Culture by Design:
How GCC Brought Just-in-Time Rapid Access Psychiatry Scheduling to Life

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2026 Texas Council Conference

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A Future Focused on Access, Care, and Community Well-being

Mission

To provide accessible, efficient and quality services to support the independent and healthy living of those we serve

Vision

Better community healthcare promoting healthy living

Focus

A Focus on Access, Provision, and Expansion of Services

Our Why

Excellence

Improving Population Health

- Risk management pooling
- Preventive Care
- Socio-economically impactful

Reducing Cost of Care

- Productivity
- Sustainability
- Cost effective
- Comparatively effective

Quadruple Aim

Patient Experience

- Patient Satisfaction
- Outcomes
- Quality
- Safety

Provider Experience

- Provider Satisfaction
- Work/Life Balance
- Workflow optimization

What is a CEO responsible for?

Culture, People and Numbers

Culture

Strengthening values, collaboration, and innovation

People

Enhancing staff efficiency, reducing burnout, and improving care

Numbers

Increasing productivity, optimizing financial outcomes, and ensuring compliance

Kotter's Change Model

Survive

Reacting • Overwhelmed • Maintaining the status quo

↓

Thrive

Purpose-driven • Innovative • Confident • Future-focused

GCC chooses to THRIVE — together.

Living Out Our Values

Our values are part of our DNA, intricately woven into who we are & how we serve

H	E	A	L	T	H	Y
Humanity	**Excellence**	**Accountability**	**Loyalty**	**Teamwork**	**Honor**	**You**
Creates more time for person-centered care	Boosts operational efficiency and innovation	Ensures compliance and quality assurance	Supports family involvement through accurate records	Enhances collaboration and documentation transparency	Promotes self-direction and continuous learning	Strengthens community partnerships with data-driven insights

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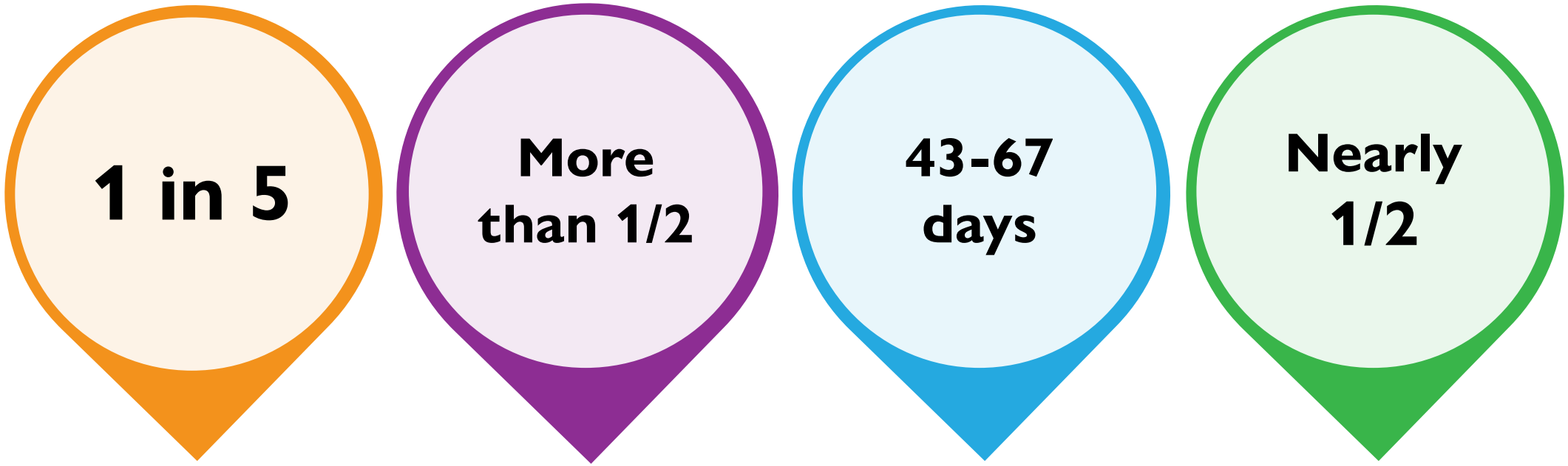
Better community healthcare promoting healthy living.

Learning Objectives

1. **Define the core components** of Just-in-Time (JIT) psychiatry scheduling, i.e. Rapid Access Scheduling, and their functions in safety net mental health settings.
2. Compare how **Rapid Access** strategies, including rapid access scheduling, real-time scheduling flexibility, and walk-in capacity, **influence no-show rates and care continuity**.
3. Apply methods for **aligning** JIT psychiatry workflows **with organizational systems**, including staffing, communication structures, and Mission, Vision, and Values.

Rapid Access Scheduling: Why, How & When

The Problem: Mental Health Access Crisis



Number of US adults with a Mental Health disorder

US adults with a MH disorder that receive no treatment

Median wait time for a new psychiatric outpatient appointment

Persons presenting to psychiatric EDs with no outpatient MH treatment in last 2yrs

Why Traditional Scheduling Fails Safety Net

- Traditional scheduling ***assumes*** stable housing, reliable transportation, and predictable schedules.
- Safety net ***reality***: high clinical acuity and crisis cycling, competing survival priorities, rapid symptom fluctuation.

Result: long waits → symptom escalation; high no-show rates; increased ED and inpatient utilization.

What we were hearing in 2024:

"Individuals come for help, and we are creating barriers to their care."

"Community Partners tell me that services are difficult to access."

The system isn't working.

What we were seeing in 2024:

- The **Average Wait Time** was **49.6 dd** for an Initial Mental Health Assessment with psychiatry,y with a **No-Show rate of 46.5%.**
- On average, only about 20% of our patients received their initial Mental Health assessment within the goal of 10 days of initial contact.

What this meant:

- Individuals were ready to engage, seeking care for symptoms that they were unable to effectively manage on their own.
- Our system was not always ready to receive them when they needed the support.

Individuals may have had to go elsewhere for treatment, or they may have given up and stopped asking for help all together.

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CARE SHOULDN'T START IN THE EMERGENCY ROOM

It should happen in a Community Health Center.

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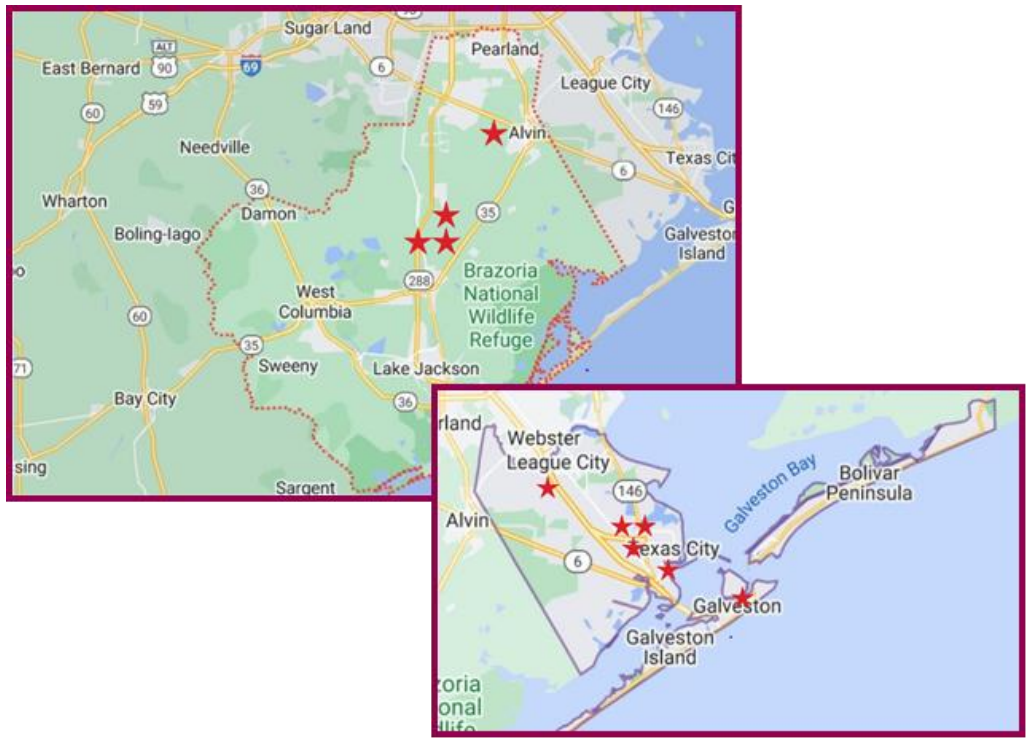
RAPID ACCESS IS THE BEGINNING OF ***HOPE.***

Rapid Access Scheduling

- Rapid Access Scheduling, designed for immediate or near-immediate access
- Borrowed from manufacturing/lean operations
- Core principle: Align service delivery with patient readiness and clinical need, not administrative convenience
- Moves away from long waitlists and fixed appointment slots weeks to months out
- Moves toward same- or next-day access, flexible scheduling rules, and care delivered when the individual is ready and reachable



"**Same Day Access** is just that – same day assessment. There's no scheduling – all assessments are available on an unscheduled basis so there are never any no-shows."

- MTM Consulting Services

Same-day/Next-day

July 2024: Same-day Mental Health Assessment, with Next-day Flexibility.

Walk-in Initial MH Assessments, QMHP/LPHA, Every Clinic, Every Day

Almost 2 years out from implementation of Same-day/Next-day (SDND), **more than 90% of persons seeking care** from GCC continue to **achieve their Initial Mental Health Evaluation in <10 days**.

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Psychiatry in 2025:

- ***Psychiatry Intakes became available within weeks***
- Follow-up psychiatry appointments booked 2 weeks to 3 months out on average
- Work-in appointments utilized on a regular basis to address clinical concerns
- Schedules booked to a fullness of 115% or more
- 20% or more of scheduled appointments ‘no-show’
- Just under 20% of appointments cancelled last minute
- By the end of day of service, psychiatry schedules almost ½ empty

… So, individuals were having to wait, even though there was room for them.

“Accessibility is a culture to be built.”

- Sheri Byrne-Haber

Rapid Intake

Minimizes required steps to get scheduled; focuses on clinical readiness, not paperwork completion.

Addresses: Wait-time Attrition

Flexible Scheduling

Includes same-day/next-day slots, adjustable provider templates, and real-time scheduling decisions.

Addresses: Mismatch between readiness and slot availability

Built-in Walk-in/Work-in Slots

Intentionally protected access capacity (not "overbooking").

Addresses: "missed appointment → lost to follow-up" cycle

Streamlined Triage

Quickly matches patient to psychiatry, bridge care, or other appropriate services.

Addresses: Mismatch between person's need and resource deployed

Core Components of Rapid Access Scheduling

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No-Shows: Myths vs. Evidence

MYTH	What the Evidence Shows
Patient apathy / lack of motivation	Forgetfulness, financial barriers, transportation, work conflicts
Patient demographics (age, race, SES)	System-level factors: wait time, scheduling rigidity, lack of walk-in capacity
Need for better reminders	Reminders help modestly; structural access changes have larger effects
“Problem populations” who can’t be engaged	Populations engage at highest rates when barriers are removed
All no-shows are the same	Initial vs. follow-up vs. chronic no-shows require different strategies

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Impact of Rapid Access on Show Rates

Shorter time to first contact (≤3–5 days)	➡	Higher show rates
Same-day/next-day visits	➡	Highest attendance, fewer cancellations
Rapid Access models (1–3 days + same-day slots)	➡	Improved engagement and throughput
Telehealth	➡	~40% drop in no-shows; more visits completed
Walk-in/virtual models	➡	~20-point gain in scheduled-to-billable conversion
Flexible access (walk-in, same-day, virtual)	➡	Fewer missed visits
Rapid access	➡	Captures help-seeking window before drop-off

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Care DIS-continuity: Myths vs. Evidence

MYTH	What the Evidence Actually Shows
Patients got better and don't need care	Attitudinal barriers (stigma, ambivalence, perceived ineffectiveness) drive most dropout
Continuity = same provider	Patients define continuity across 5 dimensions: relationship, timeliness, mutuality, choice, knowledge
Patients drop out mid-treatment	Highest dropout risk is the first 1–2 visits; the transition into care is the danger zone
Getting patients in the door is enough	Ongoing system design (multimodal treatment, reduced admin burden, flexible follow-up) sustains continuity
Telehealth always helps	Telehealth can worsen no-shows in populations with digital divide barriers
It's about the patient-provider relationship	System-level factors (scheduling rigidity, admin burdens, organizational culture) are equally or more important

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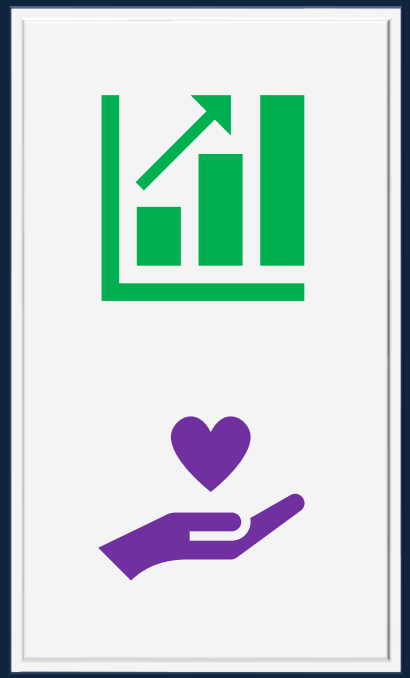
Impact of Rapid Access on Care Continuity

Rapid intake	→	Earlier engagement, ⇩ symptom escalation, stronger early alliance
Quick follow-up (post-eval, med start, missed visit)	→	Better continuity
Rapid access	→	More consistent visit patterns and fewer care gaps
Getting patients in quickly	→	Increases likelihood they stay in care
Walk-in/expanded access	→	Higher follow-up visit volume and retention
Access models	→	Steadily increase referrals and shorten time to services
Without rapid follow-up	→	Fewer than half connect to outpatient care after ED visits
Rapid access	→	Foundation for sustained, longitudinal engagement

KEY INSIGHT: Reducing the time between "decision to seek care" and "first encounter" is the **single most powerful lever** for improving Show Rates & Care Continuity.



- It targets the highest-risk moment for disengagement.
- It is the strongest modifiable predictor of attendance
- It outperforms patient-level interventions
- It creates a cascade of downstream benefits (e.g. Treatment, Referrals, dec. ED utilization)

Rapid Access: Designed for what people actually need.

Traditional Model (Before)	Rapid Access Model (After)
• Weeks to months wait time • Fixed appointment slots • Limited re-engagement after no-shows ⬇ **High no-show rates** **Frequent ED/crisis utilization** **Administrative burden managing missed visits**	• Same- or next-day access • Rapid Triage • Walk-in/work-in capacity • Flexible scheduling rules ⬇ **Improved show rates** **Faster treatment initiation** **Stronger continuity & retention**

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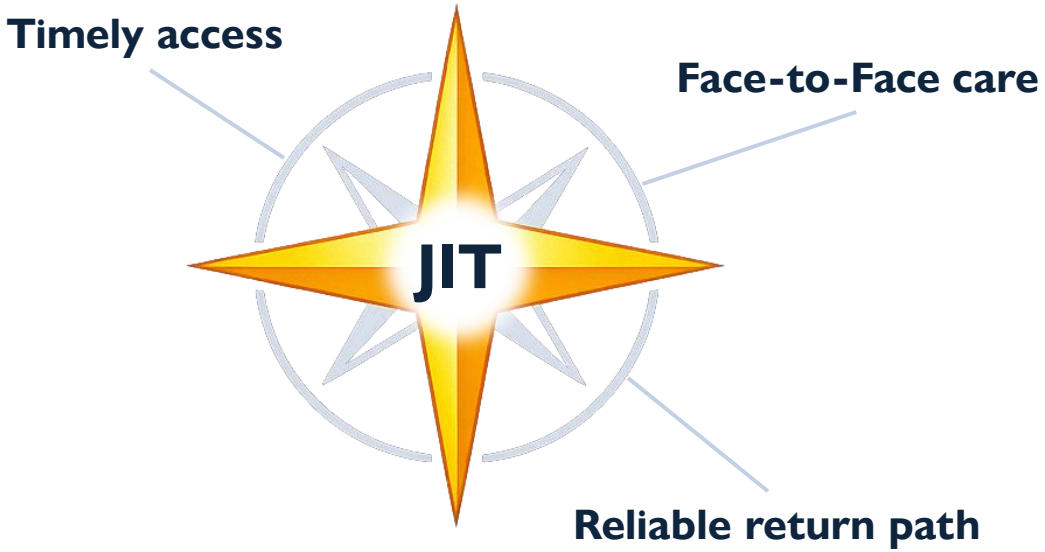
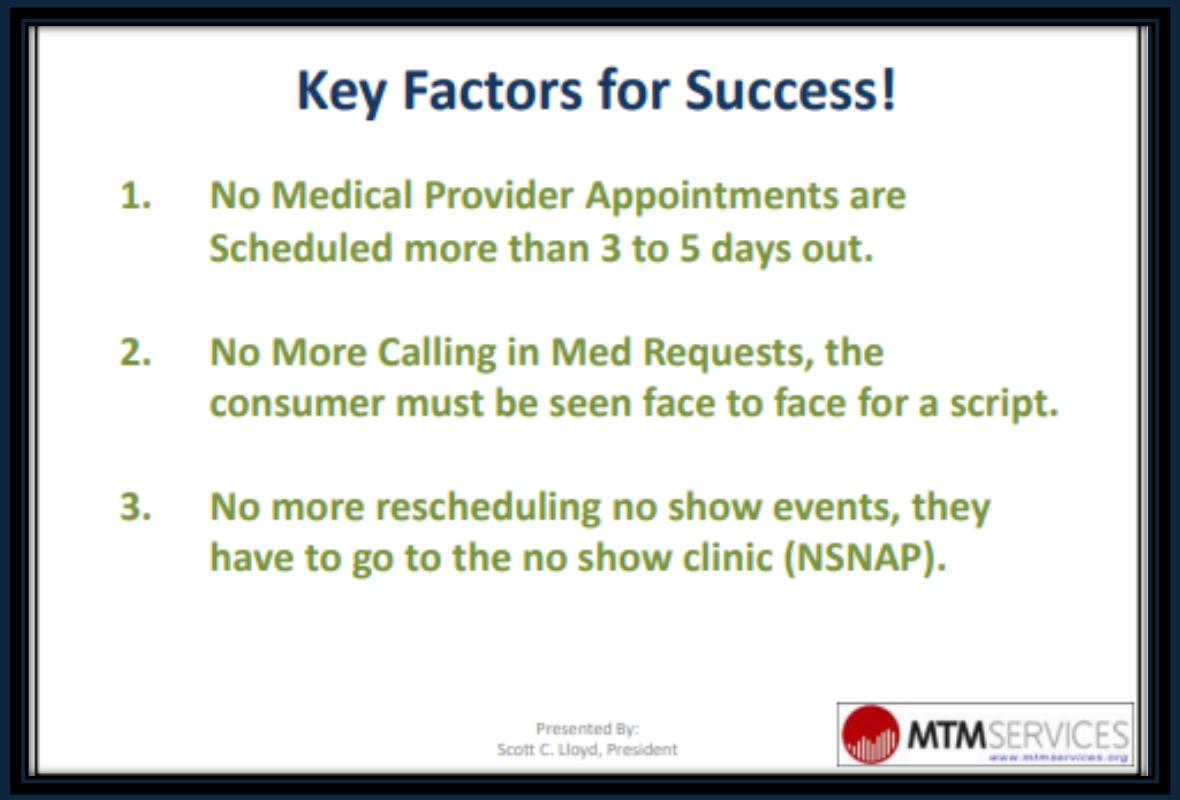
JIT as our North Star



- **Timely access:** Make appointments soon enough to match clinical need.
- **Face-to-face care:** Use real clinical contact to guide prescribing and treatment decisions.
- **Reliable return path:** Build a safe, accountable route back to care after missed appointments.

An off-shoot of Same Day Access, **Just in Time Provider Scheduling** requires these:



We started with Rapid Access to meet the need for Initial Mental Health Assessments — and realized it should shape access across the Continuum of Care.

Aligning JIT Workflows with Organizational Systems

Knowing what works is not the same as making it work.

JIT succeeds only when Operations, Communication and Values are aligned:

Culture by Design

Staffing & Operational Foundations for JIT

Model Definition

Clear definition of the model as a cornerstone, with accompanying training and information access

Dedicated Access

Dedicated psychiatry access to create predictable coverage and shared ownership of access goals

Protected Capacity

Slots are intentionally reserved same-day and next-day, not leftover from cancellations

Referral Pathways

Multi-source referral pathways from intake, crisis, walk-in, and other entry points

Access Benchmarks

Clearly defined access benchmarks to measure and sustain scheduling performance

KEY FEATURES:
JIT Psychiatry Scheduling

Target Scheduling 3 Days or Fewer

- Worst case, no prescriber appointments scheduled more than 3-5 days out

No More Calling Medication Refills

- People must be seen for a visit for a routine prescription

No More Rescheduling No-Shows

- Persons must be seen in the Psychiatry Refill Management appointments (i.e. NSNAP).

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Psychiatry Refill Management

Appointments

No
Show
Needs
An
a**P**pointment

By requiring visits for routine prescriptions, we are **eliminating the unsafe cycle** of repeatedly providing bridge prescriptions when rescheduling someone after they miss an appointment.

Instead, when they contact us, we meet their needs by providing access to an **abbreviated appointment** in real-time where the prescriber can ensure they are **safe** to continue their medications and then **reengage** them in services.

Same day scheduled

May have to wait

May not see their usual prescriber

Shorter visit

Clinical Check: OK Continue medications?

30-day Rx – NO CHANGES

4-week Psychiatry RTC

By keeping these visits SHORT and FOCUSED, we reinforce the POSITIVE behavior of engaging in services.

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Sample Psychiatry Scheduling Matrix

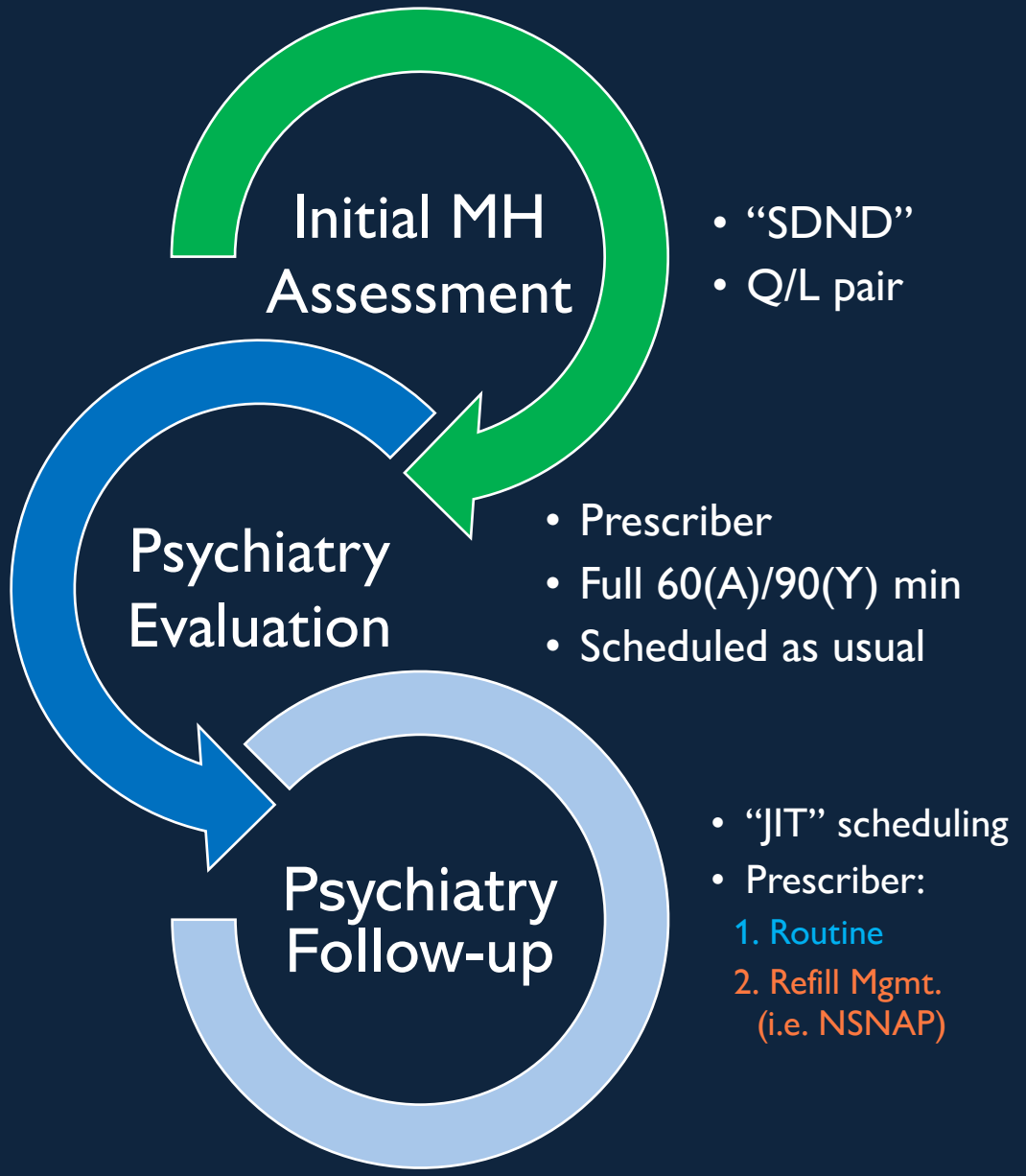
Adult Refill Management (i.e. NSNAP) appointments start at 3:20 PM

Provider/Time	8:00	8:30	9:00	9:30	10:00	10:30	11:00	11:30	12:00	12:30	13:00	13:30	14:00	14:30	15:00	15:30	16:00	16:30
Tuesday																		
Adult																		
Prescriber 1											1		3		1	2		
Prescriber 2	3		1		1		3				1		3		1	2		
Prescriber 3	3		1		1		3				1		3		1	2		
Prescriber 4	3		1		1		3				1		3		1	2		
Prescriber 5																		
Prescriber 6	3		1		1		3				1		3		1	2		
Prescriber 7																		
Prescriber 8	3		1		1		3				1		3		1	2		
Prescriber 9		1		1	2		2											
Prescriber 10																		
Prescriber 11	3		1		1		3				1		3		1	2		
Youth																		
Prescriber 12	2		2		1			1			1			1	1	1		
Prescriber 13																		

**Numbers indicate visits per unit time.*

Youth Refill Management (i.e. NSNAP) appointment starts at 3:30 PM

Rapid Psychiatry Access via JIT



Communication & Workflow Integration

Real-Time Communication

JIT success depends on clear understanding AND real-time communication, not static schedules

Same-Day Coordination

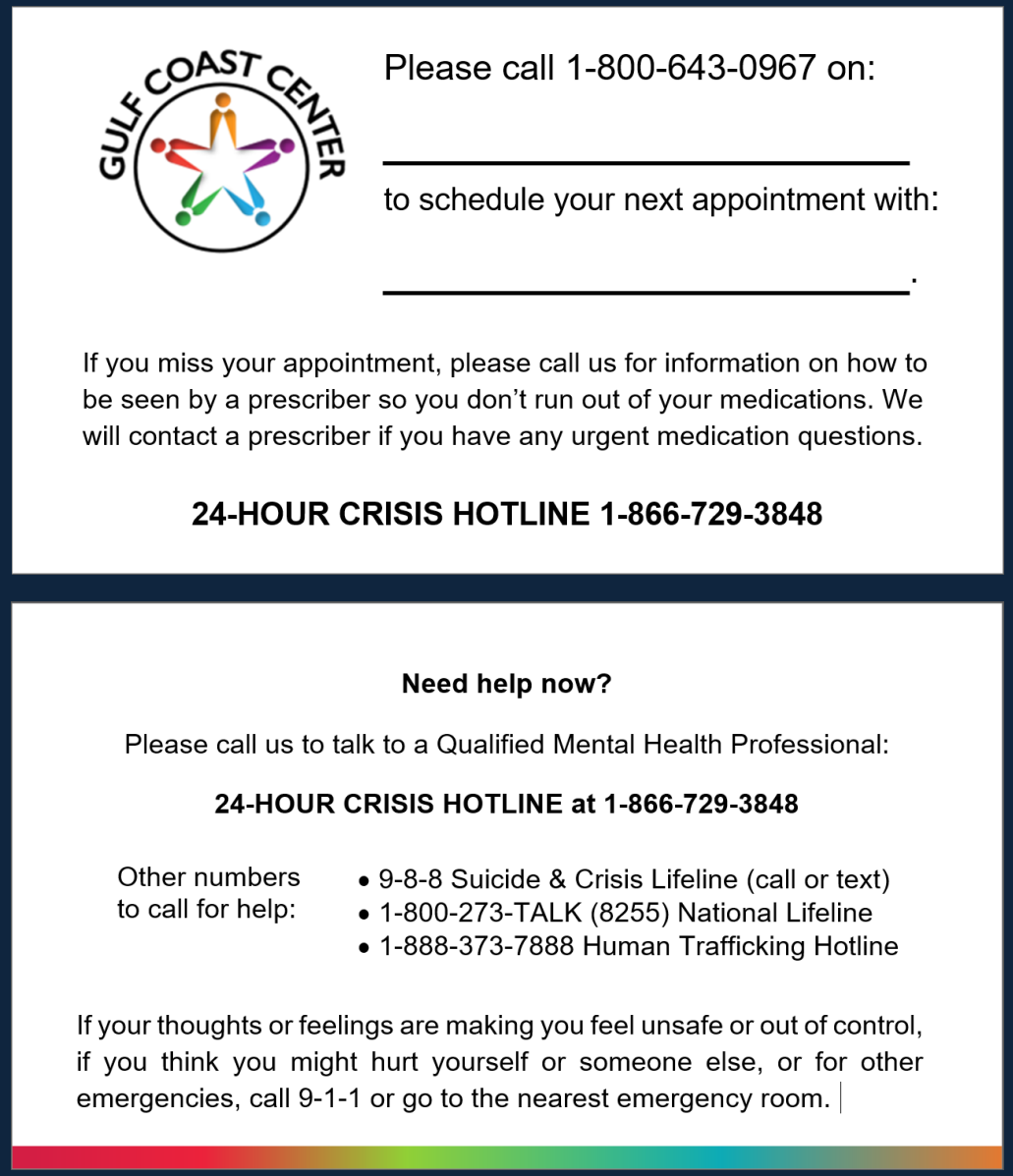
Same-day coordination between clinic, psychiatry, and support staff with clear escalation pathways

Telehealth Integration

Leverage existing integrated telehealth workflows to extend access capacity

Cross-Functional Operations

Coordination across intake, clinical, and administrative functions is required for operational success



Keeping People Connected:

Patient Letter

Appointment Card

Scripting for Staff

Documentation in Patient Record

Automated Reminder Text Messages

Automated Reminder Calls

Case Management

Outreach for Missed Appointments

Maximizing Every Opportunity for Service

Applicable Appointment Types

Initial Mental Health Assessment

- New to GCC, or has NOT been seen by GCC in the last 12 months
- Refer to Walk-in 'SDND' Clinics

Psychiatry **Evaluation**

- HAS completed Initial Mental Health Assessment (i.e. SDND)
- Has NOT been seen by Psychiatry in the last 12 months
- Schedule as usual

Routine Psychiatry Follow-up

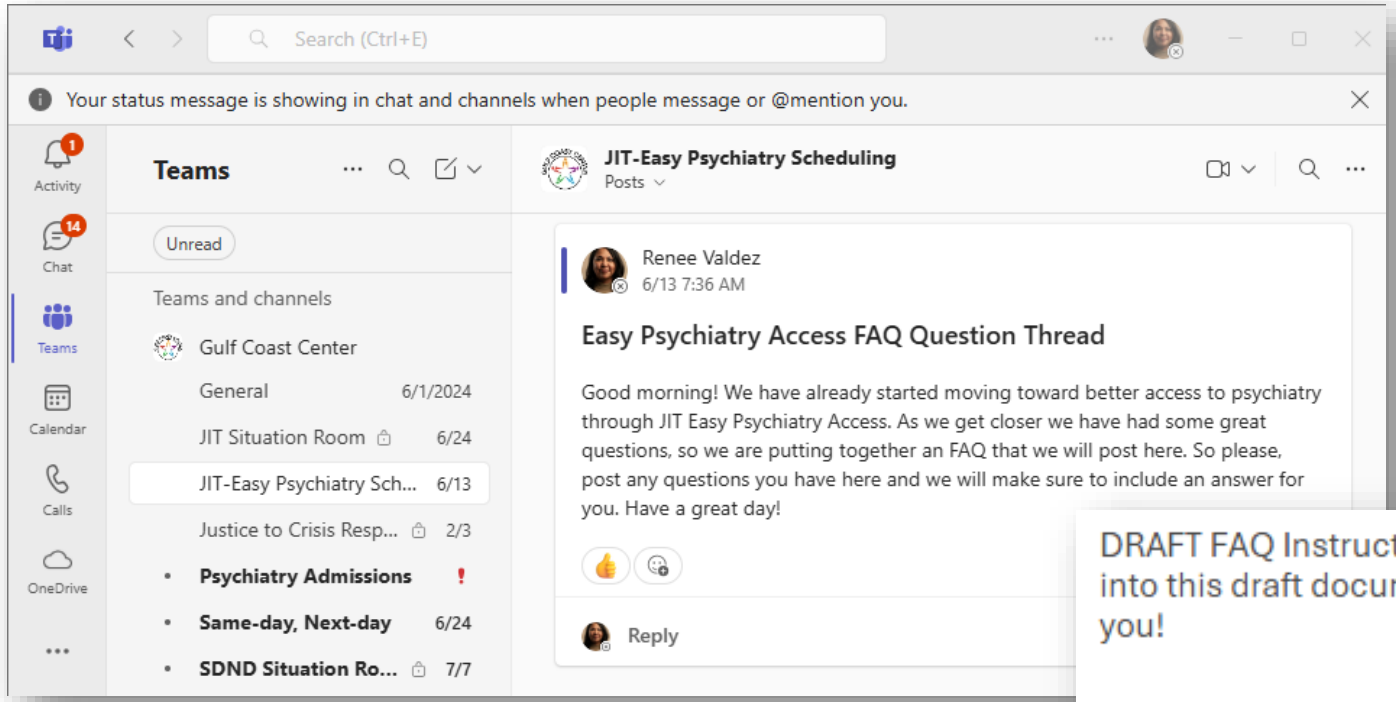
- NOT YET PAST Psychiatry RTC Date
- Regular follow-up, OR clinical issue needing sooner attention than Psychiatry RTC Date
- Schedule **SOONEST available**; NOT more than 5 business days

Psychiatry **Refill** Management (i.e. NSNAP)

- PAST Psychiatry RTC Date; No-Show last time; Needs REFILL appointment
- Same Day
- Can also be used for clinical issue requiring attention in <3 business days; plus *Flex Time*

Applies to individuals following hospital discharge.

Leveraging **Microsoft Teams** Environment to ensure dissemination of information: LIVE Microsoft Teams thread, FAQ, Full JIT Presentation, etc



DRAFT FAQ Instructions: Please place any questions you or your staff/peers have about JIT into this draft document. Then please once you get an answer, please add it in here. Thank you!

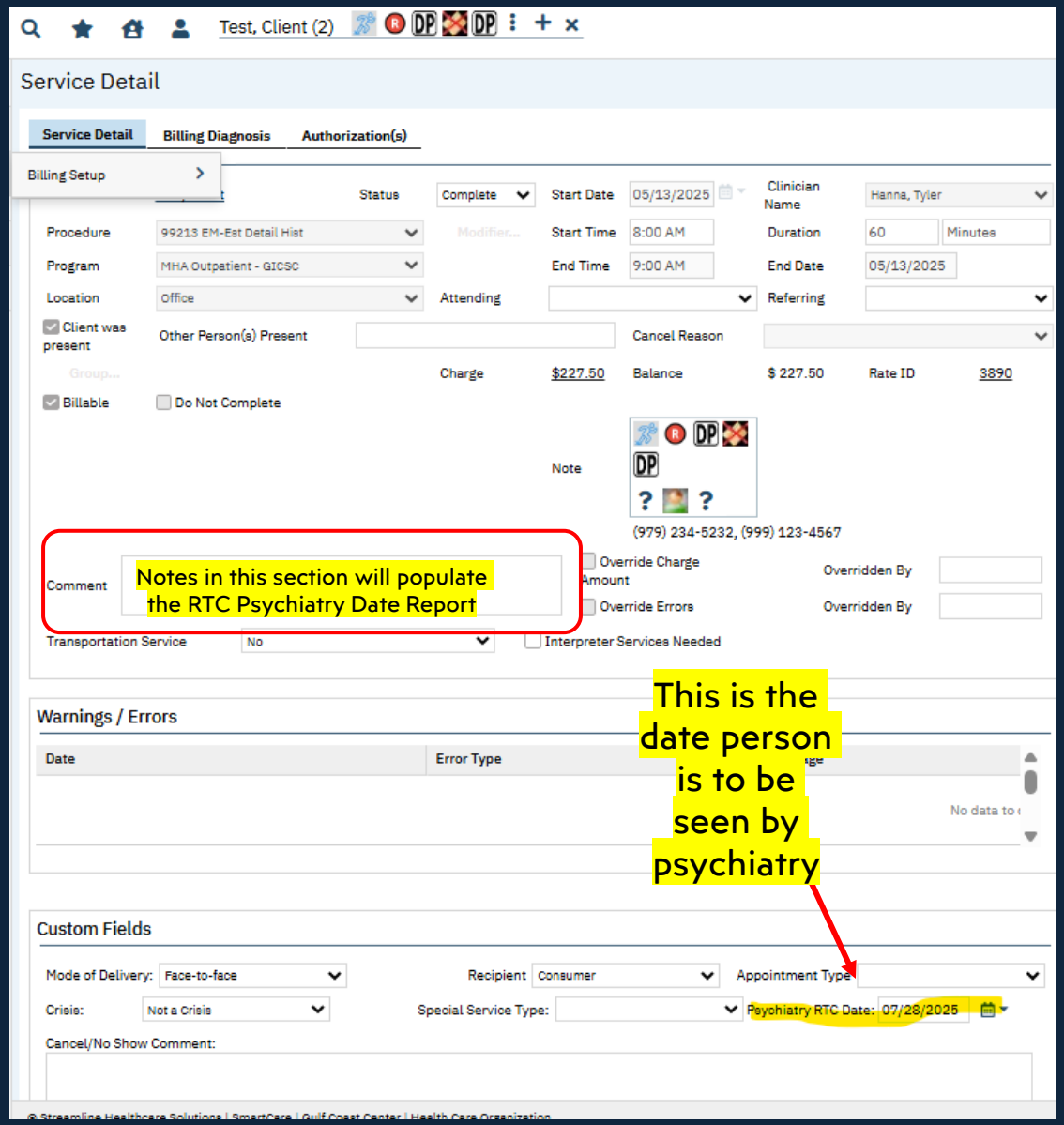
Question: How will this affect the hospital d/c process

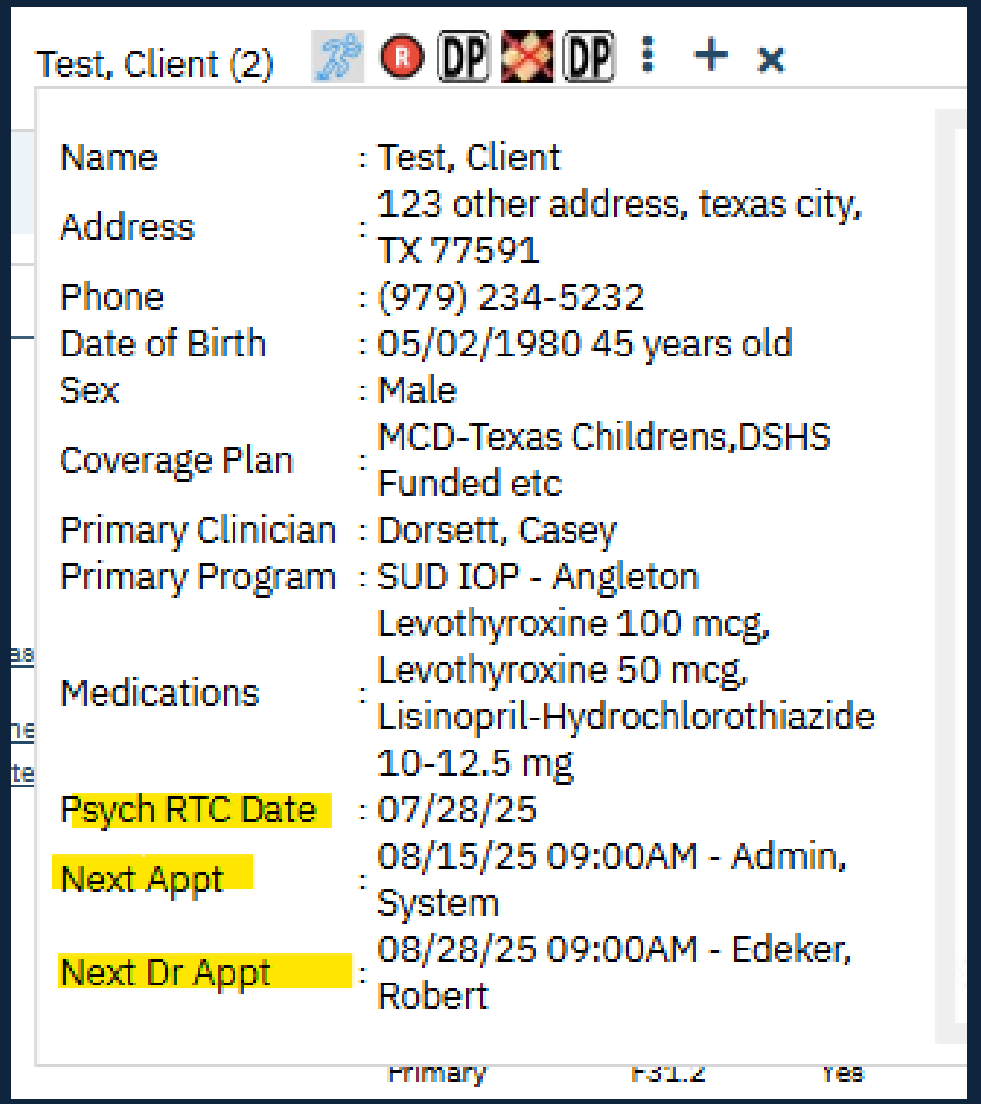
- A: established patient, back into a follow-up slot
- A: Not established, go through SDND

Just-In-Time Psychiatry Scheduling

WHO:	Individuals receiving psychiatric care at GCC
WHEN:	For return psychiatry appointments needed on or after July 28, 2025
WHAT:	We will schedule appointment within 3 to 5 days of being contacted
WHERE:	All GCC psychiatry clinics - youth and adults
HOW:	• After visit, the front desk staff will provide a reminder card • The card will say when to call to make the next appointment • When we are called, we will schedule the return appointment within 3 to 5 days

Translation of Psychiatry RTC date into EHR Client Demographics Field





Psychiatry RTC Date reflected in hover.

REMINDER TEXT (-5 days From Psychiatry RTC BY Date):

Hello, this is an important message from Gulf Coast Center for <Patient First Name>. Our records show that you are due for an appointment. Please call us when you are ready to schedule an appointment. You can call us at 1-800-643-0967.

REMINDER CALL (-3 days From Psychiatry RTC BY Date):

Hello, this is an important message from Gulf Coast Center for <patient first name>. Our records indicate that you are you are due for an appointment. To talk to someone now to schedule an appointment, press SIX. Otherwise, please call us when you are ready to schedule an appointment. Our phone number is 1-800-643-0967.

Interpretation pending; Phone calls business days only, FD call support

Patient Reminders

Maximizing Every Opportunity for SERVICE

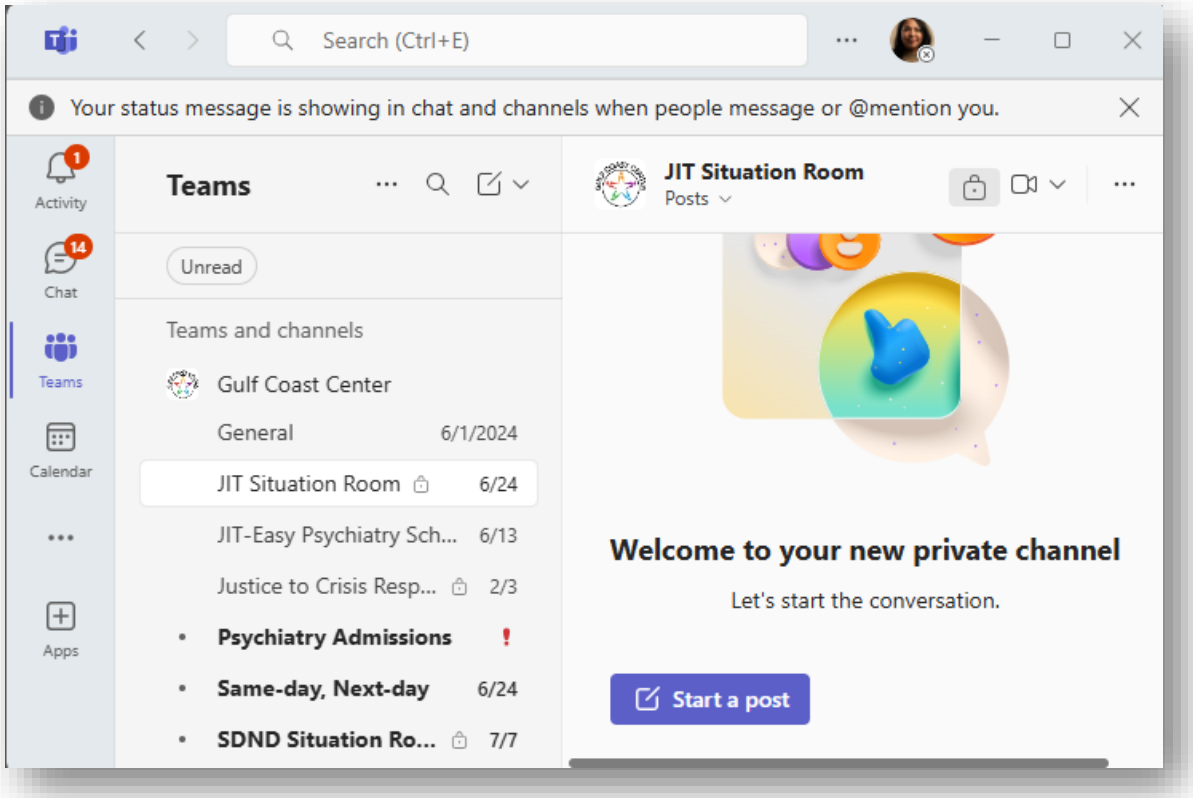
Seek guidance: Supervisor and/or Clinical Team (Prescriber / Clinic RN / Support Staff)

What if … not enough refills were sent to the pharmacy at the last visit?

What if … individual is having a clinical concern and needs a sooner appointment?

What if … person is having a clinical concern that *can't* wait for a sooner appointment?

Contingency Management: LIVE, Team-based & Solution-focused



JIT Situation Room:

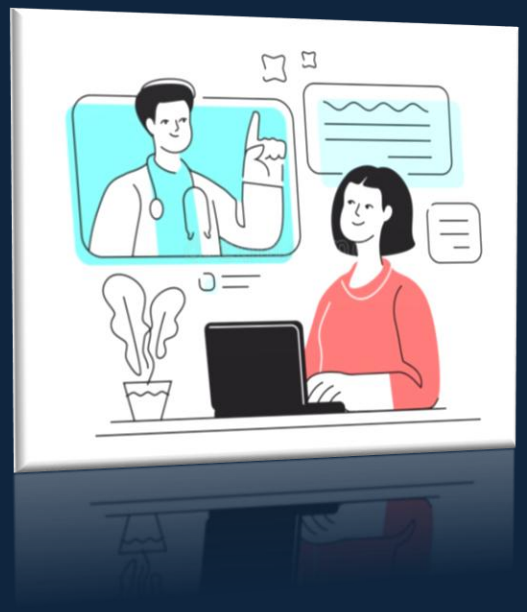
- Members: All applicable Clinical and Administrative Staff

- Post questions for ***WHAT IF..?*** issues to solicit support, ex:
  - Not sure what appointment to use?
  - Appointment not available?
  - Prescriber forgot to send enough meds?
  - Urgent Clinical Issue?
  - Refill without an appointment?
  - Out of care for months and has been hospitalized?
  - Provider called out sick

- Stay attentive to the Teams thread; Turn on notifications
- Contribute to the solution
- Communicate solution to all applicable staff

Repeated OR High-Risk Issues will be addressed systemically.

Psychiatry Cross-Coverage



Clinic A Individual needs to be seen but can't be accommodated in a timely manner.

Clinic A Staff advises their Clinic Administrator of need.

Clinic A Administrator posts need in the JIT Situation Room.

Clinic B has an availability, confirms with Clinic B Prescriber and *posts availability in JIT Situation Room Teams thread.

Clinic B Prescriber will communicate with Clinic A Staff through the Clinic A GENERAL Channel in Teams thread.

*Teams proactively post openings in the Teams Thread as they are available.

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Aligning JIT With GCC's Mission, Vision, & HEALTHY Values

"No Wrong Door" does not mean that we can meet all of an individual's needs right now.

It DOES mean that we ***COME TO CARE****.*

Coming To Care *means that we each believe in our ability to do just that – to care for those that seek help from us.*

Humanity: Immediate access when it matters most

Excellence: Fewer no-shows, more care time

Accountability: Real-time data drives ownership

Loyalty: Scheduling built around patients/supports

Teamwork: Tight coordination, shared goals

Honor: Continuous improvement in practice

You: Reliable access strengthens community trust

Providing accessible, efficient and quality services that support the independent and healthy living of those we serve.

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Real Outcomes, Lessons Learned, and What We Are Doing Now

JIT Psychiatry Scheduling Implementation at GCC

Fall/Winter 2024	JIT planning underway with integrated implementation team and MTM Consulting; continues through and after roll-out
Spring 2025	All center communications intensified in content and frequency for planned Summer Roll-out, including Medical Quarterly meetings
Apr–Jun 2025	Psychiatry RTC timeframes input into EHR; call-for-appointment card reminders provided to individuals
May 2025	Patient Letters made available at all clinics to facilitate information provision at checkout
July 2025	Secured additional psychiatry support to ensure preexisting scheduled appointments were honored
July 21, 2025	**LAUNCH:** First day individuals request services using the new call-in protocols
July 28, 2025	**GO-LIVE:** First day of new Psychiatry Schedules

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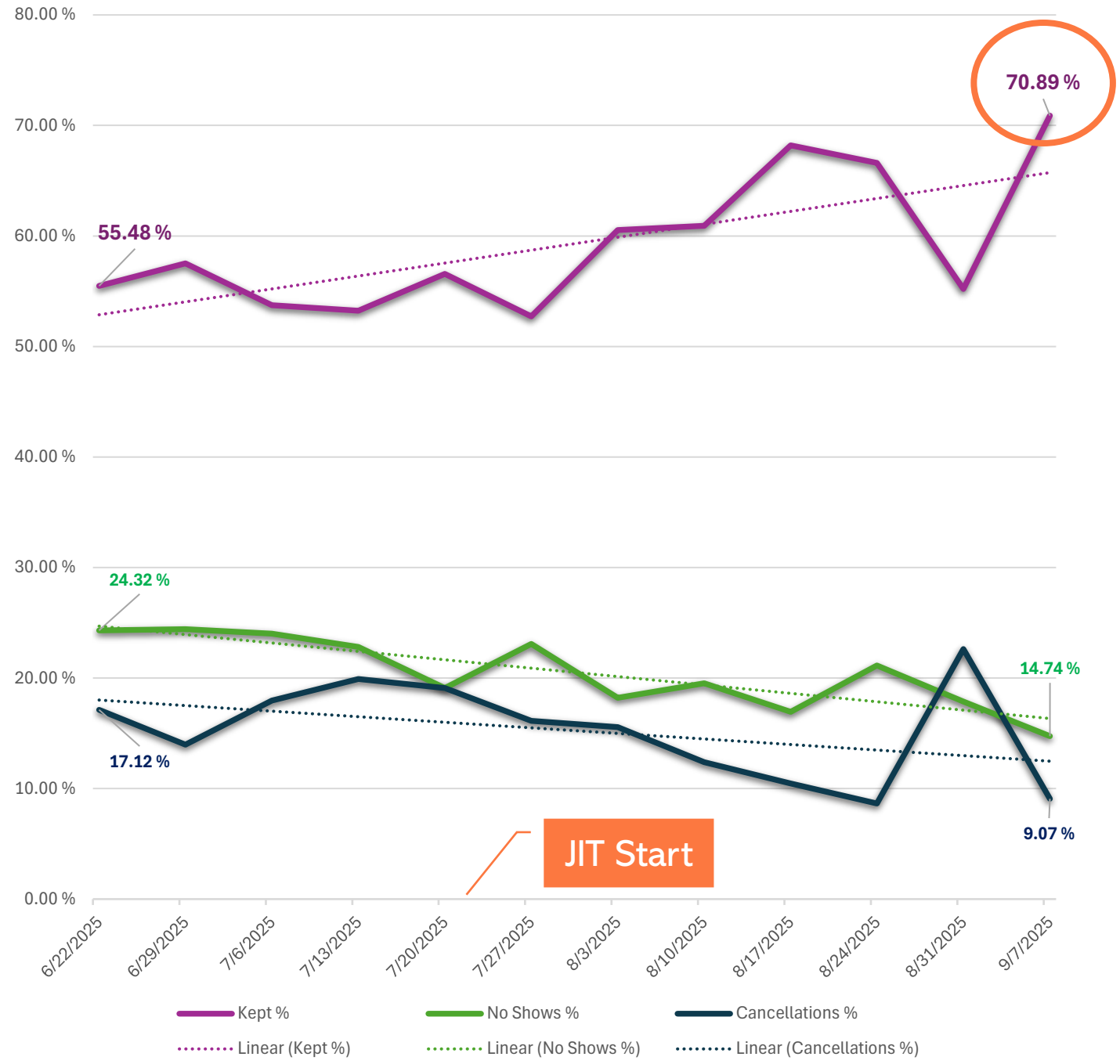
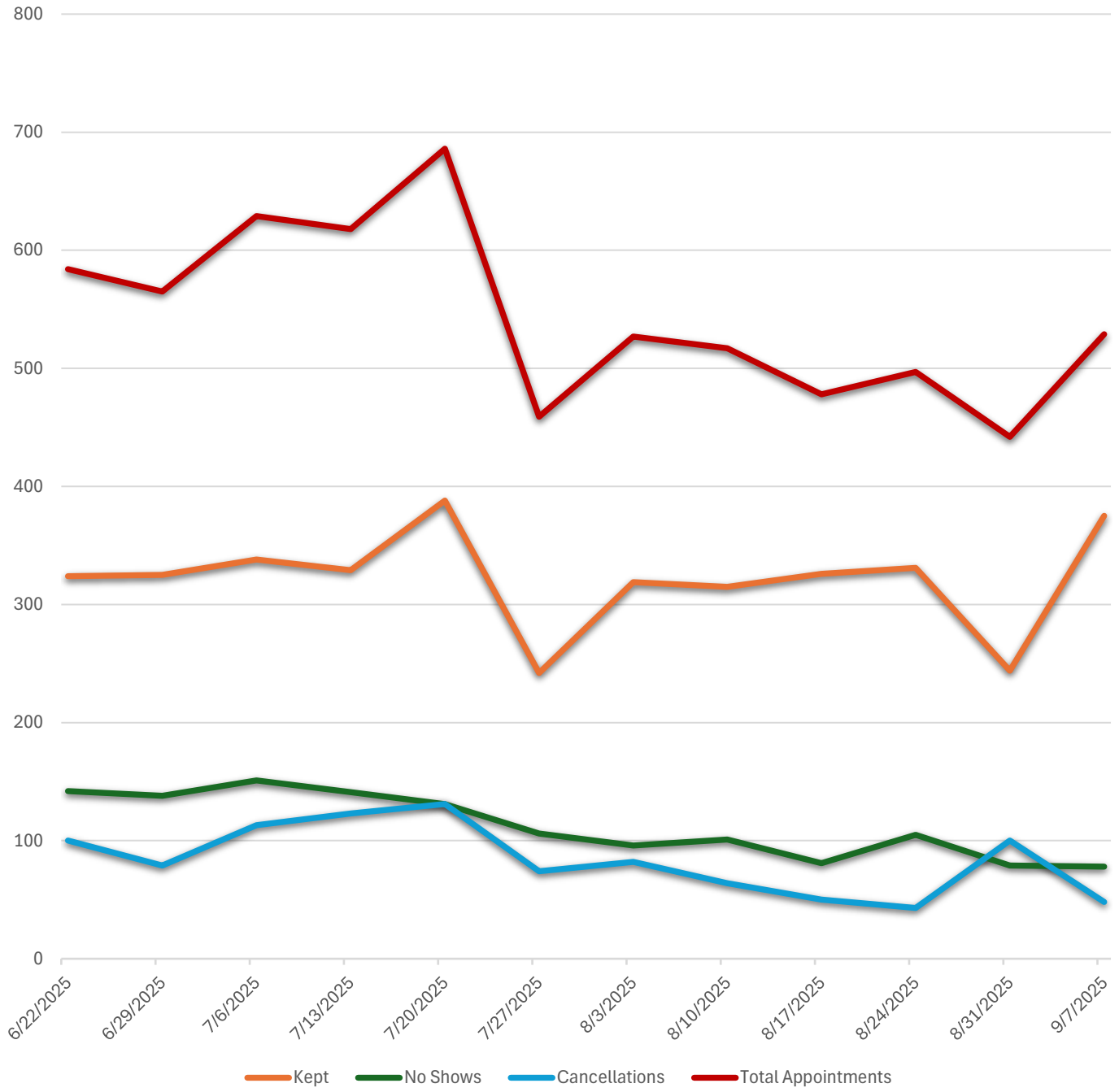


Psychiatry Appointments Status Outcomes

Rightsizing Appointments to Schedule

WITHOUT LOSING ACCESS



What We Achieved: Early Outcomes

- Initial JIT rollout produced significant improvement (+15%) in KEPT appointment rates
- Faster initiation of psychiatric care and greater consistency in early engagement
- Strong gains for high-risk patients and individuals with prior no-show history
- Early results validated the design of the model and the clinical value of rapid access

What We Learned: Change Is Not Linear

- Despite early wins, performance flattened over time and variability emerged across teams and sites, currently holding at 68-69% KEPT
- Contributors included operational fatigue, reversion to familiar workflows, and inconsistent expectations/guardrails
- JIT challenged deeply held beliefs about scheduling, productivity, and *service*

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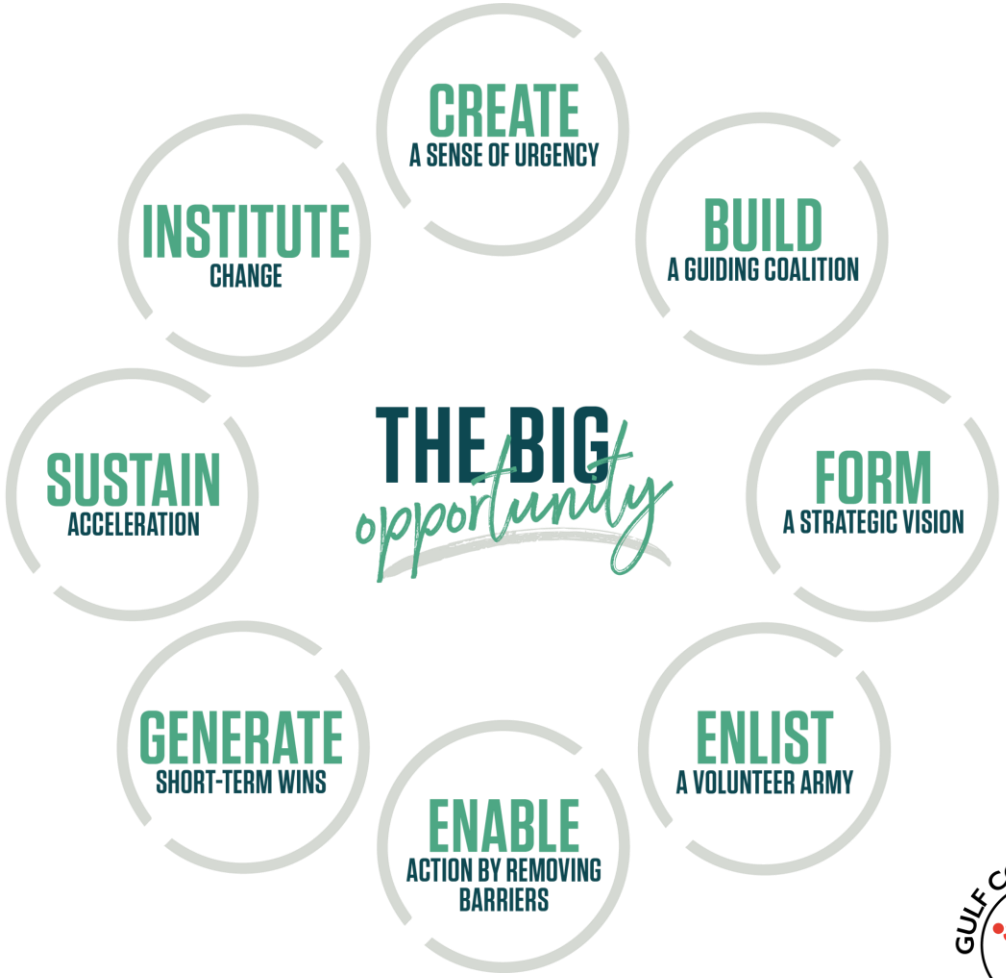
Our Golden Thread

A Golden Thread is a unifying element or connection. In clinical work, a **"golden thread"** refers to the consistent and logical connection that ties together all elements of a client's care. It ensures that every part of the client's record aligns and supports the overarching treatment goals.

For **Access to Care**, Our Golden Thread is Kotter's Change Management Model.



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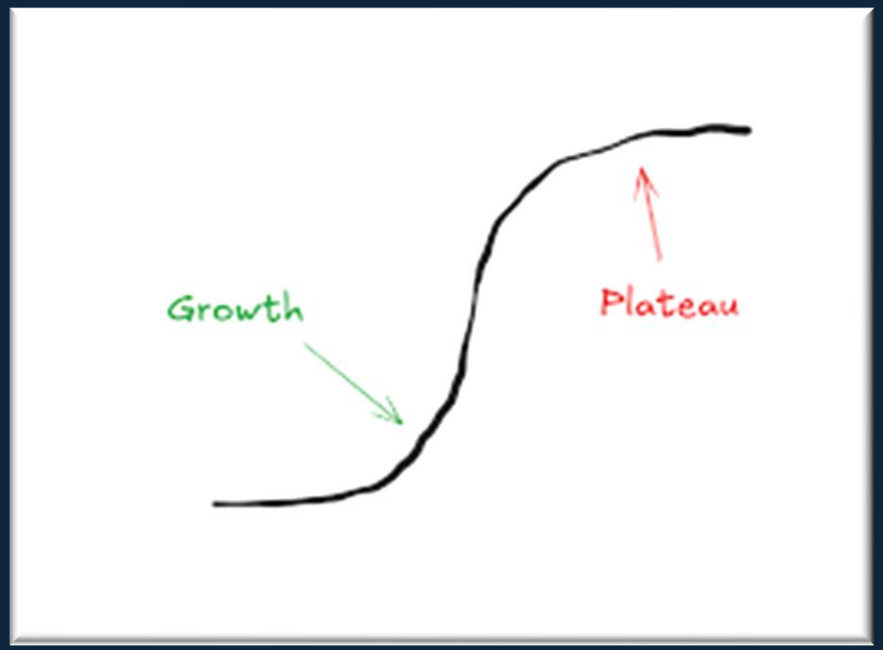
The Inflection Point: When the Plateau Became the Teacher



Early JIT gains were real: shorter waits, better show rates, faster treatment starts.

Then came the **Plateau**: fidelity drift from ambiguity, uneven buy-in, well-intentioned workarounds.

The critical **Reframe**: It is not about denying care. **JIT is about accountability, to staff and to the people served.**

CQI actions now underway: protecting rapid access capacity, determining explicit scheduling non-negotiables, CEO/CMO sponsorship, clarifying workflows, and data used to inform, not surveil.

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The High Impact Team: Starting Again With Intention

Formed to lead the re-rollout — grounded in CQI findings and staff feedback, not a top-down mandate repeated louder.

OPERATING PRINCIPLES

Open Dialogue

Staff name what gets in the way of fidelity, no blame, just understanding

Professional Vulnerability

Leaders model "we got this wrong"

Emotional Intelligence

Resistance is information, not insubordination

Psychological Safety

Predicts QI learning behavior and implementation success

HIT FUNCTIONS

1. Communication reinforcement
2. Measurement as shared learning language
3. Rapid-cycle PDSA adjustment
4. Ongoing barrier identification

GOAL

Anchor JIT in culture and operations, not just in a few champions' heads.

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5 Dimensions of our HIGH-IMPACT SHORT-TERM JIT WIN TEAM

1

HIGH-IMPACT FOCUS

Exemplify our Big Opportunity: every appointment used, every person seen on time. Show what is possible — despite variation and change fatigue.

2

TRUE CROSS-FUNCTIONAL TEAM

Members closest to the scheduling work — across clinics, geographies, and functions. Beyond 'the usual suspects.' Own the processes involved.

3

RESULTS-FOCUSED 90-DAY GOAL

A 'seemingly impossible' goal set by the team — with a clear measure, target, and timeframe. Forces innovation, not just working faster.

4

EMPOWERING SPONSOR

Defines the 'who' and 'why' — leaves the 'how' to the team. Vigilantly removes barriers. Provides visible recognition and top-cover.

5

MODELING NEW WAYS OF WORKING

Experimentation, cross-coverage, rapid prototyping. Willingness to pivot. Heightened visibility through 30-, 60-, and 90-day reviews.

You can only sustain what you have made explicit. Fidelity drifts when non-negotiables are assumed, not stated.

Buy in is not a one-time event. **Sustaining change requires ongoing re-engagement with the "why,"** connected to Mission, Vision, and Values.

Accountability reframes everything. When JIT is understood as accountability to the people served, resistance shifts to ownership.

Psychological safety is not optional. Staff must feel safe to say "this is not working" or fidelity problems go underground.

Data informs, it does not punish. Start again when you need to and call it courage, not failure.

Culture by Design,

Not by Default

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Thank you

We don't come to work
We Come to Care

Great Place To Work. Certified JAN 2026-JAN 2027 USA

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