

## FAQ: BCFPI: V4 Web Version, 2010

### Table of Contents

1.	What is the Origin of BCFPI? .....	2
2.	Is BCFPI reliable and Valid? .....	2
3.	What are the Features of the Web Version? .....	2
4.	Why Should Organizations Use BCFPI Strategically? .....	3
5.	How Can BCFPI be used to Improve Services for Specific Clients? .....	3
a)	Use Structured Immediate Triaging to Increases Productivity and Responsiveness.....	3
b)	Provide Relevant Reading Materials Upon Request, During the Intake Interview.....	4
c)	Use BCFPI File Sharing Capacity .....	4
d)	Use Evidence-based Service Planning Reports (EBSR).....	5
e)	Use ‘During service’ Checklists and Comparative Case Reports.....	6
f)	Use ‘Brief’ versions of questionnaires as a screening tool .....	6
g)	Develop and Use Intake as a ‘Specialty’ to Optimize Responses to Each Referral.....	6
6.	How Can BCFPI Data be ‘Leveraged’ to Improve the Service System?.....	7
a)	Use BCFPI to Arrange and Manage 3rd party Collection of Outcome, Satisfaction and Follow-up Data;.....	7
b)	Create and Use Real-time Aggregate Reports .....	7
	Outcome and benchmarking reports: .....	8
c)	Copies of non-Identifying Data Base Extracts for Researchers.....	8
7.	Why Should a Region or Community Try to Develop an Integrated Spectrum of CYMH Services with a System-wide Intake Protocol? .....	8
8.	How can BCFPI Support the Development of a Regional Spectrum of Services Harmonizing Service Needs and Provider Capacities? .....	8
9.	How do We Set up BCFPI for our agency and Community? .....	9
a)	What are Our Options to Set up BCFPI Agency and Program Structure and User Privileges to Match Actual Community and Agency Structure, and Privacy Rules and Best Practices? .....	9
b)	How do we Decide Whether a Structure Should be Set up as an Agency or a Program in BCFPI? .....	10
10.	How Is BCFPI Useful for Single agencies .....	11

# FAQ re BCFPI (V4: web version, 2009)

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## 1. What is the Origin of BCFPI?

BCFPI (**B**rief **C**hild and **F**amily **P**hone **I**nterview) began as a computerized Intake tool at an Ontario (population 12M, Canadian province) teaching hospital in the late 1990's. In 2000, after a global review of available intake tools, the Ontario Government mandated the use of BCFPI as an Intake tool in all (100+) Ontario treatment settings. BCFPI Inc. was created in 2003 to develop, distribute and support the system for increasingly wide-spread use. By 2008 BCFPI was in use in 3 Canadian provinces, 6 regions in Sweden and 1 county in the UK, in catchments totaling about 25 million persons.

***In November 2008 BCFPI launched its web version, with an EU server hosted in London England and a North American server hosted in Vancouver, Canada.***

## 2. Is BCFPI reliable and Valid?

Chapters 9, 10 and 11 of the interview manual (2006) document the tools satisfactory psychometric properties, attained during initial development in 1998-9. Current in-press articles (JCP&P) report on an Ontario field trial conducted after 2005 involving close to 60,000 intake interviews in 138 agencies in actual field use as an intake tool (<http://tinyurl.com/deajoy>). Original psychometric qualities were retained in field use with a train-the-trainer model used to train many interviewers in diverse settings. A second in-press JCP&P article reports acceptable predictive validity for these field intakes. <http://tinyurl.com/dmehdt> Note that BCFPI's checklist scores are **not** promulgated as diagnostic. They estimate the severity of symptoms similar to those found in common childhood disorders. The strength of the BCFPI as an intake tool is in the wide range of treatment relevant domains for which standardized symptom severity scores are provided... child mental health, child functioning, family adjustment to the problem, caregiver mood and family functioning. These are complimented by narrative detail. Sensitivity as an outcome tool is demonstrated in field use.

## 3. What are the Features of Web Version?

- Meets European and North American privacy and security standards for processing and storing personal data, including use of 2 factor authentication for system access.
- Supports virtual or real central intake. Intake workers in central or distributed locations can share consenting case intake interviews with any participating agency(s).
- Immediate single case intake reports which support assessment and treatment planning
- provides powerful real-time aggregate tabular and graphical reports, at program, agency, city, region, national levels with complex user-entered grouping and filtering variables. Includes time series. Supports internal agency lists identifying cases meeting same criteria used in corresponding aggregate reports.
- Checklist-based progress reports support ongoing case management

- Web-based follow ups: clients consenting at intake are automatically sent e-mails at regular intervals (e.g., every 6 months) for fixed period (e.g., 2 years) These link to a secure site where the client completes a brief discharge or follow-up checklist. These are used for aggregate outcomes reports (discharge, 6, 12 18 and 24 months), and will be shared with the original agency if the client consents. This system also supports phone and mail follow-ups.
- Supports inter-agency case collaboration.
- Can be used on-line by all qualified providers of child-related services... clinics, schools, agencies, doctor's offices, etc.
- No local IT costs
- supports development of service spectrum
- active triaging supports diversion of eligible cases to immediate evidence-based service
- suggest applicable evidence- based services
- links to National Library of Medicine (NLM, Washington)re suggested evidence-based services.
- supports very cost effective 3<sup>rd</sup> party checklist Follow-up
- supports diverse organizational structures
- complex searches of linked case, enrolment and interview grids (within an agency)
- user-friendly 'Add Interview' wizard
- Supports national and local norms
- Multilingual forms and User Interface (latter is pending)
- Meets accreditation requirements re gathering and analyzing CYMH outcomes

#### 4. Why Should Organizations Use BCFPI Strategically?

***CYMH needs will likely continue to exceed resources by 5X – 6X. All participants in the CYMH system should work to enhance system productivity, responsiveness, and effectiveness (i.e. cost effectiveness) while continuing to provide excellent services to their clients.***

'Strategic' use of BCFPI can make very significant contributions to the achievement of these goals.

'Strategic use' involves systematic use of each of the tool's capacities to enhance services to each client and to enhance system performance, as outlined below.

#### 5. How Can BCFPI be used to Improve Services for Specific Clients?

The first five items below are likely to impact clients directly; the remainder will provide indirect client benefits.

##### a) Use Structured Immediate Triaging to Increases Productivity and Responsiveness

***BCFPI includes an optional process during the interview which identifies cases safely eligible for immediate referral to cost-effective, satisfactory services, and structures immediate referral to these services as part of the intake interview.***

Pilot studies have shown that:

- ~ 30 % of referrals to typical CYMH facilities are eligible for and can be cost-effectively served by structured, evidence-based parent training programs (e.g. COPE, Family Help, Families First)
- Discharge and 6- 12 month follow up effect sizes are large for the behavioral problems basic to eligibility, and gains are maintained.
- Satisfaction is high.
- Case Cost are low, typically =<\$200 /case
- Cost savings are high, typically =>\$1800 /case (avoided assessment costs and face-face 1:1 treatment costs, for cases diverted from full clinical assessment and 1:1treatment)

A typical agency, region, etc. can be helped to **increase its service capacity by ~ 15%** (i.e. increase productivity) by using this element of the BCFPI tool. This translates to a return-on-investment of ~ 20:1 on BCFPI costs, for an agency, region, etc. This also **increases responsiveness** in that these cases can be served immediately rather than waiting for assessment and 1:1 service (this assumes the local community service spectrum has strategically allocated resources to these hi-volume, high effect, low cost services; see item 8 below re development of such spectrums)

Intake workers are much more likely to connect qualifying clients to these services if this option is activated. Structuring this step into the intake interview increases immediate diversion rates and system responsiveness.

## **b) Provide Relevant Reading Materials Upon Request, During the Intake Interview**

***Readings relevant to symptoms and problems are requested during 90%+ intake interviews. When provided, these are reported as helpful, enhancing the informant's understanding of similar problems and potential services.***

The system provides links to reading lists and material (provided by BCFPI and/ or users) which are relevant to the types of child and youth problems BCFPI considers. Workers can scan the results of the interview, including the client's apparent problems, and the informants stated desire /non-desire to receive such materials.

Currently, this material is manually sent, ad hoc after the interview. Soon, sites will be able to send this material attached to a personalized e-mail, with agency letter head, and appropriate disclaimers and comments reflecting the interview .

**This increases immediate system responsiveness**

## **c) Use BCFPI File Sharing Capacity**

***Efficient, secure file sharing should expedite collaboration and service delivery.***

By default, the only persons who can see (and hence use) a BCFPI file are staff in the facility where the information was recorded.

The 2nd step of the 'Finish interview dialogue' is to record client response and comments if/when asked for consent to share the client contact information and interview with another agency. This would typically be done by a central intake interviewer or an agency clinician who wanted to collaborate with another setting to best help the child. BCFPI offers several methods for electronic sharing of consenting case's interviews to support interagency collaboration amongst BCFPI users. These methods offer immediate sharing, automated supporting messages, and an audit trail of correspondence re sharing and which items were shared when amongst which agencies.

Stand alone systems require ad hoc letters, file photo-copying and (insecure) mailing of documents to support such activities, and non-integrated audit trails. BCFPI achieves all of this quickly, simply and securely within its access controlled, encrypted environment, and maintains an easily searched record of all such transactions. Each case record also includes its own record of requests to share information externally, responses, what was shared, and when it was shared.

**This supports and contributes to increases in efficiency of inter-agency collaboration.**

#### **d) Use Evidence-based Service Planning Reports (EBSR)**

***Accurately linking clients to the most cost-effective service will benefit clients directly and will enhance system cost-effectiveness. The EBSR supports such linkages.***

The BCFPI database includes a catalogue of clinical treatments targeting the CYMH problems screened by BCFPI, which have been shown to be effective in peer-reviewed studies, and which are described in an available clinician's manual, such that a clinician could potentially replicate the proven service. This list was developed by and is updated periodically by CYMH academics at the Faculty of Health Sciences (Hamilton (Canada)).

The EBSR cross references the clients age and scores => 70 to the list of proven interventions, and provides an annotated list of interventions which appear to correspond to the child's problems, together with strong cautions that these may not be applicable to the current case, and that a clinical diagnosis is needed for appropriate use of these interventions.

The references include hot-links to research in NLM supporting each intervention, from which the reader can glean further details re the intervention and related interventions. The system thus provides a portal to literature re interventions which have helped cases with seemingly similar problems.

Workers typically use these references to broaden and or confirm the range of responses they are considering for a case. Many are group interventions, which may suggest increases in efficiency compared to more familiar single case interventions.

Agencies may review their monthly statistics, and identify problem types which seem particularly daunting and prevalent for the agency. The EBSR has been used to suggest interventions which could be implemented and evaluated by the agency, to meet such challenges.

If the agency routinely gathers systematic discharge, satisfaction and outcome data, and runs the benchmark report, it can compare its effect sizes for each problem type with those reported for these

EBSR interventions. It can then evaluate whether its approaches are having optimal results, and where an seemingly superior EBSR intervention may need to be considered.

### **e) Use 'During service' Checklists and Comparative Case Reports**

***Clarity and consensus re progress and continuing problems during treatment facilitate accurate (progress-related) service management.***

(Selected) clients can be given paper BCFPI checklists to complete at appropriate treatment intervals, for entry by support staff. A comparative line graph can be produced, comparing intake and current scores (i.e., symptom levels). These can be reviewed by the worker (and family) to assess progress and plan next steps. Where needed checklist could be completed by both parents, and/or teacher(s) and/or the child/youth, if there was a need to compare different perspectives of the problem.

### **f) Use 'Brief' versions of questionnaires as a screening tool**

***BCFPI interviews are designed for completion within about 35 minutes, to minimize client burden and system cost.***

The 'Brief' version of all forms (as opposed to the 'Long version') includes all of BCFPI's standardized symptom, function and risk items, along with descriptive ratings of 'Other concerns', Readiness, Barriers, Abuse and basic demographics.

These items are sufficient for screening, and include the most reliable/ relevant screening items.

The optional 'protective items' and descriptive risk items in the 'long' forms are used by some sites. Such sites reportedly take 45, 60 or up to 90 minutes to complete BCFPI interviews. This may be appropriate for workers conducting initial interviews on cases they themselves will be continuing. These may start as screening, but transition to assessment and engagement. However, this detail and intensity is excessive for an intake screening by a screening intake clinician who is unlikely to have further involvement with the case. Screening interviews should require ~ 35 minutes.

### **g) Develop and Use Intake as a 'Specialty' to Optimize Responses to Each Referral**

***An intake worker can develop specialized skills in conducting concise screening interviews and interpreting BCFPI intake reports, and connecting the case to the most appropriate resources, thus enhancing system cost-effectiveness.***

Intake can function most effectively when conducted by a person spending 50% -100% of their time on the role. BCFPI empowers them to work actively with clients in immediately effective ways. In a larger community with an array of resources, the intake worker should be specialist in the agency's internal and external triage process and expediting client connection to the most appropriate agency or community resource. The intake worker can also be a particularly well-informed participant in community groups planning and monitoring the spectrum of community CYMH services.

Some settings may diminish the value and effectiveness of the role by rotating many staff members through the position @ ½ day or a day, once per week or month. This tends to diminish the perceived and felt value of the role, and may make it difficult for the advantages listed above to be maximized (particularly a, b, c, d, f), above.

## **6. How Can BCFPI Data be ‘Leveraged’ to Improve the Service System?**

***Given limited or shrinking availability of resources for human services, it is essential that managers of these services gather and analyze referral, waitlist, outcome, follow-up and satisfaction data to support optimization of the service system, and meet external accountability expectations of the public, accreditation bodies and funders by documenting this optimization.***

### **a) Use BCFPI to Manage and Collect Outcome, Satisfaction and Follow-up Data;**

Systematic collection and analysis of outcome data is very costly and challenging for most field settings. When attempted, compliance rates rarely reach 40%, and divert important support, management and clinical resources. Field experience (Sweden) indicates that routinely ‘contracting’ with clients to complete semi-annual follow-up checklists yields a compliance rate closer to 80% +.

The first step in BCFPI’s ‘Finish interview dialogue’ is to ask the informant for consent to be contacted in (6) months to complete a follow-up checklist. The informant’s response is recorded, and if they agree, contact information is recorded (carried forward).

Clients who consent and providing an e-mail address at intake are automatically sent e-mails at regular intervals (e.g., every 6 months) for fixed period (e.g., 2 years) These link to a secure site where the client completes a brief discharge or follow-up checklist. These are used for aggregate outcomes reports (discharge, 6, 12 18 and 24 months), and will be shared with the original agency if the client consents. This system also supports phone and mail follow-ups.

### **b) Create and Use Real-time Aggregate Reports**

BCFPI provides a number of management and planning oriented descriptive aggregate reports in tabular or graphical format. These reports can be grouped (compared) and/or filtered by complex sets of user-entered parameters, including referral date, agency, program, city, region, client age range, risk factors, etc. Time series reports will also be available (e.g., average incoming scores and effect sizes for northern teens referred with mood problems over each of past 4 years).

A user with agency privileges will be able to evoke a list of cases IN THAT AGENCY meeting these same criteria, and ‘drill into’ agency data for any case in this list.

BCFPI also provides powerful outcomes reports...

### **Outcome and benchmarking reports:**

- Tabular satisfaction reports at first 6 month follow-up interview
- Comparative Before-discharge and then follow-up (at 12 and 24 month) reports
- Effect size tables. For each Mental Health domain , for cases with starting scores => 65 on , what were average post scores, at each 6 month interval and how large were the effect sizes (Effect size = difference in pre-post means / standard deviations)
- (pending) Benchmark reports... how do these effect sizes compare to the best reported in reviewed literature, for a given problem (disorder)? This can include ad hoc service cost comparisons.

### **c) Copies of non-Identifying Data Base Extracts for Researchers**

Qualified researchers or managers, upon the consent of clinical database owners, can be provided with Sequel DB copies of segments of the data base, for academic research or administrative reports not supported by the reports listed above. An example might be a regression analysis seeking correlates of temporal changes in scores. Such data will be non-identifying, and will not include full birthdates. These files are designed so that they CANNOT be linked to other databases Such linkage usually violates data privacy regulations.

## **7. Why Should a Region or Community Try to Develop an Integrated Spectrum of CYMH Services with a System-wide Intake Protocol?**

Community CYMH services may be uncoordinated, with gaps, duplication and lack of clarity and consistency re where clients would be best served for a particular problem. This makes it difficult for parents to find the best service for their child or know where to call. This is may be increased across sectors (health, education, welfare, education, family doctors, corrections, social services, etc.). Workers may also have difficulty navigating such systems. Uncertainty re agency wait list will add to the challenge

## **8. How can BCFPI Support the Development of a Regional Spectrum of Services Harmonizing Service Needs and Provider Capacities?**

The process will unfold and continue over a multi-year period, as follows. Major changes can be made within 1 year, and refinements, increasingly based on outcomes and client satisfaction can follow.

1. Participating agencies and CYMH service providers in a region /community start using BCFPI for intake (to support this process, BCFPI is usually licenced to a region, province or country rather than single agencies, so that all qualified providers in a region can participate in this process)
  - The agencies may start by continuing to do their own intakes, or setting up a central intake or a combination of both, depending on how each agency wants to participate.

2. The agencies use BCFPI, and conduct Intakes as they see fit for 3 – 6 months. They gather statistics re type and numbers of referrals to each agency, and wait list size and duration in each agency.
3. They also agree on a resource /strategy for gathering and analyzing satisfaction, discharge and follow-up checklists, and start gathering that data. This can be based on BCFPI's management of 3<sup>rd</sup> party follow-up data processing (sec. 6a)
4. After 3 – 6 months, the agencies initiate quarterly reviews of their community and agency BCFPI aggregate reports (sec 6b) at a regional CYMH planning forum. Based on these statistics re prevalence of referral problem type, severity, age group, location, and their own abilities and specialties, they initiate an evolving plan which attempts to match the needs of referrals to which agencies will specialize in serving which groups... could be as simple as age or location, or could include problem type, severity, etc.
5. Whether intake is centralized or stays in agencies (or a combination of both), all intake workers try to triage referrals in accordance with the plan developed in #4, above.
6. The cross sector, multi-agency planning group continues the process of matching intake triaging protocols to BCFPI-measured need, monitoring fidelity to the protocol by looking at subsequent triaging patterns and success by looking at outcomes, satisfaction and unmet needs. Their goal is to maximize the number of cases served successfully (good short and long-term outcomes, high levels of satisfaction) possible with existing resources.
7. At some point, the Community may wish to advocate for additional services. The context would be a demonstration of the extent to which they had optimized and prioritized services based on existing resources, and the continuing presence of significant unmet needs.

## 9. How do We Set up BCFPI for our agency and Community?

### a) What are Our Options to Set up BCFPI Agency and Program Structure and User Privileges to Match Actual Community and Agency Structure, and Privacy Rules and Best Practices?

***BCFPI User Privileges and File Structure can be set up to Correspond to Community and Agency Structure and Privacy Rules and Practices.***

- Users can have privileges to create and/or edit and/or view and/or delete case identifier data and/or interview data and/or agency enrolment data.
- These privileges are restricted to the agency(s) where the user has these privileges.
- Thus users can only see data for cases registered in their agency
- Users can have privileges in one or many agencies and same or different privileges in each (and hence interact with case data differently in multiple agencies.)
  - Broad roles include intake interviewer (most privileges), file clerk (can set up but not conduct interviews, can manage enrolments), clinician (can read but not write)
  - The 'Express share' privilege allows a user (typically an 'authorized central intake worker) to create, for consenting cases, enrolments in any community agency, without

that agency's prior case-specific consent, and share copies of intake interviews with this agency. This supports efficient triaging to one or more of many community agencies by trusted central intake workers. Receiving agencies can reject the referral post hoc.

- The ad hoc share privilege allows a worker to request that another agency set up a referral for a consenting case and ability to view 0, 1 or several selected interviews conducted by the originating agency. The other agency must accept before data can be exchanged. This supports ad hoc referrals and collaboration.
- 'Sharing' data occurs within the context of BCFPI's secure structure. It eliminates the more costly, cumbersome and risky practice of photocopying and mailing or faxing material between locations.
  - Once these collaborative relationships are established for a consenting case, further enrolment or interview data may be shared until one of the participants terminates the relationship, whereupon future data cannot be shared.
- To protect client privacy, only users who need to see BCFPI reports or manage BCFPI files should have BCFPI privileges in an agency. This may include all clinicians who need to use BCFPI intake reports on-line (as opposed costly paper copies) with on-line links to NLM in EBSR.
- Users can be set up with privileges in their own agency only, with designated senior staff having the right to refer (share) consenting case with other agencies using the BCFPI system. This is how an agency would be set up which did its own intakes and periodically referred cases elsewhere.
- Searchable **audit trails** are maintained re all inter-change of identifying BCFPI data between agencies, including notes re client consent and purpose of the collaboration
- Workers in an actual Central Intake site can have privileges at that site and be empowered to share or expressshare (refer) cases to participating community agencies .
- Workers in a virtual intake site typically rotate through a community intake role from several community agencies (e.g. 1 day per week) and otherwise work in their own agencies, They'd have privileges in their home agency and in the central Intake and could share or express share from Central Intake to the appropriate community agency. As mentioned above (5g), infrequent intake workers seem less likely to be effective intake workers.

## **b) How do we Decide Whether a Structure Should be Set up as an Agency or a Program in BCFPI?**

- BCFPI structure includes Agencies and programs
- Some characteristics or guidelines of each are described below These may inform decisions re how to structure an organizational entity in BCFPI... an agency with assigned workers, or a program 'under' an agency...
  - An agency controls access to its programs
  - The only persons who can see data for an agency are persons with privileges in the agency

- Persons with agency privileges have the same privileges for the agency's programs
- An agency typically has one 'director' and may have no programs or several programs
- An agency usually receives external funding.
- An agency director does not usually direct other agencies
- An agency with multiple locations may be best set up in BCFPI as a single agency with each location being setup as a program 'under' the agency and agency director
- Agency programs can be in several locations
- A case can be enrolled in 1 , one or several agencies at the same time or successively
  
- Programs usually have a manger, and a program manger may manage several programs
- Programs usually receive their funding through their agency
- Programs may be set up to serve a particular area or age group, or provide a specific kind of service (West end program; teen program, Day treatment program)
- Programs are often categorized as outpatient, day treatment, residential, inpatient, group, closed custody, etc.
- A program can have more than 1 category (teen Day Treatment)
- Statistical reports provide an agency summary and summaries for each program nested under that agency.
- Outcome statistics for programs may be more informative than broad agency statistics
- A case can be enrolled in 1 , one or several agency programs at the same time or successively
- A case cannot be enrolled in an agency program before it has been enrolled in the agency
- A case cannot be discharged from an agency until it has been discharged from all agency programs.

## **10. How Is BCFPI Useful for Single agencies**

Single agencies and their cases can benefit from all of BCFPI's features, except inter-agency file sharing (5c). The concept of regional spectrum of services (7, 8) can be replaced by the concept of 'within hospital / agency' spectrum of services.