Introducing: The Clinical Load Index (CLI)

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Organizations

• Association of University and Counseling Center Directors (AUCCCD)
  • http://www.aucccd.org

• Center for Collegiate Mental Health (CCMH):
  • http://ccmh.psu.edu

• International Accreditation of Counseling Services (IACS)
  • http://www.iacsinc.org
Increasing Demand in Counseling Centers 😊

Utilization Rates and Implications

Min Utilization <1%  Average Utilization 10.9%  Max Utilization 40%

Gen Pop % Screen Positive

THE DEMAND GAP?
Key Concept:
Access vs. Treatment Continuum

Quick Review – CCMH Findings

2015 through 2018
2015: Increasing Utilization

![Average Change Over 5 Years (Fall 2009 to Spring 2015)](image)

- Institutional Enrollment: 5.6%
- Students Served: 29.6%
- Appointments Provided: 38.4%


2015: Average # of Appts for students by threat-to-self factors (implications)

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<td>Suicidal Ideation</td>
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<tr>
<td>Self-Harm &amp; Suicidal Ideation</td>
<td>7.5</td>
<td>9.7</td>
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<tr>
<td>Suicide Attempt</td>
<td>8.1</td>
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2016: Impact of Increasing Utilization

2017: Treatment Works (pt. 1)

• Treatment provided by counseling centers achieves the same level of symptom reduction (effect-size) as that reported in meta-analyses of randomized clinical trials (RCT’s).

2017: Treatment Works (pt. 2)

Average Distress Reduction

![Graph of Average Distress Reduction]

NOTE: Data from 2012-2013 Clients with at least 2 scheduled individual counseling appointments that expressed high levels of distress during their first appointment. N=68,220.

2017: Treatment Works (pt. 4)

Average Distress Reduction, Grouped by Length of Treatment

![Graph of Average Distress Reduction by Length of Treatment]
2018: Clinical Model and Dosage

Students who received services at centers utilizing a Treatment Model attended significantly more appointments.

Students who received counseling services at centers that used an Absorption Model waited significantly more days between counseling appointments.

2018: Clinical Model and Outcomes

Treatment Models had significantly greater decreases on Depression, Generalized Anxiety, Social Anxiety, and General Distress. While there were differences in the symptom change on the CCAPS-34 Subscales of Academic Distress, Eating Concerns, Hostility, and Alcohol use, these differences were not statistically significant.
Staff-to Student Ratio - History and Context

- Adopted by AUCCCD in 1970 (initially 1:1750, now 1:1,000 to 1:1,500)
- Critical advocacy tool over many years; numerous state laws.
- Utilization and operations were more consistent historically

Over the last 50 years...
- Real-world staffing, operations have evolved & diversified
- Actual ratios range widely (1:150 to 1:13,000)

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The Problem: A Tale of Two Assumptions

The student-to-staff ratio is based on two assumptions:
1. **Enrollment** assumes a constant level of % utilization
2. **1 FTE** assumes constant level of % clinical hours per FTE

→ Both assumptions are demonstrably unreliable
→ Solution: incorporate both utilization and clinical capacity into a new metric

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CLI Design Principles

1. Account for both utilization and clinical capacity
2. Parsimony
3. Easy to explain / intuitive
4. Reliable and comparable
5. Continuous scale

Goals for the CLI

1. Accurately describe the national landscape of staffing levels on a rolling basis
   • Not a “recommended standard”
2. Improve transparency (clinical capacity)
3. Create a “gravitational home” for staffing decisions, informed by counseling centers
4. Data-driven decision making and advocacy
5. A work in progress... (as you’ll see today!)
Cutting to the Chase: What does CLI Mean?

• “Clients per Standardized Counselor” or “standardized caseload”
• Range: 37 to 308

Conveys the experiences of:
• Counselor – what is it like to be responsible for?
• Client – what is it like to seek services from?
• Center – what is it like to administer services for?

CLI Ingredients

1. **Utilization**: The total number of students, with at least 1 scheduled appointment, between July 1st and June 30th each year.
2. **Clinical Capacity**: Total number of contracted/expected clinical hours for a typical full week when the center is fully staffed (excluding dedicated case management and psychiatric services).

• **Enrollment**: the number of students eligible for services (just for comparisons)
• **Let’s explore the ingredients...**
## Utilization Examples

**Small Private: (1,500 students)**
- 10% Utilization (150 clients)
- 40% Utilization (600 clients)

**Large Public: (50,000 students)**
- 10% Utilization (5,000 clients)
- 40% Utilization (20,000 clients)

**Commuter Campus: (20,000 students)**
- 1% utilization = 200 clients

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## Clinical Capacity – Some Details

- Theoretical – not actual
- Weekly for ALL providers (except psychiatry and case-managers)
- Captures all clinical hours in your center including hours that were historically excluded (trainees) or difficult to calculate (part-time)
- New concept – not just running a report
  - Report problems: sick time, parental leave, vacation, etc.
- Includes unused time (e.g., coverage during the day)
- Value of a routine contracting process? New annual routine?
Clinical Capacity – Individual Example

• “Counselor A” is scheduled to provide the following during a typical full time week:
  • 4 hours of walk-in/triage
  • 4 hours of intake appts
  • 2 hours of group
  • 2 hours of crisis coverage
  • 12 hours of therapy appointments
• = 24 hours per week
• All hours are counted in advance, effectively including attended, cancel, no-show, etc.

Clinical Capacity – Center Example

• 3 Senior staff each provide 24 clinical hours per week (3 x 24 = 72)
• 1 Asst. Director provides 16 clinical hours per week (16)
• 1 Director provides 8 clinical hours per week (8)
• 72 + 16 + 8 = 96 hours

• Clinical capacity of this center = 96 hours per week
FTE vs. Clinical Capacity (hours)

- Clinical Capacity
  - School A: 120 hours
  - School B: 80 hours

“Standardized Counselors”

- Convert hours of “Clinical Capacity” into “Standardized Counselors”
- Derived from counted hours, not institutional practices

- 60% of contract is common max clinical load (e.g., 24 of 40 hrs)
- 24 hours of “clinical capacity” = 1 “Standardized Counselor”
- # of Standardized Counselors = Clinical Capacity / 24
FTE, Clinical Capacity & Standardized Counselors

School A

HOURS: 24 24 24 24 24

School B

HOURS: 24 24 16 12 4

5 FTE
120 hours
5 Standardized Counselors

5 FTE
80 hours
3.3 Standardized Counselors

Calculating the CLI

CLI = \frac{\text{Utilization}}{\text{Standardized Counselors}}

The CLI can be thought of as:
• Clients per standardized counselor or
• Standardized caseload
Visualizing CLI and Utilization
(1 staff member for 1000 enrolled students with varying levels of utilization)

11.8% = National Average Utilization

Developing the CLI Distribution
Creating the CLI Distribution – Surveys and Data Audit Process

- Data from: FY 2017-2018 (7/1/2017 – 6/31/2018)
  - AUCCCD Survey Data (Fall 2018)
  - CCMH CLI survey (May 2019)
  - (1) Enrollment, (2) Utilization, and (3) Clinical capacity

- Audit required hundreds of hours by CCMH staff over 6 months
- 277 audits completed (phone or email), 48 not audited (“good data”)
- 11 cases removed (restructuring, data irregularities, no response)
- 442 at start, 432 total schools in final distribution

Developing the CLI Distribution – Data Review

- Evaluate distributions, look for outliers
- Initial - some messiness, but distribution looked as expected
- 85 of the 133 combined group (AUCCCD+CCMH) had at least 1 data point that was 10-15% greater/less than the other
- Audited as many centers as possible through October 1st
  - Phone interviews
  - Emails
  - Corrected data
Developing the CLI Distribution – Data Mistake Themes

• Utilization
  • Using attended appts instead of scheduled
  • Number of appointments instead of clients (common)

• Clinical Capacity
  • Included Psychiatry/Case Management
  • Forgot to count trainee hours
  • Forgot to count associate staff hours
  • Provided hours for 1 person
  • EMR problems

2017-2018 CLI Final Distribution (N=432)
Frequencies and Descriptives

Number of centers: 432
Range: 37 – 308
Mean: 118
Median: 114
Standard Deviation: 44

Visualizing the CLI Distribution
Get Your CLI Today 😊

- Website: https://ccmh.psu.edu/
- White Paper: download from website

To use:
1. Enter your data (enrollment, utilization, clinical capacity)
2. Compare and contrast
3. Download PDF
4. Advocate!
5. Let’s take a tour 😊

CLI Tour

1. “CLI Overview” tab, location of white-paper
2. “My CLI” tab
   1. How to enter data
   2. Update data
   3. Bookmark
   4. Download PDF
   5. Review of comparisons/trends
3. “Peer Comparisons” tab
   1. Review of comparisons/trends
CLI – Preliminary Analyses

From the CCMH 2019 Annual Report

Percent Utilization by Enrollment
Initial Distress by Percent Utilization

CLI by School Size (Enrollment)
CLI by Utilization

CLI and Dosage of Treatment Provided
CLI and Treatment Outcomes

Research says that caseloads matter

• “Therapists with more sessions OR more clients show less/slower change.”
  • BYU ongoing: Authors: Bailey, Erekson, Andes, Snell, & Goates-Jones
  • N=18,322 clients seen between 2009 and 2017

• “The number of clients being seen negatively predicted outcomes.”

• CLI research confirms
Take Home Points

• CLI is an annual statistic: “standardized caseload” or “clients per counselor”
  • “Standardized counselor” should not be used to compare or evaluate an individual counselor at an individual institution.
• Goal of CLI is not to be “average”
• CLI is meant to accurately inform decision making process
• Staffing levels are determined by the institution and unique local factors/context/philosophy
• Transparency and accountability

Implications and Future Directions
- Much to learn...
- Outcomes
- Clinical model decision points
- Use of specific clinical approaches
  - Triage
  - COD
  - Walk-in
- Staff experiences
- Client experiences
- Best practices
Thank you!
Discussion...