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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: Orange County Mental Health Plan

Project Title: Increasing rates of step-down to ongoing care following hospital discharge Check One: X Clinical Non-Clinical

Project Leader: Jenny Hudson Title: Division Manager Role: Coordinator

Start Date (MM/DD/YY): September, 2018

Completion Date (MM/DD/YY): September, 2021 Projected Study Period (# of months): 36 months

Brief Description of PIP: *(Please include the GOAL of the PIP and what the PIP is attempting to accomplish.)* The goal of this PIP is to increase rates of step-down to outpatient services following inpatient discharge among adult clients by applying an intervention that utilizes peer mentors to provide support to clients during the transition from inpatient discharge to outpatient care.

STEP 1: SELECT & DESCRIBE THE STUDY TOPIC

- 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).
- Describe the stakeholders who are involved in developing and implementation of this PIP. Be sure to include CFM group representation.
- Describe the stakeholders' role(s) in the PIP and how they were selected to participate.

INDIVIDUAL PARTICIPANTS: The following individuals from Orange County's Health Care Agency (HCA) Behavioral Health Services (BHS) comprise the MHP's PIP Committee.

Name	Title	Role	How Selected
Erin Batchelor	Intake Counselor, HCA/BHS Open Access	Development and implementation of the PIP	This participant has a position that works with clients transitioning from the inpatient setting to outpatient care, and so has the background necessary to guide the development and implementation of the intervention.
Jayson Benbrook	Program Manager, Adult and Older Adult Behavioral Health Services	Development and implementation of the PIP	This participant has the position that works with peer mentors, and so has the background necessary to guide the

			development and implementation of the intervention.
Stephani Bryson	Service Chief, HCA/BHS Open Access	Development and implementation of the PIP	This participant has a position that works with clients transitioning from the inpatient setting to outpatient care, and so has the background necessary to guide the development and implementation of the intervention.
Gillian Gentner	Senior Research Analyst, HCA/BHS Authority & Quality Improvement Services	Development and evaluation of the PIP	This participant holds a quality improvement senior research position and has the background necessary to guide development and evaluation of the PIP.
Jenny Hudson	Division Manager, HCA/BHS Adult and Older Adult Behavioral Health Services	Development, implementation, and evaluation of the PIP	This participant has a manager position in the Adult and Older Adult Behavioral Health function area, and so has the position and background necessary to inform the development implementation, and evaluation of the PIP.
Maria Marin	Peer Mentor, HCA/BHS Peer Mentoring Program	Development of the PIP	This participant has a position as a peer mentor, and so has the background necessary to guide the development of the intervention.
Sandra Okubo	Senior Research Analyst, HCA/BHS Adult and Older Adult Behavioral Health Services	Development and evaluation of the PIP	This participant holds a senior research position in Adult and Older Adult Behavioral Health and has the background necessary to guide development and evaluation of the PIP.
Jonathan Rich	Psychologist, HCA/BHS Authority & Quality Improvement Services	Development and evaluation of the PIP	This participant holds a quality improvement research position and has the background necessary to guide development and evaluation of the PIP.
Kelly Sabet	Adult and Older Adult Behavioral Health Services Support Manager, HCA/BHS Authority and Quality Improvement Services	Development, implementation, and evaluation of the PIP	This participant holds a quality improvement manager position and can guide development, implementation, and evaluation of the PIP.
Rodrigo Sigala	Service Chief, HCA/BHS Open Access	Development and implementation of the PIP	This participant has a position that works with clients transitioning from the inpatient setting to ongoing outpatient care, and so has the background necessary to guide the development and implementation of the intervention.
Brianne Vaughan	Research Analyst IV, HCA/BHS Adult And Older Adult Behavioral	Development and evaluation of the PIP	This participant holds a research position in Adult and Older Adult Behavioral Health and has the

	Health Services		background necessary to guide development and evaluation of the PIP.

CONSUMER PARTICIPANTS: A group of 16 consumers who were in the inpatient setting was consulted regarding their perceptions of transitioning to outpatient care following discharge from the hospital, as well as factors that could impact their abilities to engage in outpatient services after being discharged from the hospital. The consumer group consisted of adults 18 years of age and older who were soon to be discharged from Royal Therapeutic Residential Center (RTRC). (RTRC is a hospital in Orange County that provides psychiatric care, and many of the adult clients who are referred to ongoing outpatient care within the Orange County BHS are referred from RTRC). In addition, a Peer Mentor has been participating in the PIP committee meetings in an advisory capacity during the design of the intervention.

AGENCY PARTICIPANTS: This PIP will include participation from both locations of Recovery Open Access, a key component of the OC BHS system of care that has been set up to provide the first point of outpatient care to clients being discharged from inpatient psychiatric settings. All clients who are being discharged from several hospitals in the county are referred to Recovery Open Access to receive outpatient services while they are being bridged to more permanent, ongoing outpatient care. The PIP will also include participation from Royale Therapeutic Residential Center, the hospital that refers the most clients for outpatient services to Recovery Open Access. In addition, the PIP will include participation from the OC BHS Peer Mentor Program.

- 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.

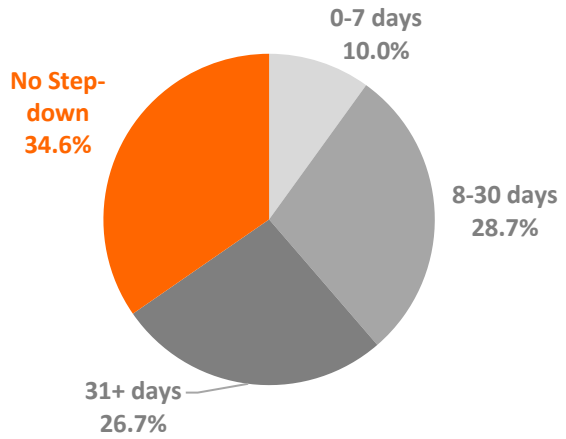
The problem that this Performance Improvement Project focuses on is the rate of adult clients who step-down to outpatient care following hospital discharge.

Orange County Behavioral Health Services (OC BHS) became aware that the rate of step-down to outpatient services following inpatient discharge among adults was a potential issue that may need improvement through reports provided by the California Department of Health Care Services (DHCS). OC BHS

wanted to gain a more comprehensive understanding of step-down rates for adult clients receiving mental health services in Orange County, so analyses were conducted using local data. The analyses focused on a component of the OC BHS system of care that is specifically set up to help clients transition from the inpatient setting to outpatient care, called Recovery Open Access. Recovery Open Access was established in part to more rapidly connect clients leaving the inpatient psychiatric setting with outpatient mental health services so they would not have to wait for long periods of time to receive medication and outpatient care from impacted outpatient clinics. Consequently, this component of the system functions as an important first point of outpatient mental health care while clients are waiting to be linked with more permanent, ongoing outpatient mental health services. The goals of Recovery Open Access are to provide outpatient mental health services to clients within 24 hours of the time of hospital discharge, to link them with ongoing outpatient mental health services within 30 days, and to keep them engaged in services until they can be linked to their ongoing outpatient mental health services. All adult clients being discharged from psychiatric care in several hospitals in the county are referred to Recovery Open Access to receive a first point of outpatient services following discharge. Recovery Open Access is a vital component the OC BHS system of care to help clients with the transition to outpatient mental health services following hospital discharge. Thus, a logical starting point to more fully understand the step-down rates of adults in Orange County was to conduct an analysis of the rates of linkage with ongoing outpatient mental health services from Recovery Open Access. OC BHS anticipated that results from this analysis would reveal where efforts to improve step-down rates could be focused.

The analysis included all clients who were enrolled in Recovery Open Access from July, 2015 to May, 2018 following hospital discharge (N = 2,519 clients). **Figure 1** shows step-down rates to ongoing outpatient mental health services for clients who linked with Recovery Open Access for first point of outpatient mental health services following hospital discharge. Results from the analysis showed that 65.4% of clients went on to link with ongoing outpatient services within an average of 21 days (range: 1-258 days) from Recovery Open Access (10.0% within 0-7 days, 28.7% within 8-30 days, and 26.7% within 31+ days), and 34.6% of clients did not end up linking with ongoing outpatient mental health services. Information on why clients take longer than 30 days to link to services is captured from an optional, open-ended comment field within our data collection system. Common themes for 43 patients with available information include clients rescheduling original appointments, or preferring a later appointment, and clients not attending their first appointment. It is important to note, that while clients may take longer than 30 days to link to ongoing outpatient care, they are still receiving outpatient services at Recovery Open Access in the interim.

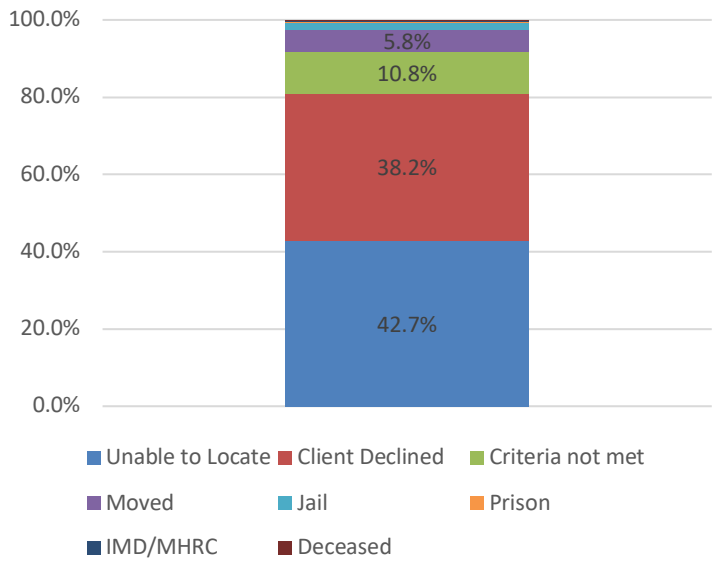
Figure 1. Percent of clients who linked with ongoing outpatient mental health services from Recovery Open Access, by days following hospital discharge



After finding that 34.6% of clients in Recovery Open Access did not link with ongoing outpatient services, an analysis was conducted to understand the reasons for not linking. **Figure 2** shows the results of the analysis. The top two most frequent reasons were that the client was unable to be located (42.7% of clients who did not link ongoing services) and the client declined services (38.2% of clients who did not link to ongoing services). These reasons indicate that an intervention could be applied that helps clients to understand the importance of ongoing outpatient care and to help OC BHS keep contact with clients to help prevent them from dropping out of mental health care after discharging from the inpatient psychiatric setting.

Information on why clients declined services or were unable to be located is captured from an optional, open-ended comment field. Information was recorded for 36 individuals. Common themes for declining services include moving to another county or wanting services in another county, refusing services or not needing services, and wanting to see a private psychiatrist or already having a therapist. Additional information for those who were unable to be located was available for 14 individuals. There were no common themes among these individuals, but examples include contact information not being available, not showing up for appointments, and being homeless.

Figure 2. Reasons clients did not transition to ongoing outpatient mental health services



A follow-up analysis was also conducted to determine the demographic characteristics of those clients who did not link to ongoing outpatient services from Recovery Open Access in order to identify possible person-level risk factors for not continuing to ongoing outpatient care. **Table 1a** shows the breakdown of clients who did not link to ongoing outpatient services by race/ethnicity. Nearly equivalent proportions of Latino (32.1%), and White (32.6%) clients and a slightly higher proportion of African American (35.1%), clients did not transition to ongoing outpatient services. The percentage of Latino and White clients who do not step down to ongoing care increases to 35% for individuals between 18 and 25 years of age (see Table 1b). Information by age for African American clients is not available due to small sample size.

Table 1a. Breakdown of clients who did not link to ongoing outpatient services by race/ethnicity

Race/Ethnicity	**No Linkage to Ongoing Outpatient Services % (n)**
African American	**35.1% (27)**
Asian/Pacific Islander	22.8% (61)
Latino	32.1% (167)
White	32.6% (379)
Other	26.1% (61)

Table 1b. Breakdown of clients who did not link to ongoing outpatient services by age & race/ethnicity

Age Group	Asian/Pacific Islander No Linkage to Ongoing Outpatient Services % (n)	Latino No Linkage to Ongoing Outpatient Services % (n)	White No Linkage to Ongoing Outpatient Services % (n)	Other No Linkage to Ongoing Outpatient Services % (n)
18-25	**27.6% (24)**	**34.5% (61)**	**34.8% (95)**	**32.6% (29)**
26-35	20.0% (17)	32.9% (56)	31.9% (122)	22.1% (23)
36-45	30.0% (12)	24.7% (19)	33.7% (65)	30.0% (15)
46+	11.6% (5)	29.9% (20)	31.5% (87)	30.4% (14)

Table 2 shows the breakdown of clients who did not link to ongoing outpatient services by primary language. A higher proportion of clients who identified Spanish as their primary language (33.7%) did not transition to ongoing outpatient services from Recovery Open Access compared to clients who identified other languages as their primary language. This finding indicates that clients whose primary language is Spanish may particularly benefit from additional efforts to link them with ongoing outpatient care. A breakdown of clients by primary language and age is not available due to small samples sizes.

Table 2. Breakdown of clients who did not link to ongoing outpatient services by primary language

Primary Language	No Linkage to Ongoing Outpatient Services % (n)
English	30.7% (642)
Spanish	**33.7% (69)**
Vietnamese	19.1% (13)
Other	23.0% (17)

Table 3 shows the breakdown of clients who did not link to ongoing outpatient services by gender. Similar proportions of male (31.1%) and female clients (30.0%) did not link to ongoing outpatient services compared to

Table 3. Breakdown of clients who did not link to ongoing outpatient services by gender

Gender	No Linkage to Ongoing Outpatient Services % (n)
Male	31.1% (429)
Female	30.0% (339)

Table 4 shows the breakdown of clients who did not link to ongoing outpatient services by age group. A higher proportion of clients in the 18-25 year age group (33.4%) did not link to ongoing outpatient services compared to clients of other age groups. This finding indicates that clients who are in the 18-25 year age group may particularly benefit from additional efforts to link them with ongoing outpatient care.

Table 4. Breakdown of clients who did not link to ongoing outpatient services by age group

Age Group	No Linkage to Ongoing Outpatient Services % (n)	Total Clients
18-25	**33.4% (233)**	**698**
26-35	29.5% (239)	809
36-45	31.6% (122)	386
46-55	29.6% (99)	335
56+	26.5% (35)	132

Table 5a shows the breakdown of clients who did not link to ongoing outpatient services by shelter status. A higher proportion (35.9%) of clients who were homeless did not link to ongoing outpatient services compared to clients who were not homeless. This figure increases to around 42% for those 26 to 45 years of age (see Table 5b). This finding indicates that clients who are homeless may particularly benefit from additional efforts to link them with ongoing outpatient care.

Table 5a. Breakdown of clients who did not link to ongoing outpatient services by shelter status

Shelter Status	No Linkage to Ongoing Outpatient Services % (n)
Homeless	**35.9% (88)**
Not homeless	30.5% (472)

Table 5b. Breakdown of clients who did not link to ongoing outpatient services by age & shelter status

Age Group	Homeless No Linkage to Ongoing Outpatient Services % (n)	Not Homeless No Linkage to Ongoing Outpatient Services % (n)
18-25	33.3% (7)	32.5% (152)
26-35	41.8% (33)	28.8% (143)
36-45	41.1% (23)	29.0% (69)
46-55	22.9% (11)	35.3% (66)
56+	29.2% (7)	23.6% (17)

Table 6 shows the breakdown of clients who did not link to ongoing outpatient services by co-occurring disorder diagnosis. A higher proportion of clients who had a substance use disorder (SUD) diagnosis did not link to ongoing outpatient services compared to clients who had a serious mental illness diagnosis (SMI) and clients who had a co-occurring serious mental illness and substance use disorder diagnosis (SMI + SED). This finding indicates that clients who have a SUD diagnosis may particularly benefit from additional efforts to link them with ongoing outpatient care.

Table 6. Breakdown of clients who did not link to ongoing outpatient services co-occurring disorder diagnosis*

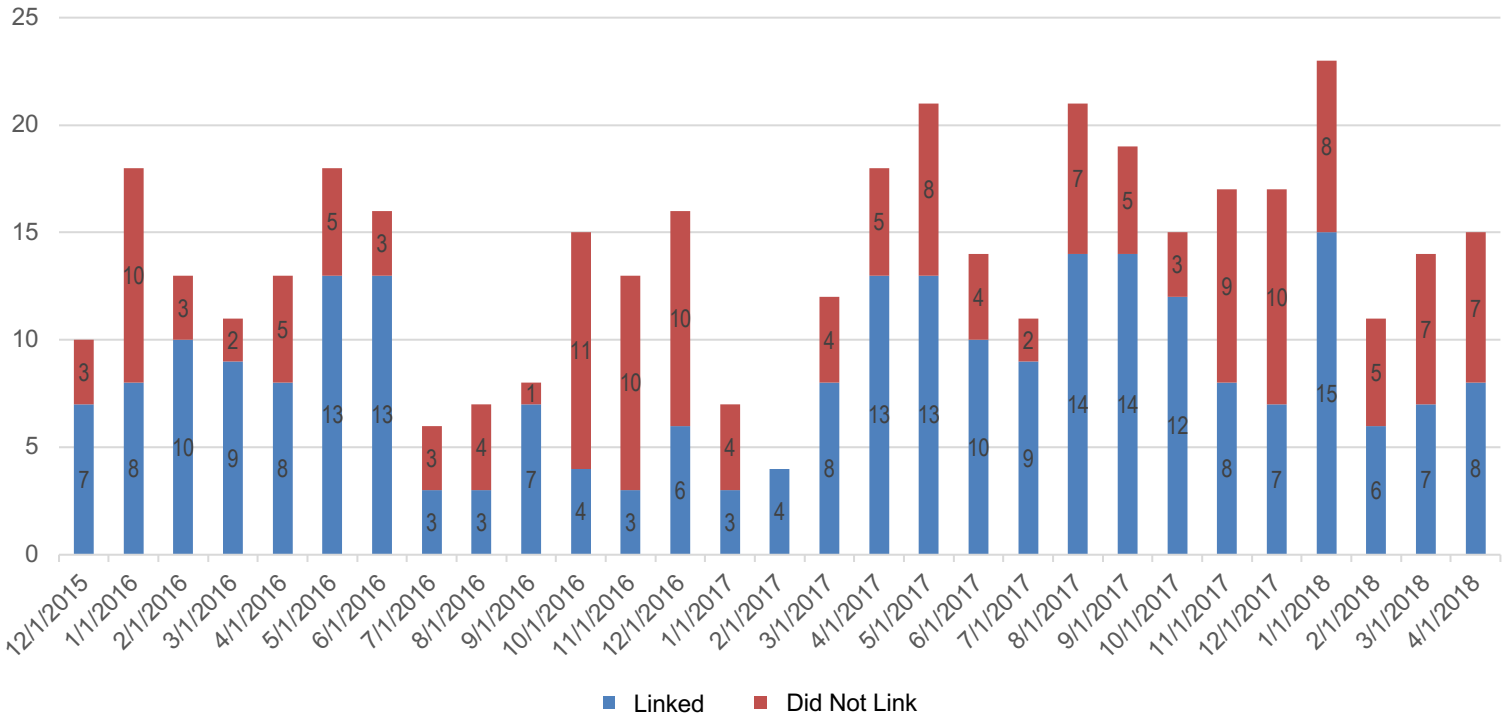
Co-Occurring Disorder Diagnosis	No Linkage to Ongoing Outpatient Services % (n)	Total Clients
SUD	**40.4% (21)**	**52**
SMI	31.5% (367)	1164
SUD + SMI	30.3% (175)	578

**Co-occurring diagnosis is an estimate. The above information includes those diagnoses that were addressed during treatment sessions with the client and may not reflect all client diagnoses. Therefore, it is likely an underestimate of co-occurring conditions within our target population.*

The results of an analysis of referral sources to Recovery Open Access showed that the hospital that referred the most clients to Recovery Open Access was Royal Therapeutic Residential Center (RTRC), located in Santa Ana. Thus, it was determined that additional information was necessary to understand how many clients who were referred from RTRC to Recovery Open Access actually linked with (attended at least one appointment) Recovery Open Access. This was considered an important analysis for understanding if there was an additional point in the transition from inpatient care to outpatient care that would require efforts for improving step-down rates among adults. Findings from the analysis showed that during the time period from December, 2015 to April, 2018, an average of **50.0% of clients being discharged from RTRC who were referred to Recovery Open Access linked with Recovery Open Access**. **Figure 3** shows the number of clients discharged from RTRC who linked vs did not link with Recovery Open Access, by month, from December, 2015 through April, 2018. The figure shows that over the last several months of available data, a large proportion of

clients referred to Recovery Open Access from RTRC did not end up linking with Recovery Open Access. Given that RTRC is the hospital that refers the most clients to Recovery Open Access, and the linkage rate with Recovery Open Access for clients being discharged from RTRC was only 50%, RTRC was determined to be a logical starting point to implement the intervention for the first year of the PIP.

Figure 3. Number of clients from RTRC referred to Recovery Open Access for first point of outpatient services, by month



Furthermore, an analysis was conducted to determine how many clients who were referred to and linked with Recovery Open Access from RTRC then went on to link with more permanent, ongoing outpatient services. Findings from the analysis showed that during the time period from December, 2015 to April, 2018, **73.6% of clients in Recovery Open Access who had been referred from RTRC went on to link with ongoing services**. **Figure 4** shows that over the last several months of available data, a large proportion of clients did not end up linking with ongoing outpatient services.

Figure 4. Clients in Recovery Open Access from RTRC who linked with ongoing outpatient services, by month

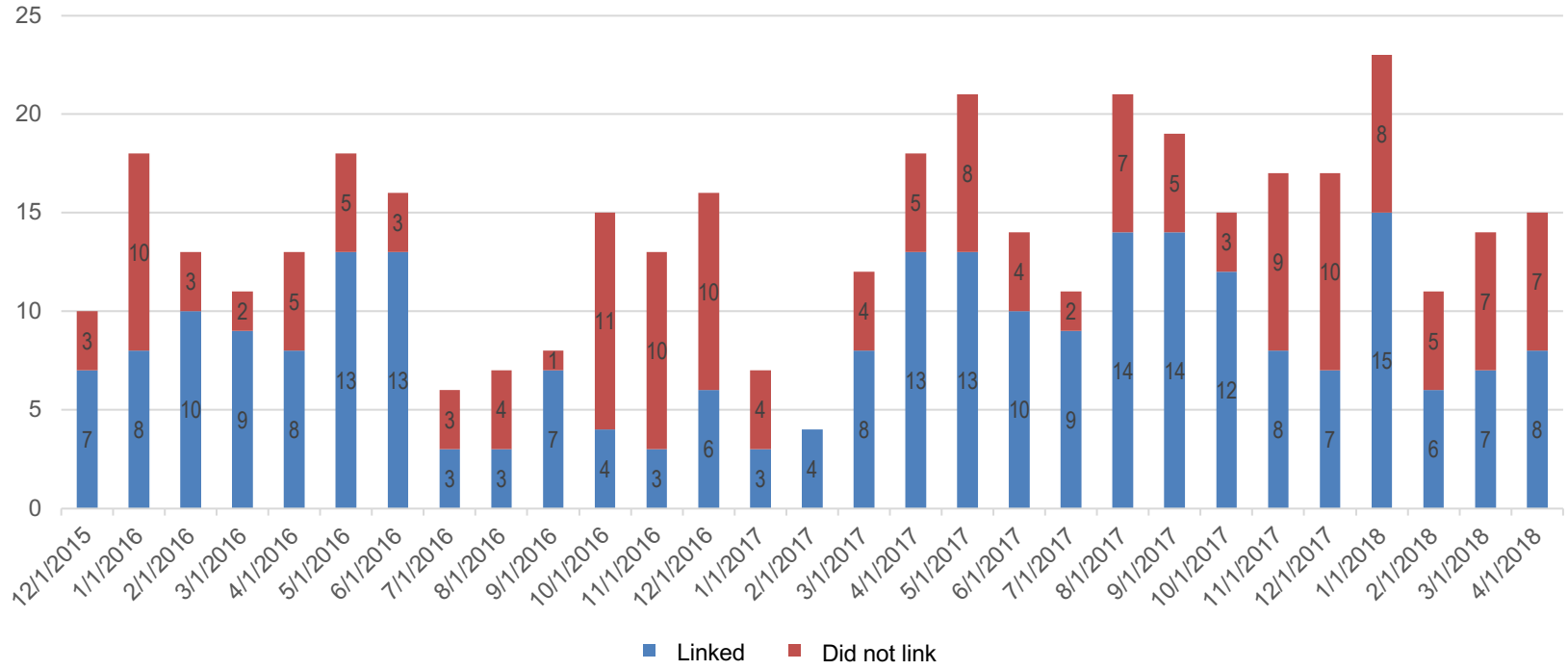


Table 7 shows the breakdown of clients who were hospitalized at RTRC acute unit for fiscal year 2017/2018. During this time, 461 clients were hospitalized, of which 51 (11%) were subsequently hospitalized within this same time period. The number of repeat hospitalization ranged from two to five hospitalizations. Table 7 display the characteristics of clients who had more than one hospitalization. Those with repeat hospitalization were more likely to be homeless, younger in age, and Latino.

Table 7. Breakdown of clients with acute hospitalization stays at the RTRC – 2017-2018 FY

	Multiple Hospitalizations	**Single Hospitalization**
Homeless	**35.3% (18)**	**29.2% (119)**
Average Age	32.6	34.2
Age Group		
18-25	**33.3% (17)**	**26.0% (106)**
26-35	39.2% (20)	37.7% (154)
36+	27.5% (14)	36.3% (148)
Gender		
Male	58.8% (30)	58.8% (240)
Female	41.2% (21)	41.2% (168)
Primary Language English	94.0% (48)	87.0% (355)
Race/Ethnicity		
Asian/Pacific Islander	15.7% (8)	18.8% (76)
Latino	**39.2% (20)**	**33.8% (137)**
White	35.3% (18)	35.6% (144)
Other	9.8%(5)	11.9% (48)

Overall, the results from these analyses support that the step-down rate among adult clients in Orange County is an area in need of improvement. **In order to improve step-down rates among adults, OC BHS will implement a peer mentor intervention, in which peer mentors will work with clients starting prior to inpatient discharge to help them transition from the inpatient hospital setting to outpatient care.** This intervention approach is based on research on the use of peer mentors in mental health services, as well as models that have demonstrated that peer mentors can help clients to successfully transition to outpatient care after hospitalization. Findings from our analyses support that adult clients in Orange County need additional assistance in the transition to outpatient mental health services following hospital discharge. Research has shown that peer staff providing mental health services can be effective in engaging clients in care.[2] The transition from the inpatient setting to outpatient mental health services is a critical period for engaging clients in ongoing mental health care. Often, the transition is a vulnerable period during which clients need strong support. It is important for clients to continue to outpatient mental health care because receipt of outpatient mental health care after psychiatric hospitalization is associated with reduction in adverse outcomes and is key to the recovery and wellness process.[1] When providing peer support that involves positive self-disclosure, role modeling, and empathy, peer staff have also been found to increase clients' sense of hope, control, and ability to effect change in their lives.[2-4] A specific example of the benefits of a peer mentor intervention for clients transitioning out of the inpatient setting comes from the New York Association of Psychiatric Rehabilitation Services (NYPRS) Hospital to Community Peer Bridger Model. This model is an evidence-based intervention that has been utilized by New York State Office of Mental Health since 1994.[5,6] The Peer Bridger Model uses peers who are trained to provide support to people who have had long stays or frequent admissions to hospitals for psychiatric care. The model aims to help people make a smooth and lasting transition following discharge from the inpatient psychiatric setting. The peers in the Peer Bridger Model work with clients to build relationships, provide emotional support, encourage recovery and community living goals, and develop a Wellness Recovery Action Plan (WRAP). They also provide transitional support, skills teaching, and connection to support and resources. A 2013 evaluation of the Peer Bridger Model showed that the intervention has positive impacts. In particular, implementation of the Peer Bridger Model was found to be associated with a 28.0% increase in outpatient visits among participants.[7] This evidence specifically highlights the potential for improving step-down rates of adult clients in OC BHS by utilizing peers to help clients transition to outpatient mental health services following hospital discharge.

In addition to the Peer Bridger Model, the Orange County Health Care Agency (OC HCA) has generated evidence for the positive impacts of peer mentors from an evaluation of the OC HCA Triage Grant. The Triage Grant program linked individuals who were seeking services for a behavioral health crisis from the emergency departments of the Crisis Stabilization Unit, St. Joseph's Hospital, or UCI Medical Center with a peer mentor program. When appropriate, clients were referred to the program by peer navigators who were stationed at the hospital emergency departments to serve as liaisons between the hospital and county staff. The primary goal of the peer mentor program was to link clients to mental health services within 30 days of hospital discharge. During the period between clients entering the peer mentor program and linking with mental health services, peers shared lived experiences and supported consumers in linking to services, engaging in treatment, developing support networks, and finding meaningful roles within the community. Concurrently, clinicians determined whether the client was already enrolled in an OC BHS program, determined the most appropriate service, and made referrals to services and resources. Peer mentors then made the appointments, assisted clients in getting to their appointments, met the clients at the point of service, and made themselves available to attend appointments if the client and clinician agreed the presence of the peer would be beneficial to the client. Once clients were fully linked to outpatient services (including intake, the plan coordinator appointment, and the appointment with the medical doctor), clients were discharged from the peer mentor program. An evaluation of the OC HCA Triage Grant program found that the majority of clients (55%) who showed up at the emergency department of the aforementioned hospitals for behavioral health crisis treatment were linked with mental health services through the peer mentor program (data not published). The OC HCA Triage Grant program ended in June, 2018, so the peer navigators

and peer mentors from the program can be utilized for the peer mentor intervention for this PIP. The benefit of utilizing these peer navigators and peer mentors is that they have already received training and experience working with a similar population of clients to those that this PIP is aiming to help.

In order to gather additional insights from consumers for the PIP intervention design, OC BHS Adult and Older Adult Behavioral Health administered a survey to clients who were receiving inpatient psychiatric care. The goal of the survey was to gather information on client attitudes and perceptions toward attending outpatient services after discharge, as well as possible barriers to attending outpatient services, and factors that clients felt would help them to transition to outpatient care following discharge. The survey was offered to all clients at RTRC prior to discharge for two consecutive weeks. A total of 16 clients (all adults aged 26 to 52 years) volunteered to complete the survey. Findings from the survey showed that 13 of the respondents stated that they planned to attend their appointment with Recovery Open Access following discharge from RTRC. Of those who responded they did not plan to attend their Recovery Open Access appointment, the reasons provided included: does not feel needs treatment, appointment not convenient, financial hardship, child care issues, and transportation issues. The most frequently cited barriers that respondents cited to attending their appointment at Recovery Open Access was transportation issues (n=11). In response to a question that asked respondents what could help them attend their appointment with Recovery Open Access, respondents reported: help with transportation (n=8), more help overall (n=7), more details regarding the appointment (n=6), and other (one respondent reported the need for "a lot of help"). Overall, the results from this survey indicate that transportation is a potential barrier to attending scheduled appointments. Providing more details on the appointment with Recovery Open Access, and more help overall, were also cited as things that could help clients get to their appointments. Insight about such issues can be provided to the peer mentors and addressed by the peer mentors on an as-needed basis to help clients attend their outpatient services.

Since RTRC discharges so many clients who are referred to receive outpatient mental health services in OC BHS, RTRC was chosen as the hospital to initiate the peer mentor intervention for this PIP. This approach will allow for the greatest reach to clients who could benefit from peer support during the transition to outpatient services with the resources currently available. Future iterations of this PIP will focus on taking lessons learned from the implementation of the intervention to expand it to assisting clients transitioning to outpatient services following discharged from other hospitals.

The target goal for step-down for this PIP has been identified from the Statewide Aggregate Specialty Mental Health Services Performance Dashboard report produced by DHCS, which provides results from the Time to Step Down analysis (http://www.dhcs.ca.gov/services/MH/Documents/2018_SMHS_Dash_Combined_Report_non-ADA_7-18.pdf). The most recent results for adults stepping down in specialty mental health services following inpatient discharge show that statewide in FY 2016-2017, the percentage of Medi-Cal beneficiaries who stepped down was 82% (including those who stepped down in 0-7 days, 8-30 days, and 31+ days; 18% did not step down at all). The goal of this PIP is to increase step-down rates to this state-wide benchmark. Baseline rates will be derived from the OC BHS analysis of adult clients who link with Recovery Open Access from RTRC.

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. (If more space is needed, press "Enter")

Will the rate of adult clients who step-down from inpatient care to the first point of outpatient mental health services increase from 50% to 82%, and will all of the clients (100%) who link with the first point of outpatient services link to more permanent ongoing outpatient mental health care (up from

73.6%) following implementation of a peer mentor intervention in which clients are paired with a peer mentor who provides support from the time of hospital discharge through to linkage with ongoing outpatient care?

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 consumer population that will be included in the first year of this PIP will include all adult clients who are receiving inpatient psychiatric care at Royal Therapeutic Residential Center (RTRC). In subsequent years, this PIP will be expanded to include clients receiving inpatient psychiatric care at other hospitals within Orange County.

This PIP will focus on clients receiving psychiatric care at RTRC who are referred to Recovery Open Access for the first year because RTRC refers the most clients to outpatient care in OC BHS compared to other hospitals in the county. Focusing on clients from RTRC for the first year will allow for the greatest reach to clients who could benefit from peer support during the transition to outpatient services with the peer mentor resources that are currently available in OC BHS.

The demographics of adult clients referred from RTRC to Recovery Open Access are from data covering July, 2015 to May, 2018. A total of 913 clients were referred to Recovery Open Access during this time period. Demographic information was available for 826 of these clients.

The breakdown of client race/ethnicity is show in **Table 8**.

Table 8. Race/ethnicity of clients referred to Recovery Open Access

Race/Ethnicity	% of Total (n)
African American	5.6% (43)
Asian/Pacific Islander	16.7% (129)
Latino	36.5% (282)
White	37.3% (288)
Other	4.0% (31)

The breakdown of client gender is shown in **Table 9.**

Table 9. Gender of clients referred to Recovery Open Access

Gender	**% of Total (n)**
Female	44.0% (349)
Male	56.0% (445)

The breakdown of client primary language is show in **Table 10**.

Table 10. Primary language of clients referred to Recovery Open Access

Primary Language	**% of Total (n)**
English	86.9% (691)
Spanish	6.7% (53)
Vietnamese	4.4% (35)
Other	2.0% (16)

The breakdown of client age groups ~~primary language~~ is show in **Table 11**.

Table 11. Age groups of clients referred to Recovery Open Access

Age Group	**% of Total (n)**
18-25	28.1% (223)
26-35	37.5% (298)
36-45	17.7% (141)
46-55	12.8% (102)
56+	3.9% (31)

The breakdown of client shelter status is show in **Table 12**.

Table 12. Shelter status of clients referred to Recovery Open Access

Shelter status	**% of Total (n)**
Homeless	33.1% (273)
Not homeless	66.9% (553)

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.

[2] 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 (number)	Goal (number)	Basis for Adopting this Indicator
1	Step-down from inpatient hospitalization to outpatient care: defined as the % of clients who link to the first point of outpatient services in Recovery Open Access following hospital discharge	Number of clients who attend at least one visit at Recovery Open Access after being discharged from the hospital	Number of clients who received a referral to Recovery Open Access	50.0%	82% (This goal has been chosen because it is the FY 16-17 state-wide rate of step-down to outpatient services following inpatient discharge reported by DHSC. The goal of this PIP is to increase the adult client step-down rate to the state-wide average. The goal is not 100% because OC BHS anticipates that not all clients who are offered peer mentor services will agree to enroll, and some clients will have an already established connection to outpatient services through a clinic or private provider.)	The percent of clients who link with Recovery Open Access will be used as an indicator for improvement in the step-down rate of adults in Orange County because Recovery Open Access is the universally available first point of outpatient services in OC BHS; all clients discharged from the inpatient setting are referred to Recovery Open Access for an appointment within 24 hours of discharge in order to receive medication services and outpatient care while waiting to be linked with more permanent, ongoing outpatient care. The percent of clients who link to this first point of outpatient care is lower than the state-wide average for step-down following hospital discharge. The goal of this PIP is to increase the rate of step-down to outpatient care following hospital discharge among adult clients in Orange County to the state-wide average rate.
2	Continuation to ongoing outpatient care: defined as the % of clients who link to ongoing outpatient care from Recovery Open Access	Number of clients who link with ongoing outpatient care	Number of clients who attended outpatient services at Recovery Open Access	73.6%	100% (This goal has been chosen because the objective of this PIP is to offer peer support services to all clients being referred to Recovery Open Access following hospital discharge. Peer mentors	The objective of this PIP intervention is to have all clients who are receiving peer support link with their permanent outpatient clinical setting. Peer mentors will be offered to clients starting in the hospital setting to help the clients transition from the

					will continue to provide support to clients while they are receiving transitional outpatient services from Recovery Open Access through until they are linked with their ongoing outpatient clinical "home".)	hospital to Recovery Open Access, and from Recovery Open Access to their ongoing outpatient clinical "home". Determining whether all clients who are connected with a peer actually end up linking to ongoing outpatient care will be a critical component of understanding the effectiveness of this intervention.
3	Repeat hospitalizations: Defined as the % of clients who are readmitted to the hospital within 30 days	Number clients hospitalized at the RTRC acute unit who are readmitted to the hospital within 30 days	Number of clients served at the RTRC acute unit	11%	10% reduction in repeat hospitalizations	The goal of this project is to successfully link hospitalized clients to ongoing outpatient treatment. The overall impact of the intervention on our system of care and the overall benefit to the clients are critical components of the intervention.

In addition to the performance indicators mentioned above, the following process indicators will be measured once the intervention is implemented. The purpose of measuring the process indicators will be to enable analysis of fidelity to the intervention design and the ability to link changes in outcomes to the intervention process. In addition, monitoring processes indicators will enable targeted modification of the intervention design if necessary.

	Process Indicator	Numerator	Denominator	Basis for Adopting this Process Indicator
1	% of clients who are offered a peer mentor	Number of clients being discharged from the hospital and referred to Recovery Open Access who are offered a peer mentor	Number of clients being discharged from the hospital and referred to Recovery Open Access	Social workers stationed at the hospital will determine which clients would benefit from being connected with a peer mentor. Part of this determination will be informed by the results from the analysis OC BHS conducted that showed certain characteristics associated with increased risk for not linking with outpatient services following inpatient discharge. This process measure will show whether the key component of the intervention – offer of a peer mentor – is

				being completed. This will enable analysis of fidelity to the intervention design.
2	% of clients who accept peer mentor services	Number of clients who are offered and accept peer mentor services	Number of clients who are offered a peer mentor	This will be measured to gain insights into whether the offer of peer mentor services are being accepted by clients. If the acceptance rate is low, OC BHS will work to understand why and make any necessary changes to the way the intervention is explained and peer services are offered.
3	% of clients who do not accept peer mentor services	Number of clients who are offered a peer mentor and do not accept	Number of clients who are offered a peer mentor	This will be measured to gain insights into whether the offer of peer mentor services are being accepted by clients. If the acceptance rate is low, OC BHS will work to understand why and make any necessary changes to the way the intervention is explained and offered.
4	Number of contacts peer mentor has with client	Number of contacts the peer mentor has with the client	Number of attempts the peer mentor has made to have contact with the client	This will be measured to show whether peer mentors are successfully able to make contact with clients to provide support. This will enable analysis of fidelity to the intervention design.
5	Focus groups to solicit consumer feedback about experiences with the peer mentoring program	N/A	N/A	Feedback will be solicited from consumers about their experiences with the peer mentor intervention to determine if any components need to be modified to improve the intervention.
6	Number of follow-up appointments after the client is referred to ongoing outpatient services	N/A	N/A	This measure will be used to understand the impact of the intervention on continued client engagement and retention

STEP 5: SAMPLING METHODS (IF APPLICABLE)

The MHP must provide the study description and methodology.

- Identify the following:
  - Calculate the required sample size?
  - Consider and specify the true or estimated frequency of the event?
  - Identify the confidence level to be used?
  - Identify an acceptable margin of error?

  Describe the valid sampling techniques used?

_____N of enrollees in sampling frame
_____N of sample
_____N of participants (i.e. – return rate)

Sampling is not applicable.

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.
- 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.

Study Design

The data for the measures that will be used as performance indicators will be collected by databases managed by the hospital, Recovery Open Access, and the peer mentors. The hospital will provide data on the clients who have been referred to Recovery Open Access, including demographics and information on whether the client has the aforementioned potential risk factors for not continuing to outpatient services (e.g. homeless status, age group, etc.) Recovery Open Access will provide data on which clients linked to Recovery Open Access following discharge from the hospital and which clients went on to link with their ongoing outpatient care "home". Data on performance indicators will be collected on an ongoing basis and analyzed on a quarterly basis and/or prior to and after implementing any modifications to the intervention (in order to track the impact of any modifications to

the intervention on the performance outcomes). Trends in the performance indicators over time will be monitored. If necessary, modifications to the intervention will be made based on the performance indicators.

The data for the process indicators will be collected on each client who is receiving inpatient care and who is referred with Recovery Open Access (for example, whether the client accepted the offer of a peer mentor; how many contacts the peer mentor had with the client). The hospital will provide data on the clients who are offered a peer mentor and the clients who accept or do not accept the offer of a peer mentor. The peer mentors will provide information on the number of contacts they have attempted and successfully had with clients. These process measures will be collected at standardized time points for each client (e.g. whether a client was offered and accepted a peer mentor – before the client is discharged from the hospital). The process measures will be monitored on a monthly basis to enable any issues or changes to the intervention to be addressed in a timely manner. Additional detail about the data collection approach for each performance and process indicator is provided in the table below:

Indicator		Source of Data	When Data will be Collected	Instruments for Data Collection	Staff who will be Collecting Data	Prospective Data Analysis Plan
Performance Indicators						
1	Step-down from inpatient hospitalization to outpatient care: defined as the % of clients who link to the first point of outpatient services in Recovery Open Access following hospital discharge	Data provided by hospital on the clients who are referred to Recovery Open Access; data provided by Recovery Open Access on the clients who link with Recovery Open Access	The data provided by the hospital and Recovery Open Access is collected on an ongoing basis. The data will be provided to OC BHS on a monthly basis and will be reviewed quarterly.	The instrument for collecting this measure will be databases managed by the hospital and Recovery Open Access. These two sources of data provide for consistent and accurate data collection for this measure because this data is collected by these sources for record keeping in a standardized way for each client.	Hospital staff and Recovery Open Access enter data into their databases for each client receiving services.	The percentage of clients who link with Recovery Open Access will be examined on a quarterly basis to monitor the progress of changes in step-down rates from hospitalization to outpatient services. Trends over time in the rate will be examined. The rate will be compared to the goal target (82%).
2	Continuation to ongoing outpatient care: defined as the % of clients who link to ongoing outpatient care from Recovery Open Access	Data provided by Recovery Open Access on clients who link with ongoing outpatient services	The data provided by Recovery Open Access is collected on an ongoing basis. The data will be provided to OC BHS on a monthly basis and	The instrument for collecting this measure will be a database managed by Recovery Open Access. This data source provides for consistent and accurate data collection for this measure because the data	Staff at Recovery Open Access enter data into the database for each client receiving services at Recovery Open Access.	The percentage of clients who link with ongoing outpatient care from Recovery Open Access will be examined on a quarterly basis to monitor the progress of changes in the rate of clients who link to more permanent, ongoing outpatient

			reviewed quarterly.	is collected and maintained for record keeping in a standardized way for each client.		care from Recovery Open Access.
Process Indicators						
1	Intervention fidelity: % of clients who are offered a peer mentor and reasons why peer was offered/how the client was deemed a good fit for the peer mentor program	This data will be collected and reported by hospital staff using a standardized tracking tool.	This data will be collected while clients are in the hospital for inpatient care.	A standardized tracking tool has been developed to collect this information. Staff will be trained on how to collect the data to ensure proper data collection.	Staff social workers located at the hospital	The percentage of clients who are offered a peer mentor and the reasons why will be monitored on a monthly basis to examine fidelity to the intervention design.
2	% of clients who accept peer mentor services	This data will be collected and reported by hospital staff using a standardized tracking tool.	This data will be collected while clients are located in the hospital for inpatient care.	A standardized tracking tool has been developed to collect this information. Staff will be trained on how to collect the data to ensure proper data collection.	Staff social workers located at the hospital	The percentage of clients who accept peer mentor services will be monitored on a monthly basis to determine if the explanation of the peer mentor program to clients requires modification.
3	% of clients who do not accept peer mentor services	This data will be collected and reported by hospital staff using a standardized tracking tool.	This data will be collected while clients are in the hospital for inpatient care.	A standardized tracking tool has been developed to collect this information. Staff will be trained on how to collect the data to ensure proper data collection.	Staff social workers located at the hospital	The percentage of clients who do not accept peer mentor services will be monitored on a monthly basis to determine if the explanation of the peer mentor program to clients requires modification.
4	Number of contacts peer mentor has with client	This data will be collected by peer mentors using a tracking tool that peer mentors already use.	This data will be collected once a client is connected with a peer mentor, starting prior to hospital discharge and continuing until the client has linked with ongoing outpatient care and is discharged from	A tracking tool that is used by the peer mentors will be used to collect this information. Peer mentors routinely use the tool to note their work with clients.	Peer mentors	The number of contacts peer mentors have made with clients will be monitored on a monthly basis to examine fidelity to the intervention design.

			the peer mentor program.			
5	Focus groups to solicit consumer feedback about experiences with the peer mentoring program	Clients who have accepted peer mentor services	Twice per year	Focus group protocol (pending development)	This data will be collected and reported by research analysis trained in qualitative research methods	The insights gleaned from client focus groups will be used to make any necessary modifications to the intervention design.

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.

Implementation of this PIP will take place over the course of 3 years, with interventions corresponding to FY 18-19, FY 19-20, and FY 20-21. Year 1 (FY 18-19) will focus on implementation of the peer mentor intervention for clients who are receiving inpatient care at RTRC. In years 2 and 3, lessons learned from the first year of implementation will be utilized to modify the intervention and involve other hospitals within Orange County in order to implement the intervention for other populations. The peer mentor intervention will target increasing step-down to outpatient care following hospital discharge from 50% to 82%. The development of the intervention has included input from consumers and a peer mentor who is a participant of the PIP committee; modifications to and expansions of the intervention will also include input from consumers. Evaluation, including fidelity checks, will be conducted to assess the implementation of the intervention and its impact on the performance indicator.

The peer mentor intervention will involve embedding trained, experienced peers into the step-down process in order to assist clients with their transition from the inpatient setting to outpatient care. The connection of the client with the peer will begin during the client's inpatient stay in order to facilitate rapport building between the peer mentor and the client, and to enable the peer to begin providing support and connection to resources to the client prior to the client being discharged.

Social workers who are stationed on the unit at the RTRC~~hospital~~ will identify clients who will be referred to the peer mentor intervention. This decision will be partly based on results from psychosocial assessments completed by the social worker, which looks at the client's diagnosis, existing resources, strengths and areas of need, to help identify the appropriate level of care. The psychosocial assessment is completed within 24 hours of hospital admission. The social worker will also gather additional information from staff at Recovery Open Access, who can provide information from the OC BHS Electronic Health Record system on the client's history of engagement, and whether or not the client is already linked to mental health services. Based on available information, the social worker will refer all clients to Recovery Open Access who are not currently linked and engaged in outpatient services or are new to the mental health system of care. Initially, all clients who are being referred for their first outpatient service post-discharge to Recovery Open Access will be offered peer support. Should peer mentoring resources become impacted, this criteria will be restricted to include clients who are at increased risk for not stepping down to outpatient care, as described by the included analyses, for example, those clients that are homeless, younger in age, Spanish speaking, of African American or Latino descent, or have had multiple recent hospitalizations. The social workers will provide information on the clients who are identified for the peer mentor intervention to a peer navigator, who will be stationed at the hospital. The role of the peer navigator is to engage with the client, explain the benefits of the peer mentoring program, and initiate the enrollment paperwork if the client accepts peer services. ~~and who will meet with the clients while they are in the inpatient setting to introduce them to the peer mentor program. Clients who agree to be matched with a peer will be linked with a peer mentor by the peer navigator~~. Once enrolled, the client will be matched to a peer mentor by the peer navigator in collaboration with the peer clinical manager, taking into account demographics (e.g., age, gender, language) and other characteristics of the client (e.g., culture, religion, personality), as well as the needs of the client. The assigned peer will then follow up with the client within 72 hours. Currently, the average hospital stay is 13 days. The peer navigator will then provide a warm handoff, consisting of a face-to-face introduction, to the peer mentor, who will begin working with the client prior to hospital discharge, and will continue to work with the clients while they are receiving their first point of outpatient services from Recovery Open Access. ~~The peer mentors will provide support to clients until they are fully linked to their ongoing outpatient services (through intake, the plan coordinator appointment, and the MD appointment).~~ If the client declines peer mentoring, then the RTRC social worker, in consultation with intake counselor at Recovery Open Access, will reassess the client's level of care. If the client has had multiple, recent, hospitalizations, and are not engaging in services, or have other extenuating circumstances, staff will then open the client to the appropriate PACT/FSP program for ongoing engagement instead of referring the client to Recovery Open Access.

For those clients that are enrolled in Recovery Open Access, a mental health assessment will be completed by a clinician to determine the appropriate level of care for the client. The clinician will review the client's hospital records and gather additional information as needed on the client's current diagnosis, impairments due to their mental health symptoms, and the level to which these impairments impact the clients daily functioning. This helps the clinician determine whether the client needs specialty mental health (SMH) treatment, lower level mental health treatment (i.e., mild to moderate services) or possibly substance use treatment only. Based on this assessment the clinician determines the best ongoing treatment for the client. If the client meets criteria for SMH services and they have multiple hospitalizations in the last year they are referred to PACT programs, or possibly FSPs if homelessness is a major factor. If they meet SMH criteria and do not have the multiple hospitalizations or incarcerations due to their mental illness they would be referred to the most convenient Outpatient Mental Health clinic for the client. If the client meets SMH criteria level of impairments are moderate the client can be directly referred to one of our contract recovery centers or the ASO if the impairments are mild. If the client's mental health issues do not qualify for SMH treatment they may be referred to the mild to moderate treatment through CalOptima. These last three occurrences are rare as these clients are referred from the hospital and therefore usually have serious impairments due to their mental illness. Lastly, if the client's symptoms are determined to be only related to substance abuse issues then the client would be linked with our substance use system of care.

When the proper follow-up treatment is determined by the clinician, the peer mentor will educate the client on the benefits of continued treatment, answer any question/concerns and help transition the client to their new clinical home for ongoing treatment. The peer mentor will provide a warm

handoff to staff during the client's first MD appointment with their permanent outpatient clinical provider, after which time the intervention will conclude, and peer services will be discontinued.

During the period that the peer mentors work with clients, they will provide support services and access to resources, such as housing and transportation, so clients can attend their outpatient mental health appointments. In addition, peer mentors will collaborate with the clinical staff at both RTRC and Recovery Open Access, where appropriate, and answer questions/concerns that the client may have. The peer clinical manager will also serve as a resource and can assist the peer mentor and provide additional strategies for engaging with the client.

Peers will provide support to the clients throughout the intervention by:

- Sharing lived experiences and explaining why engaging in follow-up treatment services is important to their recovery
- Helping clients navigate the county system post hospital discharge
- Helping clients to stay engaged in treatment by continuing to reinforce the benefits of treatment
- Assisting clients in maintaining, or developing support networks
- Assisting clients in locating community resources they may need
- Helping clients make outpatient mental health appointments – in some cases
- Arranging transportation, or transporting the client from home to their appointments and back home again (or wherever they are residing if homeless)
- Assisting clients in getting to their appointments by either transporting them there, or calling a cab for them to take them there
- Meeting the client at the appointment if the client has chosen to get to the appointment on their own
- Sitting in with clients during their appointments with either the Plan Coordinator or MD, if that is the desire of the client
- Maintaining close contact with clients who do not have housing in order to minimize the risk of losing that client prior to their scheduled follow-up appointments

In other BHS programs where they are utilized, peer mentors have had success with engaging and keeping individuals who are homeless in treatment. Peer mentors gather additional information on where homeless clients stay and hang out, gather additional emergency contact information, and work closely with outreach and engagement teams to locate these individuals when they drop out of services. Additionally, peer mentors can link clients to housing and transportation resources, which can help remove barriers to treatment.

Through the PIP process, it has been confirmed that clients who are hospitalized in a psychiatric hospital and are homeless may be eligible for Recuperative Care if they are too ill to recover from physical illness or injury on the street, but not ill enough to be hospitalized. This is a new resource to these clients. Persons must be a CalOptima beneficiary, an Orange County Resident, and have a qualifying medical condition, in addition to being homeless. Once enrolled, the Recuperative Care staff will ensure that the client is seen by their treating provider, primary care provider (PCP) or help them select one, and will provide patient education specific to medical issues and help the client navigate successfully through their assigned medical provider. Orange County will continue to explore Recuperative Care as a possible resource for RTRC clients.

~~Peer mentors will provide support to clients until they are fully linked to their ongoing outpatient services (through intake, the plan coordinator appointment, and the MD appointment).~~

Number of Intervention	List each Specific Intervention	Barriers/Causes Intervention Designed to Target	Corresponding Indicator	Date Applied	Who Will Receive Intervention
Year 1					
1	Client survey (In preparation for the intervention)	The client survey was conducted in order to gain insight from clients in the inpatient setting about attitudes toward and perceptions about continuing to outpatient care following hospital discharge, as well as to gain understanding of the potential barriers that clients face to attending their outpatient services. Insights from the survey will be utilized to help the peer navigator and peer mentors target their efforts to assist clients during the post-discharge transition to outpatient services.	**Performance Indicators:** The following performance indicators will be used to determine if the intervention has a positive impact on rates of step-down following hospital discharge: #1: Step-down from inpatient hospitalization to outpatient care: defined as the % of clients who link to the first point of outpatient services in Recovery Open Access following hospital discharge #2: Continuation to ongoing outpatient care: defined as the % of clients who link to ongoing outpatient care from Recovery Open Access **Process Indicators:** The following process indicators	September, 2018	All clients receiving services at RTRC were provided the opportunity to complete the voluntary survey prior to discharge from the hospital.
2	Work with RTRC administration and staff to determine how the peer mentor intervention will be implemented at RTRC (In preparation for the intervention)	Working with RTRC administration enabled OC BHS to work on logistics to determine how clients who will be referred to the peer mentor intervention will be identified, how to station a peer navigator at RTRC, and what processes and trainings are necessary in order to have peer mentors work with clients they are connected to prior to clients being discharged from the hospital		July-September, 2018	RTRC administration and staff, peer mentor program staff
3	Station a peer navigator at the hospital who will explain the peer mentor program and connect clients to peer mentors	A peer navigator will be stationed at the hospital to explain the peer mentor program to clients. Stationing the peer navigator at the hospital will enable clients to have direct connection with the peer mentor program while still in the inpatient setting, and will enable the peer navigator to field questions about the program and explain the purpose and benefits of having a peer mentor to help with the transition from the inpatient setting to outpatient mental		October 1, 2018 Start of intervention	All clients who are receiving inpatient care and are referred to Recovery Open Access as their first point of outpatient mental health services post-discharge

		health services. The peer navigator will also be able to link clients with peer mentors based on appropriateness of fit for the rapport between the peer mentor and the client.	will be used to determine fidelity to the intervention design and whether modifications to the intervention are needed: #1: % of clients who are offered a peer mentor and reasons why peer was offered #2: % of clients who accept peer mentor services #3: % of clients who do not accept peer mentor services #4: Number of contacts peer mentor has with client #5 Number of clients who receive a warm handoff to the outpatient clinic		
4	Social worker at RTRC completes the psychosocial assessment to determine discharge planning needs and if the client will be referred to Recovery Open Access and is eligible for the peer intervention	This referral will then be communicated to the peer navigator, who will engage with the client and facilitate the link to a peer mentor		October 1, 2018	All clients discharged from RTRC acute unit
5	Connect clients who agree to participate in the peer mentor program with peer mentors while clients are in the inpatient setting, prior to discharge	Connecting clients who agree to participate in the peer mentor program with peer mentors prior to discharge from the hospital will enable the peer mentors to begin building rapport with the clients and providing supportive services and resources to the clients while they are transitioning out of the inpatient setting and into outpatient services. Peer mentors will be able to help prevent clients from dropping out of services early in the transition process, immediately after they are discharged and before they attend their first outpatient service, as well as throughout the process of linking with ongoing outpatient care through rapport building, providing concrete resources, and providing support to clients.		October 1, 2018	All clients who are receiving inpatient care and are referred to Recovery Open Access as their first point of outpatient mental health services post-discharge
6	Ongoing peer mentoring	Clients will be linked to a peer prior to hospital discharge and will remain linked until the client has had their first appointment with the MD at their permanent clinical home		October 1, 2018	All clients who enroll in the peer mentor program
8	Recovery Open Access clinician continues the assessment process to determine where the client will be referred to for further treatment	The clinician referral will be communicated to the peer mentor, who can educate the client on the benefits of treatment, answer any questions/concerns about the		October 1, 2018	All clients enrolled in Recovery Open Access

		program they are being referred to, and help them transition to their new clinical home for ongoing treatment			
7	Referral/hand off to ongoing outpatient services	Peer mentor will provide a warm handoff to staff at the client's permanent clinical home during their first MD appointment, after which time peer services will be discontinued		October 1, 2018	All clients who remain enrolled in the peer mentor program
Years 2 and 3					
1	Solicit feedback from clients and peer mentors and apply the feedback to the intervention design	Soliciting feedback about the intervention from clients and peer mentors will enable OC BHS to determine if modifications are needed in order for the intervention to better serve clients and help them link with outpatient care following hospital discharge. The feedback can be utilized to make necessary modifications for implementation in additional hospital settings.	The following performance indicators will be used to determine if the intervention has a positive impact on rates of step-down following hospital discharge: #1: Step-down from inpatient hospitalization to outpatient care: defined as the % of clients who link to the first point of outpatient services in Recovery Open Access following hospital discharge #2: Continuation to ongoing outpatient care: defined as the % of clients who link to ongoing outpatient care from Recovery Open Access	FY 19-20 and FY 20-21	All clients who have participated in the peer mentor intervention and all peer mentors who have provided support to clients via the intervention

2	Station a peer navigator at another participating hospital, who will explain the peer mentor program and connect clients to peer mentors	A peer navigator will be stationed at another participating hospital to explain the peer mentor program to clients. Stationing the peer navigator at the hospital will enable clients to have direct connection with the peer mentor program while still in the inpatient setting, and will enable the peer navigator to field questions about the program and explain the purpose and benefits of having a peer mentor to help with the transition from the inpatient setting to outpatient mental health services. The peer navigator will also be able to link clients with peer mentors based on appropriateness of fit for the rapport between the peer mentor and the client.	The following performance indicators will be used to determine if the intervention has a positive impact on rates of step-down following hospital discharge: #1: Step-down from inpatient hospitalization to outpatient care: defined as the % of clients who link to the first point of outpatient services in Recovery Open Access following hospital discharge #2: Continuation to ongoing outpatient care: defined as the % of clients who link to ongoing outpatient care from Recovery Open Access The following process indicators will be used to determine fidelity to the intervention design and whether modifications to the intervention are needed:	FY 19-20 and FY 20-21	All clients who are receiving inpatient care from the participating hospital and are referred to Recovery Open Access as their first point of outpatient mental health services post-discharge
3	Connect clients who agree to participate in the peer mentor program with peer mentors while clients are in the inpatient setting, prior to discharge	Connecting clients who agree to participate in the peer mentor program with peer mentors prior to discharge from the hospital will enable the peer mentors to begin building rapport with the clients and providing supportive services and resources to the clients while they are transitioning out of the inpatient setting and into outpatient services. Peer mentors will be able to help prevent clients from dropping out of services early in the transition process, immediately after they are discharged and before they attend their first outpatient service, as well as throughout the process of linking with ongoing outpatient care through rapport building, providing concrete resources, and providing support to clients.		FY 19-20 and FY 20-21	All clients who are receiving inpatient care from the participating hospital and are referred to Recovery Open Access as their first point of outpatient mental health services post-discharge

			#1: % of clients who are offered a peer mentor and reasons why peer was offered #2: % of clients who accept peer mentor services #3: % of clients who do not accept peer mentor services #4: Number of contacts peer mentor has with client		

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.

Not applicable at this time.

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 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, 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?)

Not applicable at this time.

References

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