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LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
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# Non-Clinical Performance Improvement Project Implementation & Submission Tool

## IDENTIFICATION OF PLAN/PROJECT

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| MHP Name: | **County of Los Angeles – Department of Mental Health (Department, DMH)** |
| Project Title: | **Strengthening DMH Peer Resource Center Services through Continuous Quality Improvement** Check One: Clinical ☐ Non-Clinical ☑ |
| Project Leader: | **Keris Jän Myrick** Title: **Discipline Chief of Peer Services** Role: **Project Leader** |
| Start Date (MM/DD/YY): | **12/20/18** |
| Completion Date (MM/DD/YY): | **12/20/20** Projected Study Period (# of months): **24** |
| Brief Description of PIP: *(Please include the GOAL of the PIP and what the PIP is attempting to accomplish.)* | The overarching goal of this non-clinical PIP is to ensure Peer Resource Center (PRC) services are peer-driven, promote resiliency/recovery, and embrace the cultural, linguistic, and historical differences of the neighboring Los Angeles community. The PRC is intended to create an environment of learning and connection, without stigma, to increase independence and self-efficacy. This PIP aims to support the PRC in its commitment to provide information, referrals for mental and physical health services and community resources, peer connection and support, and some basic necessities. The success of this PRC pilot has the potential to impact the structure, outcomes, and quality of services provided by PRCs implemented in other Service Areas (SA). |

## STEP 1: SELECT & DESCRIBE THE STUDY TOPIC

1. The PIP Study Topic selection narrative should include a description of stakeholders involved in developing and implementing the PIP. MHPs are encouraged to seek input from consumers and all stakeholders who are users of, or are concerned with specific areas of service.

- Assemble a multi-functional team (e.g. clinical staff, consumers, contract providers as appropriate).
- 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.

**Stakeholders/non-Clinical Performance Improvement Project Committee Members**

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|---|---|
| Aldonia Wylie | Wellness Outreach Worker (WOW) – Advanced Peer Specialist |
| Amparo Ostojic | Didi Hirsch Mental Health – Peer Specialist |
| Anna Perne | DMH – Training Coordinator, Workforce Education and Training Division |
| Annie Humphrey | St. Joseph Center – Program Manager |
| Carmen Aguilar | DMH - Psychiatric Social Worker II |
| Catherine Clay | DMH – Community Health Worker, Peer Resource Center (PRC) |
| Charles Miller | DMH – Mental Health Advocate, PRC |
| Daiya Cunnane | DMH – Clinical Psychologist II - Lead Quality Improvement Analyst |
| David Snell | DMH – Mental Health Advocate, PRC |
| Helena Ditko | DMH – Program Director, Office of Administrative Operations (OAO) |
| Jennifer Regan | DMH – Clinical Psychologist II - Statistical Analysis Consultant |
| Joelene Friestad | DMH – Mental Health Clinical Program Head, Emergency Outreach and Triage Division (EOTD) |
| Joo "Eric" Lee | DMH – Mental Health Services Coordinator II, PRC |
| Joseph Cuevas | DMH – Mental Health Advocate, PRC |
| Kalene Gilbert | DMH – Mental Health Clinical Program Manager (MHCPM) III, Prevention and Outcomes Division |
| Keris Jän Myrick | DMH – Discipline Chief of Peer Services |
| Kumar Menon | DMH – Health Program Analyst III, Office of Discipline Chief, Peer Services |
| Laura Kerr | DMH – Mental Health Advocate, PRC |
| Libby Hartigan | Self-Help And Recovery Exchange! (SHARE!) – Director of Training and Quality Assurance |
| LyNetta Shonibare | DMH – Supervising Psychologist |

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| Mandy Sommers | St. Joseph Center – Director of Quality Assurance and Clinical Services |
| Marisela Soto | DMH – Medical Case Worker II, EOTD |
| Matthew Lyon | St. Joseph Center – Quality Assurance Manager |
| Patrick Corrigan | Lewis College of Human Sciences, Illinois Institute of Technology (IIT) – Training Consultant |
| Sandra Chang | DMH – MHCPM I, Cultural Competency and Ethnic Services Manager |
| Scott Hanada | DMH – MHCPM III, Peer Services |
| Sonya Ballentine | Project Director, IIT – Training Consultant |

Members of the non-clinical PIP committee were selected based on their familiarity, expertise, or interest in the subject matter. The Quality Improvement (QI) Division organized and coordinated the QI-related activities for this non-clinical PIP. The QID staff directly involved with this project include Daiya Cunnane, LyNetta Shonibare, and Kalene Gilbert. Jennifer Regan provided consultation related to statistical analysis. As the Department's Cultural Competency and Ethnic Services Manager, Sandra Chang provided guidance surrounding cultural competency practices and input from the Cultural Competency Committee (CCC). Anna Perne, Training Coordinator, provided post-training data for the Intentional Peer Support (IPS) training.

Keris Jän Myrick, Kumar Menon, and Scott Hanada were key leads in the evaluation and improvement of the PRC staff and services. Keris Jän Myrick is the Discipline Chief of Peer Services for DMH. She served as the project's leader with extensive expertise and research experience related to peer services. Ms. Myrick has worked with the National Alliance on Mental Illness (NAMI), Substance Abuse and Mental Health Services Administration (SAMHSA), and the Project Return Peer Support Network. Kumar Menon worked directly with Ms. Myrick. He maintained the Department's *Supervisors and Peers Learning Collaborative* (SuPeers LC), an intranet site dedicated to sharing announcements, documents, and links that are relevant to DMH peers and supervisors. He also worked collaboratively with Ms. Myrick on other DMH efforts targeting peer workforce advancement. Scott Hanada provided historical information on PRC implementation and coordinated PIP-related trainings for DMH, peer, staff and supervisors.

Joelene Friestad maintained program oversight for the PRC staff, volunteers, and operations until August 2019. Carmen Aguilar worked with Ms. Friestad as a Peer Support Worker. Joo "Eric" Lee became the PRC supervisor in August 2019. Catherine Clay, David Snell, Joseph Cuevas, Laura Kerr, and Charles Miller, are full-time PRC staff. Marisela Soto provides services in the PRC as a Medical Case Worker II. They all participated in a group interview, and provided information related to PRC improvement, administration and collection of outcomes data, and other activities related to this project.

Several stakeholders contributed their perspectives as self-identified peers, peer supervisors, and volunteers providing services in Legal Entity (LE)/Contracted agencies. Libby Hartigan contributed her expertise on peer support trainings and expectations. She also invited additional peer stakeholders whom provided feedback towards the project's efforts. Annie Humphrey, Program Manager, Matthew Lyon, Quality Assurance Manager, and Mandy Sommers, Director of Quality Assurance and Clinical Services

with the St. Joseph Center shared their familiarity with providing peer services under DMH and Department of Health Services (DHS) contracts. Aldonia Wylie and Amparo Ostojic provided consultation as self-identified individuals with lived experience.

Patrick Corrigan is a Distinguished Professor and Sonya Ballentine is a Project Director from IIT. They served as subject-matter experts. They have a reputable history of conducting research studies on peer services and the impact of stigma on mental illness. They provided consultation regarding peer provider trainings, including the applicability of proposed training models to the diverse needs of DMH consumers.

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.

## The Peer Resource Center Pilot

There was anecdotal evidence pertaining to the need for a dedicated team of DMH staff and volunteers to provide resources and support to unserved and underserved members of the local community. The project was developed to support community members residing-in, working-in, or visiting the neighborhood directly surrounding the DMH Headquarters (HQ). Community members regularly visited the administrative building seeking mental health and other community resources. They would receive general information assistance from the EOTD, Patient's Rights Office (PRO), and other rotating programs. Additionally, a large number of homeless individuals, who appeared to be in need of assistance and were prime candidates for engagement efforts, also resided in the area. There are six peer-run programs in Los Angeles County. The Benefits Assistance Clients Urban Project (BACUP), Painted Brain, and SHARE! Downtown are the only three peer-run programs within 10 miles of DMH HQ.

Dr. Johnathan E. Sherin was appointed as the County's Director of Mental Health on November 1, 2016. The PRC project was initiated in December 2016. In May 2017, the doors at Vermont Avenue and Sixth Street opened to the County's first Peer Resource Center pilot project. For Dr. Sherin, the PRC was symbolic of his plans to transform mental health treatment through peer-to-peer relationships and intentional communities. The PRC located at DMH HQ served as the pilot site that Dr. Sherin envisioned as a space, "where we'll have peers of all kinds to be trained and certified and part of the workforce." The PRC was launched in a short amount of time and other than peer support, there was no identified model for the pilot at implementation.

The PRC is the Department's first Directly Operated (DO) peer-run program. The most recent staff roster included five, full-time, DMH employees and five, Wellness Outreach volunteers all dedicated to providing peer support services. PRC staff have lived experiences with mental illness, homelessness, and other issues. The PRC's visitors[1] receive referrals/linkages to services and participate in the PRC's daily activities (i.e., Movie Mondays, chess and guitar lessons, and job readiness) at any given visit. The

[1] PRC service recipients/participants will be referred to as "visitors" throughout this document.

PRC reinforces the Department's commitment to cultivating a space for consumers and community members to connect with one another. The PRC offers mental health resources, information on DMH programs and services, linkages to essential public assistance and social service programs inclusive of housing support, job training, legal aid, and volunteer opportunities. The goal of the PRC was for all visitors to have a positive experience, which led to the development of its motto: "Heart forward" and its service philosophy of "Everyone leaves with something." The PRC's hours of operation are Mondays through Fridays, from 8:00 AM to 5:00 PM, with the exception of special events. All DMH holidays are observed.

PRC program services provide recovery and resiliency support to individuals of all ages. Programs can be individualized to the needs of the community, including services for individuals seeking re-entry, specific cultural/ethnic populations, LBGTQIS2 communities, and other specialty populations.

The lessons learned from this pilot project – including successes and challenges – would prove supportive to the expansion of PRCs into other SAs and LE/Contracted providers. The Department is also planning to hire a large number of peer workers to serve as a resource for veterans, individuals who are homeless and have survived the trauma of living on the streets, and community members in varying levels of their resiliency/recovery. In order to provide consistent, high quality services, clarity is important in the roles and skills necessary for peer service providers.

**Understanding Peer Services**

For the purpose of this PIP, a "peer" is a person who has lived experience with mental health systems and/or navigating the mental health system. SAMSHA (2015) defines a peer support worker's role as offering and receiving help, based on shared understanding, respect, and mutual empowerment between people in similar situations. Peer providers function as role models for those working to manage their own recovery. Consumers report feeling trust, respect, and compassion more easily than with non-peer providers. There is a great feeling of empowerment and focus on the pursuit of goals when consumers work with peer providers (Miyamoto & Sono, 2012).

As with other mental health professions, core competencies for peer workers were developed by SAMHSA (2015) to guide peer providers, managers, and programs in providing peer-directed services to the community. Core competencies are the skills and knowledge needed to perform a role. The founding principles of the peer core competencies are: 1) recovery-oriented, 2) person-centered, 3) voluntary, 4) relationship-focused, and 5) trauma-informed. The core competencies are as follows:

1. Engages peers in collaborative and caring relationships
2. Provides support
3. Shares lived experiences of recovery
4. Personalizes peer support
5. Supports recovery planning

6. Links to resources, services, and supports
7. Provides information about skills related to health, wellness, and recovery
8. Helps peers to manage crises
9. Values communication
10. Supports collaboration and teamwork
11. Promotes leadership and advocacy
12. Promotes growth and development

To align with the Department's goal to have a clear model for the PRC, ensuring the incorporation of the core competencies into PRC programing is essential. PRC staff training and support should match the core competencies in order to provide quality services to PRC visitors and the surrounding community. If PRC staff are providing services consistent with peer core competencies, then PRC visitors will receive high quality services.

Soon after joining DMH as the Discipline Chief of Peer Services, Ms. Myrick recognized the need for a re-assessment of PRC operations. There was a call for a united vision that clearly defined the PRC's mission, purpose, and long-term goals. The PRC pilot lacked continuous improvement processes where peer practices and services were being evaluated. A multi-level approach was needed to realign the PRC program with its intended purpose. A multi-year PIP would also support DMH with developing a stepwise and replicable process for pilot expansion. The project's efforts and interventions will be aimed at reinforcing PRC services that are trauma-informed, recovery/resiliency-oriented, and culturally and linguistically competent.

- What is the problem?
- How did it come to your attention?

**Problem 1 – How can the PRC's understanding of community needs be improved?**

In February and March 2017, DMH facilitated four Focus Group sessions for the purpose of gathering design and implementation suggestions. The PRC pilot was presented as a drop-in center (or respite) for community members seeking referral/linkages and/or peer-to-peer engagement. The Focus Group participants included consumers, family members, and DMH staff whom shared a consensus that visitors should "benefit from their experience" while spending time in the PRC. In addition to a physical space that promotes the Department's mission, PRC visitors should "leave with something (e.g., information, resources, a behavioral health or social services appointment, snacks, or peace of mind)." The Department relied on an anecdotal impression of the demand for a PRC that was further reinforced by these Focus Groups. The information gathered during these Focus Group sessions was valuable and limited (refer to ***Attachment 1B.1***). The session participants emphasized the importance of building relationships between DMH and the community. However, a deeper assessment of the community's needs (i.e., who are they, how do they behave, what other positive influences and negative influences might exist in their environment/community; what services or programs currently exist; and what gaps are there in the current services or programs) may have positively impacted

the PRC pilot's roll-out and overall responsiveness to services. If the PRC program can better understand the needs of the community, then PRC visitors will receive services that are more appropriately aligned with the community.

**Problem 2 – Are PRC services consumer-driven and peer-run?**

The Department is invested in providing consumer-driven/operated wellbeing programs that are recovery-focused and rich in peer involvement. The Department strives to collaborate with consumers, family members, and community members for the purpose of Continuous Quality Improvement (CQI). This is not a mandated process. CQI is a Departmental aspiration and critical component to the delivery of consumer-driven services. Consumer input should be ongoing and dictate the direction of the PRC pilot.

Consumer feedback and involvement was utilized in the development and initial implementation of the PRC through Focus Groups and the Client Advisory Board (CAB). The CAB was exclusive to consumers and involved elected officers, protocols, and regular meetings. The CAB dissolved as members transitioned into staff positions. As a result, the PRC's opportunities for improvement/community feedback became limited to comments left in an informal suggestions' box.

Open-ended comments were reviewed on a weekly basis, during PRC staff meetings. The comments were mainly positive and did not offer additional insight into the PRC's progress in providing peer-driven services that are aimed at developing productive and positive connections between the community and DMH or with supporting PRC visitors in their recovery. The open-ended comments received from PRC visitors between January 2018 and May 2019 were categorized (positive, area for an improvement, neutral, or general recommendation) and summarized in the following:

- Positive comments (58.6%) included:
  - Staff are friendly and helpful
  - Tour was helpful and informative
  - Pleased with PRC services and resources
  - Supportive and safe environment

- Comments that identified an area for improvement (22.2%) reported:
  - Poor organization of activities
  - Noise-control issues
  - Opportunities for conflict resolution
  - Negative interaction with PRC staff

- Comments that offered a general recommendation (8.8%) included:

- Additional program activities and staff are needed (e.g., case managers, employment assistance, and support groups)
- PRC brochure was not available in the Spanish language
- Additional facility resources are needed (e.g., microwave, shower, clothing, and cots)

- Approximately, 10.3% of the comments were considered neutral or described a concern not related to PRC services.

The PRC did not have a system in place to monitor and capture information about how well the pilot was working. Following the disbandment of the CAB, DMH was no longer engaging a working group of community partners whom were equally invested in enhancing peer support services. The working group would have provided valuable information on whether or not PRC activities were consumer-driven and peer-run and could also champion the PRC as a resource for the neighboring community. The PRC would have benefited from the perspective of other community-based organizations, faith leaders, parents, and youth, to name a few. Additionally, since this PRC pilot provided the best opportunity to learn more about what is and what is not working prior to full-scale implementation into other SAs, there should have been a clear plan for soliciting feedback, tracking activities and outcomes, and a record of training and supervision needs (including fidelity measures). Despite the majority of PRC visitors reporting positive experiences and opinions by way of the PRC's informal suggestions' box, there did not appear to be concerns related to program organization, activity management and availability, relational skills of PRC staff, facility functionality, and cultural/linguistic sensitivity. If the PRC program developed a clear method for receiving continuous community member feedback, then the PRC program could be molded to fit the needs and preferences of the community and PRC visitors.

**Problem 3 – Do PRC services mirror system-wide standards of practice?**

The QI team conducted a group interview with PRC staff and leadership on February 15, 2019. The PRC staff and leadership were transparent regarding their training needs. The group asserted a need for ongoing professional development and trainings. Ideal trainings would incorporate boundary-setting, safety concerns, and the unique cultural backgrounds and traumatic experiences of the surrounding community (i.e., diverse cultural and linguistic needs, assessing HIV status and providing appropriate resources, welcoming and supporting members from the Lesbian, Gay, Bisexual, Transgender, Queer and Questioning, Intersex, and Two-Spirit [LGBTQI2S] communities, and etc.).

Due to the brief development period of the PRC pilot launch, many gaps in program development were not filled. The foundational knowledge required for the process of "partnering" with PRC visitors and practicing a trauma-informed way of relating was identified as a training need. PRC staff may have some knowledge in non-clinical skills such as Health Navigation, safety, and de-escalation; however, more is needed as it pertains to how to operationalize these skills in ways that value peer practices. Despite a clear purpose, there was no identified model for development of the PRC regarding the assessment of needs in the community, CQI, consumer-driven program development, foundational skills and trainings, and onsite supervision. If the PRC program were to meet the system-wide standards of practice, then PRC visitor satisfaction rates would improve.

**Problem 4 – Does supervision support the concept of peer services?**

The PRC has undergone a number of leadership changes. In Calendar Year (CY) 2017, program management was shared between the Adult System of Care (ASOC) and EOTD. After six months of shared coverage – on a rotating basis, an EOTD Mental Health Clinical Program Manager II obtained primary oversight for the PRC. Approximately six months later, a Peer Support Worker was assigned to assist the MHCPM II with further supporting the PRC staff in their daily tasks (i.e., crisis management and ad-hoc weekly peer consultation).

In a December 2018, the QI team met with PRC management to identify areas for program improvement, from their perspective. At the close of the meeting, it was determined that QI team involvement would prove supportive in addressing one or more of the following concerns:

- The balance of a peer's role as an employee and an individual in recovery
- An seemingly unclear definition of "lived experience"
- Confusion about the differences in roles between PRC volunteers and employees
- No onsite supervisor
- Clarifying the role of the PRC in the community
- A process for documenting PRC services provided to visitors

It appeared to the EOTD staff that the lack of structure and supervision seem to be linked to the development of PRC staff conflict, incomplete projects, unprofessional behavior, and limited effectiveness of disciplinary actions. Safety in the PRC was also a concern, as there were limited security measures for the program's space. Visitors appeared reluctant to engage with the PRC if they had recently witnessed aggressive interactions. If PRC staff received consistent, supportive supervision, then the quality of services delivered and programming would improve for PRC visitors and the community.

The proposed project is aimed at returning the PRC program to its intended purpose. The initial goals were to 1) work with the community to provide resources and support by individuals who have lived experience with mental health symptoms and systems; 2) develop a sustainable system for PRC staff and managers to assess the needs of the community and maintain a platform for continuous community feedback; 3) develop a structured, supervised program with support for PRC staff and visitors; and 4) ensure the PRC visitors providing culturally and linguistically congruent services.

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

A PRC Improvement survey (refer to ***Attachment 1B.2***) was designed to assess whether or not PRC visitors were being supported through peer-driven services that promote health, home, purpose, and community (items 1 to 5) and general satisfaction with services (items 6 to 11). This survey tool consisted of 11 items with space available for open-ended comments. Respondents were instructed to use a three-point scale ("Yes," "No," "No Opinion").

The PRC Improvement survey was administered to PRC visitors from July 8, 2019 to July 19, 2019. Fifty-four visitors completed the English, Spanish, Cantonese, and Korean versions of the survey form. The survey items were adapted from the Fidelity Assessment Common Ingredients Tool (FACIT; SAMHSA, 2011) for consumer-operated programs and the four dimensions of recovery (SAMHSA, 2019). The following six items were endorsed negatively by three or more respondents:

- Item 1a, "The Peer Resource Center promotes the four dimensions of recovery: Health - by supporting me with making healthy choices that promote physical and emotional well-being."
- Item 1b, "The Peer Resource Center promotes the four dimensions of recovery: Home – by supporting me with having a stable and safe place to live"
- Item 1c, "The Peer Resource Center promotes the four dimensions of recovery: Purpose – by supporting me with having the independence, income, and resources to participate in society"
- Item 5, "I do not feel pressured to follow the advice of the Peer Resource Center staff"
- Item 8, "The Peer Resource Center is respectful of my culture"
- Item 10, "I am satisfied with the Peer Resource Center"

Examples of open-ended comments left by visitors on the PRC Improvement Survey include:

- More respect and inclusion for Latinos on behalf of African-American staff
- There is a lot of discrimination because of the lack of control
- Sometimes I feel discriminated against when events are being held
- I have notice some preference on ethnicity from some staff/volunteer members
- For there not to be any discrimination
- Staff should be more empathetic
- We need more support
- There are times there are not any [interpreters] and people do not understand
- Some staff members do not all
- Yes but the hours are (illegible) most likely to be in crisis on weekends or at night!
- Depends on who is speaking to me, not all staff is inclusive

- It has been a crisis for me not being able to receive the help that I need

The initial PRC Improvement survey data suggested PRC visitors would benefit from support with making healthy choices, developing their autonomy and independence, and engaging in meaningful daily activities (Items 1a, 1b, and 1c). Whether or not PRC visitors feel they are in-control of the resources and advice that they accept (item 5) would benefit from further exploration. Open-ended comments received, the group interview, and survey findings (item 8 and 9 and open-ended comments) showed a need for PRC services that emphasized relationship-building and better embraced the neighboring community's diverse cultural and linguistic needs. Visitors may also benefit from improvement in general satisfaction with the PRC (items 6 to 11) and additional support in functioning through crisis prevention strategies.

Based on the service needs endorsed by focus group participants and PRC visitors, the implementation of additional training for peer staff and supervisors was supported. The Intentional Peer Support (IPS) framework could positively impact the functioning of PRC visitors and be the initial training in a PRC staff education series. The core IPS training emphasizes a trauma-informed style of "relating" that focuses less on avoidance and more on ways to promote a fuller life through relationship development and building on the individual strengths of peer service utilizers. This training could serve to establish the relational skills necessary to engage and collaborate with PRC visitors.

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

After a review of the literature, Davidson, Bellamy, Guy, and Miller (2012) outlined effective strategies for implementing peer services with the following list of criteria:

- Clear job description and role identification
- Involvement of non-peer staff, organizational leaders, and individuals in recovery in the development and management of a program
- Identifying and utilizing the unique skills of each peer provider
- Having at least two peer providers in a program for mutual support
- A senior administrator that advocates for peer providers in regard to systemic issues
- Providing role-specific skills based trainings
- Supervision for peer providers focused on skills, performance, and support
- Training for non-peer staff on discrimination and accommodations, expectations for peers, ethics boundaries, maintaining positive relationships with co-workers, and resolving conflict in the workplace
- Widespread sharing of success stories

The authors also highlighted the importance of training for peer providers in the skills and tasks required for their position which include self-disclosure, building and maintaining relationships, identifying and planning for goals, crisis situations, documentation, ethics and confidentiality, managing boundaries, preventing burnout, and conflict resolution. Skill-specific trainings were consistent in effective peer service programs (Davidson, Bellamy, Guy, & Miller, 2012).

Miyamoto and Tamaki (2012) found there was limited research on the challenges of providing peer support services. They highlighted difficulties in role conflict and ambiguity, navigating boundaries, disclosure of their peer-status, low compensation, and limited work hours (Miyamoto & Tamaki, 2012). This finding was echoed in the group interview with PRC staff. A consistent, structured training series would assist in addressing training needs identified by both peers and peer supervisors/managers. Targeting skills specific to a peer's role has been found to be an effective strategy for integrating peer services into a mental health setting (Davidson, Bellamy, Guy, & Miller, 2012).

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

The overarching goal of this non-clinical PIP is to ensure PRC services are peer-driven, promote resiliency/recovery, incorporate core competencies, and embrace the cultural, linguistic, and historical differences of the neighboring Los Angeles community. The PRC pilot will contribute to the structure and quality of services provided by PRCs implemented in other SAs and counties.

Part of the PIP goal is to support the PRC in its mission of, "All visitors leave with something." This is a commitment to provide information, referrals for mental and physical health services and community resources, peer connection and support, and some basic necessities. The PRC is intended to create an environment of learning and connection without stigma to increase independence and self-efficacy.

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

The creation of a community member platform for the assessment of SA needs will contribute to the success of future PRCs' in delivering quality services and resources to PRC visitors. A PRC visitor and community member council in addition to a structured outcomes tool could provide ongoing community member feedback towards PRC program development. This could also monitor the stepwise progression of PRCs developed specifically for the needs of their SA population.

According to the PRC Improvement survey administered in June 2019, PRC visitors would benefit from additional support in developing autonomy and independence as well as engaging in meaningful daily activities. The creation of a PRC staff education series that emphasizes a trauma-informed way of "relating" and encourages peer providers to assist visitors with viewing their experiences through new angles and developing greater awareness could serve to improve the quality of PRC services countywide.

This PIP is projected to unfold over multiple years. Year One will involve the implementation of interventions aimed at establishing a model for PRC staff training and skills-building; the introduction of peer-specific supervision and program oversight; and improvements in communication with and surrounding the assessment of needs for PRC visitors. The PIP efforts being proposed for Year Two will involve expanding upon Year One findings and launching a second PRC.

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

The "Intentional Peer Support: An Alternative Approach" model trains peer providers to think about their relationships with community members as partnerships, develop awareness of personal and relational patterns, understand the impact of trauma on community members, explore the impact of the community on community members, and focus on positive change (Intentional Peer Support, 2019). The goal is to develop community-oriented assistance rather than reliance on formal services (Department of Health and Human Services, State of Maine, 2006). The National Coalition for Mental Health Recovery (2015) reports IPS has been used in crisis respite programs by peers, mental health professionals, family and friends, and community-based organizations. Table 2 below displays the identified PRC staff training needs with their corresponding IPS training objectives.

**Table 1: Identified Peer Resource Center Staff Training Needs By Corresponding Intentional Peer Support Core Training Objectives**

| # | Staff Training Need(s) | IPS Training Objective(s) |
|---|---|---|
| 1 | PRC staff should understand how they relate to others | 1). Develop a peer program based on critical self-awareness. |
| 2 | PRC staff should be able to define peer support | 2a). Identify what makes peer support different from other kinds of help<br>2b). Explain peer support in the context of social change and social justice |
| 3 | PRC staff should assist PRC visitors with increasing independence | 3a). Utilize an individual's strengths to cope with a crisis<br>3b). Use experience to relate and build trust |
| 4 | PRC staff should be able to develop, maintain, and repair relationships with PRC visitors and the community | 4a). Demonstrate ways to connect, become aware of disconnects, and work to reconnect<br>4b). Monitor challenging situations and negotiate conflict |

| | | |
|---|---|---|
| 5 | PRC staff should practice trauma-informed services | 5a). Construct trauma-informed and mutually responsible relationships<br>5b). Recognize how trauma affects lives |

Data source: Intentional Peer Support (IPS) 5-Day Core Training, DMH, August 2019.

- The study topic narrative will clearly demonstrate:
  - How the identified study topic is relevant to the consumer population

The PRC provides valuable support to the SA 4 community. With a plan to expand PRC programs to support additional communities, it is important to have a structured plan for the development and implementation of the program and address programmatic challenges. This will increase the probability of success for the community, PRC program, and PRC staff and supervisors.

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

Between September 2018 and April 2019, a total of 2,162 visitors (duplicated) were served by the PRC program. With the expansion of PRC programs to additional SAs, the programs are likely to impact a significant number of individuals in the surrounding communities. The limited number of available peer-run programs increased with the opening of the PRC bringing SA 4's total to four and the County total to 11. There is a great need for PRC programs, particularly in the expansive community of Los Angeles County.

Revising the procedures and programming of the PRC will increase the quality of services provided to PRC visitors. Improving the paths for PRC visitor/community input will assist PRC programs in better meeting the needs of their communities. Structured trainings that emphasize specific skills necessary for PRC staff will also improve services.

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

The interventions for this non-clinical PIP will be aimed at improving PRC visitors' satisfaction with services. The interventions target PRC programming in need of improvement such as creating better relationships with the PRC visitors and community; developing consistent involvement and feedback from PRC visitors and community members; refining the functioning, procedures, and training of the PRC staff and management; and providing additional cultural and linguistic support to PRC visitors. The purpose of these interventions is to improve the overall quality of care and satisfaction of PRC visitors and the community.

## 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")

Avoid using acronyms in the study question. In its report, CalEQRO may insert a necessary acronym at its discretion while stating the PIP study question.

Will enhancing community involvement, establishing a staff training series, and defining supervision standards for the Peer Resource Center support visitors in their recovery plans and overall satisfaction with Peer Resource Center services?

## 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 study population includes all visitors who utilize services from the PRC as walk-ins or participants in scheduled activities. Services are open to all Medi-Cal beneficiaries and un-insured individuals.

### Population Demographics

The PRC is located in SA 4 of Los Angeles County. SA 4 is the 5th most densely populated of the eight SAs. SA 4 has a total population of 1,188,412. According to the 2018 American Community Survey (ACS) from the United States Census Bureau and Hedderson Demographic Services, the three largest racial/ethnic groups in SA 4 were Latino at 52.0%, White at 23.8%, and Asian/Pacific Islander at 17.3%. The three largest age groups in SA 4 were 53.7% for individuals age 26-59 years, 20.6% for ages 0-18 years, and 12.1% for individuals age 65 and over. A total of 51.4% of consumers self-identified as Male and 48.6% self-identified as Female. The threshold languages for SA 4 are Armenian, Cantonese, Korean, Russian, Spanish, and Tagalog.

**Peer Resource Center Improvement Survey Demographics**

*Data Cycle 1*

The demographic information for the PRC Improvement survey respondents (N=54) during the July 8, 2019 through July 13, 2019 collection period is as follows. Respondents who did not complete the demographic information were not included:

- Gender: 40.7% Male (N=22), 38.9% Female (N=21), and 3.7% Other (N=2; specifically, “Anything I/eye want!”/”All”)
- Race/Ethnicity: 31.5% Latino (N=17), 14.8% Other (N=8), 9.3% Two or more (N=5), and 7.4% White (N=4)
- Age: 48.1% between 26 and 59 years old (N=26), 31.5% 60 years old and above (N=17), 3.7% between 16 and 25 years old (N=2), and 1.9% Two or more (N=1)

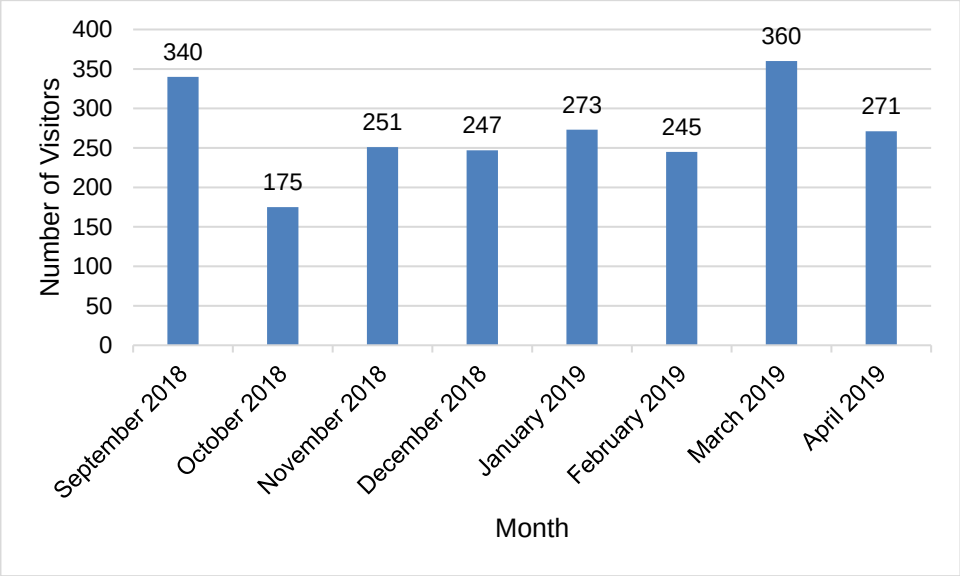
*Data Cycle 2*

Additionally, the demographic information for the PRC Improvement survey respondents (N=51) during the August 30, 2019 through September 13, 2019 collection period is as follows. Respondents who did not complete the demographic information were also not included:

- Gender: 49.0% Male (N=25), 37.3% Female (N=19), and 2.0% Other (N=1; Female/Transgender)
- Race/Ethnicity: 31.4% Black or African American (N=16), 27.5% Latino (N=14), 13.7% White (N=7), and 7.8% Other (N=4)
- Age: 56.9% between 26 and 59 years old (N=29), 25.5% 60 years old and above (N=13), and 3.9% between 16 and 25 years old (N=2)

Figure 1 presents the number of visitors that were served by PRC staff between September 2018 and April 2019. A total of 2,162 visitors (duplicated) were served. March 2019 had the highest number of PRC visitors (N=360) and October 2018 had the lowest (N=175).

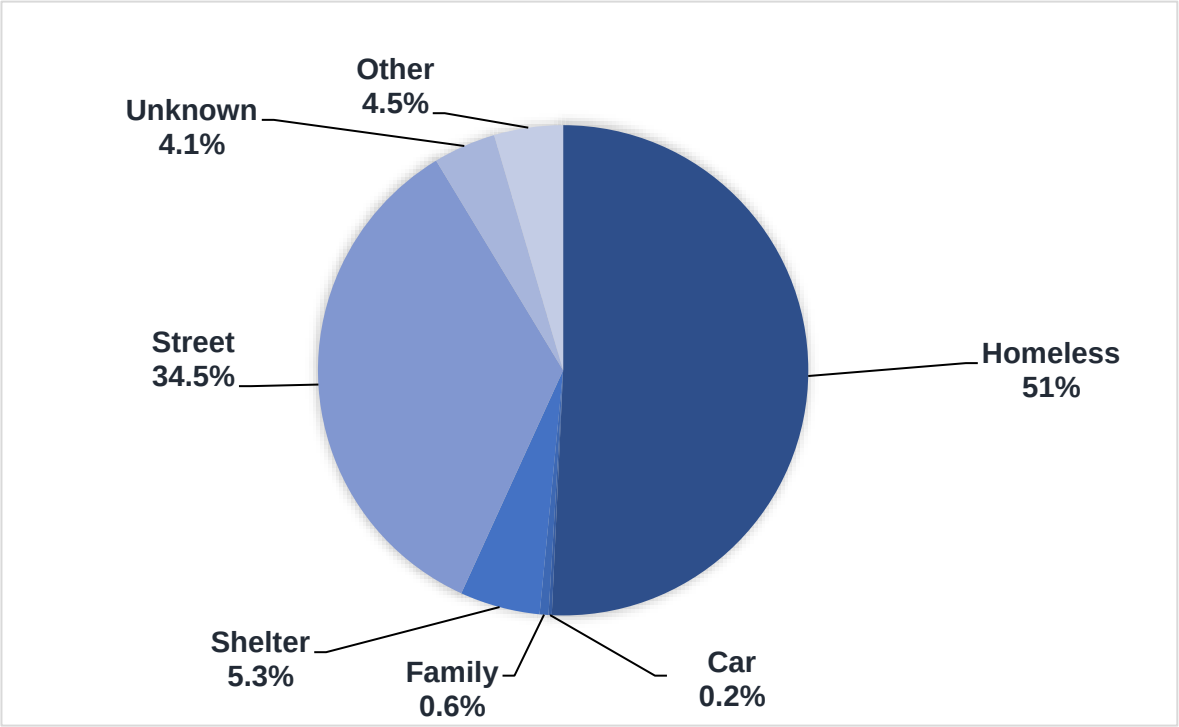
**Figure 1: Total Peer Resource Center Visitors Served by Month**
**September 2018 - April 2019**




Note: Data represents duplicated visitors and likely underreported totals for the homeless population. Data source: Dynamics 365 – PRC Dashboard, July 2019.

Figure 2 describes PRC visitors who reported their housing status between September 2018 to April 2019. Of 1,892 visitors, 51.0% (N= 960) indicated they were Homeless and 34.5% (N=653) reported "living on the Street." Additionally, 5.3% (N=100) reported living in a Shelter, 4.5% (N= 86) endorsed Other, 4.1% (N=78) were Unknown, 0.6% (N=11) reported living with Family, and 0.2% (N=4) were living in their Car.

Figure 2: Housing Status Per Peer Resource Center Visitor Report
September 2018 - April 2019




Note: Data represents duplicated visitors and likely underreported totals for the homeless population. Data source: Dynamics 365 – PRC Dashboard.

The majority of services received by PRC visitors between September 2018 to April 2019 were categorized as General Support (49.0%), Information (31.7%), Patient's Rights (3.4%), Mental Health Services (2.8%), Employment Services (2.6%), providing transportation Tokens (2.5%), or other Referral Linkage (2.0%).

The PRC has been providing peer-led services via telephone calls (2.3%), community outreach (0.3%), and in-person PRC visits (97.2%). The majority of PRC visitors were self-referred and received services/resources via an in-person visit. To date, the PRC has provided greater than 5,000 services (see Table 2) and approximately 43% of visitors self-identified as homeless.

Table 2: Year-to-Date Number and Type of Services/Resources Provided to Peer Resource Center Visitors

| Type of Service/Resource | Number of Services/Resources Provided |
|---|---|
| General | 2,231 |
| Information | 1,523 |
| Housing | 459 |
| Other | 269 |
| Mental Health Services | 176 |
| Patient's Rights | 158 |
| Employment | 113 |
| Department of Motor Vehicles (DMV) | 89 |
| Social Services | 62 |
| Legal Services | 59 |
| Medicaid Services | 36 |
| Transportation | 26 |
| Substance Use | 20 |
| Grand Total | 5,221 |

Note: Number of services is larger than the number of PRC visitors served. PRC visitors may have received more than one service or resource at each visit. Data Source: PRC, July 2019

Additional information regarding the study population is pending as the PRC continues to revise the demographic data collected.

## 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

**Specify the performance indicators in a table.**

Please refer to Tables 3, 4, and 5.

**Table 3: Non Clinical Performance Improvement Project Performance Indicators – Year One**

| # | Performance Indicators | | Numerator | Denominator | Baseline for Performance Indicator | Goal (Percentage Points; PP) |
|---|---|---|---|---|---|---|
| 1 | PRC visitors self-reported improved health, independence and increased engagement in meaningful daily activities | 1a) PRC visitors received support with making healthy choices that promote physical and emotional well-being (item 1a) | Number of positive responses to item 1a of the PRC Improvement survey | Total number of responses for item 1a of the PRC Improvement survey | 89.8% | +2 PP |
| | | 1b) PRC visitors received support with having a stable and safe place to live (item 1b) | Number of positive responses to item 1b of the PRC Improvement survey | Total number of responses for item 1b of the PRC Improvement survey | 68.6% | +10 PP |
| | | 1c) PRC visitors received support with having the independence, income, and resources to participate in society (item 1c) | Number of positive responses to item 1c of the PRC Improvement survey | Total number of responses for item 1c of the PRC Improvement survey | 74.0% | +10 PP |
| | | 1d) PRC visitors received support with having relationships and social networks that provide support, friendship, love, and hope (item d) | Number of positive responses to item 1d of the PRC Improvement survey | Total number of responses for item 1d of the PRC Improvement survey | 88.2% | +2 PP |
| 2 | PRC visitors self-reported level of functioning | 2a) PRC visitors felt they can better manage their life (item 2) | Number of positive responses to item 2 of the PRC Improvement survey | Total number of responses for item 2 of the PRC Improvement survey | 84.0% | +2 PP |
| | | 2b) PRC visitors felt they have avoided crisis situations (item 3) | Number of positive responses to item 3 of the PRC Improvement survey | Total number of responses for item 3 of the PRC Improvement survey | 80.0% | +2 PP |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | 2c) PRC visitors felt they are better able to ask for help (item 4) | Number of positive responses to item 4 of the PRC Improvement survey | Total number of responses for item 4 of the PRC Improvement survey | 85.7% | +2 PP |
| 3 | PRC visitors self-reported satisfaction with services | 3a) PRC visitors felt they are in-control of the resources and advice that they accept (item 5) | Number of positive responses to item 5 of the PRC Improvement survey | Total number of responses for item 5 of the PRC Improvement survey | 68.6% | +10 PP |
| | | 3b) PRC visitors reported feeling safe at the PRC (item 6) | Number of positive responses to item 6 of the PRC Improvement survey | Total number of responses for item 6 of the PRC Improvement survey | 92.4% | +2 PP |
| | | 3c) PRC visitors found there are several activities to choose from (item 7) | Number of positive responses to item 7 of the PRC Improvement survey | Total number of responses for item 7 of the PRC Improvement survey | 88.2% | +2 PP |
| | | 3d) PRC visitors received services that embrace their diverse cultural (item 8) | Number of positive responses to item 8 of the PRC Improvement survey | Total number of responses for item 8 of the PRC Improvement survey | 86.0% | +2 PP |
| | | 3e) PRC visitors received services in their preferred language (item 9) | Number of positive responses to item 9 of the PRC Improvement survey | Total number of responses for item 9 of the PRC Improvement survey | 88.5% | +2 PP |
| | | 3f) PRC visitors reported overall satisfaction with services (item 10) | Number of positive responses to item 10 of the PRC Improvement survey | Total number of responses for item 10 of the PRC Improvement survey | 79.6% | +10 PP |
| | | 3g) PRC visitors reported they would recommend the PRC to others (item 11) | Number of positive responses to item 11 of the PRC Improvement survey | Total number of responses for item 11 of the PRC Improvement survey | 96.2% | +2 PP |

Note: Positive responses are defined as “Yes” responses.

## Table 4: Non Clinical Performance Improvement Project Process Indicator – Year One

| # | Process Indicators | | Numerator | Denominator | Baseline for Process Indicator | Goal (Percentage Points; PP) |
|---|---|---|---|---|---|---|
| 4 | Degree to which there is a change in PRC staff pre-post training perceived knowledge | Peer Services Fidelity Measure | TBD | TBD | TBD | TBD |

## Table 5: Non-Clinical PIP Rationale for Selection of Performance Measures FY 19-20

| | |
|---|---|
| **Rationale for Selection of Study Measure 1:** | Use visitor ratings to identify areas for improvement in the delivery of resiliency/recovery-oriented services |
| Targeted Change: | Functional Status |
| Quantifiable Measure: | Visitor perceived support received from PRC towards the four dimensions of their recovery (Home, Health, Purpose, and Community) pre and post intervention |
| Numerator: | Total number of responses on items 1a, 1b, 1c, and 1d rated positively by respondents |
| Denominator: | Total number of responses on items 1a, 1b, 1c, and 1d |
| First measurement period date(s): | July 8-13, 2019 |
| Baseline benchmarks | 1. Item 1a – 89.8%<br>2. Item 1b – 68.6%<br>3. Item 1c – 74.0%<br>4. Item 1d – 88.2% |
| Source of benchmark | Results from the PRC Improvement survey administered to PRC visitors pre intervention |
| Goal: | 1a, 1d: +2 PP<br>1b, 1c: +10 PP |
| **Rationale for Selection of Study Measure 2:** | Use visitor ratings to identify areas of improvement in the types of services delivered by PRC staff |
| Targeted Change: | Functional Status |
| Quantifiable Measure: | PRC visitor perceived level of functioning as a result of PRC services pre and post intervention |
| Numerator: | Total number of responses on items 2, 3, and 4 rated positively by respondents |

| | |
|---|---|
| Denominator: | Total number of responses |
| First measurement period date(s): | July 8-13, 2019 |
| Baseline benchmarks | 2a) Item 2 – 84.0%<br>2b) Item 3 – 80.0%<br>2c) Item 4 – 85.7% |
| Source of benchmark | Results from the PRC Improvement survey administered to PRC visitors pre intervention |
| Goal: | +2 PP (All) |
| **Rationale for Selection of Study Measure 3:** | Use visitor ratings to identify areas of improvement in environment, resources, activities, and cultural competency |
| Targeted Change: | Visitor Satisfaction |
| Quantifiable Measure: | PRC visitors' satisfaction ratings pre and post intervention |
| Numerator: | Total number of responses on items 5, 6, 7, 8, 9, 10, and 11 rated positively by respondents |
| Denominator: | Total number of responses |
| First measurement period date(s): | July 8-13, 2019 |
| Baseline benchmarks | 3a) Item 5 – 68.6%<br>3b) Item 6 – 92.4%<br>3c) Item 7 – 88.2%<br>3d) Item 8 – 86.0%<br>3e) Item 9 – 88.5%<br>3f) Item 10 – 79.6%<br>3g) Item 11 - 96.2% |
| Source of benchmark | Results from the PRC Improvement survey administered to PRC visitors pre intervention |
| Goal: | 3b, 3c. 3d, 3e, 3g: +2 PP<br>3a, 3f: +10 PP |
| **Rationale for Selection of Study Measure 4:** | Determine the degree to which PRC staff adhere to peer support competencies |
| Targeted Change: | Functional Status |
| Quantifiable Measure: | Ratings of PRC staff on the Peer Support Fidelity Measure |
| Numerator: | TBD |
| Denominator: | TBD |
| First measurement period date(s): | TBD |
| Baseline benchmark | TBD |
| Source of benchmark | TBD |
| Goal: | TBD |

## STEP 5: SAMPLING METHODS (IF APPLICABLE)

The MHP must provide the study description and methodology.

- Identify the following:
  - Calculate the required sample size?

All visitors to the PRC during the survey periods were offered the survey. The monthly average number of PRC visitors presenting to the PRC for FY 18 -19 was 248.9. Using the sample size calculation of $\mathbf{n = z^2 * p * (1 - p) / e^2}$, the recommended sample size for the data collection was 152. Results should be interpreted with caution as the recommended sample size was not reached for both data cycles due to the walk-in style of providing services, variable daily number of PRC visitors seeking services, surveying for a limited two-week period, multiple declinations to complete the survey by PRC visitors, and the FY 18 -19 being a duplicated total.

  - Consider and specify the true or estimated frequency of the event?

The frequency of the survey was selected to be prior to and following the IPS training.

  - Identify the confidence level to be used?

The confidence level used for data analysis was 95%.

  - Identify an acceptable margin of error?

Using the Margin of Error (MOE) calculation of **MOE = z * √p * (1 - p) / √n,** the MOEs for the data cycles are listed below:

- Data cycle 1: N=54, MOE= +/-11.8%
- Data cycle 2: N=51, MOE= +/-12.3%

Describe the valid sampling techniques used?

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

PRC Improvement Survey:

Random sampling, a process where every member of the population has an equal chance of being invited to take the survey, was used for this data collection. All PRC visitors walking in for services during the designated survey collection periods were offered the survey. The number of surveys completed were variable due to the need for services, number of scheduled activities, and time of day the surveys were collected. The frequency of the measure was determined to be prior to any implementation of interventions and following the implementation of the IPS training. The pre IPS training survey collection occurred during the business days of July 8, 2019 and July 13, 2019.

Peer Services Fidelity Measure:

At this time, there are five-full time staff providing services for the PRC program. Each of the five staff will participate in a measure of their fidelity to peer competencies or services. This measure has yet to be constructed and frequency has not been determined. Confidence level and margin of error will be determined following the construction of the measure.

## 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.

PRC Improvement survey data is being collected for this project. Survey participants provided responses using a nominal scale (Yes/No/No Opinion). The 11-item survey tool was designed to assess the respondents' functional status and overall satisfaction with services. The open-ended comments will be categorized into themes and tallied.

- 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?

Please refer to Table 6.

Table 6: Non-Clinical PIP Methods and Sources of Data Collection
FY 19-20

| # | Data collected for Calendar Year 2019 | Methods of Data Collection and Sources of Data |
|---|---|---|
| 1 | **Pre-post intervention PRC visitor ratings** | PRC Improvement Survey completed by visitors utilizing PRC services |
| 2 | **PRC staff adherence to peer support competencies** | Peer Support Fidelity measure completed by onsite PRC supervisor |

- Describe the prospective data analysis plan. Include contingencies for untoward results.

**Data Analysis**

PRC Improvement Survey

A Chi square Test of Independence was used to compare data cycle 1 to data cycle 2. This test is used to analyze data that is independent and not matched.

**Limitations**

PRC Improvement Survey

Participants completing the PRC Improvement survey did so on a voluntary basis. Voluntary sampling may oversample PRC visitors who have strong opinions (Smith, 2019). Results should be interpreted with caution as several of the PRC visitors who completed the data cycle 1 survey also completed the data cycle 2 survey. There was no tracking of the visitors who participated in both survey periods. The drop-in style of the PRC did not allow for a matched-pairs data analysis. This increased the possibility of variables outside of the intervention creating an affect on the data.

Although the PRC is not a clinical setting, some visitors may experience mental health symptoms that would impact their ability to participate in, comprehend, or complete the PRC Improvement survey. There was no evaluation of the PRC visitors' symptoms prior to administration. The survey was also designed and translated for a sixth grade reading level. PRC visitors who did not possess this reading level may have had comprehension difficulties.

It appears the survey response scale was not sensitive enough to reflect the true experience of PRC visitors. At the recommendation of the stakeholders, a three-point scale with the response options "Yes," "No," and "No Opinion" was used. However, after the two administrations of the survey, it was observed that PRC visitors drew in boxes labeled "Maybe" or gave

more than one answer by endorsing both "Yes" and "No." For future administrations of the survey, a five-point Likert scale is recommended.

Item 5, "I do not feel pressured to follow the advice of the Peer Resource Center staff," was found to illicit contradictory ratings and comments during data cycle 1. PRC visitors rated item 5 the lowest, yet made many positive comments related to the item. One PRC visitor noted the item with the "No" response created a double negative. It is likely that Item 5 caused confusion among PRC visitors due to the inconsistency of responses. Stakeholders also agreed that the word "advice" is not an accurate descriptor of how peer service providers support consumers. The PIP committee recommended that this item be revised to remove the double negative and will replace the word "advice" with a more accurate representation of the way peers offer information and resources.

The data analysis of only one survey completed in data cycle 1 was effected by the difficulty of accessing a Cantonese version of the PRC Improvement survey. For the initial survey collection, the Cantonese version had not been updated with the final edits before translation. The response options for this version of the survey remained "Rather Not Say" instead of "No Opinion." The questions, "Is today your first time visiting the Peer Resource Center" and "Have you used the Peer Resource Center's services more than once," had not been updated to, "In the last six months, how many visits have you made to the Peer Resource Center?" The PIP committee recommended that Simplified and Traditional Chinese versions be used for later administrations as they allow for Cantonese and other Chinese-speaking PRC visitors to participate.

- Identify the staff that will be collecting data, and their qualifications. Include contractual, temporary, or consultative personnel.

Staff collecting data for this non-clinical PIP include the following:

- QI staff
- Onsite PRC supervisor

## 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.

Please refer to Table 7.

## Table 7: Non-Clinical Performance Improvement Project Interventions

| Number of Intervention | List each Specific Intervention | Barriers/Causes Intervention Designed to Target | Corresponding Indicator | Date Applied |
|---|---|---|---|---|
| 1 | Implementation of a training series for dedicated PRC staff | The IPS is a full-day training completed over the course of five day. The training targets a lack of foundational knowledge in delivering peer support services in a highly interactive environment, for individuals with diverse cultural, linguistic, and traumatic backgrounds, and that is focused on building mutual relationships. The IPS core training (2019) [3]would support PRC staff with:<br>➢ Striving for mutuality in relationships<br>➢ Staying curious, questioning assumptions, and owning judgements and opinions<br>➢ Opening up new ways of listening<br>➢ Using experience to relate and build trust<br>➢ Naming and negotiating power in relationships<br>➢ Approaching crisis as an opportunity to grow<br>➢ Sharing risk and responsibility<br>➢ Paying attention to the impact of clinical and labeling language<br>➢ Understanding how trauma affects lives | 1, 2, 3, & 4 | August 2019 |
| 2 | Reorganize PRC program oversight and onsite management | To stabilize the PRC program management the Peer Services Division will gain oversight of the PRC. This shift will place the PRC | 1, 2, 3, & 4 | August 2019 |

[3] Retrieved from: http://www.intentionalpeersupport.org/trainings/#CTAnchor on July 30, 2019

| | | | | |
|---|---|---|---|---|
| | | program in the management of leadership and experts in the peer field. The addition of an onsite supervisor will address the previous gaps in supervision and onsite management. | | |
| 3 | Establish a working group of peers and community members to provide feedback to PRC staff | Reinstitution of the Client Advisory Board (CAB): To address the lack of visitor/community feedback and involvement, the PRC will offer a forum for continuous feedback about services, program development, and resources provided by the PRC<br>• CAB will be a group of PRC visitors/community members with an organized leadership<br>• CAB will be representative of the geographical SA<br>• PRC staff will not hold leadership roles | 1, 2, 3, & 4 | TBD |
| 4 | Implementation of a Peer Services Fidelity Measure | To increase the support, skill development, and supervision of the PRC staff, an onsite supervisor will use the fidelity measure to regularly evaluate PRC staffs' peer service skills to maintain the PRC's model of practice. | 1, 2, 3, & 4 | TBD |
| 5 | Review the cultural competency procedures of the PRC program and staff | To address the cultural and linguistic needs of PRC visitors, such as providing cultural/diversity training to PRC staff and making PRC literature available in additional languages | 1, 2, 3, & 4 | TBD |

## Year One – Plan-Do-Study-Act Cycles

The Peer Resource Center (PRC) Improvement Survey Plan-Do-Study-Act (PDSA) form Cycle 1 – May 2019, describes the baseline data collection (refer to ***Attachment 1B.3***). The development of the PRC Improvement survey was to promote an increase in feedback to staff from visitors about the impact of PRC services. The survey assessed PRC visitors' ratings pertaining to PRC's success in promoting the four dimensions of recovery (home, health, purpose, and community), impact of PRC services on visitors' level of functioning, and general satisfaction with the program. A QI Analyst administered and collected responses from PRC visitors who walked in for services between July 8, 2019 and July 19, 2019. Fifty-four surveys were completed in the Cantonese, English, Korean, and Spanish languages. The PRC visitor ratings were reviewed quantitatively and qualitatively.

- Describe how the interventions will impact the indicators and help to answer the study question.

**Year One**

1. Implementation of a Training Series for Dedicated PRC Staff

The Intentional Peer Support (IPS) model targets the development of relational skills for peer support providers. The model emphasizes mutual relationships with both service utilizers and the community that are trauma-informed and individual strength-based. Specific skills include maintaining relationships, managing conflict, and understanding trauma. These skills will promote better relationships with PRC visitors and the community thereby increasing the impact of PRC services.

PRC Visitor Ratings at Pre and Post Intervention

The IPS training occurred over five days between August 19 and August 23, 2019. The six attendees completed a post-training knowledge assessment and evaluation using a six-point scale (*Excellent, Very good, Satisfactory, Fair, Poor, and Not applicable*). All six attendees ranked the following training objectives as Excellent/Very Good:

- Create guidelines for establishing a learning-community based on needs/styles/talents, not instruction alone
- Develop a peer program based on critical self-awareness
- Explain peer support in the context of social change and social justice
- Identify what makes peer support different from other kinds of help
- Identify the three principles of Intentional Peer Support (IPS)
- Recognize the four tasks of IPS

All six attendees gave the training an overall rating of “Excellent.” The six attendees also rated the IPS training as “Excellent” in that the presentation was:

1. Useful and broadened their knowledge
2. The presenter was knowledgeable and well prepared
3. The materials facilitated learning
4. The curriculum addressed cultural competency and diversity
5. The length of them was appropriate training improved their knowledge of the subject matter
6. The training was important and useful to their professional growth. The six attendees also gave the training an overall rating of “Excellent.”

2. Reorganize PRC Program Oversight and Onsite Management

The PRC was previously managed by the ASOC and EOTD, two programs with limit specialized knowledge of peer support services. The shift of the PRC’s management to the Office of Discipline Chiefs, Peer Services will initiate oversight of the PRC program by managers/supervisors with expert knowledge about peer support services, supporting peer employees, and working with the community. Furthermore, the implementation of an onsite supervisor will increase the program structure, PRC staff support, and quality of services delivered to the PRC visitors and the surrounding community.

**Year Two (Proposed)**

3. Establish a Working Group of Peers and Community Members to Provide Feedback to PRC Staff

The PRC Focus Groups had recommended the creation of a CAB to assist the PRC in program development and to receive feedback about the impact of PRC services on visitors and the community. The CAB was implemented at the onset of the PRC program; however, the CAB later dissolved and closed the avenue for visitor/community involvement. The reinstitution of the CAB would revive the platform for PRC visitor and community involvement and feedback.

4. Implementation of a Peer Services Fidelity Measure

To support maintaining quality services delivered to PRC visitors, the onsite supervisor will use a peer services fidelity measure to evaluate PRC staff. This measure will assist with monitoring PRC staff skill development, informing about training needs, and clarify expectations for PRC services. The PIP committee, Office of the Discipline Chiefs, Peer Services, and the QI Team, will develop the peer services fidelity measure at a later date.

5. Review the Cultural Competency Procedures of the PRC Program and Staff

Several PRC visitors commented that they did not feel culturally and linguistically supported by the PRC program. There was no PRC brochure available in Spanish. Several PRC visitors also reported feeling PRC staff engaged in discriminating behavior when providing services. In order to keep in line with DMH practices of supporting consumers culturally and linguistically, PRC literature will be translated into additional languages and cultural/diversity training should be provided to the PRC staff.

## STEP 8: DATA ANALYSIS & INTERPRETATION OF STUDY RESULTS

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

- Describe the data analysis process. Did it occur as planned?

Data analysis occurred as planned. The data collection that occurred in data cycle 1, between July 8, 2019 and July 13, 2019, was compared to the survey data collected in data cycle 2, between August 30, 2019 and September 13, 2019.

- Did results trigger modifications to the project or its interventions?

The results from the September 2019 PRC Improvement survey period suggested that PRC visitors would benefit from continued support in the four domains of recovery: *Health, Home, Purpose, and Community.* Additional interventions targeting PRC visitor perceived functioning related to PRC programming, and increasing PRC visitor ratings of satisfaction with the PRC program are needed.

- Did analysis trigger any follow-up activities?

The PRC supervisor and staff will continue to review Suggestion Box comments left by PRC visitors for information related to improvements and needs unmet by the current program format. A PRC Expansion Workgroup has been created by the Discipline Chief in order to improve the current PRC and assess the local need for PRC services and program design in other DMH served communities.

- Review results in adherence to the statistical analysis techniques defined in the data analysis plan.
  - Results of statistical significance testing.

Confidential information (XXX) was removed to protect privacy.

**PRC Improvement Survey**

Population

It was observed that the populations of PRC visitors completing the PRC surveys during data cycles 1 and 2 differed significantly ($p<0.05$) in language. Data cycle 2 had significantly less PRC visitors complete the survey in Spanish ($p=0.01$). There was also a larger number of Black or African American PRC visitors who completed surveys in data cycle 2 (N=16) when compared to data cycle 1 (N=4). This difference was found to be only approaching statistical significance ($p=0.05$). This is likely due to the diversity in the race/ethnicity of PRC visitors and surrounding community.

Items

Two items were found to be statistically significant ($p<0.05$), Item 4 ($p=0.03$) and Item 5 ($p=0.006$). Item 4, "I am better able to ask for help due to participating in the Peer Resource Center," displayed a significant increase in the number of "No" responses in data cycle 2 when compared to data cycle 1. This suggests that PRC visitors may not be improving their skills in self-sufficiency, self-advocacy, or knowledge of available resources.

Comments for Item 4 were:

- "I not shame of asking for help."
- "When I most needed."
- "I have brought my resident 1 per week for 1 month now."
- "Maybe."
- "I've become more involved in helping others."
- "I don't feel that I did about asking for help."
- "Yes."
- "I get to interact whit amiable attention."

Item 5, "I do not feel pressured to follow the advice of the Peer Resource Center staff," also showed a significant increase in the number of "No" responses in data cycle 2 when compared to data cycle 1. This indicates at PRC visitors may feel pressured to accept the recommendations of the PRC staff. These results should be interpreted with caution as previously discussed in the Limitations section.

Comments for Item 5:

- "I feel very calm around them."
- "Great, helpful spot!"

- "It is self service and easy to do."
- "Thanks to all staff including XXX and XXX very nice and friendly."
- "They have a lot of resources."
- "I applied 2x to facilitate a group support."
- "Staff is very agenda free."
- "Well see I am here again smile."
- "I know they are only trying to help."
- "Not at all."

➢ Does the analysis identify factors that influence the comparability of initial and repeat measurements?

Multiple factors influenced the comparability of the pre and post intervention data collections, such as variations among the populations and changes other than the intervention (i.e., management change).

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.

Please refer to Table 8.

**Table 8: Non-Clinical Performance Improvement Project Interventions – Year One**

| # | Performance Indicator | Date of Baseline Measurement | Baseline Measurement (numerator/ denominator) | Goal for % Improvement | Intervention Applied & Date | Date of Re-measurement | Results (numerator/ denominator) | Percentage Point (PP) Improvement Achieved |
|---|---|---|---|---|---|---|---|---|
| 1 | PRC visitors received support with making healthy choices that promote physical and emotional well-being (item 1a) | July 2019 | 89.8% | +2 PP | August 2019 | September 2019 | 87.5% | -1.5 PP |
| 2 | PRC visitors received support with having a | July 2019 | 68.6% | +10 PP | August 2019 | September 2019 | 68.8% | +0.2 PP |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | stable and safe place to live (item 1b) | | | | | | | |
| 3 | PRC visitors received support with having the independence, income, and resources to participate in society (item 1c) | July 2019 | 74.0% | +10 PP | August 2019 | September 2019 | 74.5% | +0.5 PP |
| 4 | PRC visitors received support with having relationships and social networks that provide support, friendship, love, and hope (item 1d) | July 2019 | 88.2% | +2 PP | August 2019 | September 2019 | 85.7% | -2.5 PP |
| 5 | PRC visitors felt they can better manage their life (item 2) | July 2019 | 84.0% | +2 PP | August 2019 | September 2019 | 80.0% | -4.0 PP |
| 6 | PRC visitors felt they have avoided crisis situations (item 3) | July 2019 | 80.0% | +2 PP | August 2019 | September 2019 | 72.0% | -8.0 PP |
| 7 | PRC visitors felt they are better able to ask for help (item 4) | July 2019 | 85.7% | +2 PP | August 2019 | September 2019 | 82.0% | -3.7 PP |
| 8 | PRC visitors felt they are in-control of the resources and advice that they accept (item 5) | July 2019 | 68.6% | +10 PP | August 2019 | September 2019 | 60.8% | -7.8 PP |
| 9 | PRC visitors reported feeling safe at the PRC (item 6) | July 2019 | 92.4% | +2 PP | August 2019 | September 2019 | 93.9% | +1.5 PP |
| 10 | PRC visitors found there are several activities to choose from (item 7) | July 2019 | 88.2% | +2 PP | August 2019 | September 2019 | 85.4% | -2.8 PP |
| 11 | PRC visitors received services that embrace their diverse cultural (item 8) | July 2019 | 86.0% | +2 PP | August 2019 | September 2019 | 92.0% | **+6.0 PP** |
| 12 | PRC visitors received services in their | July 2019 | 88.5% | +2 PP | August 2019 | September 2019 | 90.2% | +1.7 PP |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | preferred language (item 9) | | | | | | | |
| 13 | PRC visitors reported overall satisfaction with services (item 10) | July 2019 | 79.6% | +10 PP | August 2019 | September 2019 | 89.6% | **+10.0 PP** |
| 14 | PRC visitors reported they would recommend the PRC to others (item 11) | July 2019 | 96.2% | +2 PP | August 2019 | September 2019 | 93.9% | -2.3 PP |
| 15 | Peer Services Fidelity Measure | TBD | TBD | TBD | TBD | TBD | TBD | TBD |

Note: PPs in bold met the established goal.

## 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?

Data cycle 2 displayed Items 8 and 10 meeting their PP goals for improvement. Item 8, "The Peer Resource Center is respectful of my culture," showed a 6 PP increase from data cycle 1 (86.0%) to data cycle 2 (92.0%). There were no comments citing perceived feelings of being discriminated against found in data cycle 2 as compared to the six comments provided during data cycle 1.

Item 10, "I am satisfied with the Peer Resource Center," exhibited a 10 PP increase from data cycle 1 (79.6%) to data cycle 2 (89.6%). It is possible that the integration of IPS skills by PRC staff positively impacted PRC visitor satisfaction ratings.

The other nine survey items did not meet their PP goals, and in some instances, received more negative scores. Items 4 and 5 were statistically significant in their increase in the number of "No" ratings when data cycle 1 (Item 4 – 85.7%, Item 5 – 68.6%) was compared with data cycle 2 (Item 4 – 82.0%, Item 5 – 60.8%). This is likely due to the PRC visitors' need for assistance in increasing independency and self-efficacy.

Based on the limited changes in some of the performance indicators, it is likely that data cycle 2 occurred before the PRC staff had sufficient time to apply the skills learned in the IPS training intervention. The positive changes seen in Items 8 and 10 maybe due to other factors:

- There may have been an increase in satisfaction levels due to the differences among the populations as data cycle 2 have fewer Spanish-speaking respondents. Previously, in data cycle 1, reports of perceived feelings of discrimination were reported by Spanish-speaking respondents.
- In addition to the IPS training, on August 12, 2019 PRC management moved to the Peer Services Division. A new, onsite supervisor was assigned. This supervisor acted as additional staff, increased the number of PRC activities available, instituted an Office of the Day schedule for PRC staff, and revised the demographic data collected by PRC staff. These changes may have contributed to the increase in the PRC visitors' ratings of satisfaction.

The rapid opening, management of the PRC by non-peer staff, and disconnect from community feedback have left a number of gaps in the PRC program. The interventions proposed for this PIP continue to be appropriate for the identified PIP problems. The results highlight the need for an additional survey period to continue monitoring any changes that occur related to the PRC's promotion of the four dimensions of recovery *(Health, Home, Purpose, and Community),* assistance with improving PRC visitors' perceived level of functioning, and general satisfaction with PRC services.

  - What factors influenced comparability of the initial and repeat measures?
  - What, if any, factors threatened the internal or external validity of the outcomes?

- Results should be interpreted with caution as the recommended sample size was not reached for both data cycles due to the walk-in style of providing services, variable daily number of PRC visitors seeking services, surveying for a limited two-week period, multiple declinations to complete the survey by PRC visitors, and the FY 18 -19 being a duplicated total.
- The walk-in style of the PRC did not allow for all of the same PRC visitors who participated in the data cycle 1 survey to participate in the data cycle 2 survey though, some PRC visitors participated in both. Matched-pair data analysis was not possible.
- Other changes occurred in the PRC program other than the PRC staffs' application of the IPS model's skills. New management was initiated, a new onsite supervisor was assigned, and additional changes in programming occurred (i.e., increasing activities, implementation of an Officer of the Day schedule, updating the demographic collection form).
- Changes in PRC visitors and/or staff may have occurred due to the experience of being evaluated and the presence of a QI Lead Analyst.

- To what extent was the PIP successful and how did the interventions applied contribute to this success?

This PIP was successful in creating action to address gaps in providing quality peer-driven services to PRC visitors and the surrounding community. PRC procedures, programing, management, training, resources, and service delivery were reviewed. Results of the impact of PIP intervention and information gathered have improved the experience of PRC visitors. Changes will continue to improve the PRC after the completion of this PIP.

- Are there plans for follow-up activities?

Follow-up activities include maintaining and continuing the changes made in the PRC program. Additional PRCs will be developed and rolled out to other SAs in the County. A second year for this PIP would allow for continued survey periods to monitor the impact of PRC improvements on PRC visitors. The additional interventions listed would be implemented, including additional trainings (i.e., Advanced IPS training, cultural competency/diversity training, etc.), reinstitution of the CAB, application of a peer services fidelity measure, and further exploration of improving cultural support to PRC visitors.

- Does the data analysis demonstrate an improvement in processes or consumer outcomes?

The data analysis displays an improvement in PRC visitor satisfaction of services in regard to the PRC program. Changes in programing and staff relationships with visitors are improving cultural/ethnic support of the community.

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?

The location, process, procedures, and survey used during the data cycle 1 and data cycle 2 data collections were unchanged.

- Was there documented quantitative improvement in process or outcomes of care?

The quantitative improvement was assessed by reviewing the change in PRC ratings on the PRC Improvement survey pre and post training intervention.

- Describe the "face validity," or how the improvements appear to be the results of the PIP interventions.

The PRC Improvement survey displayed good face validity as the items elicited information from PRC visitors that was directly related to understanding self-report ratings and comments. Items specifically asked for PRC visitor ratings on PRC program characteristics, visitor satisfaction, and visitors' perceived level of functioning as a result of PRC programing. The majority of PRC visitor responses matched the information being assessed by the survey.

- Describe the statistical evidence supporting that the improvement is true improvement.

A Chi Square test of Independence identifies associations between two or more categorical variables. It cannot provide any assumptions about causation (Kent State University, 2019). Results should be interpreted with caution as this statistical test was determined as the best fit. However, it is intended for independent categorical variables and in the data cycles there were some PRC visitors who participated in both survey periods.

- 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?)

The PRC Improvement survey was administered over a two-week period for both data cycles. For continued monitoring and improvement, the PRC should develop avenues for continued feedback from PRC visitors such as regular administration of the PRC Improvement survey, continuous review of comments left in the Suggestion Box, and reinstitution of the CAB. As DMH rolls out additional PRCs to other service areas, or providers in other areas develop PRC programs, maintaining the process of continuous community member feedback will be key.

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