Sacramento County Mental Health Plan
Adult Clinical PIP

IDENTIFICATION OF PLAN/PROJECT

Plan Name:	**Sacramento County DHHS – Division of Behavioral Health Services**		
Project Title:	**Improving Timely Access to Outpatient Services**	Clinical: _X_ Non-Clinical: ____	
Project Leader:	**Dawn Williams**	Title: Research, Evaluation and Performance Outcomes Manager	Role:
Initiation Date:	**7/1/15**		
Completion :			

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

   The PIP development committee consisted of a cross section of administration, service provider and advocacy participants. Committee meetings were held monthly and additional sub-committee meetings also served to delineate specific tasks and keep the project on track. The Adult PIP Committee was comprised of representatives from: Mental Health Plan (MHP) Quality Management (QM), Research, Evaluation and Performance Outcomes (REPO), Adult Mental Health Programs, Cultural Competence, Contract Providers, Contract Monitor representatives and Family Advocates. These stakeholders were selected due to their knowledge and experience with the behavioral health system and the outpatient population.

   The Adult PIP Committee membership is as follows:

   County Participants
   Uma Zykofsky, LCSW, Deputy Director, Behavioral Health Services
   Lisa Sabillo, Division Manager, REPO and QM
   Jesus Cervantes, Psy D. / LMFT, Mental Health Program Coordinator, Outpatient Mental Health Programs
   Michelle Schuhmann, MPH, LCSW, Program Planner, REPO
   Dawn Williams, Program Manager, REPO
   Jane Ann LeBlanc, Program Manager, MHSA
   Melissa Jacobs, Program Manager, Outpatient Mental Health Programs

Jennifer Reiman, Program Coordinator, Outpatient Mental Health Programs
Rolanda Reed, Program Coordinator, QM
Jo Ann Johnson, LCSW, Program Manager, Ethnic Services, WET

Provider and Advocate Participation

Blia Cha, Family Advocate, MHANCA
Alexis, Lyon, MFTI, Turning Point, Adult Outpatient: Regional Support Team
Lynn Place, MHRS, Human Resource Consultants, Adult Outpatient: Regional Support Team
Sherri Mikel, MHRS, Human Resource Consultants, Adult Outpatient: Regional Support Team
Cindy Lopez, ASW, Visions Unlimited, Adult Outpatient: Regional Support Team
Stephanie Kvasager, ASW, El Hogar, Adult Outpatient: Regional Support Team
Wendy Hoffman-Blank, Visions Unlimited, Regional Support Team
Kathleen Heggun, Turning Point, Adult Outpatient: Regional Support Team
Mindy Edwards, TLCS Triage Navigator Program

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.
     - What literature and/or research have been reviewed that explain the issue's relevance to the MHP's consumers?
   - The study topic narrative will address:.
     - What is the overarching goal of the PIP?
     - How will the PIP be used to improve processes and outcomes of care provided by the MHP?
     - How any proposed interventions are grounded in proven methods and critical to the study topic.
   - The study topic narrative will clearly demonstrate:
     - How the identified study topic is relevant to the consumer population
     - How addressing the problem will impact a significant portion of MHP consumer population
     - How the interventions have the potential to impact the mental health, functional status, or satisfaction of consumers served.

The problem that this Performance Improvement Project focuses on is timeliness to outpatient services. The Sacramento County Mental Health Plan struggles to meet timeliness guidelines. Long wait times to access psychiatric services can make an existing mental health problem worse. Untimely, untreated or poorly treated mental illness can have severe emotional, behavioral, physical and financial impacts on individuals, their friends and families and the community. Complications resulting from long wait times and untreated mental illness can include unhappiness and decreased hope and enjoyment of life, family conflicts, relationship difficulties, social isolation, problems with alcohol and/or other drugs, missed school or work,

poverty, homelessness, self-harm and harm to others and increased risk of comorbid conditions as well as unnecessary placement/treatment in higher levels of care. At a systems level, long wait times result in increased rates of non-attendance (Gallucci,G., Swartz, W. & Hackerman, F. 2005: Folkins,C., Hersch, P., & Dahlen, D., 1980 Grunebaum, M., Luber, P., Callahan, M., Leon, A.C., Olfson, M., & Portera, L., 1996; Ronald, F.C., Kourany, M.D., Garber, J., & Tornusciolo, G., 1990) leading to reduced efficiency of an agency.

How did this problem come to our attention?

In January 2014, the Sacramento County MHP began a community planning process to allocate new sustainable Mental Health Services Act (MHSA) growth dollars. During this process the MHP reviewed prior community input documents (MHSA CSS, PEI, WET Innovation Planning Processes, Napper Lawsuit and Public Input, Callahan Report, Hospital Council Recommendations, External Quality Review Organization Report, Mental Health Board Feasibility Study, National Day of Dialogue (Sacramento July 2013) as well as MHP benchmark, utilization and outcome data reports. Two consistent themes emerged: Timeliness and Capacity. Due to the size of the community planning process it was to be completed in Phases. The Phase A would focus on adding MHSA funding to expand capacity in the Regional Support Team (RST) programs by reviewing and incorporating new design elements to further address the five essential MHSA principles and address both timeliness to services and capacity. Stakeholders were invited to attend and participate in Workgroup meetings to make recommendations on how the monies would be used. The Phase A Workgroup consisted of 17 members representing a range of stakeholders and consumers. Each of the four RSTs were represented as subject matter experts and DBHS staff were also available as subject matter experts. The Workgroup met over a period of 4 months and all of the meetings were open to the public and there were opportunities for public participation and input. The Workgroup developed the concept of adding a specialized team to each RST and these teams would be called Community Care Teams (CCT). The community planning process gave us the concept of the CCTs to address timeliness and capacity and the PIP Committee formed out of the community planning process assisted with developing strategies that would be used by the CCTs to improve both timeliness to service and capacity issues.

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

Timeliness data, RST system capacity data (including service and discharge data), engagement, no show data, and staff resource data were all reviewed to get an overall assessment of the timeliness to service problem that exists for the MHP.

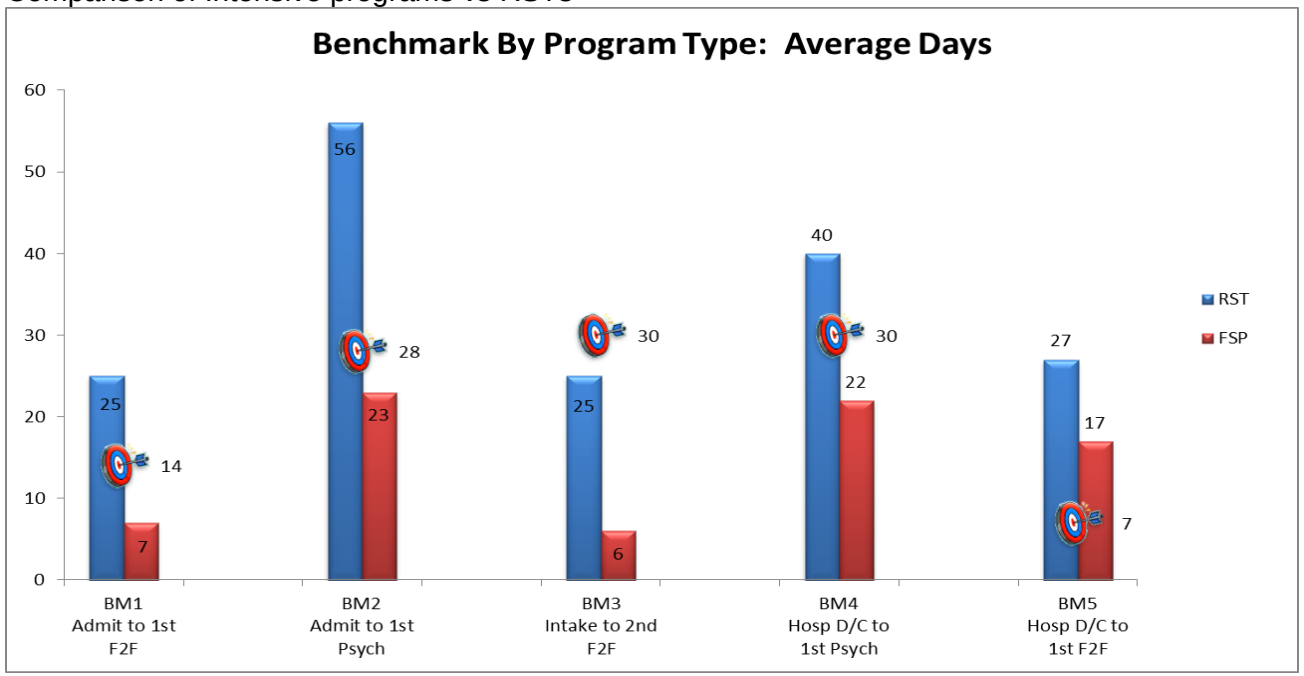
Timeliness data:
Sacramento County has measured timeliness to service for many years and has been monitoring the fluctuations in the percent of adult consumers meeting the timeliness to service benchmarks as well as the average days to first service. While some changes have been minimal, the largest decrease in percent meeting timelines and increase in average days to first appointments is seen in Benchmarks, 1, 2 and 5 (Graph 1). To get a better understanding of where the longest time to service issues were occurring, we looked at the timeliness benchmarks broken out by adult outpatient program as well as program type. This analysis of where the breakdown might be occurring showed that intensive programs (Full Service Partnership programs) had lower average days to appointment and were more likely to meet timeliness deadlines than the non-intensive

RST programs (Graph 2). Additionally, the data indicated that for Benchmarks 4 and 5, clients that were linked at time of acute hospital discharge were more likely to meet timeliness benchmarks than unlinked clients (Graph 3).

Graph 1

Average Quarterly Percent Meeting Benchmark (Adult Only)		FY 10/11		FY 11/12		FY 12/13		FY 13/14	
	Target	% Meet	Avg Days	% Meet	Avg Days	% Meet	Avg Days	% Meet	Avg Days
Benchmark 1 – Admit to 1st Face to Face	14 days	57.2%	20	24.5%	33	38.4%	27	23.2%	36
Benchmark 2 – Admit to 1st Psychiatric/Med Appt	28 days	44.2%	42	27.8%	52	25.2%	60	20.8%	64
Benchmark 3 - Intake to 2nd Face to Face	30 days	82.0%	18	82.3%	19	64.4%	20	76.3%	22
Benchmark 4 – Hospital discharge to 1st Psychiatric/Med Appt	30 days	72.1%	29	67.5%	34	65.6%	36	71.6%	26
Benchmark 5 – Hospital discharge to 1st Face to Face	7 days	65.2%	13	58.4%	17	44.2%	28	48.3%	19

Graph 2
Comparison of Intensive programs vs RSTs



Graph 3
First Appointment after discharge from Acute Hospital: Linked vs. Unlinked

Benchmark 4 – Hospital discharge to 1st Psychiatric/Med Appt				
	Linked		Unlinked	
Target=30 Days	% Meet	Avg Days	% Meet	Avg Days
RST	44%	21	5%	49
All Adult	57%	18	18%	46

Benchmark 5 – Hospital discharge to 1st Face to Face				
	Linked		Unlinked	
Target=7 Days	% Meet	Avg Days	% Meet	Avg Days
RST	69%	32	38%	68
All Adult	75%	28	45%	57

The review of the timeliness data provided enough information to demonstrate that timeliness to services is an issue for Sacramento County MHP. It was also recognized that timeliness to service is impacted by numerous barriers, such as capacity, staff shortages and lack of engagement prior to services and the data in these areas also needed to be explored and understood before strategies/interventions/measurements could be put in place to address timeliness to service.

Capacity

Capacity to serve consumers with behavioral health issues has long been an issue for the Sacramento community. There has historically been a gap between available resources and the number of consumers with need. This became much more apparent with the economic downturn in 2009. Sacramento County community mental health services were decimated. Programs funded by the County general fund were decreased and/or eliminated, leaving the community with little resources when they were needed most.

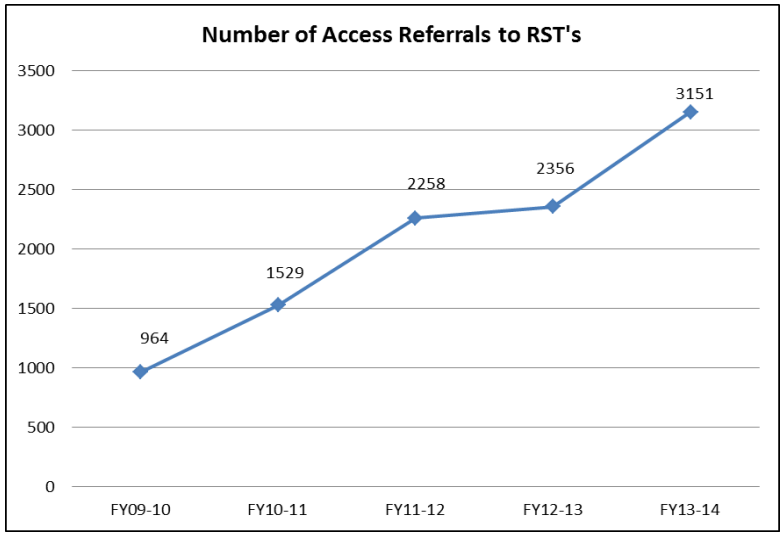
According to an abstract published by the National Institute of Health "Judging from earlier experience of financial crises in various parts of the world, stresses associated with rising unemployment, poverty and social insecurity will lead to upward trends in many national suicide rates, as well as to less readily charted increase in the prevalence of psychiatric illness, alcohol-related disorders and illicit drug use. At the same time, mental health services are being cut back as part of government austerity programs. Budget cuts will thus affect psychiatric services adversely just when economic stressors are raising the levels of need and demand in affected populations." (Cooper, 2011).

The economic downturn not only had a negative effect on the number of services available, it also played a huge role in the dramatic increase in consumers needing behavioral health services. As available outpatient services decreased and the need increased, capacity to appropriately serve consumers became a much bigger issue. Those in need of behavioral health services were forced to inundate the emergency rooms (ER's) at local hospitals as well as impact psychiatric inpatient facilities throughout the community. Data from the Office of Statewide Health Planning and Development (OSHPD) indicates an upward trend of consumers using ER's for psychiatric reasons. Emergency Room data for the Sacramento region indicates

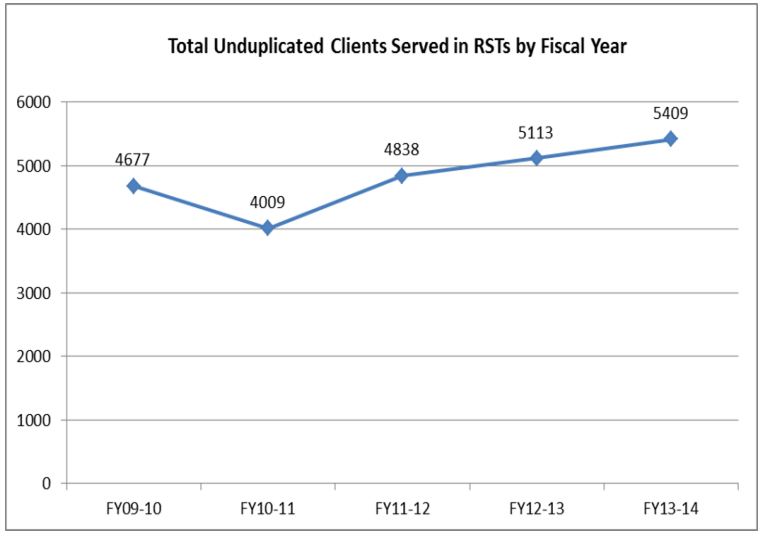
hospital ER visits for psychiatric reasons rising from just over 3% of all visits in 2009 to almost 5% of all visits in 2014, which calculates to a 67% increase in ER visits for psychiatric reasons. Not only are the number of psychiatric patients in the ER's increasing, the number of hours the patient is staying in the ER is increasing. Due to the lack of resources in the community, psychiatric patients are spending hours and sometimes days "boarded" because there is no available psychiatric beds or no available outpatient resources to help them when they are discharged.

It is estimated that 23,757 adults in Sacramento County have a need for mental health services (Department of Health Care Service, California Mental Health Prevalence Estimates, Task Team - 200% Poverty Estimates of Need for Mental Health Services for Serious Mental Illness) with approximately 48% (11,400) served in the Sacramento County Adult Mental Health system (estimates based on FY12/13 service data). In FY12/13 the RSTs provided approximately 59% of all outpatient services and served 50% of all consumers served in the adult outpatient systems. Referrals for outpatient adult specialty mental health services to the Regional Support Teams (RSTs) increased from 964 referrals in Fiscal Year 09/10 to 2,356 in Fiscal Year 12/13, accounting for a 144% increase (Graph 4). The number of consumers served at the RSTs each year is increasing and the number of unduplicated consumers served at the RSTs has increased by 16% since FY 2009-10 (Graph 5). With the passage of the Affordable Care Act, more and more people have access to health insurance and the number of referrals for Medi-Cal specialty mental health services continues to rise exponentially. In the last two years, the MHP has brought in nearly 1,000 more consumers than it has discharged. There is both the need to bring clients into services timely as well as the need to create capacity by discharging clients that no longer need specialty mental health services and can more appropriately receive their mental health services from their primary care physician.

Graph 4



Graph 5

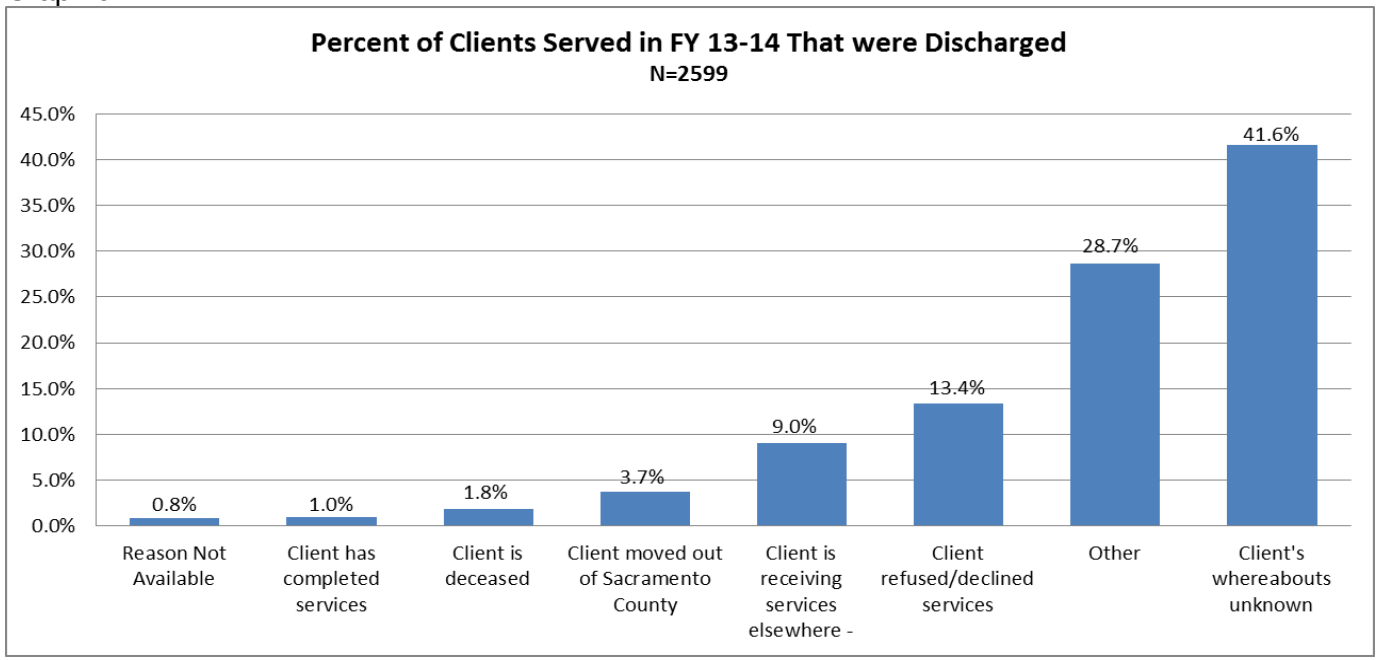


Engagement

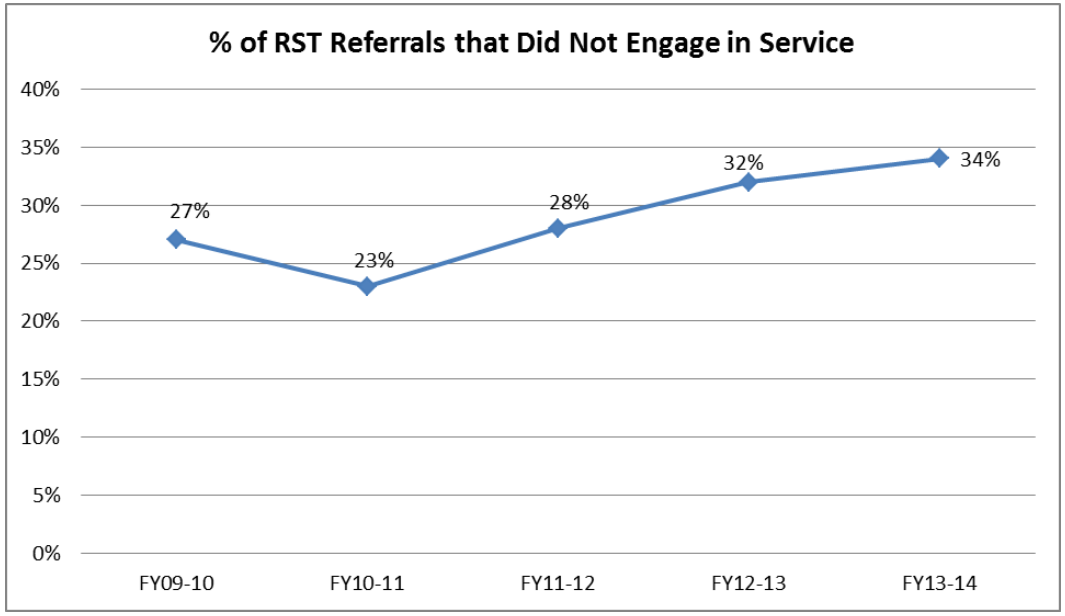
Outreach and engagement has long been proven to be successful in linking and retaining clients in mental health services. According to the OUTREACH & ENROLLMENT QUICK GUIDE: Promising Strategies for Engaging the Homeless Population, developed by the National Healthcare for the Homeless Council, “Once outreach workers have made initial contact with potential clients, they must build engagement so these individuals are comfortable and well-equipped to access services and resources.” Keeping potential clients engaged entails meeting the person where they are, building a trusting relationship, navigating the consumer through the process and equipping the consumer with the knowledge necessary to be successful.

During FY 2013-14, 55% of RST clients who were discharged were discharged due to “whereabouts unknown” or “refused/declined services” (Graph 6). A high percentage of the individuals discharged due to whereabouts unknown were clients that did not come in for an initial appointment. Referral data also shows a large percentage of consumers referred for RST outpatient services never come in for services. In FY 2013-14 34% of consumers referred from the Access team for RST services did not receive any services (Graph 7).

Graph 6



Graph 7



Staff Resources

There are not enough mental health providers (especially those providing Medi-Cal services) in California to ensure timely, appropriate access to care. The aging and retirement of baby boomers from the workforce will exacerbate the challenges of having enough qualified providers. New clinical providers, particularly for Medi-Cal beneficiaries, are needed to ensure timely access to needed care and optimal mental health outcomes. It is estimated that an additional 5,000 mental health professionals will be needed in California to accommodate the mental health and substance use disorder needs of people who will have access to services beginning in 2014. (California Institute for Mental Health, June 2013, STAKEHOLDER RECOMMENDATIONS FOR MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES presented to California Department of Health Care Services).

In addition to the challenge of having the available workforce to fill positions (as indicated above) the ability to fund additional staff has been a challenge. Despite the increase in clients served at the RSTs, the RSTs have had to continue to serve the additional clients coming into the RSTs with their existing staff resources. Although efforts were made to outreach and engage clients into service, the focus was providing quality mental health services to the clients already being served or coming in to services. In order to adequately begin to address timeliness in the RSTs, the MHSA community planning process identified the need to provide funding for additional staff to be able to implement strategies that would address some of the other

barriers to timely access to service.

Measurement Methodology

According to the State of California Department of Managed Health Care 2015, Title 28, Article 7, section 1300.67.2.2 “All health care service plans that provide or arrange for the provision of hospital or physician services, including specialized mental health plans that provide physician or hospital services, or that provide mental health services pursuant to a contract with a full service plan, shall comply with the requirements of this section…” “This section confirms requirements for plans to provide or arrange for the provision of access to health care services in a timely manner, and establishes additional metrics for measuring and monitoring the adequacy of a plan’s contracted provider network to provide enrollees with timely access to needed health care services…” “Appointment waiting time” means the time from the initial request for health care services by an enrollee or the enrollee’s treating provider to the earliest date offered for the appointment for services inclusive of time for obtaining authorization from the plan or completing any other condition or requirement of the plan or its contracting providers…”

Sacramento MHP, due to lack of valid data resources, has typically measured timeliness as the time between when a client is authorized for services and when the client receives his or her first outpatient/psychiatric service. Many underlying barriers affect this measure. No shows and cancellations especially affect this measure because the measure does not take into account whether a client missed their first face-to-face appointment. This PIP will address the use of no show/cancellation codes in the system and utilize those codes to determine whether an appointment was “offered” in a timely manner and whether the client no showed and/or cancelled the appointment.

The data presented in the community planning process and in this report is indicative of a stressed system in regards to capacity and timeliness to service. By putting processes in place to address barriers to timeliness and testing this process in the RST system (which provides over 59% of the adult mental health outpatient services) we will be able to have a positive impact on a large portion of the adult outpatient system by using the strategies that will be implemented as a part of this PIP.

The Regional Support Teams (RSTs), Community Care Teams (CCTs) are specifically designed to address engagement and timeliness to services, as well as increasing capacity. The goal of the teams is to enhance engagement and timely access to services at the RSTs using culturally and linguistically competent services. The CCTs will deliver flexible, recovery-based, individualized services, allowing for seamless transitions throughout the continuum of outpatient services and supports available in Sacramento County. Peer and family support staff will have the capacity to engage and outreach in the community, as well as an on-going role in providing support throughout treatment and transition planning.

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.

Does creating a Care Coordination Team with strategies to engage and provide timely access to outpatient services increase engagement and mental health treatment and increase overall client satisfaction?

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;
- 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 be open to all Medi-Cal eligible adults who are referred or already receiving services at one of the Regional Support Teams.

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.

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;
- 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. For example:

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

	Describe Performance Indicator	Numerator	Denominator	Baseline for Performance Indicator	Goal
1	Timeliness to first face to face appointment at RST	Number of episodes where clients had their initial face-to-face service at the RST's within 14 days of referral to RST	Total number of referrals to the RST's where the client received a service	24.8%	50%
2	Timeliness to first outpatient psychiatric service	Number of episodes where clients had their first outpatient psychiatric service at the RST's within 28 days of referral to RST	Total number of referrals to the RST's where the client received a service	21.5%	50%
3	Timeliness from Acute care discharge to first face-to-face outpatient appointment	Number of acute discharges with a face-to-face service at the RST's within 7 days of acute discharge	Number of acute discharges for RST clients	38.5%	60%
4	Timeliness from acute care discharge to first psychiatric medication appointment	Number of acute discharges with an outpatient psychiatric service at the RST's within 30 days of acute discharge	Number of acute discharges for RST clients	62.9%	80%
5	No show and cancellations rates prior to first appointments	Number of episodes where clients had a no-show or cancellation prior to first outpatient appointment	Total number of referrals to the RST's	3.7%	TBD
6	% of referred clients that engage in RST services	Number of clients referred who receive a service from the RST's	Total number of referrals to the RST's	62.8%	80%
7	% of clients that are hospitalized while waiting for 1st appointment (includes clients that eventually received outpatient services and clients that never showed for services)	Number of RST clients referred who had an inpatient hospitalization in between being authorized for services and their first face to face appointment	Number of clients referred to the RSTs	3.4%	2%
8	Level of satisfaction	Scores on the General Satisfaction domain of the CPS for RST clients meeting benchmark #1 and those not meeting benchmark #1	Total number of RST clients who completed the CPS and meet benchmark #1 and those not meeting benchmark #1	Timely Access=4.51 Not timely= 4.03	TBD
9	% of referred clients that receive engagement services prior to first face to face appointment	Number of episodes where clients had an engagement service prior to their first appointment	Total number of referrals to the RST's	10.4%	95%
10	% discharged to health provider/lower level of care for behavioral health treatment	Number of clients discharged from the RSTs to a health provider/lower level of care	Number of clients discharge from the RSTs in the FY	TBD	TBD

Rationale for Selection of Study Measure #1:	The 14 day timeliness rate is a standard that reflects the effectiveness of outpatient management and support
Quantifiable Measure #1:	The percentage of RST client episodes with time between referral and first face-to-face RST appointment within 14 days
Numerator:	Number of referrals to the RSTs during the fiscal year that were subsequently seen for their first face-to-face outpatient service within 14 days of the admit date
Denominator:	Total number of referrals to the RSTs during the FY
First measurement period dates:	July 1, 2015 – June 30, 2016
Baseline Benchmark:	24.7%
Source of benchmark:	Sacramento County MHP benchmark data for FY 13/14
Baseline goal:	50%
Rationale for Selection of Study Measure #2:	The 28 day timeliness rate for first appointment with a psychiatrist is a standard that reflects the effectiveness of outpatient management and support
Quantifiable Measure #2	The percentage of RST client episodes with time between referral and first psychiatric appointment within 28 days
Numerator	Number of referrals to the RSTs during the fiscal year that were subsequently seen for their first face-to-face psychiatric service within 30 days of the admit date.
Denominator	Total number of referrals to the RSTs during the FY
First measurement period dates	July 1, 2015 – June 30, 2016
Benchmark	21.5%
Source of benchmark	Sacramento County MHP benchmark data for FY 13/14
Baseline goal:	50%
Rationale for Selection of Study Measure #3:	The 7 day timeliness rate for an outpatient appointment following an inpatient hospitalization is a standard that reflects the effectiveness of outpatient management and support
Quantifiable Measure #3:	The percentage of RST client discharges from an acute setting with time between discharge and next face-to-face RST appointment within 7 days
Numerator:	Number of acute discharges for RST clients during the fiscal year that were subsequently seen for their next face-to-face outpatient service within 7 days.
Denominator:	Total number of discharges for RST clients from an acute setting during the FY
First measurement period dates:	July 1, 2015 – June 30, 2016
Baseline Benchmark:	38.5%
Source of benchmark:	Sacramento County MHP benchmark data for FY 13/14
Baseline goal:	60%
Rationale for Selection of Study Measure #4:	The 30 day timeliness rate for an appointment with a psychiatrist following an inpatient hospitalization is a standard that reflects the effectiveness of outpatient management and support
Quantifiable Measure #4:	The percentage of RST client discharges from an acute setting with time between discharge and next face-to-face psychiatric service within 30 days
Numerator:	Number of acute discharges for RST clients during the fiscal year that were subsequently seen for their next psychiatric service within 30 days.
Denominator:	Total number of RST clients discharged from an acute setting during the FY
First measurement period dates:	July 1, 2015 – June 30, 2016
Baseline Benchmark:	62.9%

Source of benchmark:	Sacramento County MHP benchmark data for FY 13/14
Baseline goal:	80%
Rationale for Selection of Study Measure #5:	No show and cancellation rates for first appointments impacts the time to first outpatient appointment. By outreaching to the clients sooner we hope to decrease the number of no shows and/or cancellations, in turn, getting the clients in sooner to their first appointment.
Quantifiable Measure #5:	The percentage of no show and cancellations for RST clients prior to their first appointment
Numerator:	Number of client episodes where RST clients had a no show or cancellation documented prior to their first appointment
Denominator:	Total number of referrals to the RSTs during the FY
First measurement period dates:	July 1, 2015 – June 30, 2016
Baseline Benchmark:	3.7%
Source of benchmark:	Sacramento County MHP Avatar data for FY 13/14
Baseline goal:	TBD
Rationale for Selection of Study Measure #6:	Providers will utilize engagement services prior to the client's first appointment. Engaging the client prior to first appointment will impact whether the client stays engaged in outpatient services.
Quantifiable Measure #6:	Percentage of clients referred to the RSTs who engage in services
Numerator:	Number of clients referred to the RSTs during the FY who receive a face to face service
Denominator:	Total number of referrals to the RSTs during the FY
First measurement period dates:	July 1, 2015 – June 30, 2016
Baseline Benchmark:	62.8%
Source of benchmark:	Sacramento County MHP Avatar data for FY 13/14
Baseline goal:	80%
Rationale for Selection of Study Measure #7:	Hospitalization rates will be decreased with timely access to services. When providers engage clients early they will be better able to support the client, if needed, and divert possible unnecessary hospitalizations from occurring while the client is waiting for their first outpatient appointment.
Quantifiable Measure #7:	Percentage of clients referred to the RSTs who are hospitalized prior to their first appointment
Numerator:	Number of RST clients referred who had an acute admission in between being authorized for services and their first face to face appointment
Denominator:	Number of clients referred to the RSTs during the FY year
First measurement period dates:	July 1, 2015 – June 30, 2016
Baseline Benchmark:	3.4%
Source of benchmark:	Sacramento County MHP Avatar data for FY 13/14
Baseline goal:	2%
Rationale for Selection of Study Measure #8:	Clients who engage in service and are seen in a timely manner will be more satisfied overall compared to those who are not seen timely.
Quantifiable Measure #8:	Mean scores in the General Satisfaction domain for clients who received timely services and those who did not
Numerator:	Scores from the General Satisfaction domain of the Client Perception Survey from April 2014 for RST clients
Denominator:	Total number of RST clients who completed the CPS
First measurement period dates:	July 1, 2015 – June 30, 2016

Baseline Benchmark:	Timely access=4.51, Not timely=4.03
Source of benchmark:	Sacramento County MHP Avatar and Client Perception Survey data for FY 13/14
Baseline goal:	TBD
Rationale for Selection of Study Measure #9:	Engagement services will be utilized and tracked to ensure engagement is occurring prior to first outpatient appointment.
Quantifiable Measure #9:	Percentage of client episodes where the client received engagement services prior to first appointment
Numerator:	The number of RST client episodes where clients had an engagement service prior to their first appointment
Denominator:	Total number of referrals to the RSTs during the FY
First measurement period dates:	July 1, 2015 – June 30, 2016
Baseline Benchmark:	10.4%
Source of benchmark:	Sacramento County MHP Avatar data for FY 13/14
Baseline goal:	95%
Rationale for Selection of Study Measure #10:	In order to address timeless and access to care, capacity issues also need to be addressed. Clients will be assessed and transitioned out of the MHP to lower levels of care (i.e. primary care providers), when appropriate. This, in turn, will positively impact the ability to get new clients seen timely.
Quantifiable Measure #10:	Percent of clients discharged from the RSTs to a health provider/lower level of care
Numerator:	Number of clients discharged from the RSTs to a health provider/lower level of care
Denominator:	Number of clients discharged from the RSTs in the FY
First measurement period dates:	July 1, 2015 – June 30, 2016
Baseline Benchmark:	TBD
Source of benchmark:	
Baseline goal:	TBD
C. Baseline Methodology.	
Identified Study Population: The study population will consist of all adult clients, over the age of 18, with Medi-Cal, who are authorized and referred to the RST's for traditional outpatient mental health services	

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

SECTION 6: DEVELOP STUDY DESIGN & DATA COLLECTION PROCEDURES

1
2
3
4

Number of Intervention	Specific Intervention	Barriers/Causes Addressed	Corresponding Indicator	Date Applied
1	Hire additional staff to create a Community Care Team (CCT)	Staff Resources/Capacity/Engagement	1-10	
2	RSTs to implement orientation groups to complete intake appointments to facilitate more timely access to services	Staff Resources/Engagement	1/8	9/1/2015
3	CCT will outreach and provide engagement services to clients prior to their first appointment	Engagement	1/6/8/9	7/1/2015
4	CCT staff to call the client within a 14 days of access opening the episode	Engagement	1/6/8/9	9/1/2015
5	Increase documentation of engagement services provided prior to first appointment	Measurement/Engagement	1/6/9	7/1/2015
6	Increasing medical staff hours at each RST	Staff Resources/Engagement	2/4/8	9/1/2015
7	When the RST is notified that a client is hospitalized, the CCT/RST will engage with the client to get them into services.	Engagement	3/4/7/8	9/1/2015
8	Increase documentation of no show and cancellations	Measurement	5	7/1/2015
9	CCT will assist stable clients to transition to a PCP or lower level of care	Capacity	8/10	7/1/2015
10	CCT will serve as the lead contact for clients who are touched by the Navigator program in the emergency rooms and jails	Engagement	1/6/8/9	10/1/2015
11	Discharge codes will be added to the EHR to track clients discharging to lower levels of care (i.e. Primary Care and GMC providers).	Measurement/Capacity	10	

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.

DATA TO BE COLLECTED

Service authorization and utilization data will be used to determine engagement and timeliness to services. Other data to be collected include demographics, RST admissions and discharges, psychiatric hospitalization data and client satisfaction. Data will be analyzed and reported using a pre-post methodology, comparing results from prior to the PIP implementation with results one year after implementation. Results and trends will reviewed as part of a standing agenda item in the PIP Steering Committee meeting to determine whether the interventions set forth are providing the intended results. Interventions will be adjusted as necessary.

DATA COMPLETENESS

When a client is referred to Sacramento County Mental Health Plan (MHP), the ACCESS Team, (the point of access for county mental health services) reviews the referral, assesses level of need and authorizes services. If a client meets the need for traditional outpatient services, ACCESS sends the referral to one of the four community outpatient clients, also referred to as the Regional Support Teams (RST's). The RSTs receive the authorization and referral via the electronic health record (EHR). Once the referral is received, the RST's contact the client and schedule an intake appointment. With the exception of client satisfaction, all of the data regarding client admission and services is captured in the EHR and available for reporting purposes. Client Satisfaction is compiled and extracted out of a separate database.

DATA VALIDITY

All data reported for the PIP will be extracted from Sacramento County MHP's EHR. To that extent, the data is as valid as what is entered by the provider on behalf of the client and the services the client received. The Consumer Perception Survey is completed by clients, and is limited due to self-report.

INSTRUCTIONS FOR DATA ABSTRACTORS

The Program Planner assigned to the PIP will extract data from the MHP's EHR as well as the client satisfaction database. The data will be extracted based on the indicators outlined in this PIP.

PERSONNEL AND STAFF WHO COLLECT DATA

The REPO Program Manager oversees the monthly data extraction and reporting by her staff. Her staff is comprised of Program Planners who specialize in data collection, analysis and 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, and 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.

Quantifiable Measure #1:

Time Period Measure Covers	Measurement	Numerator	Denominator	Rate of Results	Comparison Benchmark	Goal	Statistical Test and Significance

Quantifiable Measure #2:

Time Period Measure Covers	Measurement	Numerator	Denominator	Rate of Results	Comparison Benchmark	Goal	Statistical Test and Significance

Quantifiable Measure #3:

Time Period Measure Covers	Measurement	Numerator	Denominator	Rate of Results	Comparison Benchmark	Goal	Statistical Test and Significance

Quantifiable Measure #4:

Time Period Measure Covers	Measurement	Numerator	Denominator	Rate of Results	Comparison Benchmark	Goal	Statistical Test and Significance

Quantifiable Measure #5:

Time Period Measure Covers	Measurement	Numerator	Denominator	Rate of Results	Comparison Benchmark	Goal	Statistical Test and Significance

Quantifiable Measure #6:

Time Period Measure Covers	Measurement	Numerator	Denominator	Rate of Results	Comparison Benchmark	Goal	Statistical Test and Significance

Quantifiable Measure #7:

Time Period Measure Covers	Measurement	Numerator	Denominator	Rate of Results	Comparison Benchmark	Goal	Statistical Test and Significance

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 MHP 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?)