

COLUSA COUNTY DEPARTMENT OF BEHAVIORAL HEALTH
QUALITY IMPROVEMENT WORK PLAN
FISCAL YEAR 2019-2020



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Colusa County Behavioral Health Services

Quality Improvement Work Plan for 2019-2020 Fiscal Year

To be tracked in the Quality Improvement Committee

Introduction

The Colusa County Department of Behavioral Health Quality Management program has many moving parts as the outline of functions in the following grid indicates. The Program has broad oversight responsibilities for Performance Improvement Projects (PIPs), Outcome measures, Cultural Competency, Service delivery, Network Adequacy, Beneficiary protection (including Grievances and appeals and Change of provider requests), EHR implementation, Psychiatric services, Consumer involvement and Chart review.

The Quality Improvement Committee is the key in implementation of the Quality Improvement (QI) Work Plan. Membership on this Committee includes licensed clinical staff (LCSW, PhD, LMFT), interns (ACSW and AMFT), consumers, Patients' Rights Advocate, and support staff. The QI Committee meets quarterly, though data to support the work of the Committee is gathered more frequently. Several different staff are involved in gathering and presenting data to the Committee: Reception staff gather information on requests for services and timeliness of offered and initial appointments, demographic information of new referrals, and issuing of Notices of Adverse Benefit Determination (NOABD) Timely Access Notice; a clinician gathers information on access to psychiatric services and crisis service utilization; medical records staff organize chart samples for review; and others gather information on ad hoc topics.

The entire process is overseen by a licensed clinician in the role of Quality Assurance Coordinator.

QIC MEMBERS	
Name	Title
Terry Rooney, PhD	Director
Jan Morgan, LCSW	Deputy Director Clinical Services Child Division
Jeannie Scroggins, LMFT	Quality Assurance Coordinator
Sally Cardenas	Office Assistant Supervisor
Jason Fitch, ACSW	Therapist II
Walter Osbourn	Consumer Representative
Cindy Palynski	Patients' Rights Advocate
Valerie Stirling	Peer Support Specialist
Mayra Puga	MHSA Coordinator
Bessie Harbison, ACSW	Therapist II
Mark McGregor, LCSW	Program Manager Clinical Services Child Division
Shannon Piper, LMFT	Program Manager Clinical Adult and Crisis Services

Quality Improvement Work Plan		Discussion	Action Items
QI Subcommittees	PIPS 1. Administrative PIP: Co-Occurring Disorders	The Department will increase the focus on treatment of Co-Occurring Disorders. The Department will increase the diagnosing of Co-Occurring Disorder from currently sixteen percent to a number closer to National percentages which is 40% percent.	See the PIP Implementation & Submission Tool at the end of this document
	2. Clinical PIP: Clinical Engagement	The Department will continue to look at early consumer engagement as defined as having 3 appointments within 60 days from the date of the intake. An administrative staff is calling the consumer informing the consumer of the new assigned staff. The Department is sending Thank you cards to the client acknowledging and appreciating the consumer for reaching out for services and completing the intake to begin services. The Department is looking at ways early consumer engagement can be improved.	PIP Implementation & Submission Tool to be completed
	Cultural Competency	The Department will highlight the importance of cultural competence for all staff by providing regular trainings on various cultures (i.e. client culture, Hispanic culture, school culture, etc.). The membership of this committee will be expanded to include more community representation. The Department will also encourage community awareness of mental wellness through the annual May is Mental Health month activities and suicide awareness month activities.	The continued focus on addition of community representatives needs to be accomplished; Outreach efforts will be continued by the MHSA Coordinators
	Audits	DHCS/Medi-Cal Audit: The Department will establish an audit committee to respond to Medi-Cal audit requirements as needed.	Audit Committee establishment as needed
		EQRO review: The Department will continually collect data to support responding to the annual EQRO review.	Ongoing data collection and analysis
Improve Service Delivery Capacity	1. Monitor the number of Hispanic individuals being	The Department will collect data monthly on the number of Hispanic individuals being served. This data will be reviewed at each QIC meeting.	The goal will be to reach parity with the percentage of Hispanic individuals in the community compared with the current percentage of 45-55% Hispanic

Quality Improvement Work Plan		Discussion	Action Items
<i>Objective:</i> Monitor service delivery capacity.	served. The number of new Hispanic referrals will be monitored at each QIC meeting		intakes
	2. Monitor the capacity to deliver Bilingual Services	The Department will monitor the capacity to deliver Bilingual services based on item 1 above and the ease with which the need for interpretive services is met. The use of graduate level bilingual interns to fill this need will be evaluated.	The goal will be to serve each individual in their preferred language directly (i.e. without the use of the language line and preferably without interpreter)
	3. Improve relationships with local clinics and agencies	The Department will continue to encourage all providers to engage with local clinics and agencies via telephone calls, record sharing, supporting consumer use of primary health clinics, and other efforts. The Committee will monitor the Department's development of MOUs, and contracts for direct service, with FQHCs, Anthem, Northern California Health and Wellness, and hospital providers. The Department created an MD Referral Process form to improve the working relationship with community providers.	The Department should be known as a collaborator with a broad range of community providers
Improve Accessibility of Services <i>Objective:</i> Monitor accessibility of services.	1a. Document timeliness of routine mental health intake appointments (Days to intake). Review timeliness of intakes and present findings to QI Committee.	The Department will collect data monthly on the timeliness of routine (non urgent) initial appointments. If issues arise with meeting the Department standard of 10 days from request for services to a offered intake appointment the Committee will review/suggest strategies to address these issues.	The goal is to offer an intake appointment to all individuals requesting entry into services within 10 working days. This data will be collected daily by reception staff and reviewed in each meeting of the QIC.
	1b. Manage the success of the "Walk In" intake	The Committee acknowledged that the "Walk In" intake process has been so successful and the current challenge is to serve the increased number of	The goal continues to be to improve timeliness of services even beyond the 10 limit noted above. Reception staff

Quality Improvement Work Plan		Discussion	Action Items
	process. Strengthen & monitor the efficiency of the “Walk In” intake process.	consumers accessing the “Walk In” intake method of completing an intake. The Department has two “Walk In” Intake days to respond to the number of “Walk In” intakes on Tuesdays and Thursdays.	will collect data on frequency of use of the Walk In clinic versus scheduled appointments for review by the QIC
	1c. Review for NOA-A and NOA-E issued	The Committee will review for the issuing of NOABD notices and problem solve if issues are identified.	The goal is to insure that Notices of Adverse Beneficiary Determination are being issued correctly and as required. The reception staff will issue NOABD Timely Access Notices, intake clinicians will issue NOABD Denial Notices, the ACCESS Team will issue NOABD Service Delivery Notices, and the Program Managers will issue NOABD Modification Notices. The issuing of notices will be logged. QA staff will report on NOABDs to the QIC
	2. Continue to monitor “shows” and “no shows” and evaluate additional efforts to reduce the number of “no shows”.	The Department will collect data on shows and no shows for initial appointments monthly. The QIC will review this data at each meeting. The committee additionally has expanded the tracking to monitor “shows” and “no shows” for ongoing appointments for the purpose of reducing the number of “no shows”.	The goal will be to evaluate “show” rate to determine what actions might impact consumer engagement. Reception staff will collect data on no shows daily for intakes and present this data to QIC for review. Quality Assurance Coordinator will present ongoing “show” and “no show” findings in QIC. Current show rate of above 80% will be the standard against which success will be measured

Quality Improvement Work Plan		Discussion	Action Items
	3. Continue to monitor the timeliness of services for urgent conditions –10 minute response time is expected	The Department will monitor the timeliness of urgent services during regular business hours and after hours with a goal of providing urgent services “immediately” but no longer than 10 minutes after the request for such services.	The goal is for all urgent services to be offered within 10 minutes by phone and one hour for face to face contact. Reception staff will initiate collection of timeliness but clinical staff will record actual response time; QIC will review. The current success rate of approximately 75% on time responses will be the standard against which success will be measured
	4. Test call crisis after- hours and regular business number. Recommend changes when problems are identified	The Department will regularly test the responsiveness of the crisis service. The Department will measure the effectiveness of the service and accuracy of recording requests for service. The QIC will review these reports at each meeting.	Test calls will be made to the after-hours and regular-hours crisis staff monthly by assigned staff. The results of the calls will be recorded on the crisis script or other form and reviewed in QIC. Additionally, the call log will be reviewed in QIC to ensure that the test calls are logged. Office Assistant Supervisor will oversee the recording of this data.
Improve Beneficiary Satisfaction <i>Objective:</i> Measure Beneficiary Satisfaction by annual surveys <i>Objective:</i> Track consumer grievances/appeals;	Conduct consumer/family member satisfaction surveys.	The Committee to work with CIBH to review the results of the surveys as the information becomes available.	As reports are available from DHCS the Committee will review and make recommendations to the appropriate Department staff.
	Regular reports on Grievance / Appeals to be reviewed at each QIC meeting	The Department will respond to Grievances/Appeals in a timely manner. The QIC will review all beneficiary: Grievances, Appeals, Expedited appeals, Fair hearings, Expedited fair hearings, and Provider appeals to assess for system weakness/areas for improvement.	The PRA will report on all grievances/appeals Expedited appeals, Fair hearings, Expedited fair hearings, and Provider appeals received with the goal being that all grievances receive immediate attention and achieve resolution within 60 days. We must resolve an appeal within 30 calendar days of receipt.

Quality Improvement Work Plan		Discussion	Action Items
Track Change of Provider requests.	Requests for changes of provider to be reviewed at each QIC meeting	The Department will track all change of provider requests. The QIC will review these requests to assess if there are areas for improvement.	Medical Records staff will track change of provider requests daily and report to QIC. The QIC will review for patterns of change requests and respond with recommendations as needed
Improve Cultural Competence <i>Objective:</i> Continue to provide all staff training in issues related to providing culturally competent services including: Hispanic culture, Youth identifying as LGBTQ (lesbian, bisexual, gay, transgender, and questioning), client culture, etc. <i>Objective:</i> Monitor increase in Hispanic individuals served and needs for services	1.Provide training related to issues affecting quality of treatment services	The Department will encourage all staff to participate in training opportunities. Each staff person will receive an annual stipend to be used only to cover training costs. Additionally the Department will offer trainings for staff locally.	The QIC will receive reports from the MHSA Coordinators on trainings offered with the goal that each staff has the opportunity to continually improve skills in their area of responsibility. Additionally the Department expects staff to report on trainings received to their team on return from trainings.
	2.Continue outreach to Hispanic population. Assure availability of Spanish language materials for access to services and understanding of commonly diagnosed mental	The Department will continue to offer services where needed to engage children from Hispanic background (Note: over 60% of school age children are from Hispanic homes). The Department will also offer services in Spanish directly by the provider where possible, and through the use of skilled interpreters as needed. The Department will also maintain materials in Spanish and English.	The QIC will track outreach activities to the Hispanic community via reports from the MHSA Coordinators with the goal of continued increase in the number of Hispanic individuals accessing services (as measured in the above item)

Quality Improvement Work Plan		Discussion	Action Items
<i>Objective:</i> Increase understanding of stigma & combat its' effects.	health issues		
	1. Provide training on stigma to high school students via Friday Night Live/Club Live. Participate in Statewide prevention activities funded through Department participation in CALMHSA.	1. The Department will support staff involvement with Friday Night Live and Prevention activities as a method to engage school age children in overcoming stigma. The Department will participate in funding Statewide anti-stigma programing through participation in the CALMHSA Every Mind Matters project.	The QIC will track involvement with FNL via reports from the Clinical Program Manager/Prevention Coordinator with the goal of increasing the number of students impacted by this stigma reduction activity
	2. Employ consumer / providers. Promote participation by family/ consumers in MHP program planning	The Department will actively look for ways to employ consumers and encourage consumer participation in MHP program planning.	The QIC will review the number of consumers employed by the Department, which currently is 2 fulltime employed consumers
	3. Provide multiple opportunities to celebrate Mental Health Month (MAY) via community	The Department will sponsor a variety of activities tied to Mental Health Month. Each activity will be designed to celebrate the work of recovery and/or address stigma.	The Department will support and encourage consumer development of Mental Health Month activities.

Quality Improvement Work Plan		Discussion	Action Items
	events, displays at libraries and community centers, Board of Supervisors proclamation and other activities as identified		
Improve Quality of Service <i>Objective:</i> Become more versed in Recovery and Resiliency Principles.	Provide at least one training opportunity for each clinical staff member in a recovery model environment	The Department will invest in training staff in the recovery model (Motivational Interviewing, use of the MORS, Strength Based assessments, etc).	The QIC will track staff presentation of clinical trainings via reports from Deputy Director with the goal that each clinical staff has the opportunity to continually improve their ability to offer recovery model services
	Identify sample of open charts for review, conduct review using Peer Review chart review form, provide feedback to clinical staff and QIC, and monitor corrections	The Department will continuously review charting by clinical staff including therapists, case managers, facilitators, and physicians. The QIC will review reports on this activity at each meeting.	Medical records staff will identify a sample of open charts for review and complete a review of clerical issues; then route these charts to a clinician for clinical review; the results of these reviews will then be reviewed by QIC with feedback to clinical staff regarding needed corrections
	The QI Committee will monitor the frequency of crisis requests per time and day of week	The Committee will review the frequency of crisis requests by day of week and time and make recommendations for adjustments to staff/scheduling as needed.	A clinician member of the QIC will review the crisis logs and provide a report to the QIC. The QIC will make recommendations as needed to Deputy Director to improve crisis

Quality Improvement Work Plan		Discussion	Action Items
Monitor days for frequency of crisis service requests and recommend coverage adjustments as needed.	and recommend adjustments to coverage as needed.		response
Evaluation of QI Activities <i>Objective:</i> QI Committee will have a standing agenda item that will review and evaluate the results of QI activities, recommend policy changes, institute needed QI actions to address concerns, and ensure follow-up.	The QI Committee will have an agenda item at each meeting that will allow the committee to focus on the activities of the Committee and evaluate the effectiveness of Committee recommendations for policy changes	The Department will encourage a Continuous Quality Improvement (CQI) orientation in the QIC by regularly reviewing the activities of the QIC to evaluate the effectiveness of QIC recommendations.	The goal is to ensure that QIC recommended actions receive follow up until the action is complete or no longer needs QIC oversight
Evaluation of access to psychiatric services <i>Objective:</i> Monitoring	QI Committee will monitor the efficiency of the referral process to psychiatric services	The Committee will review the time line between request for medication services to the offering an appointment of these services. The Committee will review for disparity in this timeline for children versus adults; and make recommended program changes as needed.	A clinical member of the QIC will review the EHR to determine the timeline from referral to psychiatric services to offered appointment of services. The goal is to complete the referral/offered process within 15 days.

Quality Improvement Work Plan		Discussion	Action Items
timeline between ACCESS Team referral to and receipt of psychiatric			
Monitor Medication Services <i>Objective:</i> QI Committee will monitor the safety and effectiveness of medication practices.	QI Committee will monitor the findings of the medications reviewers regarding the safety and effectiveness of medication practices	The Committee will track the addition of an appropriate reviewer of prescribing practices (e.g. pharmacist) to allow of regularly review the prescribing practices of staff psychiatrist. These reviews will be reported to the QIC for oversight and needed actions.	Medical records staff will identify a sample of medication charts for review. The prescribing practices will be reviewed by a person licensed to prescribe or dispense prescription drugs and reviewed in QIC for compliance
Consumer Involvement in QI Findings <i>Objective:</i> The Department shall make every effort to inform consumers about the findings of the QI Committee.	Consumers will be regular members of the QI Committee. Each meeting of the QI Committee will have an agenda item which seeks consumer input	The Department will encourage and support the involvement of consumers in the QIC process. Consumers may receive stipends for their participation in this committee.	Consumer members of the QIC will be encouraged to update the Committee on any areas of interest or concern. QIC will provide support and advocacy as needed. The Department will consider methods for informing consumers on the work of the QIC (Minutes available in the lobby, or via the website or other methods). Minutes can be made available at Safe Haven.
Other Items To be added as identified (e.g. issues that raise quality of care concerns)			



Performance Improvement Project Implementation & Submission Tool

Planning Template

Introduction & Instruction

This tool provides a structure for development and submission of Performance Improvement Projects (PIPs). It is based on EQR Protocol 3: Validating Performance Improvement Projects (PIPs), as a mandatory protocol delivered by the Centers for Medicare & Medicaid Services (CMS) in September of 2012.

The use of this format for PIP submission will assure that the MHP addresses all of the required elements of a PIP. If the MHP uses another format, they must ensure that all of the required elements of the PIP are addressed and included in their submission. **PLEASE fully complete each section and answer ALL questions.**

- ❖ The PIP should target improvement in either a clinical or non-clinical service delivered by the MHP.
- ❖ The PIP process is not used to evaluate the effectiveness of a specific program operated by the MHP. If a specific program is experiencing identified problems, changes and interventions can be studied using the PIP process. This can be done to create improvements in the program and should be included in the narrative.
- ❖ The narrative should explain how addressing the study issue will also address a broad spectrum of consumer care and services over time. If the PIP addresses a high-impact or high risk condition, it may involve a smaller portion of the MHP consumer population, so the importance of addressing this type of issue must be detailed in the study narrative.
- ❖ Each year a PIP is evaluated is separate and specific. Although topic selection and explanation may cover more than one PIP year, every section should be reviewed and updated, as needed, to ensure continued relevance and to address on-going and new interventions or changes to the study.
- ❖ If sampling methods are used, the documentation presented must include the appropriateness and validity of the sampling method, the type of sampling method used and why, and what statistical subset of the consumer population was used.
- ❖ General information about the use of sampling methods and the types of sampling methods to use to obtain valid and reliable information can be found in Appendix II of the EQR Protocols.¹

¹ EQR Protocol: Appendix II: Sampling Approaches, Sept. 2012, DHHS, Centers for Medicare & Medicaid Services (CMS), OMB Approval No. 0938-0786

Identification of Plan/Project

MHP Name: **Colusa County Department of Behavioral Health (CDBH)**

Project Title: **Co-occurring Disorder** Check One: Clinical Non-Clinical **x**

Project Leader: **Jan Morgan, LCSW** Role: **Project Leader**

Start Date (MM/DD/YY): **05/22/18**

Completion Date
(MM/DD/YY):

Projected Study Period (# of months): **10**

Brief Description of PIP:

*(Please include the GOAL of the
PIP and what the
PIP is attempting to
accomplish.)*

Last year, our goal was to bring the frequency of diagnosis of co-occurring disorders (formerly known as dual diagnosis) more in line with the Statewide frequency of 21.3%. It was noted in FY17-18 BHC EQRO report that Colusa County was significantly lower than the Statewide average in diagnosing co-occurring disorders. Since this time we have expanded this PIP to improve our percentage of diagnosis of co-occurring disorders to mimic the National frequency of 40%.

Step 1: Select & Describe the Study Topic

1. The PIP Study Topic selection narrative should include a description of stakeholders involved in developing and implementing the PIP. MHPs are encouraged to seek input from consumers and all stakeholders who are users of, or are concerned with specific areas of service.
 - Assemble a multi-functional team (e.g. clinical staff, consumers, contract providers as appropriate).
The Department assembled a team consisting of the Deputy Director of Clinical Services, the Quality Assurance Coordinator (LMFT), the Clinical Program Manager for Children's Services (LCSW), the Behavioral Health Director (PhD) and a Consultant (LMFT).
 - Describe the stakeholders who are involved in developing and implementation of this PIP. Be sure to include CFM group representation.
The development of this PIP has largely been driven by consultation with BHCEQRO staff who helped the County recognize this disparity between Statewide and Colusa County frequency of diagnosis of co-occurring disorders. Following this recognition of the disparity, the team members noted above fully embraced the need to study this problem.
 - Describe the stakeholders' role(s) in the PIP and how they were selected to participate.
The participants are standing members of the PIP Committee in the County.
2. Define the problem.
 - The problem to be addressed should be clearly stated with narrative explanation including what brought the problem to the attention of the MHP.
 - What is the problem?
 - How did it come to your attention?
 - What data have you reviewed that suggests the issue is indeed a problem for the MHP? Describe any relevant benchmarks.
The three preceding bullets will be addressed in this paragraph.
As noted, we received encouragement from BHCEQRO staff to review the disparity in the diagnosis of co-occurring disorders. Indeed the diagnosis of such disorders in Colusa County is lower than the Statewide average; apparently we have a problem here.
The PIP Committee then dug deeper into the available data and found that the reported percentage of co-occurring diagnoses reported to BHCEQRO by the Department was only 16%. This compares to a Statewide average of 21.3% of co-occurring diagnoses and a National average of 40%

	National	Statewide	Colusa County
Percentage of consumers diagnosed with a co-occurring disorder	40%	21.3%	16%

What literature and/or research have been reviewed that explain the issue's relevance to the MHP's consumers

- When the Committee reviewed the BHCEQRO report from the 17-18 Fiscal Year, this paragraph stood out “The MHP noted a very low rate for co-occurring disorders in the Information Systems Capability Assessment. This may be an area of investigation for clinical data analytics to assist the executive team in appropriately structuring the program.” Since this company is tasked with measuring performance for all 58 Counties in the State we are in agreement that this “may be an area of investigation”.
- The Committee also found documented evidence of the diagnosis of co-occurring disorders being a significant issue in the mental health field on the SAMSHA website:

“Co-occurring disorders were previously referred to as dual diagnoses. According to SAMHSA’s [2014 National Survey on Drug Use and Health \(NSDUH\) \(PDF | 3.4 MB\)](#), approximately *7.9 million adults (emphasis added)* in the United States had co-occurring disorders in 2014.

People with mental health disorders are more likely than people without mental health disorders to experience an alcohol or substance use disorder.

SAMSHA also notes:

Co-occurring disorders can be difficult to diagnose due to the complexity of symptoms, as both may vary in severity. In many cases, people receive treatment for one disorder while the other disorder remains untreated. This may occur because both mental and substance use disorders can have biological, psychological, and social components. Other reasons may be inadequate provider training or screening, an overlap of symptoms, or that other health issues need to be addressed first. In any case, the consequences of undiagnosed, untreated, or undertreated co-occurring disorders can lead to a higher likelihood of experiencing homelessness, incarceration, medical illnesses, suicide, or even early death.

People with co-occurring disorders are best served through integrated treatment. With integrated treatment, practitioners can address mental and substance use disorders at the same time, often lowering costs and creating better outcomes. Increasing awareness and building capacity in service systems are important in helping identify and treat co-occurring disorders. Early detection and treatment can improve treatment outcomes and the quality of life for those who need these services.

- Another support for the importance of accurate diagnosis of co-occurring disorders comes from a study done at Washington State University, Spokane and The Washington Institute for Mental Illness Research & Training. This study noted:

Since the 1980's, increasing recognition has been given to the issue of comorbid psychiatric and substance use disorders (SUDs), otherwise known as dual disorders. Community and clinical studies show that dual disorders are prevalent (e.g., Kessler et al., 1996; Ross, Glaser, & Germanson, 1988; Rounsaville et al., 1991; Regier et al., 1990). In the National Comorbidity Study, a nationally representative population study, about 41-65% of participants with any lifetime substance use disorder also had a lifetime history of at least one mental health disorder (Kessler et al., 1996). The most common individual diagnosis was conduct disorder (29%), followed by major depression (27%), and social phobia (20%). Among those with a lifetime history of any mental disorder, 51% had a co-occurring addictive disorder, with those respondents with conduct disorder or adult antisocial personality having the highest prevalence of lifetime SUDs (82%), followed by those with mania (71%), and PTSD (45%). In the Epidemiologic Catchment Area Study, lifetime prevalence of alcohol use disorder was highest among persons with bipolar disorder (46%) and schizophrenia (34%; Regier et al., 1990).

One conclusion of this report is:

"Given this accumulating evidence that comorbid substance use and psychiatric disorders are

common in community and clinical studies, Minkoff (2001) has argued that dual disorders

"...should be expected rather than considered an exception".

➤ The study topic narrative will address:

- What is the overarching goal of the PIP?
The overarching goal of this PIP will be to improve the expertise of clinical staff in recognizing co-occurring disorders among individuals seeking services at Behavioral Health. Recognizing that seeking Behavioral Health services was not likely the first intervention that individuals attempted in trying to solve problems, we need to do a better job of making sure that treatment interventions are focused on the "real" diagnoses that bring consumers into care.
- How will the PIP be used to improve processes and outcomes of care provided by the MHP?
This PIP is all about improving a process of care, specifically the process of making sure that the treatment is appropriately focused on both the obvious presenting problem and the likely secondary problem of substance use for a large portion of the population seeking services.
- How any proposed interventions are grounded in proven methods and critical to the study topic?
The development of interventions will be driven by the goal of improving accurate diagnosis of co-occurring disorders. Interventions that are developed will be tried first on a small scale (using the PDSA method) before the successful interventions are rolled out to the entire system.

➤ The study topic narrative will clearly demonstrate:

- How the identified study topic is relevant to the consumer population
The study topic of accurate diagnosis is clearly relevant based the feedback the Department has received from BHC EQRO; and based on literature review. It has been clearly shown that co-occurring disorders are common in the mental health field, but are under-represented in the Department's data. If we are not accurately diagnosing a commonly occurring disorder, it is likely that we are consequently not providing the fully needed scope of interventions.
- How addressing the problem will impact a significant portion of MHP consumer population
The problem of co-occurring disorders impacts up to 51% of the population of individuals with a mental health disorder (per the Washington study noted above); though for some diagnostic categories the frequency of co-occurring disorders was noted to be as high as 82% (for individuals diagnosed with antisocial personality disorder). Thus it is likely that this same percentage of consumers of services from Colusa County has co-

occurring disorders.

- How the interventions have the potential to impact the mental health, functional status, or satisfaction of consumers served. The interventions are only “proposed” at this point but given the goal of this PIP to improve the accuracy of the diagnosis of individuals seeking services at Behavioral Health the interventions that are developed will be focused on the overall goal of insuring new consumers receive the care needed for the now accurately diagnosed problems.

Step 2: Define & Include the Study Question

The study question must be stated in a clear, concise and answerable format. It should identify the focus of the PIP. The study question establishes a framework for the goals, measurement, and evaluation of the study.

The study question for this PIP will be:

“Will enhanced focus on the diagnosis of co-occurring disorders increase the percentage of such diagnoses from an average of 16% to an average closer to the nationwide average of 40%?”

Step 3: Identify Study Population

Clearly identify the consumer population included in the study. Include an explanation of how the study will address the entire consumer population, or a specific sample of that population. If the study pertains to an identified sector of the MHP consumer population, how inclusion of all members will occur is required. The documentation must include data on the MHP’s enrolled consumers, as well as the number of consumers relevant to the study topic.

This Step may include:

- Demographic information;
- Utilization and outcome data or information available; and
- Other study sources (such as pharmacy data) that may be utilized to identify all consumers who are to be included in the study.

This PIP will address the entire population of consumers that are new to Behavioral Health services immediately and also will address consumers currently in care over time (when a revised diagnosis is entered, which most frequently occurs at the annual review).

Step 4: Select & Explain the Study Indicators

"A study indicator is a measurable characteristic, quality, trait, or attribute of a particular individual, object, or situation to be studied."² Each PIP must include one or more measurable indicators to track performance and improvement over a specific period of time.

Indicators should be:

- Objective;
- Clearly defined;
- Based on current clinical knowledge or health service research; and
- A valid indicator of consumer outcomes.

The indicators will be evaluated based on:

- Why they were selected;
- How they measure performance;
- How they measure change in mental health status, functional status, beneficiary satisfaction; and/or
- Have outcomes improved that are strongly associated with a process of care;
- Do they use data available through administrative, medical records, or another readily accessible source; and
- Relevance to the study question.

The measures can be based on current clinical practice guidelines or health services research. The MHP must document the basis for adopting the specific indicator.

In reporting on the chosen indicators include:

- A description of the indicator;
- The numerator and denominator;
- The baseline for each performance indicator; and
- The performance goal.

Specify the performance indicators in a Table.

#	Describe Performance Indicator	Numerator	Denominator	Baseline for Performance Indicator (number)	Goal (number)
1	Frequency of a diagnosis of a co-occurring disorder	Consumers given a co-occurring	All individuals seen for	The percentage of consumers given a co-occurring diagnosis currently is approximately 20%	At least 40% of consumers will be accurately

² EQR Protocol 3, Validation of Performance Improvement Project, Sept. 2012, DHHS, Centers for Medicare & Medicaid Services (CMS), OMB Approval No. 0938-0786

		diagnosis	intake and assigned to a clinician		diagnosed with a co-occurring disorder
2					
3					
4					

STEP 5: SAMPLING METHODS (IF APPLICABLE)

The MHP must provide the study description and methodology.

- Identify the following:
 - Calculate the required sample size?
CCBH is obtaining data from all open beneficiaries in the Mental Health program rather than selecting a sample.
 - Consider and specify the true or estimated frequency of the event?
The Department averages roughly 230-315 open clients each month.
 - Identify the confidence level to be used?
We would need help from EQRO staff to answer this question.
 - Identify an acceptable margin of error?
We would need help from EQRO staff to answer this question.

Describe the valid sampling techniques used?

All individuals open to mental health care at CCBH.

_____ N of enrollees in sampling frame – the N varies from month to month and can be seen below in the reported data

_____ N of sample – no sample size was utilized, rather our entire population was utilized for data

_____ N of participants (i.e. – return rate) – the N varies from month to month and can be seen below in the reported data

Step 6: Develop Study Design & Data Collection Procedures

A study design must be developed that will show the impact of all planned interventions. Include the information describing the following:

- Describe the data to be collected.
The number of individuals receiving services will be compared to the number of individuals diagnosed with co-occurring disorders utilizing data from the EHR.
- Describe the methods of data collection and sources of the data. How do these factors produce valid and reliable data representing the entire consumer population to which the study indicators apply?
Data will be collected utilizing the EHR Dashboard. All beneficiaries receiving services are entered into the EHR. This ensures a reliable data set, which represents the entire consumer population served.
- Describe the instruments for data collection, and how they provided for consistent and accurate data collection over time.
Colusa County Department of Behavioral Health has worked with Anasazi/Kingsview in the development of a dashboard to have information contained in the EHR readily available. That is the system was designed around compiling these types of data sets.
- Describe the prospective data analysis plan. Include contingencies for untoward results.
The total number of individuals diagnosed with a SUD over the total number of beneficiaries served during a given month will produce a percentage of individuals with a substance use disorder.
- Identify the staff that will be collecting data, and their qualifications. Include contractual, temporary, or consultative personnel.
Jeannie Scroggins, LMFT, Quality Assurance Coordinator will utilize the EHR Dashboard to data.

Step 7: Develop & Describe Study Interventions

The MHP must develop reasonable interventions that address causes/barriers identified through data analysis and QI processes. Summarize interventions in a table that:

- Describes each intervention;
- Identifies the specific barriers/causes each intervention is designed to address;
- Identifies the corresponding indicator that measures the performance of the intervention; and
- Maintains the integrity/measurability of each intervention.
- Describe how the interventions will impact the indicators and help to answer the study question.

Example:

Number of Intervention	List each Specific Intervention	Barriers/Causes Intervention Designed to Target	Corresponding Indicator	Date Applied
1	Share information on nationwide research on the benefits of co-occurring treatment on outcomes with clinical staff to enhance "buy-in" on establishing inclusive	Possible staff ignorance of the acceptance of a co-occurring disorder diagnosis in an MHP	Percentage of individuals diagnosed as having co-occurring MH/SUD	May 2018

	diagnoses.			
2	Review screening tools for co-occurring disorders	Lack of clinical familiarity with these tools. Lack of clinical awareness of the availability of these tools.		June 2018
3	Staff recieved training with an expert in diagnosis, Dr. Stan Taubman.	Build staff confidence in their ability to diagnose co-occurring disorders.	Percentage of individuals diagnosed as having co-occurring MH/SUD	June 29, 2018
4	"Overlapping Issues: Domestic & Sexual Violence, Mental Health, Trauma and Substance Use." Webinar sponsored by NAADAC	Develop an understanding of how substance use affects other disorders.	Percentage of individuals diagnosed as having co-occurring MH/SUD	December 12, 2018
5	Role plays using SUD assessment and questions in group supervision.	Develop staff's ability to ask difficult questions, how to ask about substance use, increase comfort identifying co-occurring disorders during the assessment phase	Percentage of individuals diagnosed as having co-occurring MH/SUD	March, 20 2019
6	ASAM Criteria training scheduled through CBHDA for CCBH Staff on October 23, 2019	Develop staff's ability to assess level of care through specific substance abuse domains and questions.	Percentage of individuals diagnosed as having co-occurring MH/SUD	July 15, 2019

Step 8: Data Analysis & Interpretation of Study Results

Data analysis begins with examining the performance of each intervention, based on the defined indicators. (For detailed guidance, follow the criteria outlined in Protocol 3, Activity 1, Step 8.)

- Describe the data analysis process. Did it occur as planned?
- Did results trigger modifications to the project or its interventions?
- Did analysis trigger any follow-up activities?
- Review results in adherence to the statistical analysis techniques defined in the data analysis plan.
- Does the analysis identify factors that influence the comparability of initial and repeat measurements?

The analysis of the study data must include an interpretation of the extent to which the PIP is successful and any follow-up activities planned.

Present objective data analysis results for each performance indicator. A Table can be included (see example), and attach all supporting data, tables, charts, or graphs as appropriate.

Example:

Performance Indicator	Date of Baseline Measurement	Baseline Measurement (numerator/denominator)	Goal for % Improvement	Intervention Applied & Date	Date of Re-measurement	Results (numerator/denominator)	% Improvement Achieved
1. Percentage of individuals diagnosed with a co-occurring disorder	5/22/2018	16%	40%				
				June 29, 2018 Staff received training with an expert in diagnosis, Dr. Stan Taubman.	October 2018	69/314 (22%)	6% above baseline
				December 12, 2019 DVN and SV, mental health, trauma and substance use webinar.	January 2019	86/263 (33%)	17% above baseline
					February 2019	85/232 (37%)	21% above baseline
				March, 20 2019 Role plays using SUD assessment and questions in group supervision.	March 2019	93/257 (36%)	20% above baseline
					April 2019	88/238 (37%)	21% above baseline
					May 2019	95/261 (36%)	20% above baseline
					June 2019	94/237 (40%)	24% above baseline and goal reached!

Step 9: Assess Whether Improvement is “Real” improvement

Real and sustained improvement are the result of a continuous cycle of measuring and analyzing performance, thoroughly analyzing results, and ensuring implementation of appropriate solutions. To analyze the results of the PIP the MPH must document the following steps:

- Describe issues associated with data analysis –
 - Did data cycles clearly identify when measurements occurred? Should monitoring have occurred more frequently?
 - Results of statistical significance testing.
 - What factors influenced comparability of the initial and repeat measures?
 - What, if any, factors threatened the internal or external validity of the outcomes?
- To what extent was the PIP successful and how did the interventions applied contribute to this success?
- Are there plans for follow-up activities?
- Does the data analysis demonstrate an improvement in processes or consumer outcomes?

It is essential to determine if the reported change is “real” change, or the result of an environmental or unintended consequence, or random chance. The following questions should be answered in the documentation:

- How did you validate that the same methodology was used when each measurement was repeated?
- Was there documented quantitative improvement in process or outcomes of care?
- Describe the “face validity,” or how the improvements appear to be the results of the PIP interventions.
- Describe the statistical evidence supporting that the improvement is true improvement.
- Was the improvement sustained through repeated measurements over comparable time periods? (If this is a new PIP, what is the plan for monitoring and sustaining improvement?)



Performance Improvement Project Implementation & Submission Tool

Planning Template

Introduction & Instruction

This tool provides a structure for development and submission of Performance Improvement Projects (PIPs). It is based on EQR Protocol 3: Validating Performance Improvement Projects (PIPs), as a mandatory protocol delivered by the Centers for Medicare & Medicaid Services (CMS) in September of 2012.

The use of this format for PIP submission will assure that the MHP addresses all of the required elements of a PIP. If the MHP uses another format, they must ensure that all of the required elements of the PIP are addressed and included in their submission. **PLEASE fully complete each section and answer ALL questions.**

- ❖ The PIP should target improvement in either a clinical or non-clinical service delivered by the MHP.
- ❖ The PIP process is not used to evaluate the effectiveness of a specific program operated by the MHP. If a specific program is experiencing identified problems, changes and interventions can be studied using the PIP process. This can be done to create improvements in the program and should be included in the narrative.
- ❖ The narrative should explain how addressing the study issue will also address a broad spectrum of consumer care and services over time. If the PIP addresses a high-impact or high risk condition, it may involve a smaller portion of the MHP consumer population, so the importance of addressing this type of issue must be detailed in the study narrative.
- ❖ Each year a PIP is evaluated is separate and specific. Although topic selection and explanation may cover more than one PIP year, every section should be reviewed and updated, as needed, to ensure continued relevance and to address on-going and new interventions or changes to the study.
- ❖ If sampling methods are used, the documentation presented must include the appropriateness and validity of the sampling method, the type of sampling method used and why, and what statistical subset of the consumer population was used.
- ❖ General information about the use of sampling methods and the types of sampling methods to use to obtain valid and reliable information can be found in Appendix II of the EQR Protocols.³

³ EQR Protocol: Appendix II: Sampling Approaches, Sept. 2012, DHHS, Centers for Medicare & Medicaid Services (CMS), OMB Approval No. 0938-0786

Identification of Plan/Project

MHP Name:	Colusa County Department of Behavioral Health (CDBH)		
Project Title:	Engagement	Check One:	Clinical ☒ Non-Clinical
Project Leader:	Jan Morgan	Deputy Director, Children's Services	Role: Project Leader
Start Date (MM/DD/YY):	03/07/2017		
Completion Date (MM/DD/YY):	Projected Study Period (# of months):		
Brief Description of PIP: (Please include the GOAL of the PIP and what the PIP is attempting to accomplish.)	The Department learned from data that an average of 25% of consumers drop out of care before the third post-intake clinical session.		
	The goal will be to increase the percentage of consumers that remain in treatment beyond 3 clinical sessions from current 75% to 85%.		
	This PIP will identify interventions that correlate with increased engagement, intending to accomplish better treatment outcomes.		

Step 1: Select & Describe the Study Topic

1. The PIP Study Topic selection narrative should include a description of stakeholders involved in developing and implementing the PIP. MHPs are encouraged to seek input from consumers and all stakeholders who are users of, or are concerned with specific areas of service.
 - Assemble a multi-functional team (e.g. clinical staff, consumers, contract providers as appropriate).
The Department assembled a team consisting of both Deputy Directors of Clinical Services (both LCSWs) (one for Adult and one for Children's), the Quality Assurance Coordinator (LMFT), the Clinical Supervisor for Children's Services (LCSW), the Behavioral Health Director (PhD) and a Consultant (LMFT). Stakeholders gave feedback on the PIP at Behavioral Health Board and Quality Improvement Committee meetings.
 - Describe the stakeholders who are involved in developing and implementation of this PIP. Be sure to include CFM group representation.
Updates on the PIP are provided at the Behavioral Health Board and Quality Improvement Committee, both of which have consumer presence. The Department has not been successful in recruiting a representative consumer for weekly meetings. The primary barrier seems to be the pace at which a PIP development process moves. Even for dedicated public servants the process is at times tedious until a PIP is identified and supported by data.
 - Describe the stakeholders' role(s) in the PIP and how they were selected to participate.
The Stakeholders who attend BHB and QIC receive regular updates on the progress of the Department's PIPs and provide feedback through their participation in BHB, QIC and Safe Haven.
2. Define the problem.
 - The problem to be addressed should be clearly stated with narrative explanation including what brought the problem to the attention of the MHP.
 - What is the problem?
 - How did it come to your attention?
 - What data have you reviewed that suggests the issue is indeed a problem for the MHP? Describe any relevant benchmarks.
The three preceding bullets will be addressed in this paragraph.
When the QIC and the PIP Committee studied the data on long wait times between intake and first clinical appointment we also noted what appeared to be a significant dropout rate before completing at least three clinical contacts post intake. This bit of information was an unexpected finding, but once it was known we felt compelled to study this issue; thus this PIP was born.
The PIP Committee then dug deeper into the available data and found that up to 39% of consumers failed to engage as measured by not completing three clinical appointments (for the month of October 2016), with the

average percentage of consumers failing to engage being 25% (for the months of October 2016 through January 2017; see table below). So clearly there was/is a problem with getting consumers engaged with clinical services.

The grid below shows the evidence we collected on percentage of individuals that dropped out within 60 days of care.

	October 2016	November 2016	December 2016	January 2017
Less than 3 clinical sessions post intake	7/18 (39%)	3/17 (18%)	4/20 (20%)	4/16 (25%)

What literature and/or research have been reviewed that explain the issue's relevance to the MHP's consumers
Several research papers on engagement were reviewed in the planning stage of this PIP. The oldest paper reviewed was released in 2002 in the Journal of Mental Health, in an article by L. Tait, M Birchwood, and P. Trower. Among the significant findings in the article were: "A significant number of persons with serious mental illness, particularly schizophrenia, are often difficult to engage in mental health community based services, particularly individuals with a dual diagnosis of substance abuse." The authors also make the point that "non-engagement should not always be viewed as a problem of clients". The authors later states "non-engagement may reflect either the extent to which services users perceived social and clinical needs are met or unmet, or results from negative evaluations of the quality of the care received or results from social experience and personality characteristics that influence attitudes towards mental health services".

A more recent paper, from 2004 in Brief Treatment and Crisis Intervention by M. McCay, K. Haogwood, L. Murray, and D Fernandez made the following points about engagement in regard to child mental health: "Perceived barriers were the most salient predictor of adherence to recommendations" and "Also, the match between parental preference for type of services offered to children and what the child actually receives has been significantly associated with longer lengths of involvement in child mental health care." The authors also noted that for children from Mexican American backgrounds, noted "parents who....expected their child to recover quickly were more likely to drop of treatment after attending just one session". On the positive side, the authors note: "...there is strong evidence that intensive engagement interventions implemented during initial contacts with youth and their families either on the telephone or during a first interview, can boost services use substantially." By weaving this concept of focusing on the initial contact as a critical element in engagement

five of seven sites in the study achieved a 100% return rate after initial appointment. The authors note “These rates of return are in considerable contrast with published data suggestion that 50% no-show rates and failure to return are extremely common”.

An even more recent paper, from 2015 in Community Mental Health Journal by K. Roeg, I. van de Goor, and H. Garresten provided the following definition of engagement: “Engagement is a determinant of how well a person will respond to professional input”. The authors also noted “...a longer duration between enrollment and the first conversation with a client were indicative for a lower engagement”; and “Clients themselves often mention their mental illness as the main reason for non-engagement”. Their final conclusion in their study of engagement was “...problem severity and number of weeks to get to a first conversation with a client make the largest unique significant contribution... *(to lack of engagement)*”. And, of course “...without engagement, a care provider cannot make a difference in someone’s life”.

An even more recent paper from 2016 in World Psychiatry by L. Dixon, Y. Holoshitz and I. Nossel the authors noted “Alliance has also been found to be important in work with individuals who have serious mental illness.” And “...independent predictors of therapeutic alliance included clinician’s recovery orientation, lower reported self-stigma and greater levels of insight.” The authors also address the issue of substance abuse and engagement in mental health care. They note “In fact, comorbid substance abuse is one of the strongest factors associated with non-initiation and non-engagement in mental health treatment”. They go on to state “One reason why individuals with dual diagnosis may be less engaged in treatment is the fragmentation of the care system”. But on a positive note they also report “...factors identified to enhance engagement included shared goals, optimistic outlook that does not focus on medications, ongoing psychoeducation, collaborative team-based care, and community outreach”.

Our final review was from a publication by NAMI in 2016 titled “ENGAGEMENT, a New Standard for Mental Health Care”. They begin their publication with this statement: “The facts say it all: **many people who seek mental health care drop out. 70% that drop out do so after their first or second visit**”. Similar to the previous authors, they note “Trusting and respectful relationships are the basis for recovery”. They also note “Successful engagement enables people to pursue recovery in life goals across multiple areas....Engagement is built and sustained on the foundation of hope, mutual trust, respect, effective communication and recognition of strength and resources that people experiencing mental illness bring to their recovery”. By contrast they state “the following characteristics create barriers to engagement: Inability or unwillingness to use creative and innovative approaches to engagement; Deficits-based rather than strengths-based orientation; Inability to work effectively within and across diverse cultures; Rigid adherence to program rules and regulations; Lack of respect for individuals and families; and Inability to convey a sense of hope for recovery and achieving life goals”. And finally they state that training for mental health professionals should focus on the following areas of

engagement: “Motivational interviewing; Shared decision making; Strengths based assessment; and Including natural supports”.

Based on these studies, engagement is clearly an important, if not the most important, element in mental health care. If an individual does not engage in services, even the most adept treatment model will not benefit the consumer. With this perspective, we have launched our Engagement PIP.

➤ The study topic narrative will address:

- What is the overarching goal of the PIP?

The overarching goal of this PIP will be to improve the consumer experience of care and the quality of care overall.

How will the PIP be used to improve processes and outcomes of care provided by the MHP?

This PIP is all about improving the client experience and subsequent engagement in clinical services.

- How any proposed interventions are grounded in proven methods and critical to the study topic?

The development of interventions will be driven by the goal of improving engagement in services, which is known to be the critical issue in consumer satisfaction with mental health care. Interventions that are developed may be tried first on a small scale (using the PDSA method) before the successful interventions are rolled out to the entire system. Other interventions that have high face validity will be rolled out as they are identified.

➤ The study topic narrative will clearly demonstrate:

- How the identified study topic is relevant to the consumer population

The study topic of engagement in services is clearly relevant to consumers; lack of engagement can lead to premature departure from care resulting in incomplete resolution of the problems that brought the consumer into care.

- How addressing the problem will impact a significant portion of MHP consumer population

The problem early departure from clinical services impacts up to 39% of the population of new consumers. This is a significant portion of the MHP consumer population; thus a successful PIP will impact a significant portion of the population.

- How the interventions have the potential to impact the mental health, functional status, or satisfaction of consumers served.

As noted above, interventions that are identified will focus on the goal of this PIP to improve the experience of individuals receiving services at Behavioral Health and the interventions that are developed will be focused on providing better care for new consumers.

Step 2: Define & Include the Study Question

The study question must be stated in a clear, concise and answerable format. It should identify the focus of the PIP. The study question establishes a framework for the goals, measurement, and evaluation of the study. **The study question for this PIP will be:**

“Will changes in our engagement process increase the percentage of consumers who remain engaged in treatment beyond 3 clinical sessions from current average of 75% to an average of 85%?”

Step 3: Identify Study Population

Clearly identify the consumer population included in the study. Include an explanation of how the study will address the entire consumer population, or a specific sample of that population. If the study pertains to an identified sector of the MHP consumer population, how inclusion of all members will occur is required. The documentation must include data on the MHP’s enrolled consumers, as well as the number of consumers relevant to the study topic.

This Step may include:

- Demographic information;
- Utilization and outcome data or information available; and
- Other study sources (such as pharmacy data) that may be utilized to identify all consumers who are to be included in the study.

The following addresses the above 3 bullet points. This PIP will address the entire population of consumers that are new, or return, to Behavioral Health services. It will not address consumers that have been in care for more than three clinical sessions or consumers that are “meds only”.

Step 4: Select & Explain the Study Indicators

“A study indicator is a measurable characteristic, quality, trait, or attribute of a particular individual, object, or situation to be studied.”⁴ Each PIP must include one or more measurable indicators to track performance and improvement over a specific period of time.

Indicators should be:

- Objective;
- Clearly defined;
- Based on current clinical knowledge or health service research; and

⁴ EQR Protocol 3, Validation of Performance Improvement Project, Sept. 2012, DHHS, Centers for Medicare & Medicaid Services (CMS), OMB Approval No. 0938-0786

- A valid indicator of consumer outcomes.

As noted above, the interventions identified will be focused on efforts that are believed to be effective in increasing consumer engagement. The success of these interventions will be measured against the baseline of an average of 25% “non-engagement” level.

The indicators will be evaluated based on:

- Why they were selected;
- How they measure performance;
- How they measure change in mental health status, functional status, beneficiary satisfaction; and/or
- Have outcomes improved that are strongly associated with a process of care;
- Do they use data available through administrative, medical records, or another readily accessible source; and
- Relevance to the study question.

The measures can be based on current clinical practice guidelines or health services research. The MHP must document the basis for adopting the specific indicator.

In reporting on the chosen indicators include:

- A description of the indicator;
- The numerator and denominator;
- The baseline for each performance indicator; and
- The performance goal.

Specify the performance indicators in a Table.

Example:

#	Describe Performance Indicator	Numerator	Denominator	Baseline for Performance Indicator (number)	Goal (number)
1	Individuals who attend more than 3 post intake appointments within 60 days of intake	Average of 30 (assuming this figure would be the number of new consumers entering treatment per month)	Approximately 495 (assuming this figure would be all open charts)	Average of 25% of consumers failing to engage	15% failing to engage; or 85 % engagement rate.
2					

3					
4					

STEP 5: SAMPLING METHODS (IF APPLICABLE)

The MHP must provide the study description and methodology.

- Identify the following:
 - Calculate the required sample size? **As a tiny county this sample size question is difficult to establish. Given this challenge we will include all new consumers who agree to post intake appointments.**
 - Consider and specify the true or estimated frequency of the event? **We have noted an average 25% failure to engage rate.**
 - Identify the confidence level to be used? **We would need help from EQRO staff to address this question.**
 - Identify an acceptable margin of error? **We would need help from EQRO staff to address this question.**
 - Describe the valid sampling techniques used? **We would need help from EQRO staff to address this question.**

_____ N of enrollees in sampling frame

_____ N of sample

_____ N of participants (i.e. – return rate)

Step 6: Develop Study Design & Data Collection Procedures

A study design must be developed that will show the impact of all planned interventions. Include the information describing the following:

- Describe the data to be collected. **Number of visits post intake for new consumers.**
- Describe the methods of data collection and sources of the data. How do these factors produce valid and reliable data representing the entire consumer population to which the study indicators apply? **EHR recording of visits will be the source.**
- Describe the instruments for data collection, and how they provided for consistent and accurate data collection over time. **Standard reports from the EHR will be used.**
- Describe the prospective data analysis plan. Include contingencies for untoward results. **We will analyze retention rates, monthly.**
- Identify the staff that will be collecting data, and their qualifications. Include contractual, temporary, or consultative personnel. **Quality Assurance Coordinator (Jeannie Scroggins) will collect data from the EHR with assistance from the EHR Coordinator (Elaine McCord).**

Step 7: Develop & Describe Study Interventions

The MHP must develop reasonable interventions that address causes/barriers identified through data analysis and QI processes. Summarize interventions in a table that:

- Describes each intervention;
- Identifies the specific barriers/causes each intervention is designed to address;
- Identifies the corresponding indicator that measures the performance of the intervention; and
- Maintains the integrity/measurability of each intervention.
- Describe how the interventions will impact the indicators and help to answer the study question.

Example:

Number of Intervention	List each Specific Intervention	Barriers/Causes Intervention Designed to Target	Corresponding Indicator	Date Applied
1	Call to newly assigned Consumers on the day they are assigned to a clinician by the Access Team	This intervention is designed to address consumers feeling "out of loop" while awaiting news on when they will be seen post intake.	Percentage of consumers engaging in treatment	Began on June 13, 2017-ongoing Intervention
2	Sending a "thank you for coming" letter/post card to new consumers	This intervention is designed to show the consumer that the Department is interested in their continued contact.	Percentage of consumers engaging in treatment	Began on July 2017-ongoing Intervention
3	Training clinicians to revise helping inform consumers that they are the assigned clinician and would like to schedule an appointment (when the consumer doesn't answer the telephone call but has given the department permission to leave a voice message) from merely asking the consumer to call back to schedule an appointment to expecting the clinician state in his telephone message a specific time that the clinician is set-aside for the meeting with the consumer to begin treatment.	This intervention is designed to change the "cold handoff" of a "you call me" where the consumer is asked to call back to speak to someone have not met to a "warm handoff" where the consumer knows that the clinical person is ready and waiting to see the consumer at a specific time and date. The consumer can then keep this appointment or call to a specific person whose voice they have now heard to make a different time for follow-up.	Percentage of consumers engaging in treatment	Began on June 2017 - ongoing Intervention
4	An engagement survey was utilized to identify consumer barriers to engagement.	This intervention is designed to identify barriers to engagement	Percentage of consumers engaging in treatment	April 2018

5	Telephone calls to consumers who have been identified as not engaged (individuals who have not attended three sessions within 60 days of intake) in order to identify causal factors of failure to engage.	This intervention is designed to identify specific causal factors for failure to engage via client report.	Percentage of consumers engaging in treatment	9/25/18-ongoing Intervention
6	"Post card completed and sent" and "offered transportation options" were added to the new Access to Services Assessment (ASA) to help track these engagement interventions.	This intervention is designed to track previous engagement interventions to identify if they were/are successful	Percentage of consumers engaging in treatment	10/2/2018 – Added into the ASA that Kingsview is currently customizing for CCBH use.
7	Intake Data Tracking Log was restructured and organized to account for the information that we now know we need since EQRO	This intervention is designed to accurately track new and returning clients who are requesting an assessment appointment.	Percentage of consumers engaging in treatment	10/9/18
8	Created a call script to follow when contacting consumers who did not remain engaged in treatment beyond 60 days	This intervention is designed to track previous engagement interventions to identify if they were/are successful	Percentage of consumers engaging in treatment	12/4/18

9	Access to Services Assessment (ASA) was trained and went live so we can now track postcards being sent and transportation being offered.	This intervention is designed to track previous engagement interventions to identify if they were/are successful.	Percentage of consumers engaging in treatment	3/1/19
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Step 8: Data Analysis & Interpretation of Study Results

Data analysis begins with examining the performance of each intervention, based on the defined indicators. (For detailed guidance, follow the criteria outlined in Protocol 3, Activity 1, Step 8.)

- Describe the data analysis process. Did it occur as planned? Data was pulled monthly but 60+ days post intake date to account for the opportunity for 3 clinical sessions to occur.
- Did results trigger modifications to the project or its interventions? The results continued to show a decline in percentage of new clients engaged in 3 face-to-face sessions within 60 days. Our internal analysis determined that due outside variables and unforeseen circumstances our engagement was dropping.
- Did analysis trigger any follow-up activities? Deputy Director did more research to find out the reasons for non-engagement. Discovered that some clients were referred out to their MCP, explaining their lack of engagement. Since then, we brainstormed and contacted EQRO to discuss a Screening PIP to appropriately recognize our mild-moderate medical necessity beneficiaries and route them to the correct service provider.
- Review results in adherence to the statistical analysis techniques defined in the data analysis plan. We would need help from EQRO staff to address this question
- Does the analysis identify factors that influence the comparability of initial and repeat measurements? We would need help from EQRO staff to address this question

The analysis of the study data must include an interpretation of the extent to which the PIP is successful and any follow-up activities planned.

Our conclusion of our PIP data analysis and findings is that there were many outside variables that were unforeseen that impacted our engagement. Unfortunately, we did not meet our goal and in fact fell below our baseline data. Our anecdotal evidence has shown that due to staff turnover, increase in demand for services, staff capacity, management capacity, change of ACCESS process, and change in Walk-in Intakes vs. Schedule Intakes process of engagement and negatively been impacted. The limitation of this study originally falls with how the previous PIP Team pulled and analyzed the data. The “how” was unknown to this current PIP Team. Thus, the reliability of baseline data is questionable. Other limitations include the validity of how we are measuring “engagement”. There may be a more accurate way to test for engagement. Moving forward, we would like to continue with this PIP by better addressing unforeseen variables, capturing a reliable baseline measurement, and implementing measurable interventions.

Present objective data analysis results for each performance indicator. A Table can be included (see example), and attach all supporting data, tables, charts, or graphs as appropriate.

Example:

Performance Indicator	Date of Baseline Measurement	Baseline Measurement (numerator/denominator)	Goal for % Improvement	Intervention Applied & Date	Date of Re-measurement	Results (numerator/denominator)	% Improvement Achieved
Percentage of new clients that engaged in treatment past 3 clinical sessions	75%	See above	85%		May 2018	27/40 (67.5%)	7.5% below baseline
					June 2018	27/41 (66%)	9% below baseline
					July 2018	15/22 (68%)	7% below baseline
					August 2018	17/21 (81%)	6% above baseline
					September 2018	10/16 (62.5%)	12.5% below baseline
					October 2018	14/26 (54%)	21% below baseline
					November 2018	8/26 (31%)	44% below baseline
					December 2018	12/21 (57%)	18% below baseline
					January 2019	23/55 (42%)	33% below baseline
					February 2019	11/37 (30%)	45% below baseline
					March 2019	11/45 (24%)	51% below baseline
					April 2019	12/38 (32%)	43% below baseline

Step 9: Assess Whether Improvement is “Real” improvement

Real and sustained improvement are the result of a continuous cycle of measuring and analyzing performance, thoroughly analyzing results, and ensuring implementation of appropriate solutions. To analyze the results of the PIP the MPH must document the following steps:

- Describe issues associated with data analysis –
 - Did data cycles clearly identify when measurements occurred? Should monitoring have occurred more frequently?
 - Results of statistical significance testing.
 - What factors influenced comparability of the initial and repeat measures?
 - What, if any, factors threatened the internal or external validity of the outcomes?
- To what extent was the PIP successful and how did the interventions applied contribute to this success?
- Are there plans for follow-up activities?
- Does the data analysis demonstrate an improvement in processes or consumer outcomes?

It is essential to determine if the reported change is “real” change, or the result of an environmental or unintended consequence, or random chance. The following questions should be answered in the documentation:

- How did you validate that the same methodology was used when each measurement was repeated?
- Was there documented quantitative improvement in process or outcomes of care?
- Describe the “face validity,” or how the improvements appear to be the results of the PIP interventions.
- Describe the statistical evidence supporting that the improvement is true improvement.
- Was the improvement sustained through repeated measurements over comparable time periods? (If this is a new PIP, what is the plan for monitoring and sustaining improvement?)