MIDD Briefing Paper

BP 15 Central Access and Open Access

Existing MIDD Program/Strategy Review ☐ MIDD I Strategy Number _____ (Attach MIDD I pages)
New Concept ☒ (Attach New Concept Form)
Type of category: New Concept

SUMMARY: Central Access is an engagement strategy that offers a single contact point or central booking point for consumers to access appointments for behavioral health treatment services. This includes information about open access times and locations. Open Access is an engagement strategy whereby organizations offer assessments on the same day they are requested by the consumer, without a scheduling delay or waitlist. This improves the time from request for assistance to assessment and beginning the intervention and reduces barriers to accessing the behavioral health network. This strategy would expand services in both mental health and substance abuse (behavioral health treatment).

Collaborators:

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Subject Matter Experts and/or Stakeholders consulted for Briefing Paper preparation. List below.

Name	**Role**	**Organization**

The following questions are intended to develop and build on information provided in the New Concept Form or gather information about existing MIDD strategies/programs.

A. Description

1. **Please describe the New Concept or Existing MIDD Strategy/Program: Please be concise, clear, and specific. What is being provided to whom, under what circumstances? What are the New Concept Existing MIDD Strategy/Program goals? For New Concepts, does it relate to an existing MIDD strategy? If so, how?**

Central Access is an engagement strategy that offers a single contact point or central booking point for consumers to access appointments for behavioral health treatment services. This includes information about open access times and locations. Open Access is an engagement strategy whereby organizations offer assessments on the same day they are requested by the consumer, without a scheduling delay or waitlist. This improves the time from request for assistance to assessment and beginning the intervention and reduces barriers to accessing the behavioral health network. This strategy would expand services in both mental health and substance abuse (behavioral health treatment).

Access to behavioral health treatment services is scattered and difficult for the public, other system professionals, and behavioral health treatment system professionals seeking higher levels of care. Establishing a central single phone number where providers and members of the public can call and

make an appointment or access information on behavioral health treatment agencies that offer open access times would greatly improve behavioral health treatment access. This system improvement would establish a central access number and encourage open access appointment times at treatment agencies.

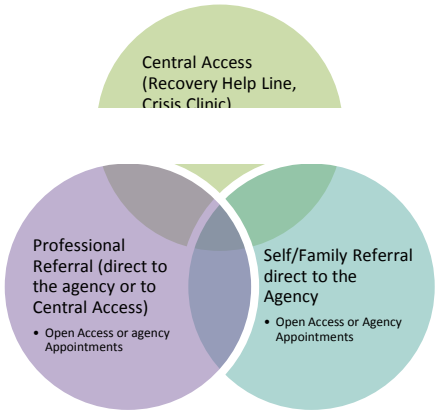
Definitions

- **Open Access** is an engagement strategy whereby organizations offer assessments on the same day they are requested by the consumer, without a scheduling delay or waitlist.
- **Next Day Appointments** is an engagement strategy that reduces wait times by offering appointments on the next business day through a central booking point. The central booking point may provide this service for multiple clinics/agencies.
- **Hybrid** is an engagement strategy that offers both Open Access and appointments. Open Access may be limited to a group of clients (Medicaid clients) or may only occur on certain days or times. The other time or clients may receive a set appointment.
- **Central Access** is an engagement strategy that offers a single contact point or central booking point for consumers to access appointments to services. This includes information about open access times and locations.

With system reform come opportunities to improve and expand services and access to behavioral health services. The current behavioral health treatment system is a mix of self/family referral and professional referral, often with guidance from information entities such as the Recovery Help Line or Crisis Clinic. Some agencies are providing Open Access Appointments using a hybrid system so there are hours of Open Access or walk-in and some level of set appointments. Other agencies are interested in exploring an Open Access system with no or very limited appointments. Encouraging the behavioral health treatment agencies in King County to offer a hybrid appointment system or Open Access system in support of Central Access would allow more complete engagement information to be available to those seeking services.

It has become apparent that a central access point of contact combined with open access availability will provide information, referral services, and linkages to the full range of voluntary behavioral health services for children, adults and older adults is both desired and needed. A central access point would not be the only point of access to services, but would allow those who are Medicaid eligible to self-refer, be referred by another professional (Screening, Brief Intervention Referral to Treatment-SBIRT, Primary Care, School), or for families seeking help for a loved one to get quality information and a rapid access to services including:

- self-help and peer support,
- outpatient, case management, medication support,
- dual diagnosis treatment,
- substance abuse services,
- behavioral health services for children with special education needs,
- 24-hour psychiatric emergency services, mobile crisis services, and a crisis hotline.
- involuntary assessment, inpatient hospitalization, and
- long-term care services for individuals found to be a danger to themselves or



others, or who are gravely disabled due to a psychiatric problem.

2. **Please identify which of the MIDD II Framework's four Strategy Areas best fits this New Concept/Existing MIDD Strategy/Program area** (Select all that apply):

☐ **Crisis Diversion** ☐ **Prevention and Early Intervention**

☒ **Recovery and Re-entry** ☒ **System Improvements**

Please describe the basis for the determination(s).

The Central Access and Open Access best fits within Recovery and Re-entry and Systems Improvements. Present access in to the behavioral health treatment system is either through professional referral (criminal justice, SBIRT, agency staff, social work staff) or by self/family referral directly to the behavioral health treatment agency. The Recovery Help Line housed through the Crisis Clinic provides information on behavioral health treatment locations and contact information for the general public and professionals in order begin the assessment and behavioral health treatment process. Gaining access to behavioral health treatment becomes a two or three part process that assists the individual in making a self/family referral, or assists the professional in helping their client make a self/family referral. At best this results in delays in starting behavioral health treatment.

B. Need; Emerging, Promising, Best, or Evidence Based Practices; Outcomes

1. **Please describe the Community Need, Problem, or Opportunity that the New Concept Existing MIDD Strategy/Program addresses: What unmet mental health/substance use related need for what group or what system/service enhancement will be addressed by this New Concept/Existing MIDD Strategy/Program? What service gap/unmet need will be created for whom if this New Concept Existing MIDD Strategy/Program is *not* implemented? Provide specific examples and supporting data if available.**

- There are multiple reasons why a systems change to include both open access and central access would benefit the system and client/consumer outcomes. Among those re the following: Potential clients and professional partners in the community (e.g., care managers in primary care, SBIRT clinicians, and school counselors) have a need to have information about how and where to access the system. A Central Access point could provide not only the information but could also provide the appointment or open access time.
- Entry into treatment or the time from the first contact to admission is an average of 17.5 days across all substance use disorder agencies in King County. The number of days for entry varies across the agencies with a high of 66.3 days and a low of 0 days.[1] These delays in initial access to treatment are compounded by an average delay of 7.9 days before initiation of treatment.
- King County clients have indicated that transportation issues, lack of motivation, scheduling challenges, lack of life skills to schedule and follow-through with future appointments, lack of availability of appointments account for 57.3 percent of the reasons for missed and no show appointments according to the 2014 DBHR WA State Provider Survey. These five issues can be addressed by reducing the wait times and acknowledging client need and ability.
- Currently mental health crisis appointments are available on a limited basis through the Crisis Clinic.

[1] WA State DBHR Substance Abuse Treatment Reports Outpatient Entry, Initiation and Engagement November 2014 to October 2015.

- Currently substance abuse residential treatment is contracted for directly by the state. However, when King County becomes a BHO, the County will be at full risk and have administrative responsibility for ensuring access to SUD Residential treatment. Creating a Central Access/Open Access will help mitigate risk by reducing the adverse effects of delayed access to behavioral health treatment.

2. Please describe how the New Concept/Existing MIDD Strategy/Program Addresses the Need outlined above.

A central access/open access to behavioral health treatment would streamline the process and reduce confusion and frustration potential clients may have finding the right place to access treatment, as well as the time for clients to begin behavioral health treatment. This both aids movement toward recovery and/or re-entry into the behavioral health system and vastly improves the behavioral health treatment delivery system.

3. What EVIDENCE exists that the approach of this New Concept/Existing MIDD Strategy/Program will successfully address the identified need? Please cite published research, reports, population feedback, etc. Why would this New Concept/Existing MIDD Strategy/Program be expected to work? If this is an existing MIDD I strategy, please provide evidence of the results from existing MIDD evaluation reports, including who has/has not benefited from this strategy.

- San Francisco developed the Treatment Access Program (TAP) that includes a toll free central access phone line. Consumers may access behavioral health services by calling the local or toll-free Central Access or by walking into any one of the clinic sites. Staff is available 24 hours, 7 days a week to assist with getting help[2]. The treatment on demand initiative, including TAP, resulted in increases in admissions and enabled more ready access to comprehensive treatments, increases in admissions by 18 to 25 year olds, and increases in admissions of people of color. [3].
- Mental health and substance use disorder treatment appointment no-shows adversely impact clinical outcomes and healthcare productivity. In one study, the interventions that had a significant positive impact on no-shows were: reducing wait times, using behavioral engagement strategies, and adding capacity. (Parikh et al., 2010)[4]
- In the medical literature, shorter wait times are associated with fewer missed appointments (Parikh et al., 2010)[5]. In this research, reducing waiting times by >10 percent affected no-show rates.
- The Network for the Improvement of Addiction Treatment (NIATx)[6] has multiple examples where moving to open access has improved both no show rates, and improved clinician productivity.

[2] San Francisco Department of Public Health website https://www.sfdph.org/dph/comupg/oservices/mentalHlth/TAP/default.asp

[3] Sears C, Davis T, Guydish J, Gleghorn A. Investigating the effects of San Francisco's treatment on demand initiative on a publicly-funded substance abuse treatment system: A time series analysis. Journal of Psychoactive Drugs. 2009; 41(3):297–304. [PubMed: 19999683]

[4] Parikh A, Gupta K, Wilson AC, Fields K, Cosgrove NM, Kostis JB. The effectiveness of outpatient appointment reminder systems in reducing no-show rates. The American Journal of Medicine. 2010; 123(6):542–548. [PubMed: 20569761]

[5] Parikh A, Gupta K, Wilson AC, Fields K, Cosgrove NM, Kostis JB. The effectiveness of outpatient appointment reminder systems in reducing no-show rates. The American Journal of Medicine. 2010; 123(6):542–548. [PubMed: 20569761]

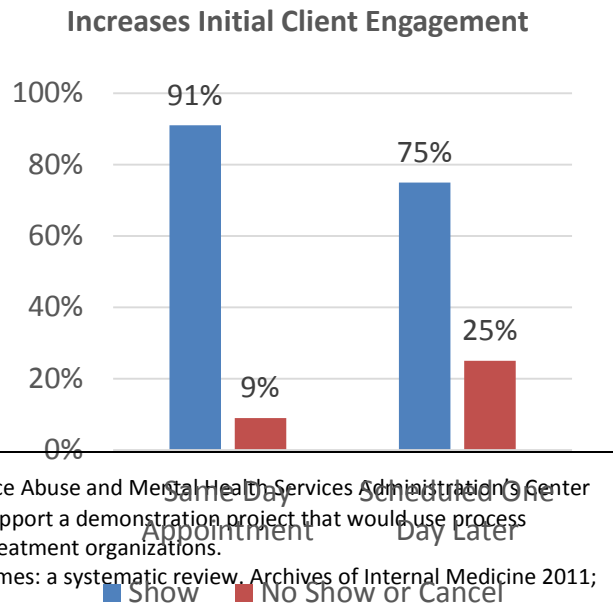
This suggests that behavioral health treatment organizations seeking to reduce no-shows in the early phases of behavioral health treatment should focus on strategies to reduce waiting times. Some clinics, in an attempt to eliminate waiting times completely, have replaced prescheduled appointments with walk-in appointments or patient-driven scheduling. Two clinics in this study went to solely walk-in appointments, while another five used a mix of walk-in and scheduled appointments. Systematic review by Rose, Ross, & Horwitz (2011)[7] discovered walk-in scheduling systems tend to be more effective with clinics that have existing no-show rates of >15 percent.[8]

Studies investigating how to reduce no-show rates have examined the effectiveness of practices such as reducing waiting times and using appointment reminders, along with behavioral engagement strategies such as contingency management and motivational interviewing. Williams, Latta, & Conversano (2008) demonstrated that when wait times were reduced from 13 to 0 days in out-patient mental health settings, no-shows dropped from 52 percent to 18 percent. Wait times can occur when demand outpaces capacity. Adding more counselors and appointments can accommodate demand for treatment. In other instances, streamlining processes reduces the workload of intake specialists, increasing their capacity to meet higher demand (Sears, Davis, Guydish, & Gleghorn, 2009)[9].

NIATX also addresses wait times with a client focused approach and recommends adjusting staff schedules to match client demand, streamlining paperwork, and using non-clinical staff to complete the non-clinical portions of the initial appointment. Each NIATx Promising Practice has resulted in opening additional assessment slots available when clients arrive for walk-in appointments.[10]

4. **Please specify whether this New Concept/Existing MIDD Strategy/Program is a/an: Best Practice Please detail the basis for this determination. Please include a citation or reference supporting the selection of practice type.**

Central Access/Open Access, also known as Same Day Appointments offer "An engagement strategy whereby organizations offer assessments on the same day they are requested by the consumer, without a scheduling delay or waitlist. This results in quicker access for the assessment and eradication of consumer no shows for assessments." – *National Council for Behavioral Health Webinar May 2015*



[6] The Robert Wood Johnson Foundation (RWJF) and the Substance Abuse and Mental Health Services Administration's Center for Substance Abuse Treatment (CSAT) combined resources to support a demonstration project that would use process improvement techniques within participating drug and alcohol treatment organizations.

[7] Rose KD, Ross JS, Horwitz LI. Advanced access scheduling outcomes: a systematic review. Archives of Internal Medicine 2011; 171(13): 1150-1159.

[8] Molfenter, 2013

[9] Sears C, Davis T, Guydish J, Gleghorn A. Investigating the effects of San Francisco's treatment on demand initiative on a publicly-funded substance abuse treatment system: A time series analysis. Journal of Psychoactive Drugs. 2009; 41(3):297–304. [PubMed: 19999683]

[10] Niatx.net http://www.niatx.net/toolkits/provider/PP_AdjustStaffSchedules.pdf

The Network for the Improvement of Addiction Treatment (NIATx) teaches participating substance abuse treatment agencies to use process improvement strategies to increase client access to, and retention in, treatment. NIATx recommends five principles to promote organizational change. The first of those principles is to "understand and involve the customer."

Figure 2 from the National Council for Behavioral Health webinar illustrates the opportunity of open access assessment appointment.

Figure 1: MTM Webinar National Council for Behavioral Health

Please see response to B3 for additional information.

Below are two examples from The Center for Drug Free Living and Central New York Services from NIATx that illustrate the potential outcomes from moving to an appointment driven assessment system to Open Access.

NIATx Promising Practice: ***The Center for Drug Free Living in Orlando, Florida reduced waiting times for treatment by implementing walk-in appointments. At first they held walk-in hours from 1-3 p.m. Monday through Thursday and gave clients the choice of scheduling an appointment or using the walk-in hours. Later, they shifted the walk-in hours to 8:30 a.m. Monday through Thursday and eliminated scheduled assessments altogether. This change eliminated their waiting list for outpatient treatment and is now an established program policy. Their automated voice messaging system now explains the walk-in procedure in detail.***

NIATx Promising Practice: Central New York Services in Syracuse, New York eliminated both waiting times (from 36 days) and no-shows for assessments (from 50 percent) by offering walk-in appointments on a first-come, first-served basis. Billable assessments increased from 38 to 71 in the first month. They informed their referral sources about this change, contacted all clients with existing appointments to explain the new process, and posted a description of the process in the clinic.

5. **What OUTCOMES would the County see as a result of investment in this New Concept/Existing MIDD Strategy/Program? Please be as specific as possible. What indicators and data sources could the County use to measure outcomes?**

Treatment organizations, already struggling to meet demand and client needs, will need strategies that improve the quality of care they provide without significantly increasing costs. The five NIATx principles have potential for helping agencies achieve these goals. (Hoffman, Green, & al, 2012)

Figure 5 & 6, show that decreasing the missed/no show appointment accomplishes both a decrease in cost and increase in clinician/staff productivity. Data source for the change include both agency level reports, information from the Central Access data base and from scheduling software used.

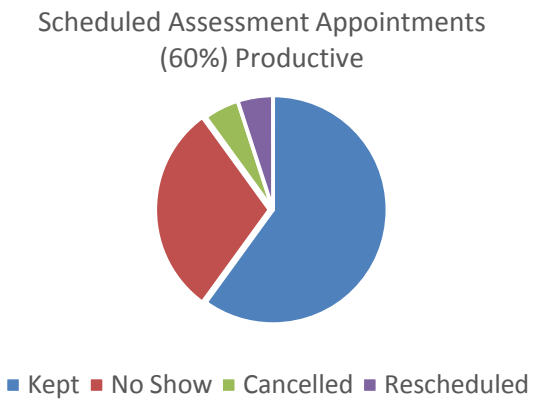


Figure 2: MTM Webinar National Council for Behavioral Health

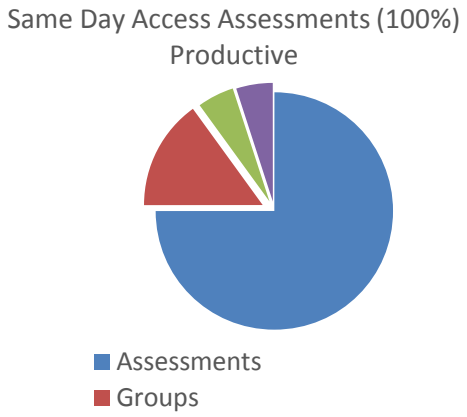


Figure 3: MTM Webinar National Council for Behavioral Health

A cross-site evaluation of NIATx agencies found significant improvements in delivery of care, including a 37 percent decline in days to admission, an 18 percent gain in retention in care between the first and second treatment session, and a 17 percent gain in retention between the first and third treatment session. A second NIATx cohort replicated the improvements.[11] [12] Through a Central Access/Open Access model, King County would anticipate similar improvements from behavioral health treatment agencies using the same process.

Although the ability to measure this is limited, one outcome of entralized access may be fewer people giving up on attempting to access treatment, greater satisfaction with the treatment entry process. A reduction in the number of calls someone needs to make to connect with an appropriate treatment provider can be expected.

C. Populations, Geography, and Collaborations & Partnerships

[11] McCarty D, Gustafson DH, Wisdom JP, et al. The Network for the Improvement of Addiction Treatment (NIATx): Enhancing access and retention. Drug and Alcohol Dependence. 2007 May 11;88(2–3):138–45. [PubMed: 17129680]

[12] Hoffman KA, Ford JH, Choi D, Gustafson DH, et al. Replication and sustainability of improved access and retention within the Network for the Improvement of Addiction Treatment. Drug and Alcohol Dependence. 2008 Nov 1; 98(1–2):63–9. [PubMed: 18565693]

1. **What Populations might directly benefit from this New Concept/Existing MIDD Strategy/Program:** (Select all that apply):

☐ **All children/youth 18 or under**	☒ **Racial-Ethnic minority (any)**
☐ **Children 0-5**	☒ **Black/African-American**
☐ **Children 6-12**	☒ **Hispanic/Latino**
☒ **Teens 13-18**	☒ **Asian/Pacific Islander**
☒ **Transition age youth 18-25**	☒ **First Nations/American Indian/Native American**
☒ **Adults**	☒ **Immigrant/Refugee**
☒ **Older Adults**	☒ **Veteran/US Military**
☐ **Families**	☒ **Homeless**
☐ **Anyone**	☒ **GLBT**
☒ **Offenders/Ex-offenders/Justice-involved**	☒ **Women**
☐ **Other – Please Specify:**	

Please include details about this population such as: individuals transitioning from psychiatric hospital to community; individuals judged incompetent by the court; children of drug users who are in foster care, etc.

Anyone seeking information or an appointment to enter behavioral health treatment would benefit from the Central Access/Open Access model. Depending on the scope of the Central Access/Open Access provided, appointments could be for mental health and substance use disorder treatment (both outpatient and inpatient), detox (more likely targeted to other professionals seeking services for a client; e.g., Screening Brief Intervention Referral to Treatment (SBIRT) counselors).

2. **Location is an important factor in the availability and delivery of services. Please identify whether this New Concept/Existing MIDD Strategy/Program addresses a specific geographic need in the following area. Please provide additional that discusses the basis for the selection**: County-wide

Central Access is provided via telephone and therefore access is countywide. Open/hybrid Access would include all behavioral health treatment agencies and would be offered countywide.

3. **What types of COLLABORATIONS and/or PARTNERSHIPS may be necessary to implement this New Concept/Existing MIDD Strategy/Program, and with whom (other jurisdictions & cities, law enforcement, first responders, treatment providers, departments within King County, housing, employers, etc.)? Please be specific.**

Partners in moving to a Central Access/Open Access model will be the current and any new behavioral health treatment providers within the King County system. Utilizing any current capacity of the Crisis Clinic, Recovery Help Line (A statewide 24-Hour helpline for Substance Abuse, Problem Gambling & Mental Health, provided by Crisis Clinic, funded by the Washington State Department of Social and Health Services' Division of Behavioral Health and Recovery[13]) would be essential.
An additional partnership would be with a medical scheduling software provider. Collaborations include the National Council for Behavioral Health and/or NIATx for consultation and technical assistance to

[13] http://www.warecoveryhelpline.org/contact/

assist King County partner behavioral health treatment agencies in developing an Open/Hybrid Access capacity at their sites and streamlining the countywide system.

D. Drivers, Barriers, Unintended Consequences, and Alternative Approaches

1. What FACTORS/DRIVERS, such as health care reform, changes in legislation, etc. might impact the need for or feasibility of this New Concept/Existing MIDD Strategy/Program? How?

Health care reform and the creation of behavioral health organizations have an impact and are drivers moving the behavioral health system to be more efficient. Medicaid standards on moving individuals from contact into assessment/treatment are also drivers for the BHO to be more efficient. The largest driver to create a more efficient system is the needs of the behavioral health treatment agencies to be both cost and personnel efficient. A Central Access/Open Access model is a proven model that addresses each of these drivers. There are four outcomes that can be expected according to NIATx[14]:

- Reduced waiting time for initial and emergent appointments;
- Reduced no-shows;
- Increased revenue; and
- Reduced costs.

2. What potential BARRIERS, if any, might there be to implementation? How might these be overcome? Who would need to be involved in overcoming them?

According to the National Council for Behavioral Health, there are a number of reasons why initiation of open access and/or central access is not successful. Among those reasons are:

- anxiety about the change,
- past failures,
- failure to use data (i.e., demand and optimal hours of operation) to structure the change, and
- Failure to review the process and make improvements/solve issues on an ongoing basis.

Conversations with providers and experiences have shown that without agency acceptance and support, a Central Access/Open Access system will go underutilized and will not be fully adopted. Past challenges that have been barriers have included:

- Limited appointment times and few agencies using an Open Access model or Hybrid model for appointments;
- Client dissatisfaction when Open Access is poorly implemented, resulting in long wait times or no appointments available;
- Hurdles in establishing Medicaid or ADATSA (Washington State substance abuse treatment program) eligibility (prior to January 2014) meant that individuals or professional calling for an appointment had to have already established financial eligibility. This created a financial disincentive for agencies to offer appointments with no assurance that payment could be billed for the assessment;
- Electronic Health Record (EHR) systems were unsophisticated or non-existent that included scheduling of appointments; and
- An excess of data entry requirements.

[14] http://www.niatx.net/Story/StoryDetails.aspx?id=140

King County in partnership with Crisis Clinic has pilot tested a Central Access/Open Access model; lessons learned will assist with overcoming the identified barriers, along with working with King County behavioral health treatment providers as partners to ensure successful implementation.

Full implementation of this model would require enhanced and ongoing communication between provider partners and the County to resolve issues, make process improvements, and ensure utilization of the tools. Provider interest in participation would be a key driver for success. The entire implementation plan would need to be developed in collaboration with provider partners to ensure participation and adoption of the model.

3. **What potential UNINTENDED CONSEQUENCES might exist if this New Concept/Existing MIDD Strategy/Program is implemented? Please be specific---for whom might there be consequences?**

One potential unintended consequence that might exist if the Central Access/Open Access model is implemented is for the system to become overloaded with more requests for treatment services than present behavioral health treatment system capacity is able to handle. This could then result in long in-person wait terms, or individuals needing to leave without being seen. Reception area management needs to be well-thought out, particularly if clients may be agitated and/or withdrawal. If well-implemented, these types of consequences should be able to be well-managed and avoided. In order to assure the redesigned system is workable for both providers and clients, data should drive the design and planning for implementation of the Central Access/Open Access model. Data and planning needs include:

- Determining demand and optimal hours of operation,
- Selecting a workable staffing model,
- Choreographing client waiting time,
- Reviewing, and reducing data gathering and duplicative/ unnecessary paper work
- Creating a transition plan,
- Evaluating the success of the transition during implementation and engaging in ongoing quality improvement.

4. **What potential UNINTENDED CONSEQUENCES might there be if this New Concept/Existing MIDD Strategy/Program is *not* implemented? Please be specific---for whom might there be consequences?**

The unintended consequences of not implementing the Central Access/Open Access model is business as usual; business as usual does not address the need to increase efficiency and provide more rapid initial access to treatment and better use of limited staff resources. Without open access, Individuals who are ambivalent about accessing treatment may fail to follow through on entering treatment if they cannot be seen at the time they are feeling acute need. Those who greatly desirous of treatment will continue to experience the frustration of what are sometimes long waits to access treatment.
If Central Access is not implemented, the fragmented, piecemeal, trial and error approach of calling agencies will continue for individuals attempting to access treatment for themselves or on behalf of others. Some individuals may give up in frustration.

5. **What ALTERNATIVE APPROACHES currently exist to address this need apart from this New Concept/Existing MIDD Strategy/Program? At a high level, how does this New**

Concept/Existing MIDD Strategy/Program compare to those other approaches in terms of cost, feasibility, etc. Could this New Concept/Existing MIDD Strategy/Program be merged with one or more of the alternatives? What are the pros/cons of merging?

Health care providers are increasingly under pressure to implement evidence-based decision making and reduce inefficiency and errors in general medical care.[15] The Institute of Medicine's *Crossing the Quality Chasm*[16] called for health care organizations to improve their quality of care through redesigning care processes and systems. More recently, these recommendations were extended to services for alcohol, substance, and mental health problems.[17] Yet, the organizational structures of most substance abuse treatment agencies are weak and demand is great, leaving the system unable to meet additional demands for access or for better quality care.[18]

There are currently no MIDD strategies that address initial access to the treatment system for non-crisis clients. Some agencies are providing Open Access Appointments using a hybrid system so there are hours of Open Access or walk-in and some level of set appointments. Other agencies are interested in exploring an Open Access system with no or very limited appointments. Encouraging treatment agencies to offer a Hybrid appointment system or Open Access system in support of Central Access would allow more complete engagement.

E. Countywide Policies and Priorities

1. **How does this New Concept/Existing MIDD Strategy/Program FIT within the CONTINUUM of care, and within other county initiatives such as Behavioral Health Integration, Health and Human Services Transformation, Best Starts for Kids, All Home, the Youth Action Plan, and/or the Vets and Human Services Levy or any other County policy work?**

Overall goals that improve efficiency, save money, improve staff utilization, reduce missed appointments, and provide better, faster, and more effective care are important to strive for and cross over all aspects of the continuum of care. The Central Access/Open Access model is one proven model that could positively impact the behavioral health system.

Behavioral Health Integration, Health and Human Services Transformation, and All Home all speak to the importance of having access to care when needed as essential. The creation of a Central Access/Open Access model integrates is consistent with this priority. All Home has been engaging in moving each of its systems to central access and could be a valuable technical assistance resource for implementation efforts.

2. **How is this New Concept/Existing MIDD Strategy/Program rooted in principles of recovery, resiliency, and/or trauma-informed care?**

[15] Institute of Medicine. Crossing the quality chasm: A new health system for the 21st century. 1. Washington, D.C: National Academy Press; 2001.
Institute of Medicine. To err is human: Building a safer health system. Washington, D.C: National Academy Press; 2000.

[16] http://iom.nationalacademies.org/Reports/2001/Crossing-the-Quality-Chasm-A-New-Health-System-for-the-21st-Century.aspx

[17] Institute of Medicine. Improving the quality of health care for mental and substance-use disorders: Quality chasm series. Washington, D.C: National Academy Press; 2006.

[18] McLellan AT, Carise D, Kleber HD. Can the national addiction treatment infrastructure support the public's demand for quality care? Journal of Substance Abuse Treatment. 2003 Sep; 25(2):117–21. [PubMed: 14680015]

As demand for behavioral health treatment services grows beyond current service capacity and resources, process improvement becomes even more important for patients and staff in behavioral healthcare settings.[19] Access to care and fast efficient engagement, assessment and beginning treatment are the primary beginnings of recovery journey.

At a 2004 National Consensus Conference on Mental Health Recovery and Mental Health Systems Transformation convened by Substance Abuse Mental Health Services Administration (SAMHSA), patients, health-care professionals, researchers and others agreed on 10 core principles undergirding a recovery orientation.[20] A Central Access/Open Access model leads to recovery and includes the following recovery principles: Self-direction: Consumers determine their own path to recovery; Individualized and person-centered: There are multiple pathways to recovery based on individuals' unique strengths, needs, preferences, experiences and cultural backgrounds; and respect: Acceptance and appreciation by society, communities, systems of care and consumers themselves are crucial to recovery.[21]

3. How does this New Concept/Existing MIDD Strategy/Program enact and further the County's EQUITY and SOCIAL JUSTICE work?

Expansion of the Affordable Care Act (ACA)[22] brought insurance coverage to nearly 200,000 additional people in King County.[23] However many individuals of color remain uninsured and continue to have unmet medical needs.

There is approximately a 10 year gap in life expectancy between areas of South King County where a higher concentration of people of color, limited English proficiency (LEP), and low-income households reside and North and East King County.[24]

Health and human services access remains an issue despite the increase in the number of those insured due the ACA. Expansion of access and improving ease of access to behavioral health services provides direct assistance in both saving lives and sustaining recovery.

The Central Access/Open Access model enacts and furthers the County's equity and social justice work by creating an access system to the behavioral health treatment system that is "fair and just" and intentionally works towards ensuring equal access to anyone seeking behavioral health care within the publicly funded King County system. Centralized Access will give all individuals in need of publicly-funded behavioral health treatment fair access to services.

[19] Kim A. Hoffman, Ph.D.1, Carla A. Green, Ph.D.2, James H. Ford II, Ph.D.3, Jennifer P. Wisdom, Ph.D., M.P.H.4, David H. Gustafson, Ph.D.3, and Dennis McCarty, Ph.D. Improving quality of care in substance abuse treatment using five key process improvement principles Journal of Behavioral Health Services Res. 2012 July ; 39(3): 234–244. doi:10.1007/s11414-011-9270-y.
[20] A http://www.apa.org/monitor/2012/01/recovery-principles.aspx
[21] http://www.apa.org/monitor/2012/01/recovery-principles.aspx
[22] The Affordable Care Act actually refers to two separate pieces of legislation — the Patient Protection and Affordable Care Act (P.L. 111-148) and the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152) — that, together expand Medicaid coverage to millions of low-income Americans and makes numerous improvements to both Medicaid and the Children's Health Insurance Program (CHIP).https://www.medicaid.gov/affordablecareact/affordable-care-act.html
[23] King County ESJ Annual Report, 2013. pp 9
[24] King County ESJ Annual Report, 2013. pp 9

F. Implementation Factors

1. What types of RESOURCES will be needed to implement this New Concept/Existing MIDD Strategy/Program (staff, physical space, training, UA kits, etc.)**?**

The following resources are needed to implement the Central Access/Open Access model:

1. A full time county staff Program Manager familiar with Project Management and LEAN/Kaizen[25] techniques in a two year term-limited temporary (TLT) position to assist in the management of consulting services and to work directly with behavioral health treatment agencies to implement Open/Hybrid Access. This includes using the NIATx developed Promising Practices to accomplish the following:
    - Eliminate Excessive Paperwork (at the treatment agency and within the County);
    - Review and work with the agencies to adjust staff schedules to meet demand;
    - Recommend non-clinical tasks to be re-assigned from clinical staff; and
    - Centralize appointment scheduling, including working with a Central Access point.
2. Work with NIATx, National Council for Behavioral and their recommended consultant for training and to assist with the Central Access and Open Access change and any difficult challenges that occur.
3. Financial assistance for agencies willing to adopt and implement Open/Hybrid Access and use of a Central Access model; and
4. Funding for training space and reimbursement for staff attending training.

2. Estimated ANNUAL COST. $100,001-500,000 Provide unit or other specific costs if known.

The pilot program, funded by a SAMHSA grant, was $195,000 per year; full implementation costs would be approximately $250,000 for Central Access/Open Access model staffing and software.
Consultant costs are estimated to be $25,000. This includes training and consultation with the behavioral health agencies.
Personnel cost for a Project Manager would approximately $129,600 (Salary $78,650, Benefits/Employer Costs $ $25,950, office space/IT $15,000, travel & other costs $10,000)
Total Central Access/Open Access model project costs are $404,600

3. Are there revenue sources other than MIDD that could or currently fund this work? Clarify response, citing revenue sources.

Discussions with NIATx and Substance Abuse Mental Health Services Administration (SAMHSA) may lead to some technical assistance being provided for the implementation of Central Access/Open Access without cost. However, there are no other firm funding sources at this time.

4. TIME to implementation: Less than 6 months from award

a. What are the factors in the time to implementation assessment?

There is a current pilot project serving several behavioral health treatment agencies working with Crisis Clinic/Recovery Help Line and a medical appointment scheduling software. Utilizing the existing resource and learning from the pilot experience will shorten the time to develop a wider spread Central Access/Open Access model for the entire King County behavioral health system.

b. What are the steps needed for implementation?

The following steps are an estimated timeline for implementation:

[25] "Lean is a methodology that eliminates waste and boosts efficiency. Kaizen means continuous improvement. This course merges both philosophies. Lean Kaizen helps you get rid of waste and continuously implement best practices." http://asq.org/training/lean-kaizen-a-simplified-approach-to-process-improvement_KAIZEN.html

Month	Stakeholders	Desired Outcomes
January 2017	Staff, provider work group members, crisis clinic	• Hiring King County project manager • Creation of the Central/Open Access provider work group • Research and selection of scheduling software • Research and gathering of information to assist in developing Open Access/Hybrid Access models
February 2017	Staff, provider work group members, crisis clinic	• Discussions/presentation to providers of Open Access/Hybrid Access models • Solicit providers to help pilot and develop Open Access/Hybrid Access models
March 2017	Staff, provider work group members, crisis clinic	• Pilot Open Access/Hybrid Access models at first provider • Pilot Open Access/Hybrid models at second provider • Discuss/presentation to providers about progress
April 2017	Staff, provider work group members, crisis clinic	• Pilot Central Access scheduling software • Pilot Open Access/Hybrid models with provider • Develop and draft the evaluation plan
May 2017	Staff, provider work group members, crisis clinic	• Review progress, challenges with stakeholders • Schedule implementation to begin January 2017 with providers coming on board using Open Access/Hybrid Access model and Central Access scheduling
June 2017	Staff, provider work group members, crisis clinic	• 1/3 of providers implement Open Access/Hybrid Access model and Central Access scheduling
July 2017	Staff, provider work group members, crisis clinic	• 1/3 of providers implement Open Access/Hybrid Access model and Central Access scheduling
August 2017	Staff, provider work group members, crisis clinic	• 1/3 of providers implement Open Access/Hybrid Access model and Central Access scheduling
September through December 2017	Staff, provider work group members, crisis clinic	• Review implementation and address any unresolved or new issues/challenges • Prepare and gather data for evaluation of both the Central Access system and the Open Access system

c. Does this need an RFP?

- It may be possible to issue a sole source contract for the consulting work; if not, a RFP would be needed.
- The software for implementation of Central Access/Open Access model, if purchased by the County, would need to go through the appropriate procurement process for software.

G. Any OTHER INFORMATION that would assist reviewers with making recommendations about this New Concept/Existing MIDD Strategy/Program? (optional). Do you have suggestions regarding this New Concept/Existing MIDD Strategy/Program?

New Concept Submission Form

#15

Working Title of Concept: Central Access and Open Access

Name of Person Submitting Concept: Geoff Miller & Brad Finegood

Organization(s), if any: KCMHCADSD
Phone: 206-263-8960, 206-263-8087
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Mailing Address: 401 5th Avenue, Suite 400, Seattle, WA 98104

Please note that county staff may contact the person shown on this form if additional information or clarification is needed.

Please share whatever you know, to the best of your ability.
*Concepts must be submitted via email to MIDDconcept@kingcounty.gov by **October 31, 2015**.*

1. Describe the concept.
Please be specific, and describe new or expanded mental health or substance abuse-related services specifically.

Central Access is an engagement strategy that offers a single contact point or central booking point for consumers to access appointments to services. This includes information about open access times and locations. Open Access is an engagement strategy whereby organizations offer assessments on the same day they are requested by the consumer, without a scheduling delay or waitlist. Together they work to improve the time from request for assistance to assessment and beginning the intervention along with reduce barriers to accessesing the current behavioral health network. This strategy would expand services in both mental health and substance abuse.

2. What community need, problem, or opportunity does your concept address?
Please be specific, and describe how the need relates to mental health or substance abuse.

It has become apparent that a central access system that will provide information, referral services, and linkages to the full range voluntary behavioral health services for children, adults and older adults is both desired and needed. A central access point would not be the only point of access to services, but would allow those who are Medicaid eligible to self-refer, be referred by another professional (SBIRT, Primary Care, School), or for families seeking help for a loved one to get quality information and a rapid access to services including:

- self-help and peer support,
- outpatient, case management, medication support,
- dual diagnosis treatment,
- substance abuse services,
- behavioral health services for children with special education needs,
- 24-hour psychiatric emergency services, mobile crisis services, and a crisis hotline.
- involuntary assessment, inpatient hospitalization, and
- long-term care services for individuals found to be a danger to themselves or others, or who are gravely disabled due to a psychiatric problem.

GEOFF: PROBABLY WANT TO THROW SOMETHING IN HERE ABOUT BARRIERS TO PEOPLE ACCESSING APPOINTMENTS WHEN NEEDED IN THE BH SYSTEM. MISSING VALUABLE ENTRY WINDOWS, GETTING

PEOPLE THE SERVICE THEY NEED WHEN THEY NEED IT. SAME DAY, NO WAIT. ALSO ALIGNS WITH FULL INTEGRATION.

3. How would your concept address the need?
Please be specific.

Addiction appointment no-shows adversely impact clinical outcomes and healthcare productivity. The interventions that had a significant positive impact on no-shows were reducing wait times, using behavioral engagement strategies, and adding capacity. In the medical literature, shorter wait times are associated with fewer missed appointments (Parikh et al., 2010). In this research, reducing waiting times by >10% affected no-show rates. This suggests that treatment organizations seeking to reduce no-shows in the early phases of addiction treatment should focus on strategies to reduce waiting times. Some clinics, in an attempt to eliminate waiting times completely, have replaced prescheduled appointments with walk-in appointments or patient-driven scheduling. Two clinics in this study went to solely walk-in appointments, while another five used a mix of walk-in and scheduled appointments. Systematic review by Rose, Ross, & Horwitz (2011) discovered walk-in scheduling systems tend to be more effective with clinics that have existing no-show rates of >15%. (Molfenter, 2013)

Central access also help eliminate system fragmentation and provides both professionals assisting clients to access treatment, but also assist the general public in gathering information about system access for themselves or for a family member.

4. Who would benefit? Please describe potential program participants.

There are multiple reasons why a systems change to include both open access and central access would benefit the system and client/consumer outcomes. Among those reasons are the following:

- Our potential clients and professional partners in the community (e.g., care managers in primary care, SBIRT clinicians, and school counselors) have a need to have information about how and where to access the system. A Central Access point could provide not only the information but could also provide the appointment or open access time.
- Our clients have indicated that transportation Issues, lack of motivation, scheduling challenges, lack of life skills to schedule and follow-through with future appointments, lack of availability of appointments account for 57.3% of the reasons for missed and no show appointments according to the 2014 DBHR WA State Provider Survey. These five issues can be addressed by reducing the wait times and acknowledging client need and ability.
- In one study, the interventions that had a significant positive impact on no-shows were: reducing wait times, using behavioral engagement strategies, and adding capacity.
- In the medical literature, shorter wait times are associated with fewer missed appointments (Parikh et al., 2010). In this research, reducing waiting times by >10% affected no-show rates.
- NIATx has multiple examples where moving to open access has improved both no rates, but also improved clinician productivity.
- The requirements to become a BHO include a detailed response that includes a transition plan, coordination of services plan, and a communications (stakeholders, consumers) plan.
- Currently mental health crisis appointments are available on a limited basis through the Crisis Clinic.
- Currently substance abuse residential treatment is contracted for directly by the state. However, when we become a BHO we will be at full risk and have administrative responsibility for ensuring access to SUD Residential treatment.

5. What would be the results of successful implementation of program?

Include outcomes that could be measured and evaluated. Please indicate whether this data is currently collected in some fashion, and in what form.

Improvements in treatment access will assist meeting our time requirments under Medicaid. Faster time from contact to appointment will reduce the harm done to the individual health by shortening the time to treatment. Reduction in no show rates will be both cost effective for the agency and directly benefit the overall health of those seeking treatment. Most importantly, improved client outcomes will result.

6. Which of the MIDD II Framework's four strategy areas best fits your concept? (you may identify more than one)

☐ **Prevention and Early Intervention:** Keep people healthy by stopping problems before they start and preventing problems from escalating.

☐ **Crisis Diversion:** Assist people who are in crisis or at risk of crisis to get the help they need.

☒ **Recovery and Reentry:** Empower people to become healthy and safely reintegrate into community after crisis.

☒ **System Improvements:** Strengthen the behavioral health system to become more accessible and deliver on outcomes.

7. How does your concept fit within the MIDD II Objective – to improve health, social, and justice outcomes for people living with, or at risk of, mental illness and substance use disorders?

Improving access to treatment will directly improve health outcomes for those needing behavioral health interventions.

8. What types of organizations and/or partnerships are necessary for this concept to be successful? Examples: first responders, mental health or substance abuse providers, courts, jails, schools, employers, etc.

The Crisis Clinic and Recovery Help Line are currently doing a small pilot linking those seeking an appointment including our SBIRT clinician in primary care and EDs to five of our treatment agency using scheduling software accessable through a secure cloud service.

9. If you are able to provide estimate(s), how much funding per year do you think would be necessary to implement this concept, and how many people would be served?

Pilot/Small-Scale Implementation:	**$ 200,000 per year, serving 2,000 to 5,000 people per year**
Partial Implementation:	**$ 250,000 per year, serving 5,000 to 6,000 people per year**
Full Implementation:	**$ 350,000 per year, serving 5,000 to 10,000 people per year**

Once you have completed whatever information you are able to provide about your concept, please send this form to *MIDDConcept@kingcounty.gov*, no later than 5:00 PM on October 31, 2015.

If at any time you have questions about the MIDD new concept process, please contact MIDD staff at *MIDDConcept@kingcounty.gov*.