



PERFORMANCE IMPROVEMENT PROJECT (PIP) DEVELOPMENT TOOL

WORKSHEET 1: PIP TOPIC

“What is the problem?”

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Performance Improvement Title	Closing the Gap Between the Access to Care Beneficiaries Receive and What is Expected
Type of PIP	<input type="checkbox"/> Clinical <input checked="" type="checkbox"/> Non-clinical
PIP Study/Intervention Period:	Start (02/2020) to End (09/2022)

1.1 What is the problem this PIP proposes to solve? How does it affect beneficiary health, functional status, or satisfaction with care?

At the close of calendar year (CY) 2019, four out of ten consumers did not receive a timely appointment when they sought outpatient DMH services for the first time. Stable access to timely specialty mental health service (SMHS) appointments is essential to managing a mental health condition. Mental illness is common and can present as a wide range of conditions that affect an individual's mood, thinking, behavior, and day-to-day life. Without treatment, these individuals are at risk for a significant decline in their health status and daily functioning, and consequently, they may even become a danger to themselves or others. Moreover, timely appointments can positively impact client health outcomes, engagement in treatment, and save someone's life. Targeted

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efforts to improve the rate that beneficiaries receive timely appointments and care across DMH align with the Centers for Medicare & Medicaid Services (CMS) Meaningful Measures framework that promotes prevention, treatment, and management of mental health and improving patients' experience of care.

When this project started, far too many directly operated (DO) and Legal Entities (LE)/Contracted programs lacked clear quality improvement (QI) processes or plans in place to facilitate small tests of change. In September 2020, DMH implemented a quarterly and provider-driven timely access to care study. This nonclinical PIP was designed to improve access to care performance for providers who offered a timely initial routine appointment to less than 69% of their potential consumers. At the study's close, DMH will possess a menu of provider-developed and tested timely access performance improvement strategies that Access to Care leadership could share system-wide

~~This PIP study's focus on improving access to care aligns with the Centers for Medicare & Medicaid Services (CMS) Meaningful Measures framework that promotes prevention, treatment, and management of mental health and improving patients' experience of care. Targeting timely access to routine appointments could improve no-show rates, capacity, and penetration rates. Consumers would receive more consistent services allowing for improved quality of mental health services. The Department created an access to care-oriented team of executives and managers to develop continuous quality improvement processes targeting improved access for all MHP consumers.~~

~~As key stakeholders in the PIP, the Access to Care leadership committee for DMH is committed to improving data awareness, accountability, and identifying barriers that challenge consumer outcomes. In collaboration with the Quality, Outcomes, and Training Division (QOTD), the two groups have assumed leadership for this nonclinical project. More specifically, the Quality Assurance (QA) and Quality Improvement (QI) Units due to their proximity to the Department's timeliness data, contributions to the concept's design and implementation, and familiarity in the improvement strategies applicable to the process of identifying and analyzing system-wide access to care issues.~~

~~In fiscal year (FY) 2020-21, DMH rolled-out a process created by the QA Unit to encourage the design and use of provider-driven QI methods. This process required Directly Operated (DO) and Legal Entity (LE)/Contracted providers who were not meeting timeliness standards to (1) identify internal and external factors and (2) develop an action plan to address their barriers to timely~~

~~appointments. Early qualitative analysis efforts revealed common internal and external factors contributing to low timeliness rates such as staffing, a high number of referrals, COVID-19 impact, and provider-designed solutions such as improved workflows and increased internal monitoring of timeliness.~~

~~Action plans, or solutions, were developed from each provider and were specific to their site's barriers and needs. In the action plans, many of the providers described similar approaches to addressing timeliness barriers. This practice lends itself to developing a menu of provider-developed and tested strategies for Access to Care leadership to share system-wide. Moreover, the consistent use of best practices produces positive outcomes for consumers seeking timely routine appointments.~~

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~~This nonclinical PIP will establish a standardized menu of strategies that guide providers in addressing timeliness barriers. Using provider-tested interventions, DMH will compile and share a set of interventions to assist providers in assessing and problem-solving for challenges in scheduling timely routine appointments.~~

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~~For this project, timely access is an examination of wait times from the date of request to the first offered appointment. The providers will institute provider-developed interventions targeting programmatic barriers to meeting timeliness standards.~~

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

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The Quality Assurance (QA) Unit, Policy and Technical Development team identified performance problems with concerning the timeliness of first offered routine appointments. ~~The QA unit's Policy and Technical Development team "develops and revises policies, forms, manuals, and bulletins associated with Medi-Cal SMHS, responds to audits, and supports DO programs in providing direct clinical services by assisting with workflows, developing and refining the Department's electronic health record system (EHRS), and facilitating the use of the EHRS both clinically (training end-users) and administratively (leveraging system data for QA purposes)."~~ This team worked collaboratively with DMH leadership to establish the data and subsequent direction of the nonclinical PIP. The Chief Information Office Bureau (CIOB), Clinical Informatics team was essential to data compilation and technical support. QA, the QI Unit, and CIOB are standing members of the Access to Care leadership committee. The Access to Care leadership team's roster includes representatives vested in the project's implementation, namely: ACCESS Center, Child Welfare Division, CIOB, Contract Monitoring, and Management Division (CMMD), Forensics, and the office of Clinical Operations – Outpatient Services. The Access to Care Leadership and nonclinical PIP committees worked collaboratively to ensure access to care efforts were directed towards the entire system. That oversight was not limited to DO programs only. ~~– worked collaboratively to ensure access to care efforts were directed towards the entire system. That oversight was not limited to DO programs only.~~ –

The Access to Care Leadership Committee reviews access to care data at least monthly, brainstormed, and made recommendations to address system-wide barriers to timely appointments, including implementing a provider-developed and tested approach to performance improvement. The providers involved in the study identified the root causes of not meeting DMH's timeliness expectations (80%).

Due to special interest, three DMH Community Health Workers (CHWs) from the Whole Person Care (WPC)/Kin to Peer (KTP) program have volunteered as stakeholders for this project. DMH's WPC/KTP program serves Los Angeles County's most vulnerable Medi-Cal beneficiaries and connects individuals experiencing homelessness, justice involvement, barriers to a healthy pregnancy, serious mental illness (SMI), substance use disorder (SUD), or complex health conditions to resources and support. Their personal experiences and perspectives, as it relates to the challenges that present when coordinating social services for high-risk and high utilizers of hospital and emergency departments, validated the relevancy and contributed to the direction of this project.

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

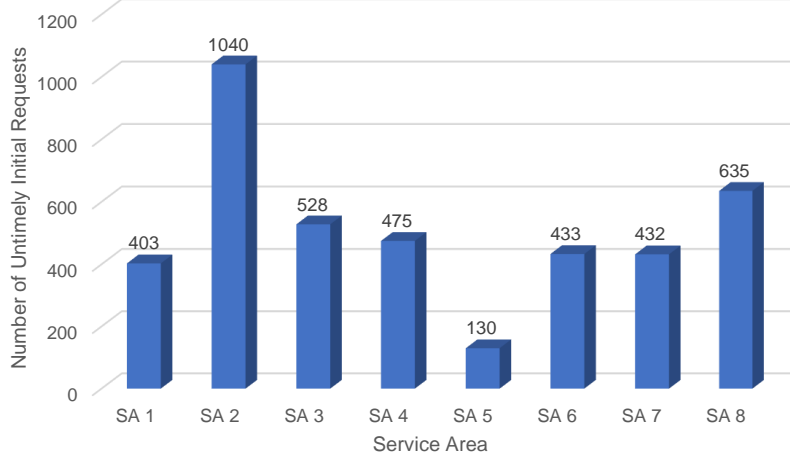
Systemwide access to care data identified the gaps in timely services, but the impact of this PIP was observed across three cohorts of providers.

First Offered Appointments

In Q4 of FY 2019-20, a high number of outpatient providers did not meet the DMH timeliness standards of 80% for routine, urgent, and hospital/jail follow-up appointments.

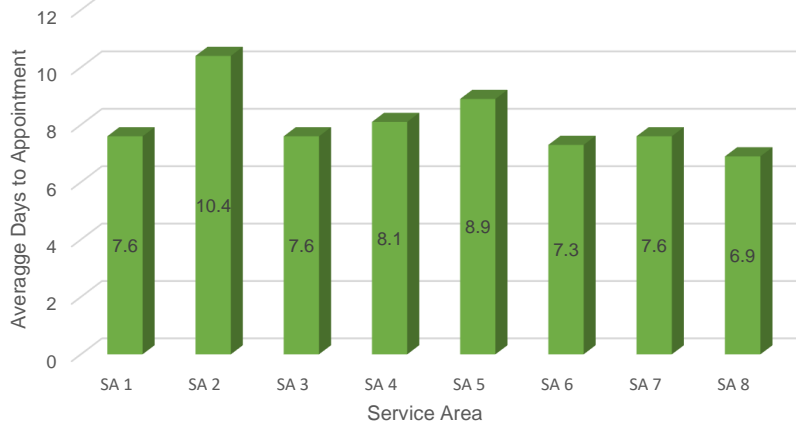
The PIP committee reviewed data from May, June, and July 2020 of providers who received greater than five referrals excluding small capacity providers, to determine the characteristics of programs experiencing barriers. Of the 555 providers that received approximately 32,776 referrals, 146 providers did not meet routine appointment timeliness standards, 82 did not meet for urgent appointments, and 27 did not meet for follow-up appointments. Figure 1.1 displays the initial requests for routine services that did not meet timely appointment standards from May to July 2020, and Figure 1.2 shows the average number of days to appointment.

Figure 1.1 Number of Initial Requests for Routine Services that Received Untimely Appointments by Service Area
May to July 2020



Data source: Power BI Timely Access to Care Reporting, Retrieved May 2021.

Figure 1.2 Average Number of Days to Initial Appointments by Service Area May to July 2020



Data source: Power BI Timely Access to Care Reporting, Retrieved May 2021

The exploratory data noted timely appointments were provided for most consumers seeking initial outpatient services. Despite the majority meeting the 10-day cut-off, it appears there could be some improvement in access by decreasing the wait times to

appointments. Addressing the lowest-performing providers should demonstrate the greatest benefit from PIP participation.

It was when providers were reviewed individually that barriers to timely access were more overt. Tables 1.1, 1.2, and 1.3 show the percent of timely appointments and mean business days until assessment appointment for providers with timeliness rates at 69% or below for routine appointments between May 2020 to December 2020, or baseline, for the study's three cohorts. Cohort A (N=17) met 49.7% of their initial requests for routine services with a timely appointment (mean business days=12.6) (Table 1.1). Cohort B (N=16) met 49.0% of their initial requests for routine services with a timely appointment (mean business days=13.5) (Table 1.2). Cohort C (N=17) met 50.9% of their initial requests for routine services with a timely appointment (mean business days=13.1) (Table 1.3).

Table 1.1. Overview of Baseline Data for Cohort A

Provider Code	Number of Timely Appointments	Percent of Timely Appointments	Mean Business Days Until Appointment
A01	81	68.6%	9.8
A02	62	68.0%	11.0
A03	17	63.0%	7.9
A04	81	60.3%	11.6
A05	163	52.7%	11.9
A06	23	52.3%	10.0
A07	161	52.3%	11.9
A08	161	52.3%	11.9
A09	29	47.7%	12.9
A10	143	45.1%	12.2
A11	9	43.6%	14.9
A12	37	34.9%	16.0
A13	10	32.3%	15.9
A14	13	22.9%	21.0
A15	10	20.8%	18.5
A16	22	65.8%	8.8
A17	17	63.0%	7.9
Total	1,039		
Average	61.1	49.7%	12.6

Data Source: Systemwide Monitoring Timely Access to Care Reports covering May to July 2020 and Created September 2020. Access to Care Trend Data Reports, Reviewed in April 2021. Note: The N for Cohort A was 17 providers.

Table 1.2. Overview of Baseline Data for Cohort B

Provider Code	Number of Timely Appointments	Percent of Timely Appointments	Mean Business Days Until Appointment
B01	24	64.9%	8.89
B02	6	60.0%	11.5
B03	30	69.8%	10.4
B04	12	66.7%	11.5
B05	74	56.1%	10.7
B06	4	33.3%	15.4
B07	35	47.4%	13.1
B08	11	52.2%	10.9
B09	9	50.0%	9.9
B10	3	57.1%	14.9
B11	1	33.3%	16.5
B12	6	42.9%	14.6
B13	2	20.0%	18.4
B14	4	36.4%	17.9
B15	4	57.1%	16.4
B16	6	36.8%	14.5
Total	231		
Average	14.4	49.0%	13.5

Note: The N for Cohort B was 16 providers. Data Source: Systemwide Monitoring Timely Access to Care Data Report covering August to September 2020 and created in December 2020 and Access to Care Trends Data Reports, reviewed in April 2021.

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Table 1.3. Overview of Baseline Data for Cohort C

Provider Code	Number of Timely Appointments	Percent of Timely Appointments	Mean Business Days Until Appointment
C01	32	68.1%	9.1
C02	30	69.8%	8.7
C03	39	63.5%	9.7
C04	5	62.5%	16.8
C05	4	66.7%	7.5
C06	147	64.9%	10.5
C07	5	66.7%	12.1
C08	4	44.4%	19.9
C09	2	33.3%	13.2
C10	18	50.0%	10.6
C11	7	50.0%	16.4
C12	4	50.0%	14.5
C13	46	44.2%	12.8
C14	12	41.4%	16
C15	4	50.0%	9.6
C16	2	25.0%	19.4
C17	1	14.3%	16.3
Total	362		
Average	21.3	50.9%	13.1

Note: The N for this cohort was 17 providers. Data Source: Systemwide Monitoring Timely Access to Care October to December 2020, Created January 2021. Access to Care Trends Data Reports, Retrieved April 2021.

System-wide Timeliness Data Review

At the onset of this project, the PIP committee reviewed timeliness data for initial assessment and psychiatry appointments to identify a starting point. The External Quality Review Organization (EQRO) encouraged the inclusion of wait times to psychiatry services due to prior timeliness self-assessment surveys or historical knowledge of DMH barriers to accessibility of psychiatry services. The PIP committee discovered system-wide data on initial psychiatry appointments was not readily accessible or complete.

The wait times to an initial psychiatry evaluation may not be a valid indicator. Consumers are not typically evaluated for medication until they have been assessed by non-medical staff, determining whether they need a medication assessment. Additionally, real-time access to psychiatry data was limited to DO programs only. There is a plan to introduce targeted improvement strategies once the committee has established a complete picture via quantitative data on the first offered psychiatry appointments among LEs.

As reported in our timeliness self-assessment survey for the FY 2020-21 external quality review (EQR), LE/Contracted providers use data entry forms that exist in their respective EHRs and the Service Request Tracking System (SRTS). Because the entry of a

County client ID number is not required in the Service Request Log (SRL) web service and SRTS, determining the length of time from initial request to subsequent clinical events (e.g., first appointment kept, first clinical service appointment, etc.) is not consistently available. Additionally, a number of contract providers had not established the ability to submit service request data via the SRL web service for a portion or the entirety of the FY 19-20 reporting period. Because of these issues, data obtained from contract providers represent a subset of service requests from this group and findings may not be representative of contract providers as a whole.”

The Department recognizes a need to monitor timeliness to psychiatry services as well as non-medical mental health services. Presently, the collection of psychiatry data is improved and modified in the department's SRL, SRTS, and other service tracking systems. Several DMH improvement projects are addressing the specific challenges to providing timely psychiatry services to consumers.

- The Chief Medical Officer for DMH is developing standards for appointment length and provider service agreements to help manage capacity and caseloads across DO clinics. The psychiatry workforce is being evaluated for re-distribution to increase system-wide capacity.
- The Medication Decision Tree Quality Improvement Project (QIP) committee piloted a survey with the same namesake at the Rio Hondo Community Health Center in SA 7 (*Appendix A*). They were the first DMH DO clinic to gather information about consumers referred for medication evaluations. Stakeholders were concerned that consumers were frequently scheduled for medication evaluations that may not be necessary or attend, thereby decreasing psychiatrist capacity. The purpose of the QIP was to determine if recording the medication evaluation decision tree results in a change to the process of scheduling medication evaluation appointments. In Q1 of FY 2021-22, the San Fernando Mental Health Center launched a similar survey in SA 2 with their adult clients.
- SA 3 is piloting a centralized scheduling process via DMH's ACCESS Center. This process was designed to improve referrals, linkages, and timeliness rates for consumers seeking follow-up outpatient mental health services post-hospital discharge (*Appendix B*).

1.4 Are there state or national standards or benchmarks related to the problem? If so, what are they? How does the MHP/DMC-ODS's data/performance compare?

DMH has clear policies (*Appendix C*) and procedures regarding access to care for initial and subsequent requests for services, including screening/triage requirements and time frames for appointments (Table 1.4). Furthermore, DHCS has set the benchmark for timely access for routine appointments at 70%, and DMH expectations are 80% since regulations may change in the future.

Table 1.4. Timeframe Requirements for Requests for Services

Emergency	Wait Time
Crisis Evaluation Services for a condition or situation in which a client presents a current danger to self or others or is immediately unable to provide for or utilize food, clothing, or shelter	ASAP, Same Day
Urgent	Wait Time
Urgent Services Services for a condition or situation that, if not addressed, would be highly likely to result in an immediate emergency condition	48 hours
Expedited	Wait Time
Expedited Services Based on screening or triage, services that require a more timely response than a regularly scheduled appointment consistent with good professional practice (e.g. has run out/will run out of medication prior to routine appointment, significant distress) (Title 28)	Prior to 10/15 business days as indicated
Other Types of Appointments	Wait Time
ACCESS - Priority ACCESS Appointment Line priority designation	5 business days
Discharge - Priority Discharged from acute inpatient facility, jail or juvenile justice facility	5 business days from date of discharge
Routine Appointments	Wait Time
Routine MHS, TCM, MSS (non-Psychiatrist)	10 business days
Routine Psychiatrist Services	15 business days

Note: The timeframes listed in this table are based on DHCS requirements.

1.5 What are the provisional or potential root causes of the problem as suggested by quantitative information that the MHP/DMC-ODS chose to address and why?

Provider Identified Barriers

The QI Unit performed a qualitative analysis of the timeliness issues and improvement plans identified by 27 providers who fell in the 69% or less range for first offered appointments considered timely in May, June, and July 2020. Providers identified several internal and external factors that were the perceived root causes for their higher rates of untimely appointments.

Providers identified internal factors such as:

- Staffing issues

- Mislabeling of referral type (urgent versus non-urgent) and data entry errors in the Electronic Health Record (EHR) systems
- Staff training needs
- Service type conflicts
- A high number of referrals

Providers also cited external factors that correlate with the COVID-19 pandemic:

- Financial issues
- Loss of consumer access or interest in services due to the transition to telehealth
- Difficult transitions to telehealth services and workflow changes
- Communication issues
- Reduced staff due to turnover
- Staff leaves and Disaster Service Worker (DSW) deployments
- Consumers unable to participate due to limited or no access to the necessary technology
- Consumers preference for in-person services
- A high number of referrals from outside providers
- Staff emotional health

Providers also noted additional external factors:

- Consumer refusal of timely referrals to other providers when an appointment was not available
- Misabeled referrals from the ACCESS Center
- Service area (SA) resource shortages
- Lacking a clear definition of “urgent” appointment
- Other factors like traffic

Themes from the data suggest that providers are often struggling with similar barriers.

1.6 Briefly state the intervention(s) selected to address the root causes.

DMH introduced a standardized process to support providers in developing and testing QI methods that best fit their clients, services, and unique challenges. At the close of each quarter, the QA Unit prompted a subset of providers whose timeliness fell in the 69% or less range to identify the internal and external factors contributing to their low performance and establish an improvement plan ([Appendix D](#)) within 30 days. Currently, QI and participating providers are working collaboratively to track the impact of the strategies on system-wide and program-level timeliness rates. The PIP committee will observe and report any differences in data.

Click here for [Step 1](#)

WORKSHEET 2: AIM STATEMENT

“What do we want to do?”

2.1 What is the aim of this PIP? The statement should define succinctly: the improvement strategy, population, and time-period of the study. (The statement should be clear and concise; the impact of interventions should be measurable.)

Will providers with timely appointment rates at 69% and below develop and implement improvement strategies targeting staffing shortages, intake and referral challenges, or other challenges to timely access successfully meet 80% of their consumers' requests for an initial routine outpatient specialty mental health services appointment within six months?

[Click here for Step 2](#)

WORKSHEET 3: PIP STUDY POPULATION

“Who do we intend to help?”

3.1 Describe the beneficiary or enrollee population affected by the problem. Provide information such as age, length of enrollment, diagnosis, and other relevant characteristics.

The study population includes DO and LE/Contracted providers with greater than five referrals and timely appointments falling in the 69% and below range at three data collection points between May 2020 and December 2020. The providers involved in this study adequately represent DMH's outpatient network and received approximately 3,054 initial requests for routine services during this timeframe. The target population includes individuals from all age groups who could be experiencing mental health symptoms ranging from mild to severe mental health symptoms. The study population also encompasses potential consumers who urgently need connections to services, resources, and support. This includes high-risk consumers whose immediate support could save lives or mitigate high-cost service utilization.

During the PIP study data evaluation period, May 2020 through January 2021, the MHP received 77,350 initial routine service requests of which 64,793 (83.8%) were timely and 12,557 (16.2%) were untimely. This and the following totals are not exclusive to beneficiaries and may include insured or indigent consumers. Child referrals totaled 27,428 (35.5%) with 19,383 (70.7%) timely and 8,045 (29.3%) untimely. Transition Age Youth totaled 13,814 (17.9%) with 11,950 (86.5%) timely and 1,864 (13.5%) untimely. Adults totaled 32,034 (41.4%) with 29,453 (91.9%) timely and 2,581 (8.1%) untimely. Older adults totaled 4,374 (5.7%) with 4,007 (91.6%) timely and 367 (8.4%) untimely. The average percentage of requests resulting in an appointment May 2020 through January 2021 was 69.3%.

Referrals for initial routine services were received through one of four systems. From May 2020 to January 2021, the contractor Service Request Log (SRL) web service system received 43,179 referrals. The average percent of SRL requests that resulted in an appointment was 74%. The IBHIS SRL received a total of 52,691 referrals. The average percent of IBHIS SRL requests that resulted in an appointment was 82.7%. The Katie A. Enterprise Monitoring System (KAEMS) received a total of 14,419 referrals. The average percent of KAEMS requests that resulted in an appointment was 45.3%. The Service Request Tracking System (SRTS) received a total of 13,367 referrals. The average percent of SRTS requests that resulted in an appointment was 27.4%.

3.2 Will all affected beneficiaries/enrollees receive the intervention(s) and be included in the PIP study population?

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☐ Yes

☒ No

3.3 If no, who would be included? (May be a representative sample, a pilot location, or some other subset of the affected population that will serve as an initial pilot).

Providers who submitted improvement strategies to address timeliness rates between September 2020 and March 2021 were sorted into cohorts based on their corresponding baseline data collection points. Cohort A is the May to July 2020 data group, Cohort B is the August to September 2020 data group, and Cohort C is the October to December 2020 data group. In this cycle, all interventions targeted routine appointments.

Cohort A (May-July 2020 Data Set)

In cohort A, 17 providers served all age groups and ranged between 27 and 457 referrals in three months (Table 3.1). There were three DO providers and 14 LE providers. SA 2 was the most represented with eight providers, followed by SA 1 (N=2), SA 3 (N=2), SA 4 (N=1), and SA 7 (N=1) (Figure 3.1). Programs in SA 5 or SA 6 did not have providers in this cohort.

SA 2 is the largest of the eight SAs of LA County. It consists of 22% of the cities that make up LA County and covers 1,000 square miles. As of calendar year (CY) 2018, the SA 2 total population was 2,262,277, making it the densest SA. In CY 2020, SA 2 received 13,651 requests for appointments. It is important to note that cohort A is made up of several SA 2 providers. These providers appear large as five providers received between 118 and 457 referrals during the May-July 2020 period. Of the eight SAs, SA 2 is the only SA that did not meet the 10-day timeliness standard for routine appointments in May-July 2020.

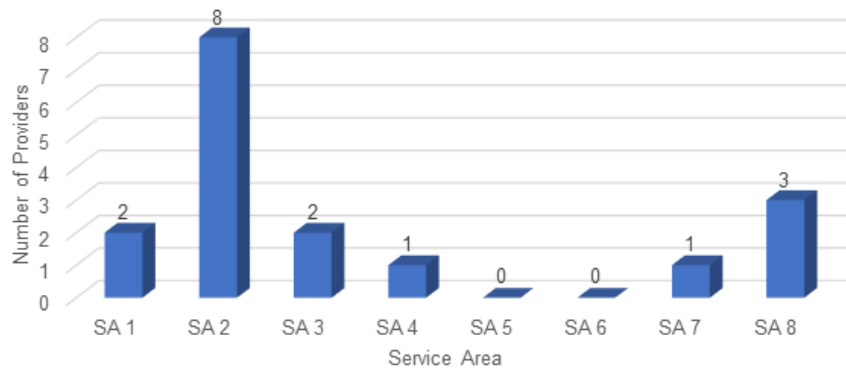
Table 3.1. Cohort A Demographics

Provider Code	Agency Type (DO or LE)	Service Area	Age Group Served [Child, TAY, Adult, Older Adult (OA)]	Number of Referrals
A10	DO	2	Adult, OA	457
A05	LE	2	Child, TAY, Adult	311
A07	LE	2	Child, TAY	308
A08	LE	2	Child, TAY	308
A04	LE	1	Child, TAY	136
A01	LE	2	Child, TAY	118
A12	LE	4	Child, TAY, Adult	106
A02	LE	8	Child, TAY, Adult	103
A14	LE	1	Child, TAY	83
A09	DO	2	Child, TAY	65
A15	LE	8	Child	48

A06	DO	2	Child	44
A11	LE	7	Adult, OA	39
A16	LE	2	Child, TAY	38
A13	LE	8	Child, TAY, Adult	31
A03	LE	3	Child	27
A17	LE	3	Child	27
Total				2,249
Average				132.3

Note: The age groups are defined as the following: Child (0-15 years), TAY (15-25 years), Adult (26-59 years), and OA (60 years and older). The N for Cohort A is 17 providers. Data Sources: Systemwide Monitoring Timely Access to Care, May to July 2020. Access to Care Trend Data, Retrieved April 2021. Provider Directory, Retrieved May 2021.

Figure 3.1. Distribution of Cohort A Providers by Service Area



Data Source: Access to Care Trend Data, Retrieved April 2021.

Forty-four percent of cohort A provides child services, 32% provides TAY services, 18% provides Adult services, and 6% provides OA services.

Cohort B (August-September 2020 Data Set)

Sixteen providers served all age groups in cohort B and ranged between 6 and 132 referrals in two months (Table 3.2). There was one DO provider and 15 LE providers. SA 3 was the most represented with four providers, followed by SA 6 (N=3), SA 2 (N=2), SA 4 (N=2), SA 7 (N=2), SA 8 (N=2), and SA 1 (N=1). Cohort B did not have any providers from SA 5 (Figure 3.2).

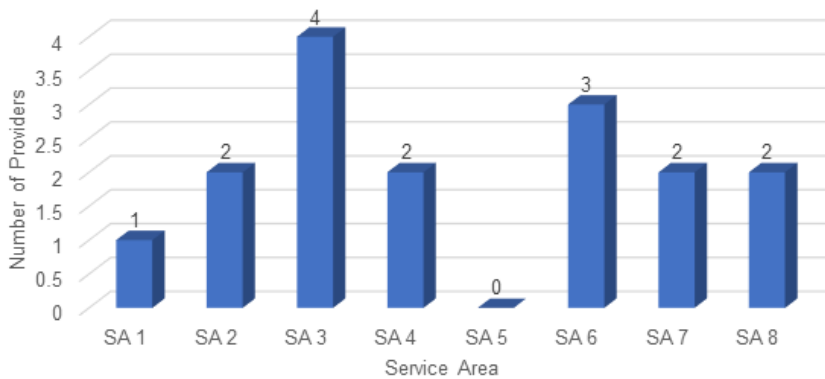
Table 3.2. Cohort B Demographics

Provider Code	Agency Type	Service Area	Age Group Served (Child, TAY, Adult, OA)	Number of Referrals
B04	LE	7	Child, TAY, Adult, OA	132
B16	LE	6	Child, TAY, Adult	132
B06	LE	4	Child, TAY	76
B03	LE	7	Child, TAY	43
B01	LE	8	Child, TAY, Adult	37
B07	LE	3	Child, TAY, Adult, OA	23
B15	LE	4	Child, TAY, Adult, OA	19
B08	LE	2	Child, TAY	18
B11	LE	8	Child, TAY, Adult, OA	14
B05	DO	6	Child, TAY	12
B13	LE	1	Child, TAY	11
B02	LE	3	Child, TAY	10
B12	LE	3	Child, TAY	10
B09	LE	3	TAY, Adults	7
B14	LE	6	Child, TAY, Adult	7
B10	LE	2	Child, TAY, Adult	6
Total				443
Average				27.7

Note: The N for Cohort B is 16 providers. Data Source: Systemwide Monitoring Timely Access to Care August to September 2020. Access to Care Trend Data, Retrieved April 2021. Provider Directory, Retrieved May 2021.

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Figure 3.2. Distribution of Cohort B Providers by Service Area



Data Source: Access to Care Trend Data, Retrieved April 2021.

Thirty-six percent of cohort B delivered TAY services, 34% were child services, 21% were adult services, and 9% were OA services.

Cohort C (October-December 2020 Data Set)

In cohort C, 17 providers served all age groups and ranged between 6 and 228 referrals in three months (Table 3.3). There were two DO providers and 15 LE providers. Service Area (SA) 3 and SA 4 were the most represented with five providers, followed by SA 1 (N=2), SA 2 (N=1), SA 5 (N=1), SA 6 (N=1), SA 7 (N=1), and SA 8 (N=1) (Figure 3.3).

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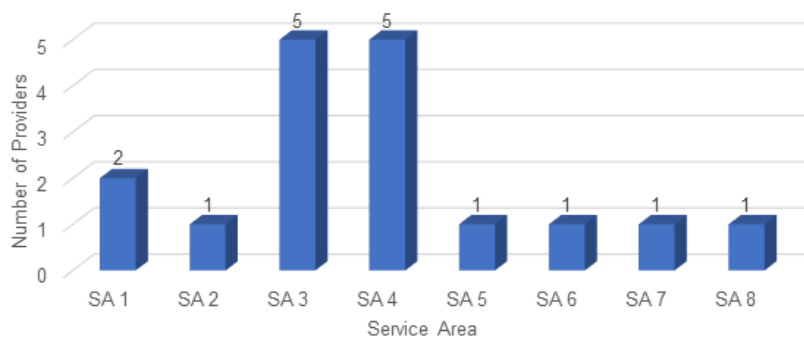
Table 3.3. Cohort C Demographics

Provider Code	Agency Type	Service Area	Age Group Served (Child, TAY, Adult, OA)	Number of Referrals
C06	LE	1	Child, TAY	228
C13	LE	4	Child, TAY	104
C03	LE	7	Child, TAY	63
C01	LE	4	Child, TAY	47
C02	LE	3	Child, TAY	43
C10	DO	5	Child, TAY, Adult	36
C14	DO	3	Child, TAY, Adult	29
C11	LE	4	Child	14
C07	LE	2	Child, TAY, Adult, OA	9
C08	LE	4	Child, TAY, Adult	9
C04	LE	3	Child, TAY	8
C12	LE	8	Child	8
C15	LE	4	Child, TAY	8
C16	LE	3	Child	8
C17	LE	3	TAY	7
C05	LE	1	OA	6
C09	LE	6	Adult, OA	6
Total				663
Average				37.2

Note: The N for Cohort C is 17 providers. Data Source: Systemwide Monitoring Timely Access to Care October to December 2020. Access to Care Trend Data, Retrieved April 2021. Provider Directory, Retrieved May 2021.

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Figure 3.3. Distribution of Cohort C Providers by Service Area



Data Source: Access to Care Trend Data, Retrieved April 2021.

Forty-one percent of cohort C delivered child services, 35% was TAY, 15% was adult, and 9% was OA.

Click here for [Step 3](#)

WORKSHEET 4: SAMPLING PLAN

“How do we select a smaller group to study?”

A representative sample of the population are included in the PIP. Such a sample may include some subset of the affected population, a pilot location, a particular caseload, or other feature.

- If the entire relevant population is included in the PIP, skip Worksheet 4.
- If the entire population is **not** included in the PIP, complete Worksheet 4.

4.1 Please describe the sampling frame for the PIP; include the criteria for selection of the sample population.

Cohorts A, B, and C

For routine appointments, providers with over five referrals, a timeliness rating of 69% or less, and submitted an Action Plan to QA between September 2020 and March 2021 were selected **to participate (see Tables 1.1., 1.2, and 1.3 for baseline data)**

Providers with five or fewer referrals were not selected as they did not have enough data to conclude a clear need for a timeliness improvement strategy. Providers who had timeliness ratings between 70% and 80% were also not selected.

DMH can make a reasonable inference based on this portion of the population as the providers that make up the cohorts are made up of both LE/Contracted and DO providers and serve all age groups. With the removal of small-sized sites, the sample contains providers serving the highest number of consumers.

4.2 Specify the criteria for selection of the sample population. (The sample should be representative of the sampling frame to ensure that the findings from the sample can be generalized to the population as a whole). Ensure that there are a sufficient number of enrollees to take into account non-response, dropout, etc.

See section **4.1**, above for the selection criteria.

Cohorts A, B, and C

The cohorts included 50 providers, which is 6.7% of 743 providers responsible for providing timely routine services upon initial request. There were six DOs, which is 4.1% of 146 DO providers. There were 44 LE/Contracted providers, or 7.4% of 597 LE/Contracted providers with routine appointment requests. Providers represented all eight service areas and served all age groups with routine appointment requests.

Twenty **(2.7%)** providers responded to an implementation survey. Three of the respondents were DOs and 17 were LE/Contracted. They served all age groups and approximately 9,224 unique consumers in one month.

4.3 State the confidence level and margin of error to be used.

- Confidence level: 95%, $z=1.96$
- Margin of error: $z^* \frac{\sigma}{\sqrt{n}}$, where σ
 - Cohorts – 4.1

Click here for [Step 4](#)

WORKSHEET 5: PIP VARIABLES AND PERFORMANCE MEASURES

“How will we know if what we’re doing makes a difference?”

5.1 What are the variables used to track the intervention(s)?

See Table 5.1.

5.2 What are the performance measures used to track the outcomes? Please describe how the performance measures assess an important aspect of care that will make a difference to beneficiary health or functional status.

DMH strives to increase the rate at which initial requests for routine services are met with a timely appointment. Potential consumers and families must receive services promptly to avoid adverse clinical outcomes. The project’s performance measure (dependent variable) is the percent of timely routine appointments (including those where referrals are declined). The (independent) variables include provider-developed interventions to address gaps in timely service delivery (Table 5.1).

The performance measure is the quarterly timeliness rating for initial routine appointments. The timeliness rating is a measure of the level of access consumers have to initial appointments. This rating describes their ability to gain needed access to mental health services when requested.

Table 5.1 Variable(s) and Intervention(s)

Goal	(Independent) Variable	¹ Intervention(s)	Performance Measure (Dependent Variable)	Improvement Rate ^{2,3}
DMH will meet timely access standards requiring that 80% of potential (and would-be) consumers receive an initial routine appointment within 10 days	Provider-developed strategy to improve timeliness rates	<ol style="list-style-type: none"> 1. Development of new intake positions/staff or intake department 2. Reassignment of current staff to complete intakes 3. Creation of new intake slots 4. Creation/revision of referral workflows 5. Increase clinician caseloads 6. Hiring new clinicians/staff to improve general/language capacity 7. Increase internal timeliness monitoring with dashboards/reports/supervision 8. Centralized scheduling systems 9. SRL and SRTS training for staff and system monitoring 10. Staff training on timeliness standards 	Quarterly timeliness rating for initial routine appointments <ul style="list-style-type: none"> • Number of timely appointments, routine • Number of untimely appointments where the referral to another provider was declined, routine 	Achieve an 80% rate of timeliness or <ul style="list-style-type: none"> • Cohort A: +30.3 Percentage Points (PP) • Cohort B: + 31.0 PP • Cohort C: + 29.1 PP • Cohorts Combined: +30.1 PP by Q3

Note: ¹Interventions were not all equally applied. ²Cohort improvement rates were calculated by subtracting the baseline rating from the goal of 80%.

³The average timeliness rating is a combined average of the three cohorts.

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Click here for [Step 5](#)

WORKSHEET 6: IMPROVEMENT STRATEGY (INTERVENTION) AND IMPLEMENTATION PLAN

“What, specifically, will we do to cause the change?”

6.1 Describe the improvement strategy/intervention. (Distinguish between the intervention(s) and the training and administrative supports required prior to implementation).

Provider-Developed Strategies (Interventions)

This study examines whether implementing provider-developed strategies targeting staffing issues, intake and referral challenges, and other provider-specific challenges can increase timeliness rates to 80% in six months.

When providers completed their Action Plans highlighting their selected strategies to improve timeliness, they were encouraged to develop strategies or interventions to address site-specific needs. The identified intervention categories were as follows.

- Development of new intake positions/staff or intake departments
- Reassignment of current staff to complete intakes
- Creation of new intake slots
- Creation/revision of referral workflows
- Increase clinician caseloads
- Hiring new clinicians/staff to improve general/language capacity
- Increase internal timeliness monitoring with dashboards/reports/supervision
- SRL and SRTS training for staff and system monitoring
- Staff training on timeliness standards
- Other: centralized scheduling systems; implementing short-term therapy model, increased utilization review, and assessment of appropriate frequency/duration of services; training incoming interns and increasing clinician hours from 32-40 that were previously cut due to the COVID-19 crisis.

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

Implementation science is moving evidence from research into practice within complex healthcare systems (Braithwaite, J., Churrua, K., Long, J.C., Ellis, L.A., & Herkes, J., 2018). This is at the essence of DMH's commitment to improving the quality of care for all consumers. This PIP study was designed to elicit evidence from providers about interventions that were effective in improving timely appointments.

The evidence will provide a menu of best practices in improving timely access as reported by providers in the MHP.

In a cluster-randomized control trial of health and social service sites examining healthcare priorities among patients, professionals, and patients and professionals collaborating, Boivin, Lehoux, Lacombe, Burgers, and Grol (2014) found patient and professional priorities differed with access to healthcare, respect and empathy, time available in consultation, and treatment costs as most important to patients. When patients collaborated with professionals, access to primary care, self-care support, patient participation in clinical decision-making, and partnership with community organizations were prioritized. Access to care is a clear priority of consumers and professionals agree when informed about consumer needs, which supports the framework of this PIP study.

This PIP study examines the initial effects of provider implementation of quality improvement processes on timely access to DMH outpatient service. Establishing benchmarks and providing baseline data to providers can increase compliance rates over time (Loy et al., 2016).

Feedback in a healthcare setting promotes confidence and competence, particularly in physicians (Kaye, Okanlawon, & Urman, 2014). This research supports developing a widely timely access standard to increase support and performance among both DO and LE providers. Implementing a standardized feedback system for all providers will improve timeliness throughout the MHP for beneficiaries and examination. Examining what strategies providers utilize to meet this standard can benefit the whole system.

Incorporating performance coaching and individualized feedback can improve clinician performance, particularly clinicians considered underperforming at baseline (Papadakis, Cole, Reid, Assi, Gharib, et al., 2018). Report cards, including performance rating systems, are useful tools that communicate the quality of care between providers and provide valuable information to consumers (Ireson, Ford, Hower, & Schwartz, 2002). This supports using a rating system such as the access to care monitoring plan, which will provide site-specific feedback and benchmarks for goals to improve timeliness.

With regard to the development of a survey to examine the implementation of provider-developed strategies (interventions), assessing the fidelity at which interventions are implemented is necessary to ensure the intervention is applied standardly. Breitenstein et al. (2010) state that assessing fidelity can address research to practice gaps. It is the best measure of the quality at which an intervention was applied. The assessments can provide insight for future training and coaching efforts.

6.3 Does the improvement strategy specifically address cultural and linguistic needs for the population/beneficiaries? If so, in what way?

The Action Plan prompted providers to identify potential cultural and linguistic factors that may negatively impact their access to care performance. Providers noted limited or no staffing capacity to meet the needs of services in preferred languages. There was also an increase in culture-specific service requests with the shift to telehealth services during the COVID-19 crisis.

Further exploration of cultural and linguistic data indicates challenges with the accuracy and quality of data. Clinical Informatics, a CIOB unit, reports barriers to collecting cultural and linguistic data from consumers. The data is not required in the IBHIS system. Clinicians often do not enter the information, or the situation (i.e., crisis) may not allow for the collection of the data. DMH leadership is exploring how to address the barriers in the Department's effort to understand system-wide inequities better.

6.4 Who is involved in applying the intervention? What are their qualifications?

Providers were responsible for identifying, applying, and tracking the effectiveness of their selected strategies. The staff spearheading these processes at the provider-level typically included quality management coordinators or program managers.

6.5 How is the MHP/DMC-ODS ensuring consistency and/or fidelity during implementation of the intervention?

With the study design, the MHP cannot ensure the consistency/fidelity of the implementation of the interventions. This would not be true to the goal of the PIP, as the focus was to assess provider-developed strategies (interventions) specific to their site/program's unique needs. There is likely inconsistency and variation among all participating providers.

Table 6.1 Improvement Strategy Summary

	Intervention	Intervention Target Population	Date (MM/YYYY) Intervention Began	Frequency of Intervention Application
1	Provider-developed strategy targeting increases in timeliness ratings	Providers with timeliness at 69% and below	09/2020 , 12/2020, 03/2021	Varies by provider

Table 6.2 Process Indicators

	Process Indicator(s)	Measurement
1	Provider timeliness ratings for routine appointments	Number of providers not meeting expectations at pre and post
2	Timeliness Strategy Implementation Survey	a. Number of providers indicating the use of interventions targeting timeliness improvement b. Perceived improvement per provider report c. Level of implementation per provider report d. Level of success of an intervention in improving access to care per provider report using a five-point Likert scale e. Number of survey respondents
3	Provider-developed Action Plans	Number of completed action plans
4	Access to care webinars and central QA/QI meetings	Range of 270-280 attendees for both meetings

Click here for [Step 6](#)

WORKSHEET 7: DATA COLLECTION PROCEDURES

“What data do we need, and how will we get it?”

7.1 Describe the (planned) methods for ensuring the collection of valid and reliable data. Include MHP/DMC-ODS data entry and collection processes.

DMH Timeliness Data

DO programs rely on the SRL form in IBHIS to document initial requests for service. A small percentage of initial requests are documented using the SRTS under specific conditions (e.g., the initial request for service results in transfer to a DO program for assessment). The SRL form in IBHIS requires the entry of a client ID number when an appointment is provided. LE/Contracted providers use data entry forms in their respective EHRs, equivalent in structure and content to the SRL. However, they may also use the SRTS. The number of business days between the request for an urgent appointment and the first offered and accepted appointment dates is tracked in the SRL form in IBHIS and SRTS. Because the time of referral is not recorded in the SRTS, tracking the number of hours between request and appointment is not possible. Data was also collected from the KAEMS which houses information regarding referrals for children involved in the foster system.

Access to care data monitoring is performed based on the date from the initial service request to the first offered or accepted appointment, as logged by the provider. Data is extrapolated and aggregated using data stored in the Department's data warehouse. The accuracy and completeness of this data are confirmed by the Access to Care Leadership team, including CIO, Clinical Informatics staff, and QA.

Data collected from providers through the Action Plans and responses to the Timeliness Strategy Implementation Survey is dependent on the evaluation skills and honest feedback of providers.

7.2 What data elements are being collected?

Independent Variables

- Provider-developed strategy to improve timeliness rates

Performance Measures

- Quarterly timeliness rating for initial routine appointments
 - Number of timely appointments, routine
 - Number of untimely appointments where the referral to another provider was declined, routine

Process Indicators

- Provider timeliness ratings for routine appointments
 - Number of providers not meeting expectations at pre and post
- Timeliness Strategy Implementation Survey

- Number of providers indicating the use of interventions targeting timeliness improvement
- Perceived improvement per provider report
- Level of implementation per provider report
- Level of success of an intervention in improving access to care per provider report using a five-point Likert scale
- Number of survey respondents
- Provider-developed Action Plans
 - Number of completed action plans
- Access to care webinars and central QA/QI meetings
 - Range of 270-280 attendees for both meetings

7.3 Who is collecting the data? How are they qualified for this task? How will you ensure that all staff collecting data do so in accordance with the plan?

Data analysis will be completed by members of the QA and QI units in conjunction with CIO. QA regularly organizes, manages, and analyzes data regarding timeliness and State and federal requirements. QI is also involved in the data analysis of beneficiary information. One of CIO's roles is to assist in housing and analyzing programmatic and Departmental data sets.

7.4 What data collection instruments and electronic data collection/analytic systems are being used (i.e., tools with which raw, original data are collected and/or downloaded for analysis)? Please note if the MHP/DMC-ODS has created any instruments for this PIP.

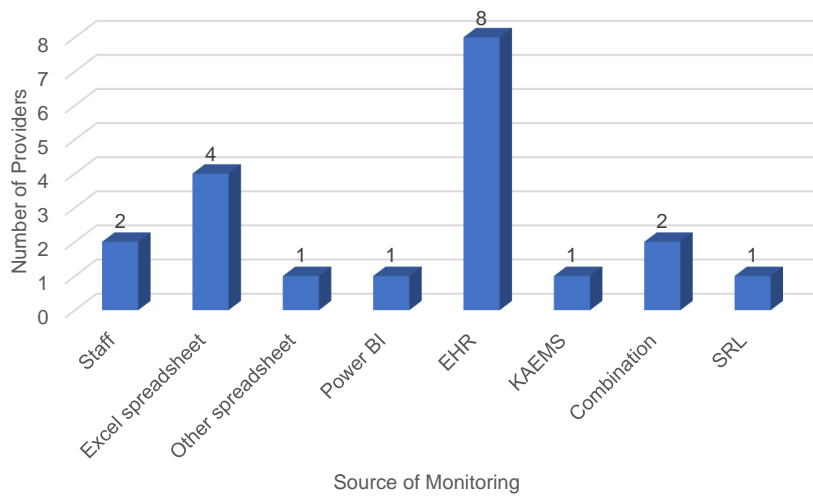
- IBHIS, SRTS, SRL, KAEMS systems linked to provider EHRs
- Action Plan – designed by QA to collect information from providers about internal and external factors impacting timely access and development of action plans to address the factors.
- Timeliness Strategy Implementation survey – designed by QI using Microsoft Forms to collect information from providers about strategies used to target the improvement of timely access. Strategy-related items were developed using the common themes among providers after Rapid Data Analysis of submitted Action Plans.

Internal Monitoring of Timely Access Data

All 20 survey respondents reported monitoring timely access internally. Ten (50%) providers reported reviewing timeliness data weekly, eight (38.1%) reported reviewing monthly, one (4.8%) bi-monthly, and one (4.8%) quarterly.

Figure 7.1 shows the methods used by the providers in tracking their internal timeliness data.

Figure 7.1. Distribution of Data Sources by Provider Preference



Note: Electronic Health Records (EHRs) may differ between providers by system and method of reporting. Data source: Non-clinical PIP Timeliness Strategy Implementation survey, May 2021.

Providers varied on the sources and ways they organized data. This led to frequent inconsistencies in provider data when compared to DMH data.

TABLE 7.1 SOURCES OF DATA

#	Variable or PM	Data Source	Frequency of Collection
1	Provider implementation of interventions (strategies)	1. Action Plan form 2. Timeliness Strategy Implementation Survey	1. September 2020 2. December 2020, and 3. March 2021 4. May 2021/One time
2	DMH timeliness data	SRL, SRTS, IBHIS, KAEMS systems	Monthly, Quarterly

Click here for [Step 7](#)

WORKSHEET 8: DATA ANALYSIS AND INTERPRETATION OF PIP RESULTS

“What do the data tell us, and what did we learn?”

8.1 How often were the data analyzed?

Plan: Timeliness ratings were reviewed monthly but reported every quarter. The Timeliness Strategy Implementation survey data was analyzed once at the close of the survey in May 2021 (Table 8.3).

Actual: Survey data collection went as planned.

8.2 Who conducted the data analysis, and how are they qualified to do so?

Plan: The timeliness rating data analysis was completed in collaboration with CIO, QA, and QI. These units are regularly involved in the organization and analysis of programmatic data. QI analyzed the Timeliness Strategy Implementation survey data.

Actual: No changes.

8.3 How was change/improvement assessed?

Plan: Improvement will be assessed by comparing quarterly timeliness percentages for routine appointments to the baseline percentages of the A, B, and C cohorts. Provider-perceived improvement and DMH timeliness data percentages will be used to assess strategy changes.

Actual: At the start of the project, the committee established a sustained implementation survey to assess the sustainability of the improvement strategies that the providers developed. This survey was designed as a 90-day follow-up assessment. The survey was revised to collect information on the provider's perceived success, level of implementation, and observable change. Upon EQR Technical Assistance (TA), the value of collecting this information in real-time was more evident. A tool for assessing sustainability is being planned as a PIP continuation activity.

Timeliness Strategy Implementation Survey Data

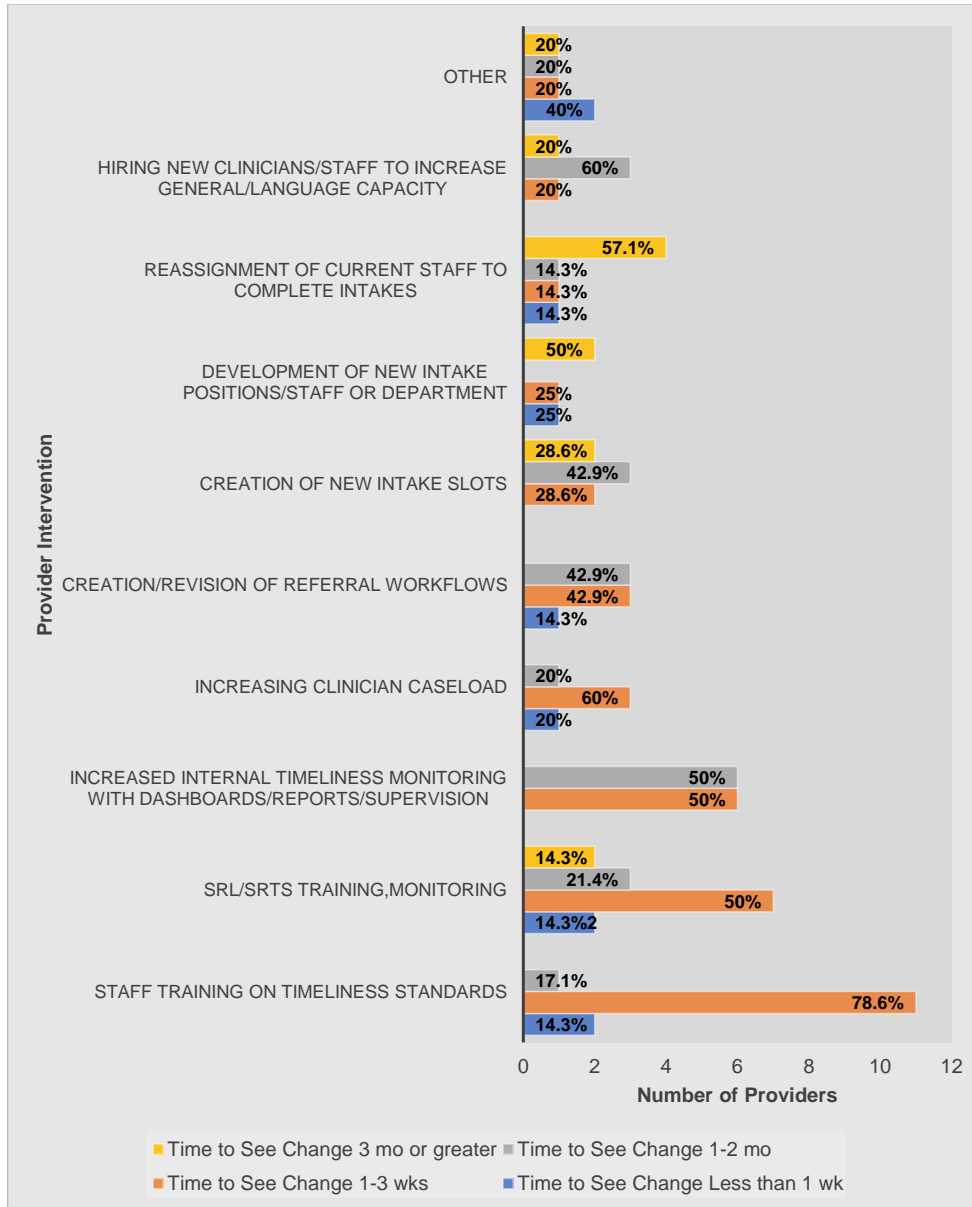
A description of the provider data collected by the Timeliness Strategy Implementation survey follows.

**Table 8.1 Perceived Success and Level of Implementation by Timeliness Strategy
May 2021**

Provider Strategy (Intervention)	Average Success Rating	Full Implementation (Number of Providers)	Partial Implementation (Number of Providers)	Not Yet Implemented (Number of Providers)
Other	4.4	4	1	0
Creation/revision of workflows	4.3	5	2	0
Increasing clinician caseload	4.2	4	2	0
SRL/SRTS training and monitoring	4.1	12	2	0
Creation of new intake slots	4.0	5	2	0
Staff training on timeliness standards	3.9	13	1	1
Increased internal timeliness monitoring with dashboards/reports/supervision	3.9	8	4	0
Reassignment of current staff to complete intakes	3.9	2	5	0
Development of new intake positions/staff or department	3.5	1	3	2
Hiring new clinicians/staff to increase general/language capacity	3.4	4	1	0

Data source: Non-clinical PIP Timeliness Strategy Implementation survey, May 2021.

Figure 8.1. Provider Estimated Length of Time to See Change after Strategy Implementation



Data source: Non-clinical PIP Timeliness Strategy Implementation survey, May 2021.

Summary of Change/Improvement per Provider Report and by Intervention

Staff Training on Timeliness Standards

The staff training on timeliness standards strategy often involved training staff in understanding the timeliness standards for each type of appointment: routine, urgent, and hospital/jail release discharge follow-up and how to document the timeliness of the appointments.

Fifteen providers elected to train staff on timeliness standards. The average rating of success in improving access to care was 3.9. At the time of the survey, 13 providers had fully implemented the strategy and one had partially implemented it. One provider endorsed not yet implemented, citing, "We do not have an (action plan)."

Eleven providers (78.6%) experienced a positive change from staff training on timeliness standards within 1-3 weeks. Two providers (14.3%) experienced a change in less than one week and one provider (7.1%) experienced a change in 1-2 months.

SRL/SRTS Training and Monitoring

The SRL/SRTS training and monitoring strategy often involved training staff on correct labeling of appointments, dispositions, dates, use of SRL/SRTS, and increasing the number of staff with access to SRL/SRTS.

Fourteen providers elected to initiate SRL/SRTS training and monitoring for staff overseeing data entry. The average rating of success in improving access to care was 4.1. At the time of the survey, 12 providers had fully implemented the strategy and two had partially implemented it. The not yet implemented response was not endorsed for this strategy.

Seven providers (50%) experienced a positive change in 1-3 weeks after implementing additional training and monitoring on information entry in SRL/SRTS. Three (21.4%) providers experienced a change in 1-2 months, two (14.3%) providers experienced a change in less than one week and two (14.3%) experienced a change in three months or greater.

Increased Internal Timeliness Monitoring with Dashboards/Reports/Supervision

The increased internal timeliness monitoring with dashboards/reports/supervision strategy often involved creating dashboards or reports to view timeliness data, creating a standing timely access agenda item in meetings, and introducing timeliness discussions into the supervision of staff and clinicians.

Twelve providers elected to increase internal timeliness monitoring with dashboards, reports, and/or supervision. The average rating of success in improving access to care was 3.9. At the time of the survey, eight providers had fully implemented the strategy and four had partially implemented it. The not yet implemented response was not endorsed for this strategy.

Six providers (50%) reported experiencing a positive change in 1-3 weeks after implementing internal timeliness monitoring with dashboards, reports, and/or supervision and six providers (50%) reported 1-2 months.

Increasing Clinician Caseload

The increasing clinician caseload strategy often involved increasing the cap on the number of consumers clinicians manage on their caseloads, increasing individual clinician capacity.

Six providers reported increasing clinician caseloads. The average rating of success in improving access to care was 4.2. At the time of the survey, four providers had fully implemented the strategy and two had partially implemented it. The not yet implemented was not endorsed for this strategy.

Three providers (60%) indicated experiencing a positive change after increasing clinician caseloads in 1-3 weeks, one provider (20%) reported a positive change in 1-2 months, and one provider (20%) reported a positive change in less than one week.

Creation of New Intake Slots

The creation of new intake slots strategy often included expanding the number of reserved spaces in clinician schedules specifically for completing intakes.

Seven providers elected to create new intake slots. The average rating of success in improving access to care was 4.0. At the time of the survey, five providers had fully implemented the strategy and two had partially implemented it. The not yet implemented was not endorsed for this strategy.

Three providers experienced a positive change after creating new intake slots within 1-3 weeks. Two providers experienced a positive change in 1-2 months. Two providers experienced a positive change in three months or more.

Creation/Revision of Workflows

The creation or revision of workflows strategy often included creating or revising existing workflows for incoming referrals or intakes.

Seven providers endorsed the creation/revision of workflows related to intakes or referrals. The average rating of success in improving access to care was 4.3. At the time of the survey, five providers had fully implemented the strategy and two had partially implemented it. The not yet implemented was not endorsed for this strategy.

One provider reported experiencing a positive change after creating or revising intake or referral workflows in less than one week. Three providers experienced a change in 1-3 weeks, and three providers experienced a change in 1-2 months.

Reassignment of Current Staff to Complete Intakes

The reassignment of current staff to complete intakes strategy often included shifting the responsibility of existing staff to complete additional or specific intakes. It can include clinicians and managers.

Seven providers elected to reassign current staff to complete intakes. The average rating of success in improving access to care was 3.9. At the time of the survey, two providers had fully implemented the strategy, and five had partially implemented it. The not yet implemented was not endorsed for this strategy.

Four providers reported that the time to see a positive change was three months or more after reassigning current staff to complete intakes. One provider reported a positive change in less than one week, one reported a positive change in 1-3 weeks, and one reported a positive change in 1-2 months after implementing staff reassignments.

Development of New Intake Positions/Staff or Department

The development of new intake positions, staff, or department strategy often included creating new positions and hiring new clinicians specifically for completing intakes, such as an Intake Coordinator. It also included the creation of a designated Intake Department to manage and process referrals and complete intakes.

Six providers elected to develop new intake positions/staff or a new intake department. The average rating of success in improving access to care was 3.5. At the time of the survey, one provider had fully implemented the strategy, three had partially implemented it, and two had not yet implemented it. Of the two providers that had not yet been implemented, one provider noted, "It is starting to be implemented this month as the position was recently filled and training recently completed." The other provider noted, "I am always advocating for additional clinical items to assist with the influx of clients. However, due to DMH processes, no additional items identified for this program at this time."

Two providers reported time to see a positive change after the development of new intake positions/staff or department was three months or greater, one provider reported a positive change in less than one week, and one reported a positive change in 1-3 weeks.

Hiring New Clinicians/Staff to Increase General/Language Capacity

The hiring new clinicians/staff to increase capacity strategy often included hiring new clinicians or staff to fill existing vacancies and shortages. It also included hiring new clinicians or staff to fulfill a need for providing services in a specific preferred language such as Armenian or Khmer.

Six providers elected to hire new clinicians/staff to increase their site's staffing and/or language capacity. The average rating of success in improving access to care

was 3.4. At the time of the survey, two providers had fully implemented the strategy, three partially implemented, and one had not yet implemented. The one provider that had not yet implemented noted, “Due to DMH processes, no extra clinical items or staff identified for this clinic at this time. However, I am always advocating.”

One provider reported seeing a positive change after hiring new clinicians/staff or increasing staffing and/or language capacity in 1-3 weeks. Three providers reported seeing a positive change in 1-2 months. One provider reported seeing a positive change in three months or greater.

Other

Five providers developed a strategy that was specific to a unique need for their site. Those strategies included setting up a centralized scheduling system for intakes; implementing a short-term therapy model, increased utilization review, assessing appropriate frequency/duration of services, training incoming interns, and increasing clinician hours from 32-40 that were previously cut due to the COVID-19 crisis.

The average rating of success in improving access to care was 4.4. At the time of the survey, four providers had fully implemented their strategy, and one had partially implemented it. The not yet implemented was not endorsed for this strategy. The time to see a positive change likely varied due to the type of Other strategy selected as two providers reported a positive change in less than one week, one provider reported change in 1-3 weeks, one provider reported change in 1-2 months, and one provider reported change in 3 months or greater.

8.4 To what extent was the data collection plan followed—were complete and sufficient data available for analysis?

Data was received from QA and CIO regarding the quarterly timeliness ratings as planned. Through the administration of the *Timeliness Strategy Implementation survey*, it was discovered that providers are using a variety of data sources, i.e., Electronic Health Records (EHRs), Excel spreadsheets, SRL/STRS, to perform internal timeliness monitoring. The use of multiple sources appeared to impact the reliability and accuracy of timeliness ratings. Self-reported timeliness performance often differed from the DMH timeliness data.

8.5 Were any statistical analyses conducted? If so, which ones? Provide target level of significance for each measure.

A repeated measures ANOVA was selected to analyze the change over time (Mauchly's Test of Sphericity) in the three cohort groups. A Paired t-test was used to compare pre-strategy timeliness percentages and timeliness percentages at the time of the Timeliness Strategy Implementation survey.

The level of significance selected for each analysis was p is less than or equal to 0.05.

8.6 Were factors considered that could threaten the internal or external validity of the findings examined?

The following factors likely threatened the internal or external validity of the PIP study findings:

- Using self-report data that multiple biases can influence.
- During the intervention stage, each of the providers was implementing multiple strategies at one time. It was difficult to determine the impact of provider-developed strategy (ies) on timeliness ratings with this structure. It was also unknown the time at which each strategy was implemented. This could be an area of expansion.

Timeliness Strategy Implementation Survey

Twenty providers completed the survey in May 2021. One hundred percent of the responding providers served Transition Age Youth (TAY), 95% (N=19) provided services to Children, 50% (N=10) provided services to Adults, and 20% (N=4) provided services to Older Adults (OA). Three providers were DO providers and 17 were LE providers. These providers served approximately 9,224 unique consumers in one month.

All 20 providers were reviewed for routine request ratings. Additionally, five providers were also evaluated on urgent appointments and two providers were evaluated on inpatient hospital/jail release follow-up appointments. One provider who completed the survey reported not submitting an Action Plan to QA, though this was a survey requirement.

The providers identified 10 categories of interventions targeting improvements in timely appointments for consumers. Providers identified the strategies used in their improvement plans and level of implementation (Full implementation, Partial implementation, Not Yet Implemented, and Decided Not to Implement). No providers indicated they decided not to implement their selected strategies. Providers were also asked to rate success on a five-point Likert scale (1-Not successful, 2-Somewhat successful, 3-No change, 4-Successful, 5-Very successful) they felt their strategy was to improve access to care.

Child Provider Strategies Versus Combined-Age Group Strategies

All the providers (N=21) who responded to the survey provide services to Transition Age Youth (TAY), 95% (N=20) of the providers who participated in the survey provide services to children, 48% (N=10) provides services to adults, and 19% (N=4) provide services to older adults. No providers served only adults and/or older adults.

Table 8.2 describes the strategies selected by Child/TAY providers compared to those selected by combined-age group providers.

Table 8.2 Percent of Provider Strategy by Age Group Served

Provider Strategy (Intervention)	Child/TAY Providers	¹ Combined-Age Group Providers
Staff training on timeliness standards	80%	70%
SRL/SRTS training and monitoring	60%	80%
Increased internal timeliness monitoring with dashboards/reports/supervision	60%	60%
Creation of new intake slots	40%	30%
Creation/revision of workflows	30%	40%
Increasing clinician caseload	30%	30%
Reassignment of current staff to complete intakes	30%	40%
Development of new intake positions/staff or department	30%	30%
Hiring new clinicians/staff to increase general/language capacity	20%	40%
Other	0%	40%

Note: ¹Combined-age group is defined as providers serving child, TAY, adult, and sometimes older adult age groups. Data source: Non-clinical PIP Timeliness Strategy Implementation survey, May 2021.

Combined-age group providers tended to use SRL/SRTS training and monitoring (80%) and other (40%) strategies more often than Child/TAY providers. Child/TAY providers leaned more on staff training on timeliness standards (80%) and creation of new intake slots (40%). This is consistent with QA's report of a trend in Child/TAY providers utilizing staff training on timeliness standards. Child providers reported having a unique challenge in determining when to start the timely access "clock" given that referrals are often received from third parties with or without the child's (or legal representatives) awareness.

Despite the tendencies of each group, there were no statistically significant differences among the strategies selected by Child/TAY and Combined-age group providers.

Provider Timeliness Ratings Pre-Post Strategy Implementation

**Table 8.3a Provider Reported Improvement of Timeliness Ratings
Pre/Post Strategy Implementation**

Provider Assigned Number	Pre Strategy Provider Reported Timeliness Rating	Pre Strategy DMH Timeliness Rating	May 2021 Provider Reported Timeliness Rating	May 2021 DMH Timeliness Rating	Provider Perceived Improvement	Actual Provider Improvement
S01	60%	60%	85-90%	100%	Yes	Yes
S03	many sites were below 70%	72.9%	routine - most sites are above 60-70%	67.6%	Yes	No
S04	It differed based on what the POC was about.	61.9%	Differs across our providers	79.7%	Unknown	Yes
S05	Less than 60%	25.5%	routine-72% (as of April 2021)	36.0%	Yes	Yes
S06	not applicable	None	100%	None	Unknown	Unknown
S07	Less than 60%.	20.8%	100%	96.2%	Yes	Yes
S08	70% below of the Access to Care expectation	78.7%	routine apts. in full compliance with access to care timeline	97.1%	Yes	Yes
S09	98%	22.9%	98%	53.2%	No	Yes
S10	69	59.1%	80	66.7%	Yes	Yes

Note: ¹Some percentages were not available for analysis. S02 was removed as it was found to be a duplicate respondent. Data source: Access to Care Trend Data, Retrieved April 2021; QI May 2021 PIP Provider Timeliness, Retrieved August 2021; Non-clinical PIP Timeliness Strategy Implementation survey, May 2021; Systemwide Monitoring Timely Access to Care January to March 2021.

**Table 8.3b Provider Reported Improvement of Timeliness Ratings (continued)
Pre/Post Strategy Implementation**

Provider Assigned Number	Pre Strategy Provider Reported Timeliness Rating	Pre Strategy DMH Timeliness Rating	May 2021 Provider Reported Timeliness Rating	May 2021 DMH Timeliness Rating	Provider Perceived Improvement	Actual Provider Improvement
S11	100%	89.7%	Routine 100%	100%	No	Yes
S12	0.6	59.1%	0.85	60.5%	Yes	Yes
S13	Less than 60%	47.7%	Routine - March - May (current date) - 20%	16.7%	No	No
S14	44-57% (range across our multiple Provider Numbers)	37.9%	Routine = 70%	81.3%	Yes	Yes
S15	less than 60 percent	100%	Unknown ¹	60.0%	Unknown	No
S16	60	62.5%	95	100%	Yes	Yes
S17	Less than 60%	97.4%	Unknown	16.7%	Unknown	No
S18	60-70	62.8%	80-85	55.8%	Yes	No
S19	0.1944	77.8%	Routine - 65%	50.0%	Yes	No
S20	Provider A- Less than 60% Provider B-Less than 60%	56.4%	Timeliness percentages are approximately 60% for routine, jail release and/or urgent appointments. We are currently working on improving staffing issues as outlined in our POC. We have utilized information obtained from our meeting with the Network Adequacy QA team to retrain staff on areas of the SRLs that will help to ensure better compliance.	86.3%	Yes	Yes
S21	0.56	35.4%	0.7	70.0%	Yes	Yes

Note: ¹Some percentages were not available for analysis. S02 was removed as it was found to be a duplicate respondent. Data source: Access to Care Trend Data, Retrieved April 2021; QI May 2021 PIP Provider Timeliness, Retrieved August 2021; Non-clinical PIP Timeliness Strategy Implementation survey, May 2021; Systemwide Monitoring Timely Access to Care January to March 2021.

In examining provider improvement rates, 13 (61.9%) of the 20 providers noted improvements in their timeliness ratings since QA's timely access monitoring process evaluated them. Four providers did not have enough information to determine if there was a change and three providers indicated no change in timeliness ratings.

Although several providers showed improvement in timely access ratings after strategies were implemented, the improvements were not statistically significant.

Summary

The survey results suggest that providers preferred improvement strategies, such as immediate capacity adjustments, administrative changes, and training, which resulted in the shortest implementation time. These strategies often had a higher provider rating of success in impacting timely access. Strategies that were highly specific to a provider's needs and those that fell in the other category were rated the highest in success in impacting timely appointments. However, these types of strategies were used by only five of the 20 providers.

Strategies that targeted personnel changes were chosen the least and were rated the lowest on success in impacting timely access. Personnel changes also appeared to take the longest to implement due to lengthy hiring processes.

Child/TAY providers leaned more on staff training on timeliness standards (80%) and the creation of new intake slots (40%) than combined-age group providers. These providers are required to engage in the additional step of consent from parents before beginning initial assessments. Combined-age group providers tended to use SRL/SRTS training and monitoring (80%) and other (40%) strategies more often than Child/TAY providers.

About 65% (N=13) of providers noted improved timeliness ratings since their initial evaluation by the QA timely access monitoring process.

Based on the data collected by the survey, Tables 8.4 and 8.5 display examples of ways the strategies can be organized to support providers seeking improvement in timely access. Providers may review the listed strategies sorted by perceived success and expected time to change (Table 8.4) or categories of improvement strategies (Table 8.5). They may select the strategy (ies) of interest or one that aligns best with their available staffing and clinic resources.

Table 8.4 Strategies by Expected Time to Change and Success Rating

Strategy and Expected Time to Change	Success Rating
Less than 1 Week	
Creation/revision of workflows	4.3
Increasing clinician caseload	4.2
SRL/SRTS training and monitoring	4.1
Staff training on timeliness standards	3.9
Reassignment of current staff to complete intakes	3.9
Development of new intake positions/staff or department	3.5
1-3 Weeks	
Other: Centralized scheduling system for intakes; implementing short term therapy model, increased utilization review, and assessment of appropriate frequency/duration of services; and training of incoming interns and increasing clinician hours from 32-40 that were previously cut due to the COVID-19 crisis	4.4
Creation/revision of workflows	4.3
Increasing clinician caseload	4.2
SRL/SRTS training and monitoring	4.1
Creation of new intake slots	4.0
Staff training on timeliness standards	3.9
Increased internal timeliness monitoring with dashboards/reports/supervision	3.9
Development of new intake positions/staff or department	3.5
Hiring new clinicians/staff to increase general/language capacity	3.4
1-2 Months	
Other: Centralized scheduling system for intakes; implementing short term therapy model, increased utilization review, and assessment of appropriate frequency/duration of services; and training of incoming interns and increasing clinician hours from 32-40 that were previously cut due to the COVID-19 crisis	4.4
Creation/revision of workflows	4.3
SRL/SRTS training and monitoring	4.1
Increasing clinician caseload	4.2
Creation of new intake slots	4.0
Staff training on timeliness standards	3.9
Increased internal timeliness monitoring with dashboards/reports/supervision	3.9
Reassignment of current staff to complete intakes	3.9
Hiring new clinicians/staff to increase general/language capacity	3.4
3 Months or Greater	
Other: Centralized scheduling system for intakes; implementing short term therapy model, increased utilization review, and assessment of appropriate frequency/duration of services; and training of incoming interns and increasing clinician hours from 32-40 that were previously cut due to the COVID-19 crisis	4.4
SRL/SRTS training and monitoring	4.1
Creation of new intake slots	4.0
Reassignment of current staff to complete intakes	3.9
Development of new intake positions/staff or department	3.5
Hiring new clinicians/staff to increase general/language capacity	3.4

Data source: Non-clinical PIP Timeliness Strategy Implementation survey, May 2021.

Table 8.5 Strategies by Category and Success Rating

Strategy and Expected Time to Change	Success Rating
Administrative Strategies	
Other: Centralized scheduling of intakes, increased utilization review	4.4
Creation/revision of workflows	4.3
Increased internal timeliness monitoring with dashboards/reports/supervision	3.9
Capacity Changes	
Other: Increasing clinician hours from 32-40 that were previously cut due to the COVID-19 crisis	4.4
Increasing clinician caseload	4.2
Creation of new intake slots	4.0
Personnel Changes	
Other	4.4
Reassignment of current staff to complete intakes	3.9
Development of new intake positions/staff or department	3.5
Hiring new clinicians/staff to increase general/language capacity	3.4
Training	
Other: Training of incoming interns	4.4
SRL/SRTS training and monitoring	4.1
Staff training on timeliness standards	3.9
Treatment Approaches	
Other: Implementing short term therapy model, assessment of appropriate frequency/duration of services	4.4

Data source: Non-clinical PIP Timeliness Strategy Implementation survey, May 2021.

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Change in Cohort Timely Access

All providers were rated for timeliness on routine appointments. The PIP focus was placed on the providers with the lowest timeliness performance to have the highest impact on beneficiary access. Baseline data was determined to be Cohort A, Cohort B, and Cohort C. The number of providers in the group with a 69% and below rating was 50. A summary of the study's population follows.

TABLE 8.6 PIP RESULTS SUMMARY

	Baseline Timeliness Rating	Baseline Time Period	First Collection Period (May-July 2020)	Second Collection Period (Aug-Sept 2020)	Third Collection Period (Jan-Mar 2021)	Total Percentage Point (PP) Change
Cohort A (N=17)	49.7%	May-July 2020	61.1% (+11.4 PP)	69.9% (+8.8 PP)	89.7% ¹ (+19.8 PP)	+40 PP
Cohort B (N=16)	49.0%	August- September 2020		63.1% (+14.1 PP)	81.2% (+18.1 PP)	+32.2 PP
Cohort C (N=17)	50.9%	October- December 2020			81.6% ² (+30.7 PP)	+30.7 PP

Note: ¹ Data from one provider was missing from the Cohort A January to March 2021 data set. ² Data from two providers was missing from the Cohort C January to March 2021 data set. Data source: System-wide Monitoring Timely Access to Care January 2021 to March 2021.

[Click here for Step](#)

Last revised date: 9/20/2021

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

“Did we make a difference, and will it have an ongoing impact?”

Provisional Findings, if applicable: (For PIPs that are in process at the time of submission, or that do not yet have any remeasurement data, please briefly provide preliminary results or impressions to date) Click or tap here to enter text.

9.1 What is the conclusion of the PIP?

Overall, timely access to care monitoring was effective in promoting the implementation of impactful interventions. The process of engaging in timely access to care monitoring and quality improvement processes improved the timely access ratings of providers who fell below 69%. The LE/Contracted and DO providers took a quality improvement approach to timely appointments by reviewing internal and external factors and developing an Action Plan to address their specific challenges.

Results from the survey suggest providers benefit from 1) program-specific strategies, 2) immediate capacity adjustments such as increasing intake slots or clinician caseloads, 3) administrative changes such as revising referral and intake workflows, and 4) SRTS/SRL or timeliness standard training and monitoring for staff.

Child/TAY providers may have unique needs when compared to other age groups served. This group would likely benefit from further exploration of their specific challenges to timely access.

9.2 Do changes appear to be the results of the PIP interventions? Please explain.

With the range of improvement seen among the A, B, and C cohorts (+ 40 PP, 32.2 PP, and +30.7 PP, respectively), it is concluded that the implementation of the timely access monitoring process appears to have a positive impact on the study population. Timeliness rates were trending upwards within three months. Ideally, a review of any change in the number of requests for referrals during the full measurement period would provide additional support to the impact of the interventions. However, the Timely Access to Care Reporting dashboard is pending a data update.

It is unclear which particular interventions (strategies) had the greatest impact as providers applied multiple interventions simultaneously. However, providers who completed the Timeliness Strategy Implementation survey indicated that site-specific

and administrative strategies (revising workflows, creating intake slots, etc.) were the most successful in improving timely access performance in the shortest amount of time.

9.3 Does statistical evidence support that the change represents a real improvement or difference?

The pre strategy and post strategy timeliness ratings for the survey respondents were analyzed with a paired T-test. No statistically significant differences were indicated (p=0.4).

The A, B, and C Cohorts were evaluated individually with a repeated-measures ANOVA. The A and B cohorts were statistically significant (Cohort A, p=0.02; Cohort B, p=0.01) regarding the measurement of change over time with Mauchly's Test of Sphericity. This significant change over time illustrates the increasing level of improvement in cohort timeliness ratings that occurred as the providers implemented their selected interventions. It was determined that there was not enough measurement data available for Cohort C to determine statistical significance.

Commented [DC4]: Statistical information updated

9.4 Did any factors affect the methodology of the study or the validity of the results? If so, what were they?

Observer Effect

Providers may have some level of improvement based on the fact that their timely access is being observed. This PIP study analyzes the change that occurred during the initial implementation of a timely access monitoring process by QA. No previous similar process has been instituted in the past. Providers also invest heavily in activities involving the DMH QA, which typically monitors billing and compliance activities.

Self-Report Data

Data collected from providers in the Action Plan and Timeliness Strategy Implementation survey was solely self-report. The accuracy of self-report data is questionable and can be impacted by multiple biases.

Multiple Interventions (Strategies)

During the intervention stage, each of the providers was implementing multiple strategies at one time. With this structure, it is difficult to determine an individual strategy's impact on provider timeliness ratings. It was also unknown the time at which each strategy was implemented. This could be an area of expansion.

Timeliness Strategy Implementation Survey

Survey Respondents in Multiple Cohorts

Survey respondents often listed associations with multiple provider sites. The sites were selected for the QA timely access monitoring process based on the specific site's timeliness rating. This made it possible for providers to have sites in multiple cohorts. Participating in the survey were seven providers in cohort A, four in cohort B, three in cohort C, two providers had multiple sites in multiple cohorts, two providers were recently evaluated by QA and not assigned a cohort, and QA had not evaluated one provider on timely access.

DMH Hiring Freeze

Due to the COVID-19 crisis, DMH instituted a hiring freeze in CY 2020 on most positions. The hiring freeze remained in effect during the time that providers were surveyed in May 2021. The freeze may have impacted DO providers' ability to hire new staff to increase capacity or develop new intake departments.

9.5 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?)

Repeated measurement was taken for the A, B, and C cohorts. Sustained improvement in timely routine appointments occurred across all cohorts. In Cohort A, timeliness rates increased by 40 PP from baseline (May, June, July 2020) to January 2021. Cohort B timeliness rates increased by 32.2 PP from baseline (August, September 2021) to January 2021. Cohort C's combined timeliness rates increased by 30.7 PP from baseline (October, November, December 2020) to January 2021.

9.6 How were untoward results addressed?

With the size of the MHP and the number of extraneous variables, little could be done to address untoward results. There were situations in which some providers engaged in the QA timely access monitoring process and did not improve or performed worse. The QA unit created a follow-up process to further assist and support providers whose timeliness ratings did not improve over two quarters.

The challenges to data quality were to be considered when analyzing the data and making interpretations and applications. Providers frequently reported reliance on staff for data entry as a barrier to a portion of timeliness performance.

For future related studies, it was determined that start and stop times for interventions (strategies) could be collected from providers to attempt further clarity of the impact of each intervention.

9.7 What is the MHP/DMC-ODS's plan for continuation or follow-up?

This PIP study's goal has been achieved by improving the three cohorts' timeliness ratings over the course of the study. As this goal has been met, the PIP committee would like to end this particular project to pursue other needs within the realm of Access to Care. There are a number of continuous quality improvement projects of interest to continue the efforts that resulted from this PIP study. The project could be designed to continue developing an evidence-based menu of provider-developed interventions that target improvements in timely access. The menu will be shared to promote system-wide improvements. Processes from this study will be considered for expansion to urgent and hospital/jail release follow-up appointments and initial medication assessment appointments.

Additional projects compatible with the Department's strategic priorities may include a review of service inequities occurring among untimely appointments pending the development of strategies to improve the quality and accuracy of cultural and linguistic consumer data. Additionally, the Access to Care Leadership Committee is developing a Consumer and Family Subcommittee group to better inform timely access improvement efforts about the experiences of consumers and families attempting to access mental health care.

Influenced by this PIP study, on April 19, 2021 DMH established a Learning Collaborative for SA 2 child service providers/programs to address timely access barriers. Participants will engage in their quality improvement process that targets timeliness, capacity, and staff wellbeing and work collaboratively towards system improvement. A potential project could test the providers' improvement strategies and analyze the group's impact on SA 2 timeliness for non-slot-based routine child services.

Developing efforts to improve consumer access to care include a QIP utilizing the feedback and recommendations established through a DMH-contracted effort with Wondros. Wondros is a global creative agency dedicated to solving complex communication challenges to build social movements and inspire action. They conducted a study on the barriers consumers face when attempting to enter DMH's system of care. One-on-one interviews with DMH staff and consumers led to recommendations for system improvements (i.e., revised welcome packets/orientations) and will contribute to developing interventions targeting seamless and supportive transitions into DMH's outpatient treatment.

Click here for [Step 9](#)

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APPENDICES

Appendix A: Medication Decision Tree PDSA Worksheet



OFFICE OF ADMINISTRATIVE OPERATIONS – QUALITY, OUTCOMES, AND
TRAINING DIVISION

Quality Improvement Project (QIP) PDSA Worksheet

PLAN Phase	
Steps	Response
1. Identify the Problem	We want to test a change to solve the following problem: Consumers are scheduled for medication evaluation appointments that may not be used or be indicated for the consumer, which blocks out valuable psychiatrist time. (may be more countywide than specifically in Rio Hondo)
2. List Project Stakeholders	Our team includes: Antonio Banuelos, Rio Hondo; Dagoberto Roman, Rio Hondo; Intake clinicians, Rio Hondo, Quality Improvement: Kalene Gilbert, Jennifer Regan, LyNetta Shonibare, Daiya Cunnane
3. Project Goal	Our aim is: To determine if recording the results of the medication evaluation decision tree results in a change to the process of scheduling medication evaluation appointments. We are validating the use of the decision tree process, which has been occurring in the clinic but is not documented.
4. Current Process	Our process looks like: Currently, staff are using the medication evaluation decision tree paper form to make decisions regarding scheduling and are not recording this information other than scheduling the appointment for those that need an evaluation.
5. Proposed Interventions/Changes	These are potential changes we could make: Recording the information on the medication evaluation decision tree on a form so that the team can track the data and look for trends.

Appendix A

	We have selected the following change to test: Staff will complete a Microsoft Forms version of the decision tree and we will evaluate the process on a monthly basis by reviewing the data as a team.
	How will we know that a change is an improvement? (see What data do we need? table below) Does the % of consumers receiving med eval change based on formal use of decision tree? Are there a significant number of consumers either receiving or not receiving a medication evaluation where it turns out the decision made did not line up with need?
6. Prediction	We think the following things will happen when we test this change: The percentage of consumers needed a medication evaluation will continue to be high. We will be able to review the top factors indicating an evaluation and what factors tend to correlate.

Data we need	Who will collect it?	Where/How will they get it?	When will they get it?
New referrals given medication evaluation	Rio Hondo Team	Microsoft Forms	Start collecting March 2021 ending June 2021
Average time to medication evaluation (time of request to time seen, factor in no shows)	Rio Hondo Team	Microsoft Forms	Start collecting March 2021 ending June 2021
Factors associated with needing a medication evaluation	Rio Hondo Team	Microsoft Forms	Start collecting March 2021 ending June 2021
Factors associated with not needing a medication evaluation	Rio Hondo Team	Microsoft Forms	Start collecting March 2021 ending June 2021
Number of consumers that were indicated to need medication evaluation that attended the evaluation	QI Team	IBHIS	Start evaluating monthly basis as of April 2021
Number of consumers that attended medication evaluation that were prescribed at least one medication	QI Team	IBHIS	Start evaluating monthly basis as of April 2021

DO Phase	
1. Implement the change	Did any problems or unexpected events occur? There were no problems or unexpected events. The Rio Hondo team received feedback from the clinicians completing the form that the factors listed on the form covered the majority of situations for consumers and they did not want to add any categories. They reported that it took on average about 1-2 minutes to complete the form and that it was feasible to complete it.
	The team observed the following: The existing form and factors were sufficient to capture the experience. The amount of times "Other" was selected was relatively low in comparison to the other categories.
STUDY Phase	
1. Review findings	When the team reviews the feedback and data, how did things change? The percentages of consumers indicated for a medication evaluation, those that declined, and those that declined an earlier appointment were similar to what they had been prior to the implementation of the form. The top categories were in line with expectations that if a consumer was currently on medication, has a history of being on medication, and has a high motivation for medication treatment, the consumer would very likely receive a medication evaluation.
	Was the team's prediction accurate? If not, what was different? Yes, the number of consumers that were indicated to receive a medication evaluation remained high. The most common factors contributing to the decision made logical sense to the team.
	What did the team learn? This project validates the use of the decision tree process. The high follow-up and prescription rates demonstrated that the team has been making the decisions in the right direction. The team found it helpful to see the data as they allowed more insight into the population served. For this project, it was all licensed clinical social workers (LCSWs) making the decisions and the team found that it was important for anyone else doing this work to have a strong team with clinical training and expertise. The decision tree was also viewed as a great tool for associate social workers (ASWs), who are in training to be able to consult on the decision. Other recommendations from the Rio Hondo team are to make sure the whole team is involved in that everyone scheduling intakes and medication evaluations knows the process and is in good

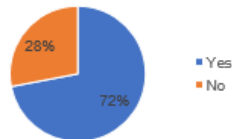
	communication with each other. At other clinics, there may need to be some training to get staff to think about their workflow and it may involve a paradigm shift. They also stressed the need to have support from the supervising psychiatrist to help identify the target individuals for consultation.
ACT Phase	
	<p>How will we respond to this change? <input type="checkbox"/> adopt (implement) <input type="checkbox"/> adapt (refine and retest) <input type="checkbox"/> abandon</p> <p>As the project validated the current use of the decision tree process, the team will discontinue the formal use of the tracking form at the end of May.</p>
	If adopting or adapting, what is the team's plan for the next step? The team will continue using the workflow of the medication evaluation decision tree without the formal tracking component. If the team notices significant changes to their engagement rates or a high volume of consumers scheduled for an evaluation that were not indicated for medication, they can revisit the formal tracking with the form to look at trends again.

Evaluation of Medication Evaluation Decision-Tree Rio Hondo Pilot: Three-Month

432

Unique
consumers
assessed

Percent of consumers needing evaluation



3.5

Mean number of days between
intake and medication evaluation

0 - 23

Range of days between intake
and medication evaluation

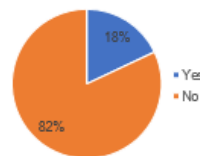
Most Common Reasons Medication Evaluation Needed



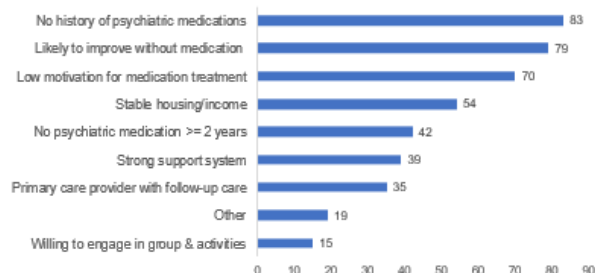
"Other" Reasons

Physical Health
Rule Out Bipolar Disorder
Symptoms and History
(Mental Health and Medical)
Referral from PCP
Referred by current therapist
Consumer requested

Percent that declined
earlier appointment



Most Common Reasons Medication Evaluation Not Needed



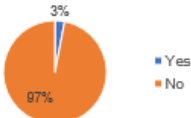
"Other" Reasons

Consumer requested therapy
Declined medication services
Receiving meds with
PCP/outside psychiatrist
Client reporting low severity of
symptoms

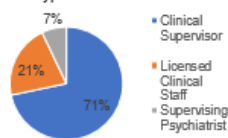
Percent of Consumers
that Declined Evaluation



Percent of Staff that Consulted

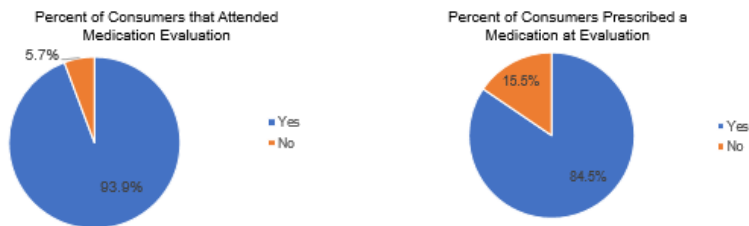


Type of Staff Consulted



LOS ANGELES COUNTY
DEPARTMENT OF
MENTAL HEALTH
hope. recovery. wellbeing.

Evaluation of Medication Evaluation Decision-Tree Rio Hondo Pilot: Three-Month



Correlation Matrix for Factors That Contribute to Scheduling a Medication Evaluation

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
1. Currently on psychiatric medication	1.00	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
2. High motivation for medication treatment	0.09	1.00	-	-	-	-	-	-	-	-	-	-	-	-	-	-
3. History of psych medication within 2 years	-0.15	-0.10	1.00	-	-	-	-	-	-	-	-	-	-	-	-	-
4. History of psychiatric hospitalizations	0.21	-0.03	0.21	1.00	-	-	-	-	-	-	-	-	-	-	-	-
5. Psychotic Symptoms	0.13	-0.06	0.01	0.33	1.00	-	-	-	-	-	-	-	-	-	-	-
6. History of or active substance use disorder	-0.01	0.02	-0.06	0.06	0.07	1.00	-	-	-	-	-	-	-	-	-	-
7. SI, HI, Gravely Disabled	-0.16	0.06	-0.14	-0.10	-0.09	-0.12	1.00	-	-	-	-	-	-	-	-	-
8. Hospital discharge	0.30	-0.14	-0.12	0.09	0.21	0.00	0.04	1.00	-	-	-	-	-	-	-	-
9. Poor support system	-0.23	-0.09	0.00	-0.06	-0.06	0.00	0.15	-0.12	1.00	-	-	-	-	-	-	-
10. Homeless/at risk	0.06	-0.09	0.00	0.19	0.18	0.16	-0.04	0.01	0.32	1.00	-	-	-	-	-	-
11. Poor insight	0.10	-0.23	0.00	0.14	0.26	-0.06	-0.12	0.15	0.00	0.03	1.00	-	-	-	-	-
12. Mania	0.10	-0.08	0.08	0.19	0.11	0.11	-0.09	0.21	-0.07	0.03	0.01	1.00	-	-	-	-
13. No PCP or follow-up care	-0.14	0.02	-0.04	-0.01	0.00	0.03	-0.06	-0.13	0.03	0.01	-0.02	-0.05	1.00	-	-	-
14. Failure to improve after psychotherapy	-0.01	-0.06	-0.13	-0.03	0.03	-0.03	-0.12	0.01	-0.01	0.04	0.07	0.08	-0.07	1.00	-	-
15. Released from justice system	0.00	-0.04	0.00	0.06	0.02	0.08	-0.08	-0.07	0.07	0.07	-0.04	0.05	0.06	-0.03	1.00	-
16. Other	-0.17	0.01	-0.06	-0.12	-0.10	-0.03	-0.02	-0.11	-0.02	-0.10	-0.07	-0.06	0.06	-0.05	-0.03	1.00

Correlation Matrix for Factors That Contribute to Not Scheduling a Medication Evaluation

	1	2	3	4	5	6	7	8	9
1. No history of psychiatric medications	1.00	-	-	-	-	-	-	-	-
2. Likely to improve without medication	0.39	1.00	-	-	-	-	-	-	-
3. Low motivation for medication treatment	0.13	0.14	1.00	-	-	-	-	-	-
4. Stable housing/income	0.30	0.32	0.08	1.00	-	-	-	-	-
5. No psychiatric medication >= 2 years	0.13	-0.07	0.42	0.16	1.00	-	-	-	-
6. Strong support system	0.10	0.11	-0.08	0.38	-0.01	1.00	-	-	-
7. Primary care provider follow-up care	-0.41	-0.21	-0.36	-0.05	-0.38	0.03	1.00	-	-
8. Willing to engage in group & activities	0.10	-0.03	0.17	0.07	0.05	0.01	-0.01	1.00	-
9. Other	-0.28	-0.34	-0.08	-0.15	0.02	-0.05	-0.12	-0.02	1.00

Appendix B: SA 3 Centralized Scheduling Pilot Fact Sheet

**COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH
QUALITY, OUTCOMES, AND TRAINING DIVISION – QUALITY ASSURANCE UNIT**

**Centralized Scheduling Pilot – Service Area 3
Hospital Discharges**

(Offered Appointment within 5 Business Days from Date of Discharge)
Pilot begins February 1st, 2021

Purpose and Goals

To centrally schedule hospital discharge appointments through the ACCESS Center in order to maximize provider capacity and efficiently/quickly/easily provide clients with an appointment.

Overall Process

1. Hospital calls ACCESS when discharging a client to obtain an appointment for the client
2. ACCESS identifies the most appropriate Provider and available appointment, provides Hospital with appointment date/time, and schedules the appointment with the Provider
3. Provider contacts client the day before the appointment to inform of the method of delivery (in person, telephone, or telehealth)

Guidelines

1. Appointments will be scheduled by ACCESS for both Child/Adolescent and Adult clients
2. Appointments will be scheduled by ACCESS for both New and Existing Clients (Active or Inactive)
3. Only appointments within SA3 will be scheduled
4. Appointments may not be scheduled for the same day



Quality Assurance Bulletin

Quality Assurance Unit

County of Los Angeles – Department of Mental Health

March 18, 2021

Jonathan E. Sherin, M.D., Ph.D., Director

No. 21-02

ACCESS TO CARE EXPECTATIONS AND REMINDERS

The Los Angeles County Department of Mental Health (DMH) is committed to providing our clients timely access to mental health care that is the right service by the right provider at the right time. In an effort to support our providers in this commitment, this Bulletin provides expectations and reminders related to access to care throughout the DMH system.

No Programs Are Exempt from Access to Care

Access to care requirements are across the board. No programs (e.g., Full Service Partnership (FSP), Wraparound, Multidisciplinary Assessment Team (MAT), Specialized Foster Care, CalWorks, AB109) are exempt from the access to care requirements in DMH Policy 302.07 – Access to Care and 302.14 – Responding to Initial Requests for Service. As a reminder, based on policy 302.14, all requests for services when the client/potential client is not currently being treated at your provider must be logged into the Service Request Log (SRL) or other DMH approved application (e.g., Service Request Tracking System (SRTS) or SRL web service).

Routine Requests - Inability to Accept Requests

The Department is committed to ensuring efficient management of the capacity of the DMH system of care. To that end, it is crucial that there are established criteria around the inability to accept new requests for services. The following criteria have been developed to provide guidance on when a provider should reach out to DMH to discuss when they can no longer accept new requests for services for routine requests (refer to DMH Policy 302.07 for the definition of routine):

- Over the past three consecutive months, the typical (median) wait time for a routine appointment is greater than fifteen (15) business days AND the percentage of initial appointments offered within 10 business days is less than 60% OR
- Over the past three consecutive months, the typical (median) wait time for a routine appointment is greater than twenty (20) business days OR

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- For Legal Entity providers, the LE has minimally reached 60%, but no later than 75%, of their Maximum Contract Amount (MCA) and/or Funded Program Amount for the fiscal year and as a result believes they will no longer be able to accept additional clients.

If one of the above three criteria exists, the provider must notify their Service Area Chief and Lead Contract Monitor (for Legal Entity providers) as soon as possible. If the inability to serve routine clients is for an intensive program (e.g., Full Service Partnership or Wraparound), the lead for the intensive program must also be notified. The notification should be made as soon as it is known there may be factors that prevent serving new clients and prior to not accepting new clients. At the point of notification, there should be a conversation to determine if/when a provider will not accept new requests.

At the point when it is agreed upon that a provider will not accept new requests, the provider must immediately update the Network Adequacy: Provider and Practitioner Administration (NAPPA) application to reflect that they are no longer accepting new clients. This allows the ACCESS Center, all service providers and the public to have current information into which providers are and are not accepting requests by ensuring the Provider Directory is up-to-date. In addition, the Quality Assurance QA Unit will utilize this information to provide a list of providers no longer accepting requests to Department management.

Urgent / Hospital Discharge / Jail Release Appointment Requests

All providers must make every effort to accept urgent, hospital discharge and jail release appointment requests for service. If a provider is currently not accepting routine requests, the provider must discuss with their SA Chief and CMMD Lead (if applicable) whether they must continue to accept urgent/hospital discharge/jail release requests. Providers may not have agency policies that prevent accepting these requests. However, providers may determine on a case-by-case basis that specific urgent/hospital discharge/jail release requests cannot be accepted based upon inability to provide timely services. Providers should have a detailed written procedure on handling requests that cannot be accepted (e.g., through active linkage/warm handoff). Providers who are not open on the weekend should likewise have a detailed written procedure on handling urgent appointment requests, which must be seen within 48 hours (e.g., connection to a local urgent care center).

Refusing Requests

Providers have a responsibility to provide the services for which they are certified. Providers should rarely refuse a client an assessment and/or turn a client away. For example, an assessment should not be denied simply because a client states they do not want psychotherapy or a client is currently receiving services from another provider. Providers may only refuse to provide clients with specific services they are

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certified to provide after having completed an assessment of the client and with appropriate clinical justification. Providers cannot have a blanket policy in which the provision of one service is dependent upon another (e.g., a “no medication-only” policy). Each case must be individually evaluated. The provider may only impose limitations on services based upon community standards of care including professional ethical standards.

Providers should not refuse clients who reside outside of their respective service area and/or outside of the time and distance standards to appointment location if it is the client’s preference to receive services from them. In addition and under most conditions, providers should accept indigent clients in the same manner they accept all other clients. If a contracted provider believes funding issues will prevent acceptance, they should discuss this issue with their Lead Contract Monitor. Any policies or procedures that may lead to refusal of services should be discussed with the Service Area Chief, Lead Contract Manager or the Quality Assurance Unit.

The above direction should not be interpreted to prohibit providers from referring individuals back to their private insurance carrier (e.g., Kaiser) when appropriate. However, individuals with dual coverage that includes Medi-Cal must be served. In the majority of cases, Medi-Cal is the payer of last resort. Therefore, for clients with other health coverage, the other health coverage should normally be claimed to first. Please contact the Central Business Office (CBO) for additional information (CBO@dmh.lacounty.gov).

Monitoring Plan

As of September 2020, the Quality Assurance Unit has been monitoring access to care timeliness across the DMH system of care. All directly-operated and legal entity providers are monitored at the provider level on a quarterly basis. The metrics being monitored include (1) percent of untimely appointments across each of the request types (Urgent, Hospital/Jail Discharge, and Routine), (2) Notice of Adverse Benefit Determination (NOABD) issuance, and (3) quality of data (SRTS dispositions QA entered timely, SRL records finalized timely, and SRL webservices submitted timely). The DMH benchmark for timeliness is 80%, and providers falling below that value are notified by the QA Unit as follows:

- 70-79% - notification email only
- 60-69% - notification email and request to submit a plan of correction
- Below 60% - notification email, request to submit a plan of correction, and technical assistance meeting (as needed)

The monitoring process for access to care is meant to be a collaborative process with providers working towards problem-solving and identifying solutions to ensure timely access to care for our clients.

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DMH Policies 302.07 and 302.14 have been updated to reflect the information in this Bulletin and are awaiting final signatures. Other notable changes to these policies include:

- Added time and distance standards to appointment location per DHCS requirements (i.e. the time and distance it takes a client to travel from their residence to the nearest provider site shall be no more than 30 minutes and 15 miles unless the client prefers another location);
- Removed the need to record the initial request or transfer in *both* the SRTS and SRL, and clarified when each log must be used;
- Replaced reference to the Notice of Action (NOA) form with the NOABD form and referenced DMH Policy 200.04 - Beneficiary Problem Resolution Process;
- Incorporated applicable elements of former DMH Policy 302.04 - Triage and DMH Policy 302.12 - Provision of Services Without an Appointment.

If directly-operated or contracted providers have any questions related to this Bulletin, please contact the QA Unit NetworkAdequacy@dmh.lacounty.gov

Appendix D: Plan of Correction Form

Los Angeles County Department of Mental Health
 Quality Assurance Unit
 Policy & Technical Development Team

Access to Care – Plan of Correction

Date: _____
 Provider Name & Provider Number: _____
 Program Manager Name: _____
 Phone Number: _____ Email: _____
 Quality Assurance Representative/s Name: _____
 Phone Number: _____ Email: _____
 Contact(s): Name / Position: _____
 Phone Number: _____ Email: _____

Identification of Factors Contributing to Difficulties
1. Internal factors: <i>(Be sure to include any language/cultural issues, misunderstanding requirements, workflow issues, challenges with applications/technology)</i> 2. External factors: <i>(e.g., number of referrals sent over, service area coordination issues)</i>
Action Plan
1. Plan to address identified factors: 2. Responsible parties: 3. Estimated date of completion: _____
Process for Issuing NOABDs <i>(include responsible parties)</i>
For QA Staff Only
Acceptable Additional information needed

**Appendix E: Implementation Survey
Non-clinical Timeliness Strategy Implementation Survey**

May 2021

Thank you for submitting a completed Plan of Correction Template for DMH's Quality Assurance Unit's Access to Care Monitoring process. The purpose of this survey is to collect data on the impact of your action plans or other strategies in improving timely access to care within your program(s). Your program's responses will inform the Quality Improvement and Quality Assurance units on the effectiveness of timeliness improvement strategies designed and implemented by individual programs. We hope to organize the information and lessons learned into a resource for other programs or background information for countywide and DMH-led improvement efforts. There are no right or wrong answers – your input and time are much appreciated

* Required

1. Please enter the name of your program. *
2. Please enter the Provider Number of your program. *
3. What age group(s) does your program serve? Select all that apply *
 - Child (0-15 years)
 - Transition Age Youth (TAY; 16-25 years)
 - Adult (26-59 years)
 - Older Adult (60+ years)
4. On average, how many unique consumers does your program serve in a one-month period? *
5. For what type of appointments was your program asked to complete a POC? Select all that apply. *
 - Inpatient/Jail Release Discharge
 - Routine
 - Urgent

Plan of Correction (POC) Template Interventions - Service Requests

6. Did you identify Service Request Log (SRL) or Service Request Tracking System (SRTS) training and monitoring as a strategy on the POC? *
 - Yes
 - No

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7. Please select the outcome that best describes the status of your strategy. *
- Fully implemented (All elements of your strategy are completely finished.)
 - Partially implemented
 - Not yet implemented
 - Decided not to implement
8. How successful do you feel SRL or SRTS training and monitoring were in improving access to care? (1-Not successful, 2-Somewhat successful, 3-No change, 4-Successful, 5-Very successful) *
- 1 2 3 4 5
9. About how long did it take for you to see change after implementing your strategy?*
- Less than 1 week
 - 1-3 weeks
 - 1-2 months
 - 3 months or greater
10. What has caused you to not yet implement or decide not to implement the strategy?*
11. Did you identify training staff on timeliness standards as strategy on the POC? *
- Yes
 - No
12. Please select the outcome that best describes the status of your strategy. *
- Fully implemented (All elements of your strategy are completely finished.)
 - Partially implemented
 - Not yet implemented
 - Decided not to implement
13. How successful do you feel SRL or SRTS training and monitoring were in improving access to care? (1-Not successful, 2-Somewhat successful, 3-No change, 4-Successful, 5-Very successful) *
- 1 2 3 4 5
14. About how long did it take for you to see change after implementing your strategy?*
- Less than 1 week
 - 1-3 weeks
 - 1-2 months
 - 3 months or greater
15. What has caused you to not yet implement or decide not to implement the strategy?*

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16. Did you identify new intake positions/staff or departments as a strategy on the POC?*

- Yes
- No

17. Please select the outcome that best describes the status of your strategy. *

- Fully implemented (All elements of your strategy are completely finished.)
- Partially implemented
- Not yet implemented
- Decided not to implement

18. How successful do you feel SRL or SRTS training and monitoring were in improving access to care? (1-Not successful, 2-Somewhat successful, 3-No change, 4-Successful, 5-Very successful) *

1 2 3 4 5

19. About how long did it take for you to see change after implementing your strategy?*

- Less than 1 week
- 1-3 weeks
- 1-2 months
- 3 months or greater

20. What has caused you to not yet implement or decide not to implement the strategy?*

21. Did you identify reassignment of current staff to complete intakes as a strategy on the POC? *

- Yes
- No

22. Please select the outcome that best describes the status of your strategy. *

- Fully implemented (All elements of your strategy are completely finished.)
- Partially implemented
- Not yet implemented
- Decided not to implement

23. How successful do you feel SRL or SRTS training and monitoring were in improving access to care? (1-Not successful, 2-Somewhat successful, 3-No change, 4-Successful, 5-Very successful) *

1 2 3 4 5

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24. About how long did it take for you to see change after implementing your strategy?*

- Less than 1 week
- 1-3 weeks
- 1-2 months
- 3 months or greater

25. What has caused you to not yet implement or decide not to implement the strategy?*

26. Did you identify the creation of new intake slots as a strategy on the POC? *

- Yes
- No

27. Please select the outcome that best describes the status of your strategy. *

- Fully implemented (All elements of your strategy are completely finished.)
- Partially implemented
- Not yet implemented
- Decided not to implement

28. How successful do you feel SRL or SRTS training and monitoring were in improving access to care? (1-Not successful, 2-Somewhat successful, 3-No change, 4-Successful, 5-Very successful) *

1 2 3 4 5

29. About how long did it take for you to see change after implementing your strategy?*

- Less than 1 week
- 1-3 weeks
- 1-2 months
- 3 months or greater

30. What has caused you to not yet implement or decide not to implement the strategy?*

31. Did you identify creation/revision of referral workflows as a strategy on the POC? *

- Yes
- No

32. Please select the outcome that best describes the status of your strategy. *

- Fully implemented (All elements of your strategy are completely finished.)
- Partially implemented
- Not yet implemented
- Decided not to implement

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33. How successful do you feel SRL or SRTS training and monitoring were in improving access to care? (1-Not successful, 2-Somewhat successful, 3-No change, 4-Successful, 5-Very successful) *

1 2 3 4 5

34. About how long did it take for you to see change after implementing your strategy?*

- Less than 1 week
- 1-3 weeks
- 1-2 months
- 3 months or greater

35. What has caused you to not yet implement or decide not to implement the strategy?*

36. Did you identify increasing clinician caseload as a strategy on the POC? *

- Yes
- No

37. Please select the outcome that best describes the status of your strategy. *

- Fully implemented (All elements of your strategy are completely finished.)
- Partially implemented
- Not yet implemented
- Decided not to implement

38. How successful do you feel SRL or SRTS training and monitoring were in improving access to care? (1-Not successful, 2-Somewhat successful, 3-No change, 4-Successful, 5-Very successful) *

1 2 3 4 5

39. About how long did it take for you to see change after implementing your strategy?*

- Less than 1 week
- 1-3 weeks
- 1-2 months
- 3 months or greater

40. What has caused you to not yet implement or decide not to implement the strategy?*

41. Did you identify hiring new clinicians or staff to improve general/language capacity as a strategy on the POC? *

- Yes
- No

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42. Please select the outcome that best describes the status of your strategy. *

- Fully implemented (All elements of your strategy are completely finished.)
- Partially implemented
- Not yet implemented
- Decided not to implement

43. How successful do you feel SRL or SRTS training and monitoring were in improving access to care? (1-Not successful, 2-Somewhat successful, 3-No change, 4-Successful, 5-Very successful) *

1 2 3 4 5

44. About how long did it take for you to see change after implementing your strategy? *

- Less than 1 week
- 1-3 weeks
- 1-2 months
- 3 months or greater

45. What has caused you to not yet implement or decide not to implement the strategy? *

46. Did you identify increased internal timeliness monitoring with dashboards/reports/supervision as a strategy on the POC? *

- Yes
- No

47. Please select the outcome that best describes the status of your strategy. *

- Fully implemented (All elements of your strategy are completely finished.)
- Partially implemented
- Not yet implemented
- Decided not to implement

48. How successful do you feel SRL or SRTS training and monitoring were in improving access to care? (1-Not successful, 2-Somewhat successful, 3-No change, 4-Successful, 5-Very successful) *

1 2 3 4 5

49. About how long did it take for you to see change after implementing your strategy? *

- Less than 1 week
- 1-3 weeks
- 1-2 months
- 3 months or greater

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50. What has caused you to not yet implement or decide not to implement the strategy?*

51. Did you identify a different strategy other than the ones mentioned above? *

- Yes
- No

52. Please list the other strategies you implemented. *

53. Please select the outcome that best describes the status of your strategy. *

- Fully implemented (All elements of your strategy are completely finished.)
- Partially implemented
- Not yet implemented
- Decided not to implement

54. How successful do you feel SRL or SRTS training and monitoring were in improving access to care? (1-Not successful, 2-Somewhat successful, 3-No change, 4-Successful, 5-Very successful) *

1 2 3 4 5

55. About how long did it take for you to see change after implementing your strategy?*

- Less than 1 week
- 1-3 weeks
- 1-2 months
- 3 months or greater

56. What has caused you to not yet implement or decide not to implement the strategy?*

Timeliness Data Monitoring

57. Are you monitoring your timeliness data?

- Yes
- No

No Timeliness Tracking

58. What causes your program not to track timeliness data? *

Timeliness Tracking

59. Please enter the format or system you are using to monitor your timeliness data. For example, Excel spreadsheets. *

60. How often is your program reviewing your timeliness data? *

- Weekly
- Monthly
- Bi-monthly

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- Quarterly

61. What was your program's timeliness percentage when QA requested a completed POC Template? *

62. What is your program's current timeliness percentage for each of the types of appointments you were initially evaluated (Intake/Jail Release Discharge, Routine, and/or Urgent)?