnout, our managers could rank cases on their likelihood of success based on empirically-derived algorithms. A clinician's caseload would therefore become more balanced between cases at risk for failure and those more likely to bear therapeutic fruit.

Actual data on which cases might be most frustrating can help minimize caseload decision based more on bias or inaccurate presumptions.

Our data were remarkably helpful in spurring changes in our training, supervision, and procedures. For example, we determined that parent characteristics were more predictive of who improved or stayed the same as opposed to child variables. In other words, if we wanted to know which cases would most likely bring therapeutic success, we should look not so much at the child's age, level of impairment, or diagnosis as we should at the parents' psychiatric history and marital status. We also learned that the cases most likely to fail were those that involved children who had more than one psychiatric condition, a prior trial of medication, and significant disciplinary problems at school. These kinds of findings told us that we had to organize our intake evaluations to focus as much on parent characteristics as those related to the children. For example, if we found that a mother had a history of depression, we had better address management of any current maternal depression up front, perhaps before treating the child directly. The data also supported the referral of adolescents who had a combination of psychiatric and conduct problems to programs that provided more intensive, wrap-around services.

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The mantra in our clinical services has always been, "You can't manage a mystery." Collecting relevant data about your operation forms the basis for good decision-making.

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