San Joaquin County Behavioral Health Services
Children's Psychiatric Timeliness Performance Improvement Project
September 2021

Project Leader/Manager/Coordinator	Donna Bickham, LCSW Deputy Director, QAPI, and Fay Vieira, LMFT, Deputy Director of Children and Youth Services
Contact email address	dbickham@sjcbhs.org fvieira@sjcbhs.org
Performance Improvement Title	Children's Psychiatric Timeliness PIP
Type of PIP	☐ Clinical ☒ Non-clinical
PIP period (# months): 14	Start 06/2020 to End: 8/2021

The initial draft of this report was prepared September 2020. A revised draft was prepared Aug/September 2021. Edits were made throughout, but significant changes are depicted in green. A track-change version is available for the EQRO reviewer.

Briefly describe the aim of the PIP, the problem the PIP is designed to address, and the improvement strategy.

The goal of the Children's Psychiatric Timeliness PIP is—by the end of FY 20/21—to increase the proportion of children who are offered an initial psychiatric evaluation within 15 days of *first request* by (1) scheduling psychiatric appointments immediately after the initial request, (2) offering families the choice of scheduling an appointment at the first-available clinic, and (3) referring children to a BHS-operated clinic when wait time at a contractor-operated clinic approaches 15 days.

What MHP/DMC-ODS data have been reviewed that suggest the issue is a problem?

The QAPI Council reviewed timeliness-related performance data for both children and adult systems of care. Initially (early 2020) the QAPI Council had focused on developing strategies to improve *timeliness from first contact to first attended clinical intake assessment*, but, following technical assistance from our EQRO reviewer, we determined that these performance outcomes had already improved in the previous

fiscal year, and a more significant concern had to do with *timeliness from referral to initial psychiatric evaluation*.

When we looked at the proportion of initial requests for psychiatric evaluations that were offered an appointment within 15-days of request, we discovered that our children's system of care was only meeting the standard 58% of the time. Our adult system of care, by contrast, was meeting the standard 71% of the time. Based on these findings, we decided to do a performance improvement project to increase timeliness for children and their families seeking psychiatric evaluations.

Table 1. Timeliness of Psychiatric Evaluations, 7/1/19 to 6/30/20

Enrollee Population	# of offers for psych evaluation	# of offers that met 15-business day standard	% of offers that met 15-business day objective
Children	**304**	**177**	**58.2%**
Foster	54	36	66.7%
Adult (includes older adult)	1054	752	71.4%
Older Adult	68	54	79.4%
All	1358	929	68.4%

What are the barrier(s) that the qualitative and/or quantitative data suggest might be the cause of the problem?

Barriers were identified through qualitative and quantitative methods:

Clinicians' Perspectives: Children and Youth Services (CYS) clinicians discussed causes of psychiatric wait times in June 2020. Identified reasons for long waits included:

- **Chronic pediatric psychiatrist shortages** in each clinic, the county as a whole, and the entire region.
- **Fluctuating demand** across the system of care, month to month, but also within each clinic.
- BHS practices have historically discouraged distributing a client's care team across more than one clinic. Upon identification of need, consumers are offered psychiatric services only at the clinic where they are already receiving clinical (i.e., non-psychiatric) care. As a result, **the current scheduling system does not permit a geographically flexible distribution of services** during periods of staffing shortages or high demand.
- **Waiting for a supervisor to sign off on the referral form prior to scheduling an initial psychiatric evaluation** unnecessarily delays access

even though the vast majority of requests are confirmed to meet medical necessity.

Psychiatrists' perspectives: Psychiatrists and clinicians met on July 14, 2020 to discuss causes and possible strategies to reduce wait times. Psychiatrists described:

- **Access challenges related to geography.** Before COVID-19, patients relied on public transportation or rides for services. In addition, staff meetings were in-person, and either psychiatrists or clinicians had to drive to meetings at various locations, further limiting the time they had to meet with clients. Since COVID-19, many appointments are virtual, and no longer require transportation.
- **Less reliance on telemedicine before COVID-19**. While psychiatrists spoke of the benefits of face-to-face meetings and the difficulties with using new technologies, they also acknowledged that young people are more tech savvy and comfortable with video-facilitated meetings and show rates have increased since the COVID-related transition to telemedicine.

Consumers' perspectives: The evaluator, deputy director of quality improvement, and a CYS chief clinician met with the Consumer Advisory Committee (CAC) on July 16, 2020, to get feedback on barriers to timeliness and strategies for reducing wait times. Their feedback is included in Section 6, below.

Other data: There are currently 3.9 FTE psychiatrists serving 4 outpatient clinics (Central Campus 2.2 FTEs; Manteca 0.56; Tracy 0.4; Lodi 0.8). This means that there can be very **little flexibility in appointment scheduling** if clients are expected to receive psychiatric services at the same location as their clinical services. For example, expecting consumers to wait for the availability of a single part-time provider at their "home" clinic while there may be two available providers at another clinic unnecessarily delays access.

Who was involved in identifying the problem? (Roles, such as providers or enrollees, are sufficient; proper names are not needed.) Were beneficiaries or stakeholders who are affected by the issue or concerned with the issue/topic included

SJCBHS's process of identifying performance problems:

Managers in 24-Hour Services, Adult Systems of Care, and Children's System of Care review their system's Performance Dashboard and bring key concerns to monthly QAPI Council meetings. The QAPI Council is comprised of BHS program managers, senior leadership, administrators, consumer/family representatives and a contractor evaluator. Problems and strategies are discussed to determine if data are accurate; if problems are short-term and easily resolved; or if they require more rigorous efforts or systemic changes.

Those issues that are most concerning or require a greater degree of planning and analysis are discussed as potential PIP ideas.

Individuals involved in identification of *this* PIP:

- In June 2020, CYS managers reviewed the children's system of care dashboard and identified psychiatric timeliness concerns and potential strategies.
- In July 2020, QAPI Council members and senior managers agreed to pursue the Psychiatric Timeliness PIP and appointed the QAPI director, evaluator, a CYS chief, and an IS programmer to serve as the core PIP team. The PIP team has been responsible for validating performance data, collecting stakeholder feedback on causes of the problem and potential strategies, and developing procedures around selected interventions.
- In August 2020, members of the PIP team conducted discussion groups with CYS managers, members of the Consumer Advisory Council, and psychiatrists to better understand the causes of and discuss strategies for resolving the problem.
- The PIP team monitors data and reports back to the QAPI council and senior managers on a monthly basis.

Notes from the meeting with CYS managers, CAC, and psychiatrists are attached in Appendix A

Are there relevant benchmarks related to the problem? If so, what are they?

Network Adequacy Standards require MHPs to provide timely access to care. Timely access refers to the "number of business days in which a plan must make an appointment available to a beneficiary from the date the beneficiary, or a provider acting on behalf of the beneficiary, requests a medically necessary service." The timely access standard for initial psychiatrist appointments is 15 days (p17 of Final Rule).

The most recent statewide EQRO report (FY18/19) provides DHCS standards for medium counties and data on average business days from on first offered psychiatry appointment. On average, medium counties are offered psychiatry appointments within 30 days, however, DHCS standard for medium counties was 17 business days. Unfortunately, data on psychiatric timeliness were not reliable because some counties measured *offered* appointments while others measured *kept* appointments. In addition, some counties measured from *intake* while others measured from *determination of need* (pp 39-40 of FY 18/19 EQRO Report).

As a result, for the purposes of this PIP, SJCBHS has established our own standard for psychiatric timeliness—80% will meet 15-day standard—and clarified the definition of psychiatric timeliness as *number of business days from initial request by parent/guardian for psychiatric evaluation to first offered psychiatric appointment*. This goal was established with the understanding that to the extent possible, BHS will strive to achieve network standards and also with an understanding that it may still fall short of the goal during periods of unforeseen circumstances.

Step 1: Identifying the PIP Topic

WORKSHEET 2: DRAFTING THE AIM STATEMENT

What is the Aim Statement of this PIP? (The Aim statement should be concise, answerable, measurable and time bound.)

Can SJCBHS increase the proportion of children who are *offered* an initial psychiatric appointment within 15 days of parent/caregiver request from a baseline of 58% in FY 19/20, to 70% by January 2021, and 80% by March 2021, and sustain an 80% goal for at least 3 months by:

- Scheduling psychiatric appointments on the same day as parent/guardian request
- Offering the first available opening at a different clinic if there is an earlier timeslot available
- Referring children to BHS-operated clinics when wait time at contractor-operated clinics approach 15 days

Briefly state the improvement strategy that this PIP will use. (Additional information regarding the improvement strategy/intervention should be supplied in Step 6.)

Modify the initial psychiatric referral procedures at county-operated clinics so that:

- Clinicians provide a warm handoff or phone transfer to the front desk to initiate the scheduling process, and psychiatric appointments are scheduled on the same day as the parent or guardian request.
- Families are offered a sooner psychiatric appointment if one is available at a different clinic than where they receive clinical services.

Develop agreements with the contractor-operated clinics so that:

- Children are referred to the county-operated clinic if wait times for psychiatric services are longer than 15 days.

Who is the population on which this PIP focuses? Provide information on the study population such as age, length of enrollment, diagnosis, and other relevant characteristics of the affected population.

See Worksheet 3, below.

What is the timeframe for this PIP, from concept development to completion?

Start June 2020

End July 2021

The following Gantt Chart describes the PIP processes that occurred following the 2019 EQRO review:

	2020												2021							
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	July	Aug
Pursuit of earlier PIP concept																				
PIP on pause due to COVID-19																				
Review of data and development of current PIP concept																				
Development of PIP implementation strategies																				
Implement county-based strategies																				
Post-intervention data monitoring																				
Implement contractor-based strategy																				
Final report																				

Additional Information or comments

NA

Step 2: Developing the Aim Statement

WORKSHEET 3: IDENTIFYING THE PIP POPULATION

Who is the population on which this PIP focuses? Provide information on the study population such as age, length of enrollment, diagnosis, and other relevant characteristics of the affected population. Please include data, sources of information and dates of sources. The study population is all children/youth (<18) whose parent or guardian request an initial psychiatric evaluation. Initial requests for psychiatric evaluations may occur during a clinical intake assessment or any period following and are often made through consultation with the clinical team and after non-psychiatric interventions are attempted without clinical progress. If, under very unusual circumstances, a parent or guardian requests a psychiatric evaluation but subsequently the child is determined to not meet medical necessity, the child will not be included in the study population and will typically be referred to a lower level of care. In Fiscal Year 2019/20, there were 304 initial requests for children's initial psychiatric evaluation. We anticipate this figure to remain fairly constant, barring significant changes due to COVID-19. In Fiscal Year 2020/21, the number of documented requests for an initial psychiatric evaluation grew to 593. The documented increase may have been due to clearer definitions of first request, improved data monitoring, and greater reliability of data entry as the PIP progressed.
Will all enrollees be included in the PIP? ☒ Yes, all enrollees who meet the above criteria will be included in the PIP study population ☐ No
If no, who will be included? How will the sample be selected? NA
Additional Information or comments NA

Step 3: Identifying the PIP Population

WORKSHEET 4: DESCRIBING THE SAMPLING PLAN

If the entire population is being included in the PIP, skip Step 4.

If the entire population is NOT being included in the PIP, complete the following:

Describe the sampling frame for the PIP. A sampling frame is the list from which the sample is drawn. It includes the universe of members of the target PIP population, such as individuals, caregivers, households, encounters, providers, or other population units that are eligible to be included in the PIP. The completeness, recency, and accuracy of the sampling frame are key to the representativeness of the sample N/A
Specify the true or estimated frequency of the event.
Determine the required sample size to ensure that there are a sufficient number of enrollees taking into account non-response, dropout, etc.
State the confidence level to be used.
State the margin of error.
Additional Information or comments

Step 4: Describing the Sampling Plan

WORKSHEET 5: SELECTING PIP VARIABLES AND PERFORMANCE MEASURES

The questions below can be answered generally. Please complete the tables below for specific details.

What are the PIP variables used to track the intervention(s)? The outcome(s)? Refer to the tables 5.1 – 5.3 for details.

1) Independent variables (used to track interventions):

    a) Number of initial psychiatric evaluation appointment requests that are offered the opportunity to schedule an appointment within 24 hours (one day) of request

    b) Number who are offered an earlier psychiatric appointment at a different clinic than the clinic currently serving them

    c) Number who accept the earlier psychiatric appointment at a different clinic

    d) Number of psychiatric referrals from contractor-operator to county-operated clinics

2) Dependent variables (used to track outcomes):

    a) Number of first requests that are *offered* an initial psychiatric evaluation appointment within 15 business days

What are the performance measures? Describe how the Performance Measures assess an important aspect of care that will make a difference to beneficiary health or functional status?

We are using the following performance measure to assess timely access to initial psychiatric care for children:

- Percent of children who are offered an initial psychiatric evaluation appointment within 15 business days of parent/guardian request

Timely access to services is widely understood to contribute to better health outcomes, so much so that Centers for Medicare & Medicaid Services CMS) issued a Managed Care Federal Rule in 2016 establishing timeliness standards for primary and specialty (including psychiatric) timely access.[1] These performance measures are

[1] https://www.dhcs.ca.gov/formsandpubs/Documents/FinalRuleNAFinalProposal.pdf

based on the 15-day standards for specialty healthcare services. While a search of academic literature on the clinical outcomes of timely access to pediatric psychiatric services offers few findings[2], delays in adult psychiatry demonstrate an increase in psychiatric hospitalizations,[3] and timely access to children's services contribute to greater family satisfaction.[4] Timeliness of offer is directly associated with appointment attendance.[5]

What is the availability of the required data?

Data sources and collection methods are described in Step 7, below.

Data for the dependent variable (i.e., percent offered a psychiatric appointment within 15 business days) are available from the Timeliness App's Managers' Reports. These reports offer real-time timeliness and access data for any clinic and for any time period. Clinic managers can access the reports from their workstations during business hours and remotely off-hours. In addition to tracking the dependent variable for this PIP, managers use these reports to track other timeliness variable and also to identify individual referrals that are failing to meet timeliness expectations so that they can implement immediate strategies on an as-needed basis.

In addition, the CYS Dashboard reports psychiatric timelines data monthly and by fiscal year for all CYS programs, overall, for foster care clients, specifically, and for individual contractor programs. Dashboards are used by the QAPI Council to monitor this performance measure as well as other timeliness measures.

To track the dependent variables (for the sake of monitoring fidelity) the PIP team will compile, analyze, and monitor data from the clinics' Psychiatric Referral Logs. These sources are described in greater detail in Worksheet 7.

[2] McLennan J. D. (2015). Wait time to what? Could reducing wait times for child mental health services worsen outcomes?. *Journal of the Canadian Academy of Child and Adolescent Psychiatry = Journal de l'Academie canadienne de psychiatrie de l'enfant et de l'adolescent*, *24*(1), 55–58.

[3] Williams, M. E., Latta, J., & Conversano, P. (2008). Eliminating the wait for mental health services. *The journal of behavioral health services & research*, *35*(1), 107-114.

[4] Jones, E., Lucey, C., & Wadland, L. (2000). Triage: a waiting list initiative in a child mental health service. *Psychiatric Bulletin*, *24*(2), 57-59.

[5] Sherman, M. L., Barnum, D. D., Buhman-Wiggs, A., & Nyberg, E. (2009). Clinical intake of child and adolescent consumers in a rural community mental health center: Does wait-time predict attendance?. *Community Mental Health Journal*, *45*(1), 78-84.

TABLE 5.1 VARIABLE(S) AND INTERVENTION(S)

Goal	(Independent) Variable	Intervention	Performance Measure (Dependent Variable)	**Improvement Rate**
Increase in psych appt timeliness	1. # of psych appointments scheduled within 24 hours (one-day) of initial request 2. # of first requests that are offered an earlier appointment at a different clinic 3. # of first requests that accept earlier appointment at different clinic 4. # of psych referrals transferred from contractor-operated to county-operated clinics	1. Schedule appointment on the same day as first request 2. Offer choice of earlier appointment at different county-operated clinic, if available 3. Refer to county-operated clinic if wait times at contractor-operated clinic approaches 15 days	1. % of first requests that are offered a psych appointment within 15 days	1) Increase the proportion of psychiatric intake appointments that are offered within 15 days from 58% in FY 19/20 to 80% by March 2021. 2) Maintain 80% objective for at least 3 consecutive months

TABLE 5.2 SOURCES OF INDEPENDENT AND DEPENDENT VARIABLES

	Variable	Source of Data	Availability of Data
1	# of psych appointments scheduled within 24 hours (one-day) of initial request	Timeliness App	On demand
2	# of first requests that are offered an earlier appointment at a different clinic	Psychiatric Referral Log	On demand
3	# of first requests that are scheduled at a different clinic	Psychiatric Referral Log	On demand
4	# of first requests that are offered psych appointment within 15 days	Timeliness App	On demand

Step 5: Selecting the PIP Variables and Performance Measures

WORKSHEET 6: DESCRIBE IMPROVEMENT STRATEGY (INTERVENTION) AND IMPLEMENTATION PLAN

Answer the general questions below. Then provide details in the table below.

Describe the improvement strategy/intervention.

County-operated CYS Stockton and Lodi Clinics - Modify the initial psychiatric referral procedures at county-operated clinics:

1. **The front desk will offer parents/guardians the opportunity to schedule a psychiatric appointment on the same day or within one business day of their request for psychiatric evaluation:** When a parent or guardian—working in concert with the clinician—requests a psychiatric evaluation for their child, the clinician will submit a time-sensitive referral to the front desk. Whenever possible, the clinician will make a warm handoff (or phone transfer) to front desk staff. Within one business day of receipt, the front desk staff will contact the parents/guardian to schedule a psychiatric intake for their child. *How is this different*: Previously, families would have to wait until clinical supervisor approval, which could take as long as 2 weeks, thereby narrowing the window of opportunity for a timely first offer.

2. **When the first available psychiatric intake appointment is at a different clinic than the child's clinical care team, the front desk will offer both options.** To facilitate consumer choice, the front desk staff person at both Lodi and Stockton clinics will be able to view and schedule psychiatric intake appointment slots in each other's Sharecare calendars. BHS decided to start by providing consumers a choice between Stockton and Lodi clinics because these are both county-operated, are the largest clinics, and are less than 13 miles apart. The client's clinical care team will remain at their original clinic, but if the parent/guardian chooses a different clinic for their psychiatric intake, the family may need to attend future psychiatric appointments at that location as well. Regardless of where the client receives psychiatric care, the care team—including the clinician and psychiatrist—will continue to meet in-person or by video monthly for case review. If available, the clinician will attend the initial psychiatric evaluation with their client at any clinic they choose. *How is this different?* Previously, all psychiatric intake appointments were scheduled at the same clinic as the client's clinical care team. Clerical staff did not share scheduling systems between clinics. Clinicians did not attend psychiatric intake appointments.

Contractor-operated Manteca, Tracy, and March Lane clinics – Develop interagency agreements, policies, and procedures so that:

3. **The contractors will refer children to BHS-operated clinics if the psychiatric evaluation wait times approach 15 business days.** (See Appendix B for draft agreement.) *How is this different?* One of the two contracted clinics provides both clinical and psychiatric services, but during periods of high volume or staffing shortages, it cannot always meet timeliness standards. The other contractor relies on BHS psychiatrists stationed at its clinics, but similarly, cannot always meet the demand. This intervention will allow the larger, county-operated clinics, with a greater number of psychiatrists, to absorb the demand when needed.

COVID-19 considerations: These interventions are particularly appropriate during the pandemic because many client care appointments and care team consultations are now conducted by video conferencing and are not affected by geographic limitations. Parents and guardians will need to be informed that while psychiatric intakes may be performed virtually, future psychiatric appointments may be in person, and as a result, they should consider the possibility of future transportation barriers and choose psychiatric services accordingly.

What was the quantitative or qualitative evidence (published or unpublished) suggesting that the strategy (intervention) would address the identified barriers and thereby lead to improvements in processes or outcomes?

Consumer feedback:

- There was consensus among Consumer Advisory Committee members that providing options of where to go for services was a good idea: “Makes sense to me because BHS is all of San Joaquin County.” In an August 2020 CAC meeting, participants liked how the strategies created more opportunity to “get what they need.” They encouraged the PIP team to explore how using Zoom can mitigate transportation barriers even after the COVID-19 crisis has subsided.

Staffing limitations and geographic barriers:

- The drawback of systems of care that have multiple smaller clinics scattered throughout a wide geographic region is that psychiatrists are spread out and assessment slots at each individual location are therefore limited. The benefit of geographic dispersal is that clinics are more accessible. Network Adequacy

Standards set an expectation of a maximum of 30 miles or 60-minute drive for San Joaquin County. The distance by car between Stockton and Lodi is approximately 13 miles; between Stockton and Manteca is 14 miles; and between Manteca and Tracy is 14 miles. These distances are not insurmountable for clients who live between clinics and/or who have access to an automobile. By offering a choice, clients can mitigate some of the supply and demand mismatches and experience more timely service.

Best practices in psychiatry:

- **Telemedicine:** The unprecedented expansion in the use of telemedicine/video conferencing since the COVID-19 outbreak is widely considered a best practice. According to an APA webinar on the subject, "Many psychiatrists have quickly transitioned to using telehealth and found it beneficial for certain patients. As states lift stay-at-home orders, and data shows COVID-19 continues to spread in some areas, the use of telehealth remains an important tool for patients to access mental health and substance use disorder treatment while keeping patients, clinicians, families, and communities safe through physical distancing." Telemedicine renders many of the geographic limitations on where clients receive services irrelevant. COVID-19 has pushed our behavioral health systems of care to use relatively new phone-, laptop- and tablet-accessible technologies faster than we may have done so.

- **Consumer choice:** In a 2015 meta-analysis of 34 empirical studies showed that clients who were actively involved in decisionmaking about their treatment showed higher satisfaction, increased completion rates, and better clinical outcomes.[6] Rather than assuming clients would choose the same clinic for their psychiatric services as they would for their clinical services regardless of wait time, this PIP allows clients/caregivers to choose the best option based on their own preferences. Some may choose a closer clinic at a later date; others might choose a farther clinic but at a sooner date.

- **Warm handoffs:** While several recent studies have shown that warm handoffs are not in themselves a predictor of engagement—for example, they must be accompanied by the development of therapeutic alliance between client and referring provider and their efficacy depends on the quality of the referral

[6] Lindhiem, O., Bennett, C. B., Trentacosta, C. J., & McLear, C. (2014). Client preferences affect treatment satisfaction, completion, and clinical outcome: a meta-analysis. *Clinical psychology review*, *34*(6), 506–517. https://doi.org/10.1016/j.cpr.2014.06.002

process[7],[8]—they are nonetheless considered by SAMHSA to be a "hallmark" of integrated care[9] The warm handoff described in this PIP assumes that a through comprehensive assessment and/or ongoing treatment, a therapeutic relationship is developing between the client/caregiver and clinician, and that the caregivers and clinicians are reviewing client needs and coming up with a treatment plan that involves psychiatric care together. Therefore, by the time that the caregiver requests a psychiatric referral, they are likely educated and motivated to attend the appointment, and the warm handoff is predominantly aimed at improving coordination of care.

Does the improvement strategy address cultural and linguistic needs? If so, in what way?

According to the U.S. Department of Health and Human Services, Culturally and Linguistically Appropriate Services (CLAS) "is about respect and responsiveness: respect the whole individual and respond to the individual's health needs and preferences." While the proposed strategy does not directly address the cultural and linguistic needs of specific marginalized populations, allowing consumers to choose a timelier intake slot demonstrates greater respect for consumer agency and responsiveness to their immediate healthcare needs. In addition, providing a choice of locations may allow consumers and their clinician to identify psychiatric providers who are more compatible with their needs. For example, Lodi Clinic does not have a female psychiatrist. By expanding the pool of potential psychiatrists from which clients and their parents/guardians can choose, girls who have been sexually abused and receive clinical services in Lodi will be able to request psychiatric services at a different clinic from a female psychiatrist.

When and how often is the intervention applied?

The intervention is applied with any child (<18) when their parent or guardian requests a psychiatric intake appointment from the clinical care team. The request for psychiatric services is frequently made in consultation with the clinician and may occur during clinical intake assessment or at any time during the course of clinical

[7] Horevitz, E., Organista, K. C., & Arean, P. A. (2015). Depression treatment uptake in integrated primary care: How a "warm handoff" and other factors affect decision making by Latinos. *Psychiatric Services*, *66*(8), 824-830.

[8] Tedder, Jamie, "Examining the Warm Handoff in Rural Integrated Care" (2020). Electronic Theses and Dissertations. Paper 3802. https://dc.etsu.edu/etd/3802

[9] Integration.samhsa.gov. (2019). *ORGANIZED, EVIDENCE-BASED CARE: Behavioral Health Integration*. [online] Available at: https://www.integration.samhsa.gov/news/Implementation-Guide-Behavioral-Health-Integration.pdf [Accessed 24 Sep. 2019].

treatment, especially if the child is not demonstrating improvements in symptoms or behaviors.

A core component of the intervention—scheduling the psychiatric intake appointment—will begin as soon as the request is made. The clinician will document the request and inform the front desk staff, who will attempt to schedule an appointment within one business day.

During FY 19/20, 304 new children's psychiatric requests were made, ranging from 17 per month (in May, during COVID) to 42 per month (in October). The PIP team assumes that the number of requests for psychiatric services will remain the same, but like in previous years, will fluctuate from month to most notably increasing in the fall, when school starts.

FY 20/21 update: The number of documented psychiatric referrals increased from an average of 25 per month in FY 19/20 to an average of 45 per month in FY20/21. The documented increase was the result of more reliable data entry as staff became more familiarized with the Timeliness App data collection system and processes.

Who is involved in applying the intervention?

Clinicians provide psychosocial assessments and ongoing therapeutic services and consult with parents/guardians to help them determine behavioral healthcare needs. During an assessment or following a period of treatment in which a child does not demonstrate emotional, functional, developmental, or behavioral improvement, the clinician may recommend a psychiatric evaluation.

At any point during an assessment or ongoing treatment, the parent/guardian may request an initial psychiatric evaluation for their child. This may occur under advisement of the clinician or through independent decision making.

At the end of the service, the clinician will provide a warm handoff (or phone transfer if request is made by phone) to the front desk office worker and the **front desk office worker** will offer the soonest available appointment regardless of where client receives therapy services. If for some reason an immediate warm handoff or phone transfer is not completed, the front desk office worker will attempt to contact the parent/guardian within 1 business day and every 24 hours for 3 days. If the front desk office worker is unable to contact the parent/guardian, the clinician will attempt to contact the parent/guardian and document their effort in Clinician's Gateway.

If the consumer/family picks appointment at a different clinic than where they receive their therapeutic services, the front desk worker will inform the family that there may be times that they will need to travel to see their doctor at a different location; that

their therapy services will not change locations; and that their clinical team will work closely with their psychiatrist even though they are not located in the same office.

To help facilitate the transition, the clinician will attend the initial psychiatric evaluation in person, or by Zoom or telephone, if necessary.

The **clinical supervisor** will review psychiatric referral and client plan before psychiatric intake appointment or within 2 business days (whichever is sooner) to ensure the referral process is complete.

How is competency/ability in applying the intervention verified?

The Psychiatric Referral Procedure (See Appendix C) was developed to ensure all PIP-involved staff are aware of expectations. To ensure a complete and accurate referral, the clinician must complete a Request for Psychiatric Evaluation Form that includes a checklist with all required documents (See Appendix D). Per the written procedure, the clinical supervisor is responsible for tracking each referral within 2 business days of request for psychiatric services.

A Chief Mental Health Clinician participated in the identification of the timeliness problem and in the development of the PIP intervention. She is responsible for ensuring that the PIP remains a standing item on the CYS manager's weekly 'huddle' meeting and collecting documentation that managers are training their staff in any changes to the referral and scheduling process.

How is the MHP/DMC-ODS ensuring consistency and/or fidelity during implementation of the intervention (i.e., what are the process indicators)?

To ensure fidelity and to determine if the PIP is a factor in timeliness improvements, the PIP team will track the following indicators:

- Number and percent of psychiatry requests that are offered and appointment slot within 24 hours (one day)
- Number and percent of psychiatry requests that are offered a different location due to an earlier available time
- Number and percent of psychiatry requests that accept different location

TABLE 6.1 IMPROVEMENT STRATEGY SUMMARY

	Intervention	Intervention Target Population	Date (MM/YYYY) Intervention Began	Frequency of Intervention Application	Corresponding Process Indicator(s)
1	Offer psych eval within 24 hrs. of request (Lodi/ Stockton)	Clients (<18) whose parents request initial psych eval	August 3, 2020	Approx. daily	% of clients who are offered to schedule a psych eval within 24 hrs. (one day) of request
2	Offer first avail psych eval regardless of location (Lodi/ Stockton)	Clients (<18) whose parents request initial psych eval	August 3, 2020	Approx. daily	% of cases in which first avail was at a different clinic % of parents/ guardians who chose first avail at different clinic
3	Contractors refer to BHS psych	Clients (<18) whose parents request initial psych eval	January 1, 2021	Approx. daily	% of cases in which first avail was at a different clinic % of parents/ guardians who chose first avail at different clinic

Step 6: Describing the Improvement Strategy (Intervention) and Implementation Plan

WORKSHEET 7: DESCRIBING THE DATA COLLECTION PROCEDURES

Describe the methods for collecting valid and reliable data.

Front desk staff receive paper-based Psychiatric Referral Forms from clinicians and enter the time-stamped referral date into the Timeliness App. Front desk staff enter first, second and third-offered appointment dates, accepted appointment dates, date of kept assessments, and appointment dispositions into the Timeliness App. They keep track of appointment locations in the Psychiatric Referral Log spreadsheet.

What are the data sources being used?

The sources of data are:

1. Psychiatric Referral Form – This includes information needed by the psychiatrist to prepare for an evaluation, including diagnosis, psychiatric history, and symptoms. After the parent/guardian requests a psychiatric evaluation, the clinician completes this form and submits it to front desk. Prior to submission, the clinician timestamps the form, which then becomes the data source for the service request date.

2. ShareCare Calendar and Scheduling Process – Much of the data for this PIP comes from the scheduling process between front desk staff and parents/guardians. First available appointment data derive from shared Sharecare Calendars used by front desk staff to identify and fill psychiatric intake appointment slots. Data related to date and location of first offer, and date and location of scheduled appointments derive from face-to-face or phone call interactions between front desk staff and parents/guardians, and are entered into Timeliness App and Psychiatric Referral Log?

3. Appointment disposition – After a scheduled psychiatric appointment, the front desk clerical staff enter the appointment disposition (kept, no-show, etc.) into the Timeliness App.

What are the data elements being collected?

- Date of first request for psychiatric services
- Location of client residence
- Date that psychiatric evaluation offer (goal: within 24 hours)
- Date/location of first offered psychiatric evaluation (goal: within 15 days)

- Date/location of scheduled appointment (goal: within 15 days)
- Date of kept appointment (goal: within 15 days)

What is the frequency of data collection (daily, weekly, monthly, annually, etc.)?

Data is collected daily, in real time.

Who will be collecting the data?

All data will be collected by trained front desk office staff and overseen by their supervisor as well as Chief Mental Health Clinician for the purposes of this PIP.

What data collection instruments are being used? Please note if the MHP/DMC-ODS has created any instruments for this PIP.

The PIP is using two instruments to compile data:

- **Timeliness App**: SJCBHS and contract providers use this shared application to document timely access to services, including: first contact/referrals for clinical assessment and first requests for psychiatric evaluations, offered and scheduled intake assessments and psychiatric assessments, and appointment dispositions. Most of the data needed to measure process and outcome measures are captured in this application.

- **Psychiatric Referral Log:** The front desk staff at each clinic maintains an Excel-based referral log to track additional data related to psychiatric referrals. For the purposes of this PIP, we added the following fields to the referral log: city of residence; location of first offered; and location of accepted psychiatric evaluation. This will allow us to track how frequently clients are offered a sooner appointment and how frequently they accept an appointment that's different from where they received clinical therapy.

Step 7: Describing the Data Collection Procedures

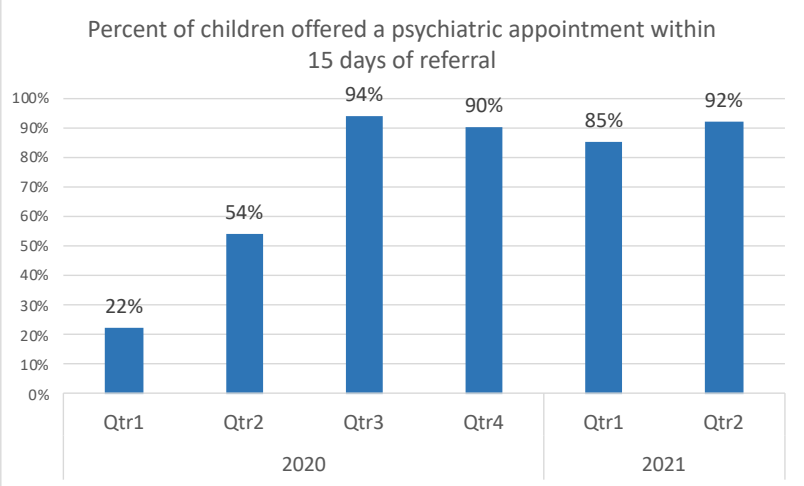
WORKSHEET 8: DATA ANALYSIS AND INTERPRETATION OF PIP RESULTS

After carrying out the PIP, collecting, analyzing and interpreting the data, answer the following questions *with respect to the original aim of the PIP*:

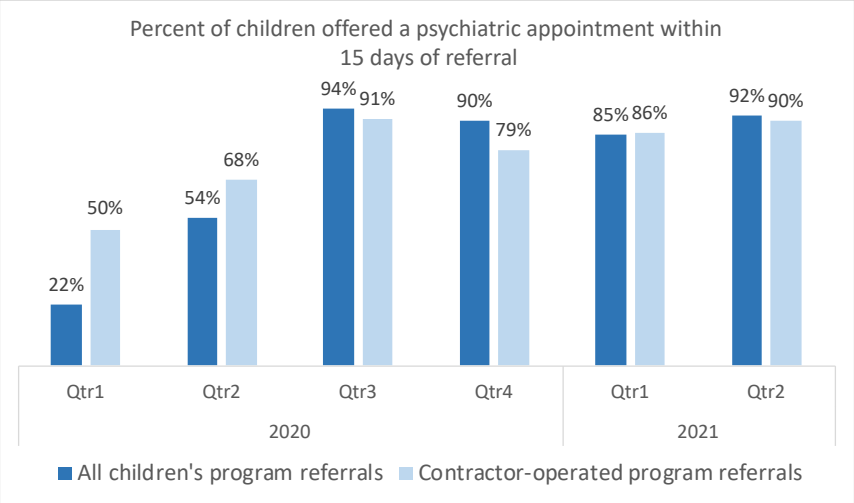
What are the results of the study?

In FY 2019/20, prior to the intervention, 58.2% of children were offered an initial psychiatric evaluation within 15 business days of referral. The goal of the PIP was to achieve a 15-day benchmark of 70% by the end of 2020, 80% by March 2021, and sustain 80% for the remainder of the study period.

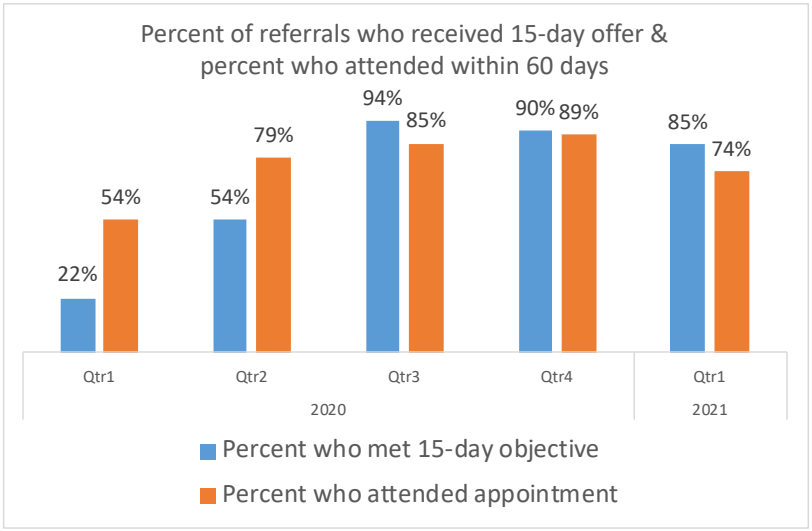
The initial PIP interventions (namely same-day scheduling and offering a psychiatric appointment at the first available clinic location) began early in Quarter 3 (August 3, 2020). During this initial intervention period, psychiatric timeliness improved significantly and remained timely for several subsequent quarters. The PIP achieved and sustained an 80% objective over the most recent 4-quarter period.[10]



Starting in January 2021, contractor-operated clinics began referring to county-operated clinics when their initial psychiatric wait times approached 15 business days. The following chart compares 15-day wait times of all referrals (both contractor and county) to that of contractor-operated clinics only and found that contractor wait times were typically longer than children's overall wait time, but like overall wait times, they improved dramatically as soon as the PIP was launched. Wait times improved again after contractor clinics began referring to county-operated clinics in January 2021.



While the goal of the PIP was just to meet timeliness objectives, we also noted a relationship between a timely offer and children attending initial psychiatric services. The following table compares side-by-side the percent of offers that were made within 15 days of referral and the percent of children who ended up attending their appointment within 60 days or referral. Prior to the launch of the PIP, of the referrals that were offered an appointment within 15 days, 54% ended up attending their appointment. The percentage of referred children who ended up attending their appointments increased to between 74% - 89% once the interventions were implemented.



How often were the data analyzed?

The PIP team, including an IT programmer, developed an automated report generator to allow timeliness data to analyzed on demand for any program or time period. Additionally, findings for the children's system of care as a whole are available on a

monthly dashboard, and are reviewed monthly by the children's director, evaluator, and QAPI council.
Who conducted the data analysis, and how are they qualified to do so? A professional outside evaluator conducted the data analysis. She has been providing research assistance and performance evaluation for SJCBHS for over a decade.
How was change/improvement assessed? Change was assessed by comparing performance on a quarterly basis, since before the launch of the PIP interventions until 6 months after the interventions were in place, in order to ensure that the outcomes were sustained.
To what extent was the data collection plan adhered to—were complete and sufficient data available for analysis? There were no changes to the data collection plan for the performance indicator (dependent variable). Changes made to the independent variables and associated data collection plan are described in Workbook 9, below.
Were any statistical analyses conducted? If so, which ones? Provide level of significance. We compared the mean number of days between referral and offered psychiatric intake for Q1 2000, prior to the intervention (N = 73, mean = 27.1 days, SD = 14.3) to Q1 2021, following implementation of all interventions (N = 168, mean = 11.2, SD = 8.0) and observed a difference in mean of 15.9 days. Using an unpaired t test and a 95% confidence interval, we found a two-tailed P value of less than 0.0001. The difference of means is considered extremely statistically significant.
Were factors considered that could threaten the internal or external validity of the findings examined? The evaluator downloaded and analyzed raw scheduling data to validate summary reports from the Timeliness App. There were no significant deviations. Supervisors continuously monitored data entry; and do not believe there were significant data entry issues either. See Worksheet 9, below, for additional discussion related to internal and external validity of findings.

Present the objective results at each interval of data collection. Complete this table and add (or attach) other tables/figures/charts as appropriate.

In addition to the comparison of means, we looked at rate of change in the percentage of clients who met the 15-day objective between Fiscal Year 2019/20 and Fiscal Year 2020/21. Results are presented in table 8.1 below.

TABLE 8.1 PIP RESULTS SUMMARY

Performance Measures	Baseline Measurement	Re-measurement 2	% Improvement
% of psychiatric referrals that were offered a psychiatric intake appointment within 15 days	Fiscal Year 19/20 58.2% (N=304)	Fiscal Year 20/21 90.1% (N= 615)	54.8% improvement

Step 8: Describing the Data Analysis and Interpretation of PIP Results

WORKSHEET 9: LIKELIHOOD OF SIGNIFICANT AND SUSTAINED IMPROVEMENT THROUGH THE PIP

What is the conclusion of the PIP?

The PIP resulted in an extremely significant improvement in timeliness from referral to first offered psychiatric intake appointment.

Do improvements appear to be the results of the PIP interventions? Explain.

To understand whether the interventions had an influence on outcomes, we looked at three independent variables. Due to the logistics of collecting data, these variables differ slightly from those proposed at the beginning of the PIP, yet they are useful for showing the degree to which the interventions were applied and their potential influence on outcomes:

1) **Number of days between date of referral and date received by the front desk for scheduling purposes.** Prior to the PIP interventions, this interval could be delayed because each referral required supervisor approval. The PIP attempted to eliminate this delay by allowing clinicians to immediately transition the referral to the front desk for scheduling. We found that between April 1 – June 30, 2021, on average it took 1.9 days for the front desk to receive the referral (SD = 3.5). The median, however, was 0 days, meaning that most frequently, it took less than a day to receive the referral.

2) **Percent of referrals who accept a psychiatric appointment at a different clinic.** Of the 445 referrals with documentation of both the home clinic location and the clinic where the family accepted their psychiatric appointment, close to a third (28.5%) chose a psychiatric appointment at different clinic, presumably because it was closer to get to, earlier, or at a more convenient time.

3) **Percent of referrals from contractor-operated clinics that were transferred to county-operated clinics.** Of the 72 VCCS Tracy, Manteca and School-Based referrals during the first half of 2021, 7 (10%) were transferred to a county-operated clinic. Of the 13 Victor referrals, 4 (31%) were transferred to a county-operated clinic.

Findings from all three independent variables suggest that the interventions were applied frequently and with some fidelity. Given that the PIP interventions aimed at some of the most obvious causes of delay, here is little doubt that the implementation

of a streamlined referral process, providing a choice of clinics, and transfers between contractor and county-operated clinics had significant influence on outcomes.
Does statistical evidence support that the improvement is true improvement? Statistical evidence supports true improvement (see Worksheet 8 above).
Did any factors affect the methodology of the study or the validity of the results? If so, what were they? Performance data were collected in the Timeliness App. Because the data are used for the PIP as well as to demonstrate NACT standards, both the data collection tool and the data collection process were validated by the IS department, managers, and the evaluator over a significant period of time. Data related to the PIP interventions (independent variables) were collected in an Excel-based referral log, which is also used for more than just the PIP. Several fields were added to this log, which required some front desk training, and resulted in some delay. However, there was sufficient data to demonstrate fidelity.
What, if any, factors threatened the internal or external validity of the outcomes? During the study period, following the intervention, there was some concern that psychiatrist shortages might have an impact on timeliness in spite of all efforts made to reduce barriers, However, despite the retirement of a part time psychiatrist and an unexpected leave of absence for a full-time psychiatrist, there was every indication that timeliness standards were being met. Another factor that might have affected the external validity relates to staff motivation. Merely focusing on the need to meet timeliness meant that clinical staff, front desk, and managers were paying greater attention to performance and engaging in interventions that fall outside those described in this report. For example, the deputy director described having had to make personal requests to psychiatrists to open up timeslots for several referrals that were not meeting timeliness standards. Such interventions fall outside of the PIP expectations and are hard to sustain over time.
Was the improvement sustained through repeated measurements over comparable time periods? (If this is a new PIP, what is the plan for monitoring and sustaining improvement?) Dashboards with timeliness-related performance data were reviewed monthly by the PIP team, managers, and the QAPI Council as part of standard processes.
Were there limitations to the study? How were untoward results addressed?

The only untoward events that occurred during the study period had to do with the observation, early on, that front desk staff were not recording the date that they had received the referral in the referral log. Th delay did not affect the validity of the performance measurement but did prevent the CYS Director from observe how fast clinicians were receiving referrals. Once the data were being recorded reliably (April 2021) the Director was able to see that there were frequent instances where the transfers were delayed due to clinician error, and as a result, intervened on a case-by-case basis. However, the problem with these delays has not yet been fully resolved and continue to moderately impact timeliness.
What is the MHP/DMC-ODS's plan for continuation or follow-up? The children's system of care will continue to implement the interventions as described in this PIP, and the QAPI Council and CYS managers will continue to monitor timeliness data on a monthly basis.

Step 9: Address the Likelihood of Significant and Sustained Improvement Through the PIP