COLUSA COUNTY
DEPARTMENT OF BEHAVIORAL HEALTH
ANNUAL WORK PLAN
2015-2016

Colusa County Behavioral Health Services

Annual Work Plan for 2015/2016 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, 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 QI Work Plan. Membership on this Committee includes licensed clinical staff, interns (ACSW and MFTi), consumers, Patients' Rights Advocate, and support staff. The QI Committee meets every other month, 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 "Shows" (formerly known as "no shows" but changed to shows to reflect a more positive focus) for initial appointments, ethnicity of, language spoken by, gender of, and age of new referrals, and issuing of Notices of Action; 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 Improvement Coordinator (unfortunately this role is currently vacant though it has been open for continuous recruitment for an extended period of time. The County has advertised the role widely, even including direct recruitment at the annual CALQIC conference). In the interim the QI process is managed by the Deputy Director of Clinical Services, Adult division with assistance from a consultant.

QIC MEMBERS	
Name	Title
Terry Rooney, PhD	Director
Deana Fleming, LCSW	Deputy Director Clinical Services Adult Division
Jan Morgan, LCSW	Deputy Director Clinical Services Child Division
Kim Perry, ACSW	Therapist II
Chantelle Estess	Office Assistant Supervisor
Amy Manville	Consumer Representative
Karina Rios	Patients' Rights Advocate
Valerie Stirling	Peer Support Specialist
Sally Cardenas	Office Assistant III
Jack Joiner, LMFT	Consultant
Senaida Rangel	MHSA Coordinator
Brizia Martinez, ACSW	Ethnic Services Manager, Therapist II
Shannon Piper, LCSW	Clinical Program Manager, Adult Division

Quality Improvement Work Plan		Discussion	Action Items
QI Subcommittees	**<u>PIPS</u>** **1. Recovery**	The Department will continue to focus on Recovery by providing clinicians with tools to measure client recovery status. The current tool being used and studied for assisting with moving clients through the recovery process is the MORS (Milestones of Recovery Scale).	**See the PIP Implementation & Submission Tool at the end of this document**
	2. Prevention/early intervention	The Department is considering developing a PIP that will measure the pre and post effectiveness of an early intervention group on substance use by mental health consumers	**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 Stomp Out Stigma rally.	**The addition of community representatives needs to be accomplished; the CC Committee must be restarted.**
	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**

Quality Improvement Work Plan		Discussion	Action Items
Improve Service Delivery Capacity *Objective*: Monitor service delivery capacity.	**1. Monitor the number of Hispanic individuals being served. The number of new Hispanic referrals will be monitored at each QIC meeting**	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 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 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 with FQHCs, Anthem, Northern California Health and Wellness, and hospital providers. The Department will consider surveying other agencies to measure the effectiveness our outreach efforts.	**The Department should be known as a collaborator with a broad range of community providers**
Improve Accessibility of Services *Objective*: 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 scheduled intake appointment the Committee will review/suggest strategies to address these issues.	**The goal is to serve 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.**

Quality Improvement Work Plan		Discussion	Action Items
	1b. Review the effectiveness of the "Walk In" intake process	The Committee will review the impact of the Walk In intake on the timeliness of intake.	**The goal is to improve timeliness of services even beyond the 10 limit noted above. Reception staff 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 NOA-A and NOA-E notices and problem solve if issues are identified.	**The goal is to insure that Notices of Action are being issued correctly and as required. Access Team will issue NOA-As and reception staff will issue NOA-Es. The issuing of notices will be logged. QA staff will report on NOAs to the QIC**
	2. Continue to monitor "no shows" and evaluate additional efforts to reduce this number.	The Department will collect data on no shows for initial appointments monthly. The QIC will review this data at each meeting. The Committee will review the effectiveness of the Walk In model versus the scheduled appointment model for impact on the show rate.	**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 and present this data to QIC for review. 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 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. Office Assistant Supervisor will oversee the recording of this data.**
	5. Monitor timeline between referral to and receipt of psychiatric services	The Department will evaluate the time to access psychiatric services following referral by the ACCESS Team.	**A QIC committee member will track and report on timeliness of psychiatric access for new referrals from the Access Team. The goal is 45 days from**

Quality Improvement Work Plan		Discussion	Action Items
			referral to initial MD contact
Improve Beneficiary Satisfaction *Objective*: Measure Beneficiary Satisfaction by annual surveys *Objective*: Track consumer grievances/ appeals; Track Change of Provider requests.	**Conduct consumer/family member satisfaction surveys.**	The Department will participate in DHCS mandated consumer satisfaction activities (POQI). The Committee will review the results of these surveys as the information becomes available.	**As reports are available from DHCS the Committee will review and make recommendations to the appropriate Department staff. The Department will consider the development of an in-house satisfaction survey.**
	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 30 days.**
	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**

Quality Improvement Work Plan		Discussion	Action Items
Improve Cultural Competence *Objective*: Continue to provide all staff training in issues related to providing culturally competent services including: Hispanic culture, GLBTQ youth (lesbian, gay, transgender, and questioning youth), client culture, etc. *Objective*: 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 free trainings for staff locally.	**The QIC will track staff participation in trainings via reports from Deputy Directors with the goal that each staff has the opportunity to continually improve skills in their area of responsibility. Additionally the Department will consider developing a report on trainings received to be completed by staff on their 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 health issues	The Department will continue to offer services in all schools in the county (as well as in the clinic) 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 Deputy Directors with the goal of continued increase in the number of Hispanic individuals accessing services (as measured in the above item)**
Objective: Increase understanding of stigma & combat its' effects.	**1.Provide training on stigma to high school students via Friday Night Live/Club Live. Participate in Statewide prevention**	1. The Department will support staff involvement with Challenge Day and Friday Night Live (and Club Live) as a method to engage school age children in overcoming stigma. The Department will participate in funding Statewide anti-stigma programing through	**The QIC will track involvement with FNL/CL via reports from the Prevention Coordinator with the goal of increasing the number of**

Quality Improvement Work Plan		Discussion	Action Items
	activities funded through Department participation in CALMHSA.	participation in the CALMHSA Every Mind Matters project.	**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 0%**
	3.Provide multiple opportunities to celebrate Mental Health Month (MAY) via community events, displays at libraries and community centers, BOS proclamation and other activities as identified	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. The QIC will monitor this effort and provide support to overcome administrative barriers**
Improve Quality of Service *Objective*: Become more versed in Recovery 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). As noted above the Department will focus one of the two PIPs on the implementation of Recovery model services.	**The QIC will track staff presentation of clinical trainings via reports from Deputy Directors with the goal that each clinical staff has the opportunity to continually improve their ability to offer recovery model services**

Quality Improvement Work Plan		Discussion	Action Items
Objective: Perform QI reviews of open charts quarterly	**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**
Objective: Monitor days for frequency of crisis service requests and recommend coverage adjustments as needed.	**The QI Committee will monitor the frequency of crisis requests per time and day of week and recommend adjustments to coverage as needed.**	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 Directors to improve crisis response**
Objective: Full implementation of all relevant clinical and administrative features of the Anasazi Software Program.	**Continue to work with Kingsview to identify and implement appropriate elements of the Anasazi EHR**	The Department will continue with the implementation of the Anasazi E H R product. The effectiveness of this product will be a regular QIC review item.	**The QIC will monitor the effective utilization/implementation of the EHR via reports from QIC members, many of whom are also members of the EHR Workgroup and of the Leadership Team. The QIC will advocate for improvements as needed**

Quality Improvement Work Plan		Discussion	Action Items
Evaluation of QI Activities *Objective:* 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 insure that QIC recommended actions receive follow up until the action is complete or no longer needs QIC oversight**
Evaluation of access to psychiatric services Objective: Monitoring timeline between ACCESS Team referral to and receipt of psychiatric	**QI Committee will monitor the efficiency of the referral process to psychiatric services**	The Committee will review the time line between approval for medication services by the ACCESS Team to the scheduling 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 Access Team log to determine the timeline from referral to psychiatric services to receipt of services. The goal is to complete the referral/service process within 45 days. A baseline percentage of achievement of this goal is to be established**
Monitor Medication Services *Objective:* 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 Department will regularly review the prescribing practices of staff psychiatrists. 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**

Quality Improvement Work Plan		Discussion	Action Items
			prescription drugs and reviewed in QIC for compliance
Consumer Involvement in QI Findings *Objective:* 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)**
Other Items To be added as identified (e.g. issues that raise quality of care concerns)			

Additional archival data used for capacity tracking:

Figure 1

Outpatient Service Penetration Rate of Medi-Cal Beneficiaries by ETHNICITY

For Calendar Years 2006, 2007, 2009, 2011, 2012 and 2013

(Source: APS and BHC Data Tables)

	TOTAL IN POPULATION						TOTAL SERVED						PERCENT TOTAL (PENETRATION RATE)					
	2006	2007	2009	2011	2012	2013	2006	2007	2009	2011	2012	2013	2006	2007	2009	2011	2012	2013
CAUCASIAN	1,228	1,196	1,226	1,146	1160	1130	188	202	224	213	209	216	15.3%	16.9%	18.28%	18.59%	18.02%	19.11%
HISPANIC	3344	3283	3437	3618	3572	3681	109	137	151	194	196	228	3.26%	4.17%	4.39%	5.36%	5.49%	6.19%
OTHER	372	374	335	202	249	428	38	48	36	36	30	35	10.2%	12.8%	10.7%	8.57%	12.05%	8.17%
TOTAL	4944	4828	4995	5182	4981	5239	335	387	441	443	435	479	6.78%	8.02%	8.23%	8.55%	8.79%	9.14%

Figure 1A

Outpatient Service Penetration Rates by Medi-Cal Beneficiaries by ETHNICITY

For Calendar Years 2006, 2007, 2009, 2011, 2012 and 2013

Source: APS and BHC Data Tables

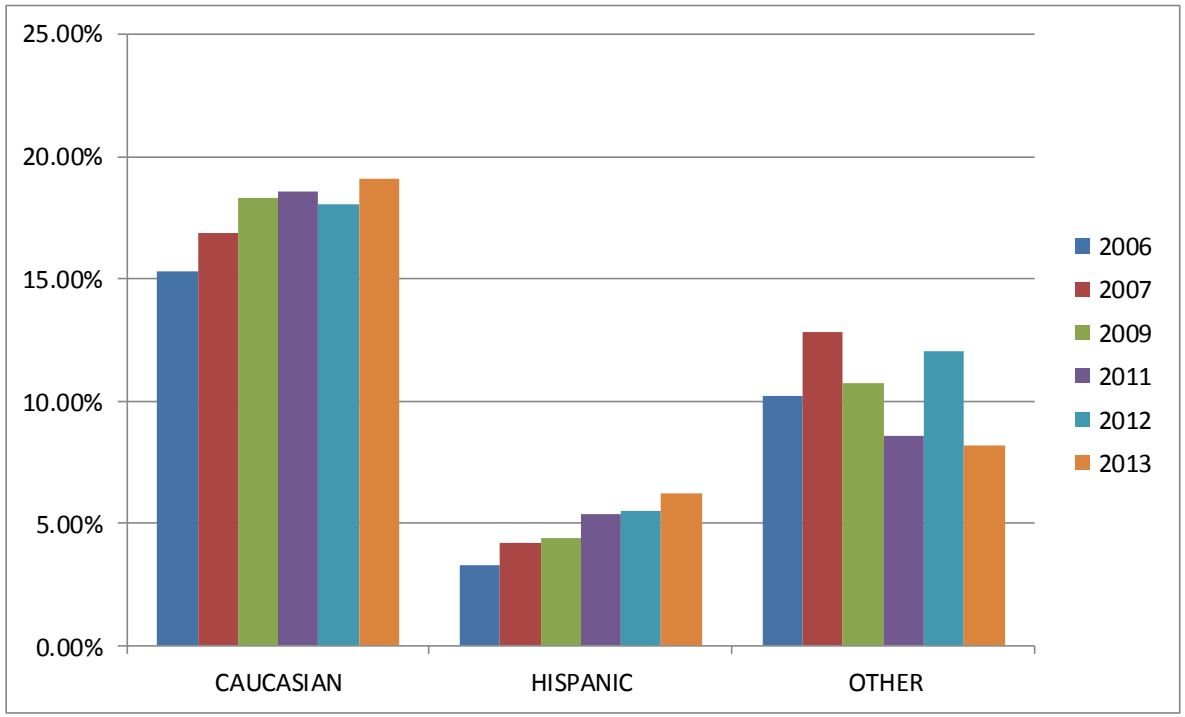


Figure 2

Outpatient Service Utilization of Medi-Cal Beneficiaries by **GENDER**

For Calendar Years 2006, 2007, 2009, 2011 and 2012

(Source: APS Data Tables)

	TOTAL IN POPULATION					TOTAL SERVED					PERCENT TOTAL (PENETRATION RATE)				
	2006	2007	2009	2011	2012	2006	2007	2009	2011	2012	2006	2007	2009	2011	2012
FEMALE	2767	2703	2783	2849	2904	205	224	235	232	255	7.4%	8.3%	8.4%	8.14%	8.78%
MALE	2178	2125	2213	2333	2293	130	163	176	211	202	5.9%	7.7%	7.9%	9.04%	8.81%
TOTAL	4945	4828	4996	5182	5197	335	387	411	443	457	6.8%	8.0%	8.2%	8.55%	7.96%

Figure 2A

Outpatient Service Utilization of Medi-Cal Beneficiaries by GENDER

For Calendar Years 2006, 2007, 2009, 2011 and 2012

(Source: APS Data Tables)

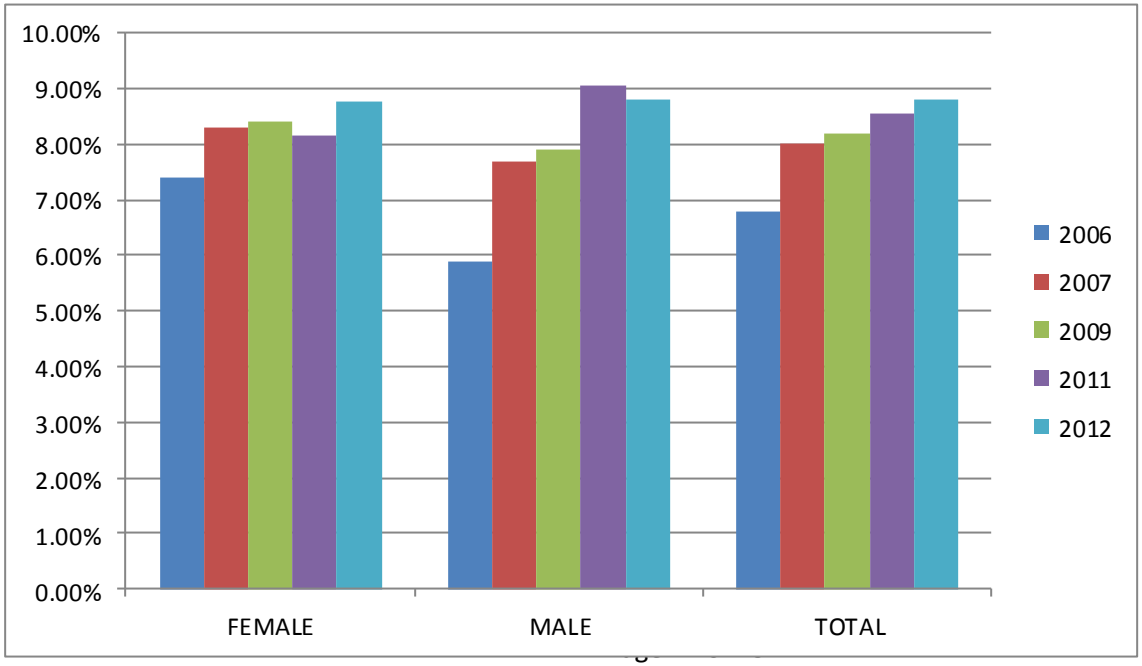


Figure 3

Comparison of Colusa County Population for Calendar Year 2010 (most recent census data available)

and Medi-Cal Beneficiaries for Calendar Year 2013

(Source: US Census Data and BHC Data Tables)

	CAUCASIAN		HISPANIC		OTHER		TOTAL
COUNTY POPULATION	13,854	64.6%	11,804	55.1%	1,315	6.1%	21,419*
MEDI-CAL BENEFICIARIES	1,130	21.7%	3,681	70.8%	428	8.2%	5,197**

*NOTE US Census data numbers total a number a sum greater than 21,419 due to multiple counts of individuals. Percentages are based on percentage of the total population of 21,419, and also total a number greater than 100% due to the US Census Bureau method of structuring the count of individuals

This table reflects the majority of Hispanic status within Colusa County, though as noted the data compiled are complicated by the counting system used in the latest US Census of 2010. The numbers do reflect the reality that the majority of school age children are Hispanic.

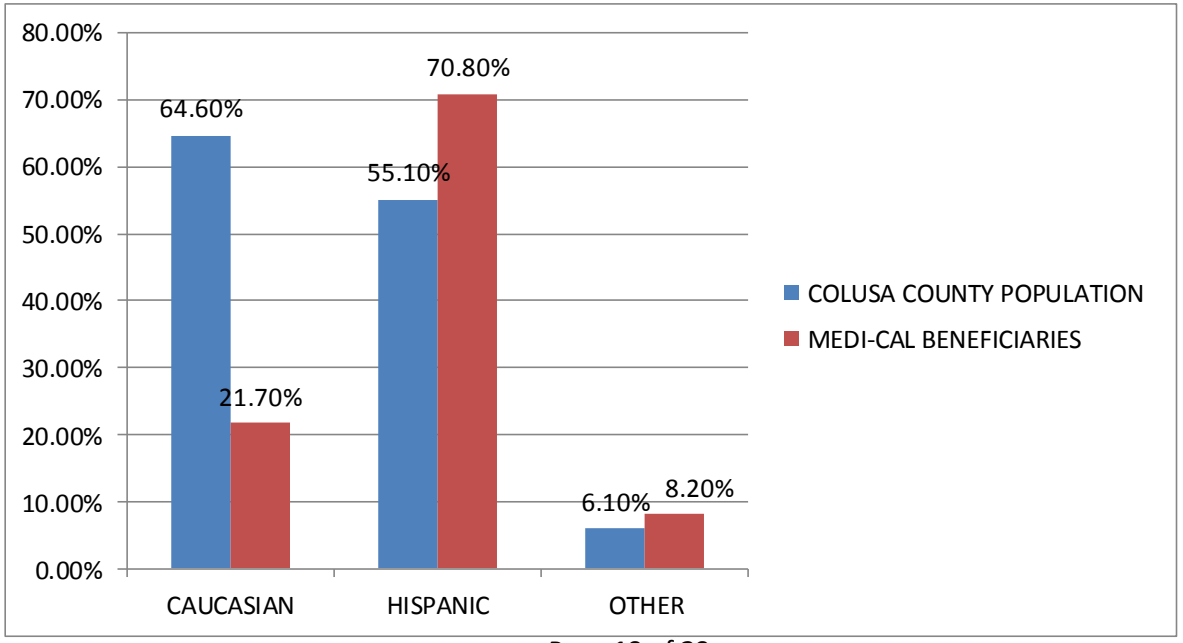
**NOTE Medi-Cal beneficiaries total is an average number as provided by BHC data tables

Figure 3A

Comparison of Colusa County Population for Calendar Year 2010 (most recent census data available)

and Medi-Cal Beneficiaries for Calendar Year 2013

(Source: US Census Data and BHC Data Tables)



Performance Improvement Project
Implementation & Submission Tool

Planning Template

Identification of Plan/Project			
Plan Name:	**Colusa County Department of Behavioral Health**		
Project Title:	**Recovery**	Clinical: _x___	Non-Clinical: _____
Project Leader:	**Deana Fleming**	Title: Deputy Director, Adult	Role: Project leader
Initiation Date:	**January 2015**		
Completion :	**N/A**		

Section 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.

     The Department participated in the Advancing Recovery Collaborative. When the collaborative ended the Department was able to move from being a part of a large, very informative and well-funded learning experience to a local focused project. The Leadership Team (which

consists of upper and midlevel managers recognized the need to have both clinical and administrative staff involved in defining the local effort. As a result a PIP team was developed to include both Deputy Directors, a fiscal analyst and a consultant who had been involved in previous PIPs. Other staff members will be invited as needed. The inclusion of a consumer member is under discussion as the PIP team would like to include at least one consumer.

- Describe the stakeholders who are involved in developing and implementation of this PIP, and how they were selected to participate.

  The stakeholders will be the clinical staff in the Adult Team. All these staff were trained in the scoring of the MORS (Milestones of Recovery Scale), the Strength Assessment, and Group Supervision. All have practiced scoring the MORS since January 2015.

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?

       Prior to participating in the ARC the Department did not have a viable method for measuring recovery. We had participated in each round of the State sponsored "Performance Outcomes Quality Improvement" (POQI) administrations but were not able to extract useable data from the data base (just one challenge of a very small county were experts in extracting and compiling data are unavailable). Without a meaningful way of measuring client progress through recovery we continued in an unstructured way of expecting each clinician to determine the level of service for each individual consumer. We had no way of knowing if the level of service matched the true needs of the consumer. It is possible that some of the more well consumers were getting a higher level of service than the consumers with greater needs simply because more well consumers are "easier" to work with and often more fun to work with because the clinician can have an experience that more closely matches working with the "worried well". It is also possible that consumers were "stuck" at a phase of recovery and weren't being encouraged to grow because it was "just where the consumer has always been" (such as a consumer as a long term resident of a board and care home not being encouraged to try supported independent living).

       Also in the absence of a structured method of helping clinicians improve the selection of

interventions for consumers we continued in our expectation that all clinicians could develop a broad range of appropriate consumer driven interventions. With the introduction of the Strength Assessment and Group Supervision we may have an opportunity to grow clinical skills.

- How did it come to your attention?

  These issues came to our attention initially through frustration with completion of the POQI surveys each cycle and never receiving any useful feedback other than the handwritten comments of consumers. Surely our friends at the State could develop a feedback loop to counties since all counties were participating in this project which helped the State meet Federal requirements….but no. Then as we participated in the ARC our lack of a meaningful way of measuring Recovery came into focus. The more we looked at the idea of measuring Recovery the more we realized that it is not just about a score on a tool (MORS) but rather what are we as a Department doing to help consumers realize their full potential; and in the process what are we doing to help clinical staff enhance their ability to be part of the solution rather than a factor in consumer dependence on they system.

- What data have you reviewed that suggests the issue is indeed a problem for the MHP? Describe any relevant benchmarks.

  In the very early stages of this PIP we looked at the pattern of MORS scores from January to June 2015. We had initially expected to focus on consumers at level 4 and 5 with the goal of determining how this movement from 4 to 5 happened. We found that the majority of consumers had a MORS score of 5 (38%), which indicates that they are engaged with treatment but still not able to function without significant support. This was the largest group of consumers. The next largest group was individuals with a MORS score of 6 (26%); and only 13% had a MORS score of 4. Based on this initial data it appeared that the Department was very able to help consumers move from MORS score from 4 to MORS score 5. A surprising finding from this initial data was that 11% of consumers were at MORS score 7, indicating that they were likely ready for discharge planning. Since this group contained only 12 individuals the PIP Team is considering focusing on this group first for two reasons: first, this is a manageable

number of individuals to focus on individually, and second if we can successfully use the MORS tool to help focus treatment interventions with this small group we will be more able to market the use of MORS scores to tailor treatment interventions for other groups.

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

  Since MORS is a proven tool for measuring recovery based on many scientific research studies we did not find it necessary to conduct a literature review of this tool. We did meet with the primary investigator of the MORS in the ARC project and learned how the tool was validated.

- The study topic narrative will address:
  - What is the overarching goal of the PIP?

    The overarching goal of this PIP is to assist consumers reach the highest level of recovery possible.
  - How will the PIP be used to improve processes and outcomes of care provided by the MHP?

    AS noted above, this PIP is expected to benefit adult consumers by helping them achieve higher levels of recovery. Through use of the MORS as a measure of movement through stages of recovery we expect to be able to learn how to tailor interventions to match the consumers stage of recovery (for example we expect to learn what level and kind of services an individual at MORS 7 needs to be ready for discharge; versus the level of services an individual at level 4 might need to move to engagement (a key feature of MORS level 5). Ultimately the success of this PIP will impact all consumers regardless of MORS level.
  - How any proposed interventions are grounded in proven methods and critical to the study topic.

    This is a harder question to answer at this time as we are just beginning to assess the needs of the individuals at MORS level 7. We do know that matching services with needs is critical both to helping the individual recover and in making sure that the individuals that need the higher level of services are receiving those services.
- The study topic narrative will clearly demonstrate:
  - How the identified study topic is relevant to the consumer population

    We believe our study topic is completely relevant to adult consumers. We believe all consumers wish to do better and we want to do the best job we can to be a part of the

healing process.

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

  As noted above eventually we expect our learning through this PIP will help us provide the proper service to individuals all along the MORS continuum. That means that every adult who receives treatment here will reap the benefits of our attempts to measure recovery and target services appropriate to the individual's level of recovery.

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

  If successful consumers addressed in the first phase of this PIP will move from level 7 to level 8 (unless the individual is receiving benefits due to disability as the MORS scale does not allow a score higher than 7 in that circumstance). Individuals who reach level 8 are by definition fully able to live and interact with the community without the assistance of mental health professionals. And as noted as we expand our knowledge how using the MORS to identify successful interventions for various levels of recovery all consumers will benefit from this PIP.

Section 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.

What are the barriers that keep clients from reintegrating into the community?

OR

How can services be tailored to the needs of consumers to facilitate their movement through the recovery continuum as measured by the MORS?

Section 3: Identify Study Population

Clearly identify the consumer population included in the study. An explanation about 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 MHPs enrolled consumers, as well as the number of consumers relevant to the study topic.

This section may include:

- Demographic information;

  This study will include all adult consumers receiving at least one variety of mental health service, and excludes "meds only" consumers. The current number of consumers in this category is 211.
- Utilization and outcome data or information available;

  Data will include MORS scores and service utilization data
- Other study sources (such as pharmacy data) that may be utilized to identify all consumers who are to be included in the study.

Section 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."[1] 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.

  Our study indicators will include MORS scores, minutes of service in the categories of individual therapy, group therapy, plan development, case management, medication support;

The indicators will be evaluated based on:

- Why they were selected;
- How they measure performance;
- How they measure change a mental health status, functional status, beneficiary satisfaction; and/or
- Have outcomes improved that are strongly associated with a process of care; client moving up in level
- 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.

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

In reporting on the chosen indicators include:

- A description of the indicator; MORS
- The numerator and denominator; 106/211 (numerator= # of clients scored) (denominator= # of clients opened to MH)
- The baseline for each performance indicator; and baseline= 106 clients scored from the # of opened adult MH clients
- The performance goal. all opened adult MH clients get scored (211)

Specify the performance indicators in a Table. For example:

#	Describe Performance Indicator	Numerator	Denominator	Baseline for Performance Indicator (number)	Goal (number)
1	**# of minutes of service for consumers at level 7**			**Not yet established**	**Not yet established**
2	**MORS score: length of time on level 7**			**12 consumers currently at level 7**	**8 of these 12 at level 8 and ready for discharge**
3	**# of minutes of service for consumers at level 5**			**Not yet established**	**Not yet established**
4	**MORS score: length of time on level 5**			**40 consumers currently at this level**	**25 of these 40 at level 6**

Section 5: 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.

For example:

Number of Intervention	List each Specific Intervention	Barriers/Causes Intervention Designed to Target	Corresponding Indicator	Date Applied
1	Develop a menu of services for individuals at MORS 7	No current routine for addressing readiness for discharge and expected service pattern	Unknown length of time and service pattern for individuals at this level	August 2015
2	Measure the pattern of services for individuals at level 7	No current expectation of measuring level of services	This data is available but not presently measured	August 2015
3	Develop a menu of services for individuals at MORS 5	No current routine for addressing expected service pattern	Unknown length of time and service pattern for individuals at this level	September 2015
4	Measure the pattern of services for individuals at level 5	No current expectation of measuring level of services	This data is available but not presently measured	September 2015

Section 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.
- 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?
- Describe the instruments for data collection, and how they provided for consistent and accurate data collection over time.
- Describe the prospective data analysis plan. Include contingencies for untoward results.
- Identify the staff that will be collecting data, and their qualifications. Include contractual, temporary, or consultative personnel.

  Clinicians will collect data (scores) from clients. Data will be extracted from system for reporting.

Section 7: 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 other QI projects?
- 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.

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**

Section 8: Assess Outcomes of PIP

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, in 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?

Section 9: Plan for "Real" Improvement

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?)