3E: Non – Clinical

Performance Improvement Project (PIP) 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:	**Los Angeles County Department of Mental Health (LACDMH)**		
Project Title:	**Improving the Responsiveness of the LACDMH 24/7 Hotline by implementing the ACCESS Center QA Protocol**	Check One: Clinical Non-Clinical ✓	
Project Leader:	**Julie Valdez**	Title: Mental Health Clinical Program Manager III	Role: **Project Leader**
Start Date (MM/DD/YY):	**July 1, 2016**		
Completion Date (MM/DD/YY):	**September 30, 2018**	Projected Study Period (# of months): **27**	

Brief Description of PIP:
(Please include the GOAL of the PIP and what the PIP is attempting to accomplish.)

In Los Angeles County, the ACCESS Center 24/7 Hotline serves as the entry point for mental health services. Due to the breath and nature of the requests/calls to the Hotline, the ACCESS Center serves as an appropriate point of focus in LACDMH's efforts to systemically address barriers to access to care. The Non-Clinical PIP for this fiscal year involves the implementation of a Quality Assurance (QA) Protocol for the LACDMH ACCESS Center.

The ACCESS Center operates the 24/7, Statewide, toll free number (1-800-854-7771) for both emergency and non-emergency calls. The QA Protocol process is non-punitive and designed to improve cultural responsiveness, customer service, appropriate screening of calls and referrals to specialty mental health services and appropriate resources resulting in better clinical care, and documentation of call information critical to track current services being provided and history of services already received. The PIP implementation focuses on: 1) monthly evaluations of recorded and random calls from the entire consumer population that call the ACCESS Center on the 1 (800) line during the study period; 2) training all agents on the QA Protocol and providing feedback following the QA reviews to address areas of improvement; 3) training all ACCESS Center supervisors on the QA Protocol, validation of the calibration process and identifying areas of training for staff based on QA reviews; 4) review of outcomes on the performance indicators selected for the PIP on a monthly/quarterly basis at the PIP meetings and 5) reviewing and addressing barriers that impede performance improvement through Plan Do Study Act (PDSA) cycles and Continuous Quality Improvement efforts.

For FY 17-18, the PIP focused on reviewing data related to three clinical care outcome measures in addition to the five outcome measures tracked for FY 16-17 – identifying presenting problem, medical needs, and substance use issues. Further the data analysis presents data by the type of call (Crisis versus Referral); and based on the time of the call – Business hours versus Afterhours. Additional interventions were also implemented to address barriers identified that impeded improved performance on the selected outcome measures.

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.

PIP Stakeholder Involvement

The current Non-Clinical PIP team membership is as follows:

Ann Lee	Service Area (SA) 8 Quality Improvement Committee (QIC) Chair
Antonio Banuelos	SA 7 QIC Chair
Deborah Mahoney	Chair , Children's Countywide Programs, LACDMH
David Tavlin	SA 5 QIC Co-Chair
Helena Ditko	Program Director, Office of Consumer and Family Affairs, LACDMH
Jerry Sefiane	Health Program Analyst II, Office of Consumer and Family Affairs, LACDMH
Jessica Walters	Supervising Psychologist, ACCESS, LACDMH
John Medina	Mental Health Services Coordinator II, ACCESS Call Center Agent (Spanish speaking)
Julie Valdez	Mental Health Clinical Program Manager III, ACCESS, LACDMH
Kimber Salvaggio	SA 2 QIC Chair – Adult Providers
Kary To	SA 4 QIC Chair
LyNetta Shonibare	Clinical Psychologist II, Quality Improvement Division (QID), LACDMH
Maricela Velasquez	Mental Health Services Coordinator II, ACCESS, LACDMH (Spanish speaking)
Mark Carlock	Research Analyst II, ACCESS, LACDMH
Monika Johnson	SA 5 QIC Chair
Michelle Rittel	SA 2 QIC Chair – Children's' Providers
Michelle Munde	SA 8 QIC Co-Chair
Naga Kasarabada	Mental Health Clinical Program Manager III, QID, LACDMH
Nancy Fernandez	Medical Case Worker II, ACCESS, LACDMH (Spanish speaking)
Nora Gonzalez	Medical Case Worker II, ACCESS, LACDMH (Spanish speaking)
Patricia Lopez White	Training Coordinator, ACCESS, LACDMH
Randall Cox	Medical Case Worker I, ACCESS, LACDMH (Spanish speaking)
Reina Perez-Vidaurri	Mental Health Clinical Supervisor, ACCESS, LACDMH (Spanish speaking)
Selena McQueen	Mental Health Clinical Supervisor, ACCESS, LACDMH
Socorro Gertmenian	SA 6 QIC Co-Chair
Victor Sanchez	Mental Health Clinical Supervisor, ACCESS, LACDMH (Spanish speaking)

Stakeholders' Roles

Drs. Kasarabada and Shonibare maintain Quality Improvement (QI) roles for QID at LACDMH. As the Mental Health Clinical Program Manager III for ACCESS Center, Ms. Valdez oversees ACCESS Center and serves as this project's leader. ACCESS Center supervisors directly involved in the PIP's QA review process and who regularly participate in PIP meetings include: Dr. Walters, Ms. McQueen, Ms. Perez-Vidaurri, and Mr. Sanchez. Ms. Velasquez and Dr. Carlock oversee the randomization procedure required when selecting calls for the QA reviews by supervisors. They also provide monthly ACCESS Center data related to call volume and Call Center Agent responsiveness. Ms. Lopez White is the Training Coordinator at the ACCESS Center. She facilitates trainings on the ACCESS Center QA Protocol for all ACCESS Center staff and supervisors. Ms. Lopez White also works collaboratively with QID in providing monthly data for scanning and analysis. ACCESS Call Center Agents that are responsible for answering calls and who have contributed during PIP meetings include: Mr. Medina, Ms. Velasquez, Ms. Fernandez, Ms. Gonzalez, and Mr. Cox. Ms. Ditko, the Program Director for the Office of Consumer and Family Affairs, and her Health Program Analyst II, Mr. Sefiane stand in as advocates for consumers and families. SA QIC Chairs, Ms. Salvaggio, Ms. Rittel, Dr. To, Dr. Johnson, Mr. Tavlin, Dr. Gertmenian, Mr. Banuelos, Dr. Lee, Ms. Munde, and Ms. Mahoney contribute a SA perspective to discussions regarding the response from ACCESS Center to SA-specific needs. SA Chairs and Co-Chairs are directly involved in the ACCESS Center Test Calls Study project and have been available to share their knowledge and experiences.

2. Define the problem.
   - The problem to be addressed should be clearly stated with narrative explanation including what brought the problem to the attention of the MHP.
     - What is the problem?
     - How did it come to your attention?
     - What data have you reviewed that suggests the issue is indeed a problem for the MHP? Describe any relevant benchmarks.
     - What literature and/or research have been reviewed that explain the issue's relevance to the MHP's consumers?
   - The study topic narrative will address:
     - What is the overarching goal of the PIP?
     - How will the PIP be used to improve processes and outcomes of care provided by the MHP?
     - How any proposed interventions are grounded in proven methods and critical to the study topic?
   - The study topic narrative will clearly demonstrate:
     - How the identified study topic is relevant to the consumer population
     - How addressing the problem will impact a significant portion of MHP consumer population
     - How the interventions have the potential to impact the mental health, functional status, or satisfaction of consumers served.

ACCESS Center 24/7 Hotline

The ACCESS CENTER operates the Statewide, 24 hours a day, 7 days a week (24/7) toll-free telephone number (1-800-854-7771) for both emergency and non-emergency calls. ACCESS Center services include: deployment of crisis evaluation teams, information and referrals, gatekeeping of acute inpatient psychiatric beds, interpreter services, and ambulance services. The ACCESS CENTER 24/7 Line often serves as a Medi-Cal beneficiary caller's first point of contact with LACDMH. The ACCESS Center 24/7 Hotline will greatly benefit from PIP involvement as there are multiple areas for improvement to be identified by routinely and systematically assessing the responsiveness of the 24/7 Hotline as reflected in the test calls study trends over the past few years and the resultant impact on timely access to care and quality of care. Greater than 147,000 calls were made to the ACCESS Center in CY 2016, including those which were the Caller/Consumer's first attempt at accessing LACDMH mental health services. For Jan-June 2017,

there were a total of 81,210 calls to the hotline and an additional 12,245 calls in July 2017 with the year to date total at 93,455. This data demonstrates the high call volume for the ACCESS Center and the potential negative impact on timely access to care when responsiveness to the large volume of diverse requests that come in from culturally diverse callers with unique needs for services may be affected.

Test Calls Study: Monitoring Accessibility to the 24/7 Toll Free Access Line

The LACDMH Test Calls Study is conducted on an annual basis and facilitates a quality improvement process aimed at addressing barriers to access associated with responsiveness of the 24/7 Hotline. A "Secret Shopper" test call approach is used for this study where all test callers are provided with set Test Calls Guidelines/Instructions. Test Callers, while using a fictitious name, develop their own non-emergency script for Specialty Mental Health Services (SMHS) and choose from the sample non crisis-related scenarios provided. Test Callers are instructed not to call with an emergency or crisis scenario that would result in the dispatch of a mobile crisis team and are encouraged to keep their call short and succinct. Test Callers are asked not to make or accept assessment appointments and are able to identify themselves as a Medi-Cal beneficiary, if asked. Test Callers are permitted to obtain a phone number and inform ACCESS Center staff of their preference to contact the clinic directly. Test callers identify themselves as residents of the County, if asked. The performance of the phone system and interactions with the Toll Free Line staff are rated using a 24/7 Test Calls Survey form. Additional information on the procedures and guidelines for the test calls study (CY 2016) can be accessed via http://psbqi.dmh.lacounty.gov/QI.htm

ACCESS Center management and staff collaborate with QID staff and SA QIC Chairs and Co-Chairs yearly for this study and towards the development of the annual report. For CY 2015, SA QI liaisons organized and facilitated 10 Test Calls (5 calls in English and 5 in non-English during day time and after hours). The Non-English calls are specified per the SA's identified threshold languages. After hours calls are designated as before 8:00 AM or after 5:00 PM on weekdays or anytime during weekends or holidays. In order to distribute test calls, each SA was assigned one specific month to complete their calls. The goal of the Test Calls Study is to identify potential areas for quality improvement and strengths in the responsiveness of the LACDMH ACCESS Center 24 Hour, 7 day a week Toll Free number to Medi-Cal beneficiaries/callers. The Test Calls Study findings from CY 2012 through CY 2015 are presented in Table 1.

The purpose for the Test Calls Study is to monitor:

- Responsiveness of the 24/7 Toll-Free Line.
- Caller overall satisfaction with staff knowledge and helpfulness.
- Capability to respond to English and non-English calls.
- Caller satisfaction with the interpreter services provided.
- Whether staff members provide their first name to callers.
- Whether staff members assess if the call is a crisis or emergency.
- Specialty mental health service referrals or information provided by ACCESS Center staff as requested by test caller.
- ACCESS Center staff maintenance of a written log that contains the: name of the beneficiary (test caller), date of request for services, and initial disposition of the request.
- Whether staff members refer beneficiary complaints to the Patients' Rights Office

TABLE 1: TRENDING OF ACCESS CENTER TEST CALLS DATA
CY 2012 – CY 2015

INDICATOR	2012	2013	2014	2015
Percent Test Calls Completed	97%	98%	98%	100%
ACCESS Staff Provided First Name to Caller	67%	82%	77%	72%
ACCESS Staff Requested Caller's Name	68%	77%	74%	68%
Calls in Non-English Language	58%	48%	43%	51%
Reported Satisfaction with Interpreter Services	67%	71%	86%	91%
ACCESS Staff Provided Referral	81%	89%	94%	93%
ACCESS Staff Assessed Crisis or Emergency	69%	75%	77%	72%
Reported Satisfaction with ACCESS Services	84%	85%	80%	77%
Call was Logged by ACCESS Staff	52%	60%	59%	52%

Indicators that showed decline over the last three years are in bold

Trending of ACCESS Center Test Calls Data: The consistent methodology involved in the Test Calls Study Project allowed for reliable conclusions to be drawn from this project. The following summarizes Test Call Study findings between CY 2012 and CY 2015. Findings indicated in bold contributed to the design of this PIP.

- The percentage of completed test calls increased from 97% in CY 2012 to 100% in CY 2015.
- Percent ACCESS Center staff providing their first name to the test caller increased from 67% in CY 2012 to 72% in CY 2015.
- Percent ACCESS Center staff requesting test callers name **dropped from 77% in CY 2013 to 74% in CY 2014 and further dropped to 68% in CY 2015.**
- Percent of Non-English languages test calls were 58% in CY 2012 and 51% in CY 2015. Per the Test Calls Study protocols, 50% of the calls are required to be Non-English calls. Therefore the 51% indicates this requirement was still met.
- Satisfaction with interpreter services increased from 67% in CY 2012 to 91% in CY 2015.

- Percent ACCESS Center staff providing mental health referrals increased from 81% in CY 2012 to 93% in CY 2015.
- Percent ACCESS Center staff asking test callers if the call was an emergency or a crisis increased from 69% in CY 2012 to 72% in CY 2015.
- Percent test callers reporting **satisfaction with the ACCESS Center services decreased from 85% in CY 2013 to 80% in CY 2014 and further dropped to 77% in CY 2015.**
- Percent of **test calls that were logged by the ACCESS Center dropped from 60% in CY 2013 to 59% in CY 2014 and further to 52% in CY 2015.**

Rationale for this Non-Clinical PIP

The Non-Clinical PIP for FY 16-17, focused on Test Calls Study trend data and identified a need for improvement in the following areas that showed a steady decline in performance over the last three years (from CY 13 to CY 15):

1. Percent requesting caller's name;
2. Percent of callers satisfied with ACCESS Center services; and
3. Percent of actual calls logged by the ACCESS Center.

Upon reviewing some of the reasons for the above decline in performance the following factors were noted as potentially contributing to this decline. Reasons for dissatisfaction with the ACCESS Center Agents were that they were not knowledgeable to provide appropriate information and referrals/help needed by the client and did not have good customer service. For calls not logged by the ACCESS Center Agents, one potential factor was the implementation of a new Electronic Health Record (EHR) – IBHIS in July 2015 that impacted performance related to logging of calls on a new system. For decline related to Agents requesting caller's name this was related to several new staff hired for the ACCESS Hotline during CY 2015. The outcome measure related to staff assessing whether the call was related to a crisis or emergency also showed decline but this was only between CY 2014 and CY 2015. Although this was not included in the initial phase of this PIP the goal was to continue to track performance on the test calls study. Additionally, the PIP focused on evaluating whether appropriate action was taken for all types of requests that necessitate providing referrals for Specialty Mental Health Services (SMHS) – crisis and referral, thereby addressing this area as well.

Further, the offering of language interpreter services is an important outcome measure tracked by the Department of Health Care Services (DHCS) on a quarterly basis for all Mental Health Plans (MHPs) per Title 9 mandate and was included in the list of outcomes measures for this PIP considering the critical need for monitoring responsiveness of the 24/7 Hotline to the preferred language requests of the diverse communities of the Los Angeles County Medi-Cal beneficiaries with unique cultural and linguistic backgrounds. ACCESS Center developed a QA Protocol (***Attachment 3E.1***) that involves supervisors' review of recorded calls in a systematic manner and addressing the aforementioned areas for improvement. These performance indicators were selected as they demonstrate how the implementation of QA protocol makes an impact on improved Agent's performance in the critical areas related to the appropriate triaging and documentation of calls that are essential to deliver timely access to care, culturally responsive and quality customer services, clinical care and continuity of care (as the lack of appropriate and timely referrals to SMHS may impact the caller's ability to access these services and clinical care) for callers calling the ACCESS hotline with requests for Specialty Mental Health Services (SMHS). The goal was to focus on these specific areas and monitor and track performance on a monthly basis to address barriers identified through systematic and focused efforts via PDSAs and Continuous Quality Improvement (CQI).

LACDMH has selected the implementation of this QA Protocol by ACCESS Center as a Non-Clinical PIP for FY 16-17. Year Two, FY 17-18 was approved by the EQRO review team during April 2017 review session. For FY 17-18, the PIP focused on reviewing data related to three clinical care outcome measures in addition to the five outcome measures tracked for FY 16-17 – identifying presenting problem, medical needs, and substance use issues. Further the data analysis presents data by the type of call (Crisis versus Referral); and based on the time of the call – Business hours versus Afterhours. One additional measure was to also examine the performance of the CY 2017 test calls study results in three areas in comparison to the CY 2016 in view of the implementation of the PIP with the ACCESS Center starting FY 16-17 focusing on these same areas. The goal was to evaluate whether the improved performance in these areas on actual calls reviewed for this PIP will also be replicated in the Test Calls reviewed for CY 2017 in the same areas.

Additional interventions were also implemented in FY 16-17 to address barriers that were noted that impact improved performance on the selected outcome measures. The PIP team which includes key stakeholders from the ACCESS Center, QID, SA QIC Chairs and Co-Chairs, and the Office of Consumer and Family Affairs worked collaboratively to implement this project.

Literature Review that explains the Issue's relevance for the MHP's consumers

Former President Obama's commitment to health care reform was directed at expanding access to health care for an estimated 50 million uninsured individuals. Research findings suggested that not only has the ACA decreased the number of uninsured Americans, but has substantially improved access to care for those who gained coverage. As a result of ACA, most health plans must cover preventive services, such as depression screening for adults and behavioral assessments for children, at no additional cost. The implementation of ACA has resulted in the largest expansion of mental health and Substance Use Disorder (SUD) services in the 21st century. Moreover, greater than 4.7 million California residents were enrolled in comprehensive Medi-Cal benefits since ACA was executed.

The California Department of Health Care Services (DHCS) monitors access to Medi-Cal covered healthcare services for low-income and disabled individuals across California and this includes services provided by LACDMH. Approximately one in twenty adults residing in California is managing symptoms of Serious Mental Illness (SMI) that negatively impact their Activities of Daily Living (ADLs). When the impact of severe emotional disturbances on a child's daily functioning was examined, the rate of adverse outcomes was higher (Technical Assistance Collaborative and Human Services Research Institute, 2012).

An estimated one half of California's adults with mental health needs did not receive mental health treatment during the past year and less than one third of those that are uninsured received treatment (Padilla-Frausto et al., 2012). Access to healthcare is a complex phenomenon and factors that affect access to healthcare exist at different points in the system. Individual Level Factors; Practitioner Level Factors; System and Process Level Factors; and Resource Based or Practical Factors have been identified and examined by the National Collaborating Center for Mental Health (2011).

Factors that Impact Access to Health Care

Individual Level Factors include feelings of shame; stigma and fear; lack of knowledge about mental health symptoms or services; distrust of health care services; language barriers; masking and normalizing of mental health symptoms; cultural attitudes; and lack of support to access health care services.

Practitioner Level Factors include poor communication with clients; poor attitudes with clients; practitioners' communication style; stereotyping individuals; and lack of sensitivity about their clients' cultural background and beliefs.

System and Process Level Factors include: a lack of provision and capacity in mental healthcare services; poor allocation of services and poor quality of services; long wait times; absence of clear policies and where these policies are located; disruptions due to changes in the healthcare system and poor communication about referral procedures; communication difficulties about the nature of services, such as the lack of a "common language;" a lack of trained and available interpreters for people with limited English proficiency; and a lack of materials and information translated into the individuals' language.

Resource-Based or Practical Factors include: lack of time; transportation issues; childcare issues; poor appointment systems; inflexible clinic hours; and the cost of services.

Lack of access to care: can impact an individual's overall physical, social, and mental health status; reduce the prevention of disease and disability; limit the detection and treatment of health conditions; negatively impact quality of life; lead to preventable deaths; and affect an individual's life expectancy.

Barriers to access to care can lead to: unmet health needs; delays in receiving appropriate care; reduced access to preventive services; and hospitalizations that could have been prevented.

Mental Health Hotlines offer access to comprehensive mental health and crisis services and provide information and referrals to health and social service organizations for a broader range of individuals/callers. They are made available to diverse groups of individuals at various stages in their recovery. The National Suicide Prevention Lifeline, 2-1-1, and local Nurses' Advice Lines are among the nation's most popular sources for telephonic supportive services. Due to the breath and nature of a hotline caller's attributes and requested needs, it is essential that Call Center protocols embrace the diversity of the callers they serve. Culturally competent and responsive customer service is critical when mental health, physical health, and substance use needs are being addressed over the telephone.

Per the barriers to access to care described earlier, a variety of factors come into play when a consumer makes their first call to the ACCESS Center 24/7 Hotline. These barriers may include individual factors such as stigma and fear; language barriers; practitioner factors such as communication, cultural attitudes, language capacity; system factors such as wait times or lack of well qualified interpreters; and practical factors such as lack of time to call back if they are disconnected or did not get the information they requested. It is critical that the aforementioned barriers to access to care are systematically addressed. In Los Angeles County, the ACCESS Center 24/7 Line serves as the entry point for mental health services. **For this PIP, the focus was on barriers impacting performance by ACCESS Agents in responding to calls as reflected in: 1) the gathering and documentation of critical caller information such as : a) presenting problem, medical needs, substance use issues required to appropriately triage the call and refer to Specialty Mental Health Services thereby impacting clinical care b) other important information such as caller's name and phone number for ACCESS to have in place if the Agent needs to call back the caller if they get disconnected 2) offering interpreter services in response to the preferred language needs that impacts both cultural responsiveness and accurate information necessary to appropriately triage the call for SMHS services**

and 3) good customer service to engage the caller to gather pertinent information to appropriately assist the caller who may be calling the Hotline the first time and needs immediate access to clinical care.

The following description of the call volume, response times, and Non-English call volume for the ACCESS Center presents the context and background related to the outcome measures being reviewed for this PIP.

ACCESS Center Call Volume. Data on the ACCESS Center Calls Answered within 1 minute is related to this Non-Clinical PIP as it offers insight on responsiveness and call volume; both can directly impact performance. Per Table 2 on the ACCESS Center responsiveness for FY 16-17 (***Attachment 3E.2***) for calls made to the ACCESS Center 1 (800) line during daytime hours, 82% of the total Business hours calls (71,569) answered within one minute compared to the 80,613 calls received during After Hours with 78% that were answered within one minute. The ACCESS Center is vulnerable to system-level factors that impact healthcare, such as long wait times and reduced call responsiveness. The percentage of ACCESS Center 24/7 calls that are answered within one minute is presented in the monthly report and subsequently reviewed by the PIP team. The ACCESS Center 24/7 line is equipped to receive calls from consumers/callers that prefer any of Los Angeles County 13 threshold languages and other non-threshold languages. ACCESS Center's non-English language calls were also examined as a part of this PIP.

ACCESS Center Non-English Language Calls. Individual level factors that impact access to care such as language barriers and cultural attitudes are an important area of focus for improvement in the services provided by ACCESS Center 24/7 Line staff***.*** ACCESS CENTER staff offer language interpreter services either by linking callers to the Language Line or by directly assisting the caller if the Agent is able to provide services in the preferred language of the caller. This process is in accordance with ACCESS protocols and Title 9 Regulation requirements to document all initial requests for services. From 2010 to October 2016, interpreter services were provided to the ACCESS Center by AVAZA, a countywide contracted vendor formerly known as "OCI." As of October 13, 2016, the following three (3) new language interpreter service vendors were approved for utilization: Language Line Services, Inc., TransPerfect Translations International, Inc., and WorldWide Interpreters, Inc. English and non-English callers will be included in this PIP.

Table 3 summarizes the total number of Non-English language calls received by the ACCESS Center for CY 2012 through CY 2016. The trend over the past five years indicates that the majority of Non-English language callers have requested Spanish language interpretation services, followed by Armenian and Korean language services. The call volume for Non-English calls is approximately about 8,000 calls per year. In CY 2015, a total of 7,659 Non-English calls were received by ACESS Center. For a majority of the Non-English calls received, Spanish (95%) was the preferred language of the caller. The next highest number of calls were received in Korean (N=108) followed by Armenian (N = 80) and Mandarin (N = 62). In CY 2016, about 5% of the calls received by ACCESS Center requested a language other than English (N=8,035). Ninety-four (94%) percent of the Non-English calls requested were for Spanish (N=7,514). The next highest number of calls were received in Armenian (N=130) followed by Korean (N = 116) and Mandarin (N = 86). The call volume for these three languages is higher in CY 2016 compared to CY 2015. Based on these trends, it is clear that ACCESS Center requires staff to provide timely and appropriate services to cater to the preferred language needs of the callers on a daily basis in a culturally responsive manner.

TABLE 3: NON-ENGLISH LANGUAGE CALLS RECEIVED BY THE ACCESS CENTER
FIVE YEAR TREND
CY 2012–2016

*Language	2012	[1]2013	2014	2015	2016
AMHARIC	2	0	1	0	0
*ARABIC	4	21	24	6	16
*ARMENIAN	61	48	225	80	130
BAHASA	0	0	0	0	1
BENGALI	2	1	0	0	1
BOSNIAN	0	0	1	0	0
BULGARIAN	0	0	0	0	0
BURMESE	0	0	0	0	0
*CANTONESE	7	46	60	46	40
CAMBODIAN	0	0	0	0	7
CEBUANO	0	0	1	0	0
*FARSI	59	70	81	58	56
FRENCH	1	1	2	2	2
GERMAN	0	0	0	1	0
GREEK	0	0	0	1	0
HEBREW	0	1	2	1	0
HINDI	5	0	1	0	0
HUNGARIAN	0	0	0	3	0
ITALIAN	0	0	0	0	0
JAPANESE	5	3	2	2	4
KHMER	35	10	5	3	1
*KOREAN	83	109	132	108	116
KURDISH-BEHDINI	0	0	1	0	0
LAOTIAN	0	0	2	0	0
*MANDARIN	40	57	30	62	86
MONGOLIAN	0	1	0	0	0
NEPALI	0	1	2	0	0
PASHTO	0	0	0	0	0
PERSIAN	0	0	0	0	1

*Language	2012	[1]2013	2014	2015	2016
POLISH	0	0	0	0	1
PORTUGUESE	0	0	1	0	1
PUNJABI	0	0	0	1	0
ROMANIAN	1	0	0	0	1
*RUSSIAN	26	15	11	12	16
SAMOAN	0	5	0	0	0
SERBIAN	0	0	0	0	2
SLOVAK	0	0	0	0	1
*SPANISH ([2]AVAZA Language Services Corporation)	4,552	2,509	1,402	1,089	1,474
SPANISH ACCESS CTR	4,043	11,240	6,135	6,159	6,040
SPANISH SUBTOTAL	8,595	13,749	7,537	7,248	7,514
*TAGALOG	14	16	18	7	10
THAI	1	1	2	1	0
TURKISH	1	0	0	0	0
URDU	3	2	1	0	0
*VIETNAMESE	23	24	24	**17**	**28**
TOTAL	**8,968**	**14,186**	**8,169**	**7,659**	**8,035**

*LACDMH Threshold Languages excluding Other Chinese and English in CY 2016. [1] The total for non-English calls and Spanish ACCESS Center Calls for CY 2013 is inaccurate and over reported due to errors in the Web Center System. [2]Telephone Interpreter Line Calls. Data Source: LACDMH ACCESS Center, CY 2012 - CY 2016.

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.

Study Questions

This PIP set forth to examine if implementing the QA Protocol for the LACDMH ACCESS Center 24/7 Line would result in:

1. Ten (10) Percentage Points (PP) improvement in ACCESS Center calls *where language interpreter services were offered* in the fourth quarter of FY 16-17 when compared to the First (Baseline) quarter of FY 16-17?

2. Ten (10) PP improvement in ACCESS Center calls *where the Agent requested the caller's name* in the fourth quarter of FY 16-17 when compared to the First (Baseline) quarter of FY 16-17?

3. Two (2) PP improvement in referrals provided to Specialty Mental Health Services (SMHS) for calls requesting these services?

4. Five (5) PP improvement in ACCESS Center calls *where Agents demonstrated respect/customer service* in the fourth quarter of FY 16-17 when compared to the First (Baseline) quarter of FY 16-17?

5. Four (4) PP improvement in ACCESS Center calls *showing an identified presenting problem* in the fourth quarter of FY 16-17 when compared to the last quarter of FY 17-18?

6. Four (4) PP improvement in ACCESS Center calls showing identified medical needs in the fourth quarter of FY 16-17 when compared to the last quarter of FY 17-18?

7. Three (3) PP improvement in ACCESS Center calls showing identified substance abuse issues in the fourth quarter of FY 16-17 when compared to the last quarter of FY 17-18?

8. Two (2) PP improvement in ACCESS Center calls *where the caller's information was documented* in the fourth quarter of FY 16-17 when compared to the last quarter of FY 17-18?

9. Five PP improvement on the *test calls study results for CY 2017 compared to CY 2016* for the three indicators: a) Percent requesting caller's name; b) Percent of callers satisfied with ACCESS Center services; and c) Percent of actual calls logged by the ACCESS Center

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 ACCESS Center serves as a resource for providing information on referral, linkage, and crisis intervention services per callers' requests and is established to provide 24/7 referral, crisis and linkage services for Medi-Cal beneficiaries per Title 9 Mandate. A team of multidisciplinary staff are skilled at providing various forms of mental health referral and crisis services 24 hours a day and seven days a week, including all holidays. The ACCESS Center is capable of coordinating 24/7 crisis services for intensive mental health treatment programs such as the Full Service Partnership (FSP) program; manages after hours Patients' Rights calls; and serves as the after hours gate-keeper regarding crisis bed availability. The ACCESS Center also offers information and referrals for Specialty Mental Health Services (SMHS) such as: Therapeutic Behavioral Services (TBS) for Children; Field Capable Clinical Services (FCCS); the GENESIS Program for Older Adults; System of Care Navigators; Wellness Center services; and Specialized Foster Care. In the event of a major incident, as the Secondary Disaster Operations Center (DOC), the AC activates and coordinates with the Critical Incident Response Team (CIRT) team. The ACCESS Center is equipped to provide aforementioned services in all 13 Los Angeles County threshold languages and all non-threshold languages requested by the callers.

ACCESS Center staff offer language interpreter services either by linking callers to the Language Line or by directly assisting the caller when the agent is proficient in the caller's preferred language. This process is in accordance with ACCESS protocols and in Title 9 Regulation requirements to document all initial requests for services.

Study Population

The study population for this PIP includes a random sample of the entire consumer population that calls the ACCESS Center 1(800) line during FY 16-17 and current FY 17-18. This includes callers from all geographic areas of the County and will encompass both callers with Limited English Proficiency (LEP) who require interpreter services as well as callers who prefer to speak English. Callers requesting referrals for SMHS, crisis response, beneficiary grievance information, and other general information will be the focus of this study. The customer and interpreter services offered and documentation of important information clinical related and demographics, received from the caller by the ACCESS Center staff are areas for quality improvement and will be examined as a part of this PIP.

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

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

- 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.

Non-Clinical PIP Outcome Measures and Corresponding Performance Indicators

The five performance indicators included in this PIP are as follows: 1) Culturally Competent and Linguistically Appropriate Services – the outcome measure that captures information related to this indicator is the QA Checklist question related to the offering of interpreter services; 2) Access to Care - the outcome measure that captures information related to this indicator is the QA Checklist question related to a) caller's name was requested and b) appropriate action plan was taken by providing appropriate SMHS referrals 3) Consumer/Customer Satisfaction - the outcome measure that captures information related to this indicator is the QA Checklist question related to the Agent's demonstrated respect/customer service; 3) Clinical Care - the outcome measure that captures information related to this indicator is the QA Checklist question related to Agents identifying a) presenting problem b) medical needs and c) substance use issues as this information is critical to provide appropriate referrals for clinical care 4) Continuity of Care - the outcome measure that captures information related to this indicator is the QA Checklist question related to the documentation of critical information of the call such as the date of the call, name of the caller, phone number of the caller, and disposition of the call. This information impacts provision of appropriate Continuity of Care as without this information documented, a second call from this caller will not have the previous history of services received from LACDMH and referrals provided by ACCESS.

Baseline data was established in Q1 (July through September 2016) during FY 16-17 excluding baselines for Clinical Care, which were established from May 2017 and for FY 17-18 these have been tracked and reviewed.

Outcome measures data on the QA Checklist is collected monthly and reviewed by an ACCESS Center supervisor. Data (Teleform) is then scanned by QID staff, tabulated in the form of checklists and outcomes tables for the 8 measures for this PIP, and presented on a monthly and quarterly basis. Monthly data is aggregated by each quarter to measure improvement. Quarterly and monthly outcomes are reviewed by the PIP team during monthly committee meetings.

These performance indicators were selected as they show how the implementation of QA protocol makes an impact on the Agent's performance in the critical areas related to the appropriate triaging and documentation of calls thereby impacting timely access to care, culturally responsive services, clinical care and continuity of care (as the lack of appropriate and timely referrals to SMHS may impact the caller's ability to access these services and clinical care).

The performance indicators and corresponding outcome measures chosen for this PIP are further described in Table 4.

TABLE 4: PERFORMANCE INDICATORS AND CORRESPONDING OUTCOME MEASURES
FY 17-18

#	Performance Indicators	Corresponding Outcome Measure	Numerator	Denominator	Baseline	% Expected Improvement in Percentage Points (PP)
1	Culturally Competent and Linguistically Appropriate Services	**Offered language interpreter services (1.3)**	Number of non-English calls where language interpreter services were offered	Total calls selected for monthly and random review	84%	+10
2	Access to Care	**Calls where caller's name was requested (1.5)**	Number of calls where agent requested caller's name	Total calls selected for monthly and random review	88%	+10
		Specialty Mental Health Services (SMHS) referrals (5.3)	Number of calls where agent provided a SMHS referral	Total calls selected for monthly and random review	98%	+2
3	Consumer/Customer Satisfaction	**Demonstrated respect/customer service (4.1)**	Number of calls showing demonstrated respect for caller	Total calls selected for monthly and random review	95%	+5
4	*Clinical Care	**Identify presenting problem (2.1)**	Number of calls showing identified presenting problem	Total calls selected for monthly and random review	91%	+4
		Identify medical needs (3.6)	Number of calls showing identified medical needs	Total calls selected for monthly and random review	71%	+4
		Identify substance abuse issues (3.7)	Number of calls showing identified substance abuse issues	Total calls selected for monthly and random review	82%	+3

5	Continuity of Care	**Documentation** (6.1)**	Number of calls where client information was documented	Total calls selected for monthly and random review	60%	+10

Note: *New clinical care indicators (2.1, 3.6, 3.7) were added in May 2017.
** Documentation criteria for evaluation on this PIP were changed in April 2017 to include 4 criteria for a rating of "Yes" for documentation – caller's name, date of call, disposition of call, and caller's phone number. Previously, this was checked "Yes" any one of the client related questions on the Checklist documented.

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?

FY 16-17 Randomization Selection Procedure (*Attachment 3E.3*)

The FY 16-17 process of selecting recorded ACCESS Center calls for QA review was as follows:

- The entire population of ACCESS agents is included in the QA process. The first step in the process involves generating a random ordering of these agents. Agents are selected according to their random position until the list is exhausted after which a new randomized list is generated. There are currently 72 active agents included in the process.
- Randomly selected calls are assigned each week therefore the second step in the process involves generating a random selection of dates from the previous week.
- In the next step, a time of day is randomly selected between 12:00 a.m. and 11:59 p.m.
- The next step in the process is to locate a call for the selected agent that occurred on the randomly selected date as close to the randomly selected time as possible (within 15 minutes). If no call meets the stated criteria (Agent/Date/Time), an alternative time of day is selected. If the agent did not take calls on the selected date (was not working that week), a new date is randomly selected.
- The entire population of inbound calls is subject to random selection with the exception of those handled by the Appointment Line and those calls lasting less than 300 seconds (5 minutes).

- In the final step, the selected calls are randomly assigned to an evaluator (Supervisor) for review. This assignment occurs randomly given an overlap in the Supervisor's and Agent's work schedules. Currently, there are up to eight Supervisors available for QA call review.
- A total of 8-9 calls were selected per week leading up to the 24-32 calls per month in the absence of a supervisor out of the 9 per month and few supervisors potentially unable to review calls every week.
- Due to the small sample size, a 95% Confidence Level was used and a 10% margin of error was considered acceptable.

- Random.org site was used to select a random sample each week based on the number of supervisors available. For example, if six supervisors were available, six agents were selected.

FY 17-18 Randomization Selection Procedure (as of August 1, 2017)

Due to the high call volume of the ACCESS Center, yet small sample size (.26%) evaluated for FY 16-17, it was highly recommended by the External Quality Review Organization (EQRO) in July 2017 and by DMH Quality Improvement Division consequently that the ACCESS Center evaluate more calls per week per the procedures discussed below. These procedures were discussed with the EQRO PIP consultant and team during the July 18th 2017 Technical Assistance call. Therefore, the following changes were made:

- Each supervisor will be assigned 5 randomized "blind" calls to listen to/evaluate per week. Each supervisor will select five from the list of 8 randomized "blind" calls that will be given to them each Monday.
- Each supervisor will listen to/evaluate 5 calls per week at their respective workstations. Calls to be evaluated will be recorded calls from the audio log.
- Calls will be evaluated using the QA Checklist on Teleform to mark all applicable measures as Yes/No or N/A. The supervisor will also enter comments for all the measures being evaluated for this PIP on the Customer Service Evaluation (CSE) Form ***(Attachment E.7)*** to indicate clearly why a call was rated as N/A for a specific measure. This will facilitate verification of the data received from ACCESS when QID scans the forms and reviews the output on these measures.
- Criteria agreed upon during the ACCESS calibration meeting on July 28th as to what constitutes a meeting to review with an agent and what does not are as follows:
- When any one of the following line items from the evaluation form are scored as a "NO" the supervisor must meet with the agent.
    - ✓ 2.1 – Identified presenting problem
    - ✓ 4.1 – Demonstrated respect for the caller
    - ✓ 5.3 – Action plan was appropriate
    - ✓ 6.1 - Client information items were documented
- When a Supervisor needs to meet with an agent they will meet in the file room for privacy and confidentiality.

- After a supervisor has evaluated the call regardless of whether it requires a face to face, the supervisor submits the evaluation form along with the customer service evaluation (CSE) form to the ACCESS Training Coordinator. If the call did not require a face to face, he/she will fill in the name of the agent, call date, call time, call duration and check the evaluated call only box on the CSE ***(Attachment E.7).***

This new process of sampling results in supervisors reviewing more than 1 call per week. Currently there are 8 supervisors who can review calls and this will result in 40 calls per week if all supervisors review calls (5 calls each) that week. Out of these, those that are reviewed face to face would be only those that meet the current criteria sent for the review meeting as described above thereby. This increases the sample size from 8 calls a week to potentially 40 calls a week (160 calls per month X12 months = 1,920. 1920/147,565 calls received = 1.3% compared to 0.26% in FY 16-17) and with the new criteria for review meetings will also address the current logistics issues to review a large number of calls (all calls) face to face with Agents and limit this to only those that do not meet criteria.

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

STEP 6: DEVELOP STUDY DESIGN & DATA COLLECTION PROCEDURES

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

- Describe the data to be collected.
- Describe the methods of data collection and sources of the data. How do these factors produce valid and reliable data representing the entire consumer population to which the study indicators apply?
- Describe the instruments for data collection, and how they provided for consistent and accurate data collection over time.
- Describe the prospective data analysis plan. Include contingencies for untoward results.
- Identify the staff that will be collecting data, and their qualifications. Include contractual, temporary, or consultative personnel.

Data Collection and Associated PIP Team Efforts

For FY 16-17, 24-32 ACCESS Center calls were randomly selected on a monthly basis per the sampling procedures described above and reviewed by a supervisor using the QA Checklist ***(Attachment 3E.4)*** to rate the 8 outcomes measures selected and CSE.

For FY 17-18, **the data collection procedures by ACCESS Center** were revised as of August7, 2017 including random sampling procedure as described in Step 5 to increase the sample size (***Attachment 3E.5)***. The CSE form was also used to track calls that needed face to face review with the Agent and those that did not.

Due to the high call volume and the small sample size evaluated for FY 16-17, it was highly recommended by the External Quality Review Organization (EQRO) and DMH Quality Improvement Division that the ACCESS Center evaluate more calls per week.

Therefore, the following changes were made:

- Each supervisor will be assigned 5 randomized "blind" calls to listen to/evaluate per week. Each supervisor will select five from the list of 8 randomized "blind" calls that will be given to them each Monday.
- Each supervisor will listen to/evaluate 5 calls per week at their respective workstations. Calls to be evaluated will be recorded calls from the audio log.
- Calls will be evaluated using the QA Checklist on Teleform (***Attachment 3E.6****)* to mark all applicable measures as Yes/No or N/A. The supervisor will also enter comments for all the measures being evaluated for this PIP on the Customer Service Evaluation (CSE) Form (***Attachment 3E.7****)* to indicate clearly why a call was rated as N/A for a specific measure. This will facilitate verification of the data received from ACCESS when QID scans the forms and reviews the output on these measures.
- Criteria agreed upon during the ACCESS calibration meeting on July 28th as to what constitutes a meeting to review with an agent and what does not are as follows:
- When any one of the following line items from the evaluation form are scored as a "NO" the supervisor must meet with the agent.
    - ✓ 2.1 – Identified presenting problem
    - ✓ 4.1 – Demonstrated respect for the caller
    - ✓ 5.3 – Action plan was appropriate

- ✓ 6.1 - Client information items were documented

- When a Supervisor needs to meet with an agent they will meet in the file room for privacy and confidentiality.
- When it is determined that an agent requires a feedback session, the meeting will include areas of improvement and strengths as well. Supervisors can schedule themselves to use the file room by adding their name to the schedule that is on the door in the designated cubicle area.
- After a supervisor has evaluated the call regardless of whether it requires a face to face the supervisor submits the evaluation form along with the customer service evaluation (CSE) form to the ACCESS Training Coordinator. If the call did not require a face to face, he/she will fill in the name of the agent, call date, call time, call duration and check the evaluated call only box on the CSE **(*Attachment 3E.7*)**.
- During any evaluation period, issues related to the Audio log should be communicated to the ACCESS IT lead, randomization issues should be addressed with ACCESS RA II, and scheduling issues with ACCESS Training Coordinator.

Data receipt and analysis protocols by QID: The QA Checklist Teleform surveys from the QA reviews by the ACCESS Center supervisors for the previous month are forwarded to QID team in the second week of the following month by the ACCESS Training Coordinator for scanning of the forms and data analysis and reports on outcome measures by the QID team. These data are verified when there are questions/issues to be resolved before reporting the outcomes for each month in the Data Tables presented to the PIP team on a monthly basis. Currently for the FY 17-18, the ACCESS PIP meetings are scheduled for every second Thursday of the month.

Reviewing all calls received through ACCESS Center is not feasible. Randomly selecting calls on a monthly basis ensures equal probability any call is selected. Monthly data, in the form of recorded English and non-English calls, is randomly selected for evaluation using the ACCESS Center QA Checklist.

The ACCESS Center QA Checklist is used to rate the calls each month. Since the same checklist is used each month, and the same objective rating criteria are used in evaluating the checklist, consistent evaluation criterion for all the calls rated each month by the ACCESS Center supervisor is more likely.

The data analysis plan involves reviewing progress for each rating and on all outcome measures, on a monthly and quarterly basis. Contingencies for untoward results have been addressed on an ongoing basis. For example, the analysis of calls to review results by crisis/referral/general info/ambulance starting May and June 2017 showed that there were important differences for crisis calls versus referral calls on different outcome measures. The same was observed for Business Hours versus After Hours. These results were addressed with ACCESS Center Management and discussed during PIP meetings to identify important interventions that were implemented. For example, the ACCESS Center implemented the Skill Sets assignments in August 2017 to ensure Agents assigned to the Crisis versus Referral skill sets gain knowledge and skills and expertise to perform well in their assigned skill sets. This process will be explained further in the Interventions section. Another example of untoward results during the past four months of this PIP following the April EQRO review when this PIP was presented was a decline in performance in the last quarter of the FY 16-17 compared to the third quarter on multiple outcome measures. A closer review of the potential reasons indicated that the high call volume in May 2017 due to May is Mental Health month with multiple Media campaigns impacted performance. May was the month with the highest call volume for both Business Hours and overall Total Calls and also evidenced the lowest response times for calls answered within a minute for both Business Hours (74%) and After Hours (70%) compared to

other months in FY 16-17 (***Attachment 3E.8)***. ACCESS Management made efforts to staff appropriately to meet the high call volume needs, however has encountered challenges to schedule trained and available staff on all shifts to meet such needs.

The ACCESS Center QA Checklist data is reviewed, and rated by ACCESS Center supervisors. As full-time and permanent LACDMH employees, ACCESS Center supervisors who conduct the QA review to collect the data have extensive experience working at the ACCESS Center and are well equipped to conduct QA reviews. They are licensed social workers and MFTs. The random sampling was conducted by the ACCESS Research Analyst who had experience in research design and sampling procedures. The data analysis and reporting was done by the QID team with qualified professionals with data analysis and QI background and experiences – Chief Research Analyst, Clinical Psychologist, and QID MH Clinical Program Manager III.

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.

TABLE 5: NON CLINICAL PIP INTERVENTIONS
FY 17-18

Number of Intervention	List each Specific Intervention	Barriers/Causes Intervention Designed to Target	Corresponding Indicator	Date Applied

1	Implement ACCESS Center Quality Assurance (QA) Protocol for supervisors	Areas of improvement identified are: improved documentation, Customer service and offering of language interpreter services	Standardize ACCESS Call Center Agent and supervisor training and QA reviews initiated to establish inter-rater reliability and calibration	July – Sept 2016 Baseline period
2	Launch QA Protocol at the ACCESS Center for review of calls by supervisors and feedback to agents	Inconsistency for call handing among ACCESS Center agents	Increased call logging, staff proficiency, appropriate referrals for SMHS, and demonstrated respect/customer service	Qs 2-4 of FY 16-17
3	Implement Skill Sets/Workgroup Protocol (***Attachment 3E.9***)	Lack of sufficient knowledge and skills and training needed to appropriately triage and respond to the caller's needs in a timely manner based on the type of call (Crisis/Referral and English / Non-English) and to provide culturally responsive and quality customer service	Improved customer service and timely responsiveness to the ACCESS Center callers for all types of calls – Crisis/Referral and for English as well as Non-English	August 2017
4	Implement the New Call Center Application (***Attachment 3E.10***)	During the focus group conducted in June 2017 to gather information related to decline in performance related to call logging, multiple barriers were identified by the ACCESS Agents with the current system – IBHIS to document calls as listed below: • Navigation through multiple screens and windows to document call that is not user friendly and delays completion of documentation	Improved documentation resulting from a more efficient Call Center System appropriate to document calls for a Call Center	Proposed timeline for implementation – six months to a year from Aug 2017

		• Frequent freezing of the system resulting in loss of information documented • Difficulty documenting calls where caller's demographic information is not available and requires navigation through multiple screens and windows		
5	Memo issued by ACCESS Management (***Attachment 3E.11***) clarifying how to document calls where caller's DOB is not available	Focus group identified inconsistent instructions across shifts on how to document calls where caller's DOB is unknown	Improved and consistent documentation of call information for calls where caller's DOB is unknown	August 4, 2017

Non-Clinical PIP Team Efforts
EQRO Review and Post EQRO Review to Present

April 13, 2017 – Non-Clinical EQRO review session for FY 16-17. PIP team received valuable feedback regarding sample size, selected outcome measures, and the complexity of this PIP. The ACCESS Center PIP was approved for an additional year with expected improvements and updates to the project's design. Non-Clinical PIP team confirmed plans to include additional data analysis and performance monitoring; specifically, examining differences in performance between After Hours versus Business Hours or Crisis versus Referral, and the inclusion of outcome measures associated with improved clinical care. PIP team will be prepared to present annual outcome data for FY 16-17 during the FY 17-18 EQRO session, in September.

May 4, 2017 – Non-Clinical PIP team meeting: The PIP team discussed three new outcome indicators (presenting problem, substance abuse issues, and medical needs) scheduled for May 2017 data analysis. The option to identify the call as After Hours versus Business Hours has been implemented and will be examined during the review of May 2017 data. May and June 2017 data on the aforementioned measures will serve as baseline for Q1 of FY 17-18. PIP team discussed the following ACCESS Center staff vacancies and the potential impact on performance: five Medical Case Workers, one Community Worker, two Supervisors, and one Senior Typist Clerk.

June 15, 2017 – QID facilitated a focus group with ACCESS Call Center Agents. Only 16% of the Test Calls were logged in March 2017 that raised concerns about the decline in performance in test calls contrary to the improved performance on Actual calls for the PIP. The Agents' focus group supported the goal of improving consistency in documenting test calls. Agents discussed interesting information regarding their perception of test calls versus actual calls. They indicated that they are trained to mainly document either crisis or referral calls that require providing referrals for SMHS and documenting actions taken and explained that they encounter barriers when documenting other general information type of calls where callers are not willing to accept specific referrals to clinics with potential time slots (similar to test calls) or are not willing to give demographics and other details needed to

complete documentation fully on the calls. On such calls, they explained that they need to go through multiple windows and screens entering "Not Applicable" on the current system and a long and tedious process while there are calls in queue waiting for them to attend. This sometimes results in them not documenting such calls and taking the next call, which is of greater importance such as a crisis call requiring dispatch of the PMRT team. They also explained that sometimes they are able to easily identify a call as a test call and do not document the call – for example when a caller is up front asking for a referral in a specific SA. This is because callers outside DMH would not request referrals specific to a SA, rather ask for help and it is the Agent who requests their address to identify the location most convenient and easily accessible. The focus group findings resulted in consequent interventions including memo issued by ACCESS Management giving consistent instructions across shifts on documentation related to calls with missing demographics and Chief Information Office Bureau informed of the findings by QID to identify proposed action plan to address the barriers in documentation related to IBHIS. The **seventh PDSA** cycle ***(Attachment 3E.12)*** was derived from this focus group and the following highlights were shared with the team:

- Agents reported inconsistency in the directions received from supervisors (regarding logging calls) across shifts.
- Agents reported feeling pressured to respond to calls that are waiting in queue.
- The Integrated Behavioral Health Information System (IBHIS) differs from the old system and the former ACCESS Call Center Management System (ACCM) involved fewer steps and is preferred.
- Agents reported technical barriers such as their computer freezing and subsequent loss of caller information and difficulty navigating the multiple prompts and command boxes in IBHIS.

June 15, 2017 – Non-Clinical PIP team meeting: PIP team discussed how media campaigns aimed at outreaching Underserved Cultural Communities (UsCC) contributed to a noticeable increase in the total number of daytime calls for May 2017. The following ACCESS Center staff changes were also identified as potential gaps in coverage: three agents have moved from PM shift; the PM shift has five Medical Case Worker and two supervisor vacancies; and, one Community Worker position remains open for the AM shift. PIP team established plans to explore if time of day of the call impacts performance. If there are notable differences, and addendum table will be created. Highlights from the agents' focus group were discussed with the team. PIP team established that a future focus group would prove helpful to see if there were any changes to Agent –reported inconsistencies in the instructions received from supervisors regarding logging of calls. In order to be consistent with State requirements, the *Documentation* criteria were expanded to include the three criteria per Title 9 (date of call, caller's name, and disposition) and also caller's number per ACCESS team decision in April 2017 and the calls were evaluated against these criteria for the May outcomes data. Interestingly, performance related to documentation improved in May despite raising the bar by expanding to three additional criteria. There were differences noted in Business Hours versus After Hours outcomes for few measures (***Attachment 3E.8***). Performance was better for After Hours compared to Business Hours on the following measures: providing SMHS referrals, Identifying substance use issues, and Business Hours performance was better on the following measures: offering language interpreter services, requesting caller's name, demonstrated respect and customer service.

July 20, 2017 – Non-Clinical PIP team meeting: Feedback from the Final EQRO FY 16-17 Report was received and reviewed by the PIP team. PIP team confirmed plans to incorporate feedback and suggestions made by the EQRO review team, in a timely manner. In response to their feedback, the Teleform will be revised to include language requested by the caller (option to select English or Non-English) and list the preferred language of the caller for Non-English calls. QID and ACCESS Center recently collaborated on modifications to the random sampling procedure to be implemented in August. In support of incorporating EQRO's feedback, a greater number of calls will be reviewed by supervisors (five calls per week) without the Agent present.

ACCESS Center will select important criteria that if not met, the supervisor would meet with the Agent. The call assignment process will be changed from starting with the agents that are scheduled during the week to be based on the supervisors that are on schedule.

EQRO demonstrated interest in the actual number of calls that led to a SMHS referral. Criteria 5.3 – "*Action plan was appropriate"* is now being checked for all calls. Calls that led to a Referral or mobile response team dispatch will be tracked separately by the ACCESS Training Coordinator starting for the July 2017 data prior to submitting data to QID. Outcomes data for June was reviewed (***Attachment 3E.13***) and it was noted that there were differences noted in Business Hours versus After Hours outcomes on the outcome measures. Performance was better for After Hours compared to Business Hours on the following measures: providing SMHS referrals similar to May outcomes data and also on demonstrated respect/customer services, and identifying medical needs. However, Business Hours performance was better on the following measures: offering language interpreter services, requesting caller's name, identifying presenting problem and substance use issues, and documentation.

The following ACCESS Center staff vacancies were reported: five Medical Case Workers; one AM Nurse; one PM Nurse; and two supervisors (to be filled by September).

August 11, 2017 – Non Clinical PIP team meeting: The PIP team reviewed the new Quality Assurance (QA) expectations; as established during the July 28th Calibration meeting. Not all supervisors were available for the Calibration meeting. The new QA expectations were launched the following week, on August 7, 2017, after remaining supervisors were updated. Since the implementation of the new QA expectations, ACCESS Center reported receiving a greater number of evaluations and feedback from evaluators. The majority of the submitted QA reviews have been evaluation only with very few requiring a face-to-face meeting. Plans to examine Non-English calls for differences were discussed. More specifically, it was explained that the percentage of calls selected for QA review for language requests received in Spanish should reflect the proportion of calls received in Spanish for the monthly call volume. EQRO reviewers agreed that oversampling should be sufficient as a true random sample would not always result in the non-English calls to be reviewed due to low percentage of these calls (5%). PIP team discussed the importance of reviewing non-English calls where interpreter services were used for other Non-English calls besides Spanish. QID explained to consider including such calls and having the supervisors review these to the extent possible.

Changes to the random sampling procedure were reviewed. In the past, calls were randomized by the agent. The call and agent would be matched to an evaluator. The new procedure starts with the evaluator's schedule and then matches an agent with a similar schedule. Evaluators are provided 8 blind calls, with no indication of who the agent may be, and are instructed to select five calls to review for the week. Information Technology (IT) support at ACCESS added Audio Log to each supervisor's computer. Supervisors complete evaluations from their own workstation and are able to plan their own schedules for reviews. PIP team identified the May Media Campaigns and staff movement across shifts between April 2016 and June 2017 as reasons for the decline in performance for Q4.

Plan-Do-Study-Act (PDSA) in Year Two. The following PDSAs contributed to improvement in ACCESS Center operations during Year Two of this Non-Clinical PIP.

The **seventh PDSA cycle** (***Attachment 3E.12)*** was aimed at stimulating discussion among ACCESS Call Center Agents regarding the process of (and possible barriers to) logging calls made to the ACCESS 24/7 Hotline**.** On May 4, 2017, PIP team discussed the benefits of a QID-led focus group with ACCESS Center

Agents to brainstorm and provide a summary on how to address reasons for a decline in performance related to logging calls. On June 15, 2017, QID facilitated a focus group with 14 ACCESS Call Center agents. The meeting was held at ACCESS Center and contained a mixture of new and seasoned daytime shift staff. Members of the ACCESS Center leadership team were not present for this meeting. Discussion derived from the agents' focus group appeared to support the goal of improving consistency in documenting test calls. ACCESS Management will be working with the Chief Information Officer (CIO) and CIOB team to address IBHIS related barriers to timely and accurate logging of call information. ACCESS Management will address inconsistencies in instructions to Agents by supervisors. QID will obtain monthly updates on the progress of the intervention to address the above two areas at the PIP meetings.

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?

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.

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.

FY 16-17 PIP Findings

Data analysis was conducted on a monthly basis. PIP team discussed drops and improvements in performance and explored potential contributors. Data analysis involved the review of Customer Service Checklist data, which allowed a more detailed review of how agents were rated, as well as PIP changes in performance on a monthly, quarterly, and recently added measures by time of call (After Hours versus Business) and type of call (Crisis versus Referral).

Annual Outcomes for FY 16-17

Quarterly outcomes data was aggregated for Q1 through Q4 for FY 16-17 (***Attachment 3E.14***) and is summarized as follows:

1. The percent of non-English calls where **language interpreter services were offered increased from 84% to 86%.** There was a 9 PP decline in performance between Q3 (96%) and Q4 (86%). The expected achievement was 10 PP.

2. The percent of calls where the agent requested the caller's name decreased from 88% to 86%. There was an 8 PP decline in performance between Q3 (94%) and Q4 (86%).
3. The percent of calls where the agent provided a SMHS referral decreased from 98% to 89%. There was a 3 PP decline in performance between Q3 (92%) and Q4 (89%).
4. The percent of calls showing **demonstrated respect for the caller increased from 95% to 96%.** There was a 2 PP decline in performance between Q3 (98%) and Q4 (96%). The expected achievement was 5 PP.
5. The percent of calls where the presenting problem was identified increased from 91% in May 2017 to 92% in June 2017.
6. The percent of calls showing identified medical needs decreased from 71% in May 2017 to 53% in June 2017.
7. The percent of calls **where substance abuse issues were identified increased from 75% in May 2017 to 89% in June 2017**.
8. The percent of calls where the caller's information **was documented increased from 60% to 77%.** The expected achievement was 10 PP.
9. The test calls results for the three indicators selected to be reviewed for CY 2017 in comparison to CY 2016 included test calls findings for Q1 and Q2 of CY 2017 (Jan-June 2017, test calls started from March 2017). Table 6 shows the findings.

TABLE 6: TRENDING OF ACCESS CENTER TEST CALLS DATA
CY 2016 and CY 2017

INDICATOR	CY 2016	CY 2017 YTD
ACCESS Staff Requested Caller's Name	63%	74%
Reported Satisfaction with ACCESS Services	84%	86%
Call was Logged by ACCESS Staff	64%	37%

The expected improvement for these three indicators was 5 PP. This expectation was fully met for the outcome measure related to "Agents requested caller's name" with a 11 PP improvement. There was improvement but only 2 PP for the indicator related to customer satisfaction with ACCESS services. There was a steep decline for the "calls logged" measure. March showed a major drop in calls logged at 16%. As explained earlier, the focus group convened with the ACCESS Agents on June 15, 2017 identified some of the barriers encountered and factors contributing to the differences in call logging results for "actual" calls being reviewed for the PIP versus "test" calls implemented annually per the Title 9 State mandate. The Agents' focus group

supported the goal of improving consistency in documenting test calls. Agents discussed interesting information regarding their perception of test calls versus actual calls. They indicated that they are trained to mainly document either crisis or referral calls that require providing referrals for SMHS and documenting actions taken. They explained that they encounter barriers when documenting other general information type of calls where callers are not willing to accept specific referrals to clinics with potential time slots (similar to test calls) or are not willing to give demographics and other details needed to complete documentation fully on the calls. On such calls, they explained that they need to go through multiple windows and screens entering "Not Applicable" on the current system and this is a long and tedious process while there are calls in queue waiting for them to attend. This sometimes results in them not documenting such calls and taking the next call, which is of greater importance such as a crisis call requiring dispatch of the PMRT team. Examples were provided of such instances. They also explained that sometimes they are able to easily identify a call as a test call and do not document the call – for example when a caller is up front asking for a referral in a specific SA. This is because callers outside DMH would not request referrals specific to a SA, rather they just present their problem and it is the Agent who requests their address to identify the location most convenient and easily accessible to provide a SMHS referral. This feedback shared about test calls were shared with the SA QIC Chairs to ensure test callers are cautious in following the right instructions for conducting test calls so that the Agents do not become aware it is a test call. The focus group findings also resulted in consequent interventions including memo issued by ACCESS Management giving consistent instructions across shifts on documentation related to calls with missing demographics and Chief Information Office Bureau informed of the findings by QID to identify proposed action plan to address the barriers in documentation related to IBHIS.

After Hours and Business Hours Comparison for June 2017

After Hours (AH) and Business Hours (BH) data comparisons in performance were aggregated for May and June 2017 and are summarized in the following.

In a review of May 2017 data where BH performed better than AH (Attachment 3E.8):

- BH (92%) performed better than AH (82%) on the percent of non-English calls where language interpreter services were offered.
- BH (92%) performed better than AH (82%) on the percent calls where the agent's requested the caller's name.
- BH (100%) performed better than AH (91%) on the percent of calls showing demonstrated respect for the caller.

In a review of May 2017 data where AH performed better than BH (Attachment 3E.8):

- AH (91%) performed better than BH (85%) on the percent of calls where the agent provided a SMHS referral.
- AH (71%) performed better than BH (70%) on the percent of calls showing identified medical needs.
- AH (83%) performed better than BH (50%) on the percent calls showing identified substance abuse issues.

In a review of May 2017 data where there was no difference in performance between AH and BH (Attachment 3E.8):

- AH (91%) and BH (91%) demonstrated similar performance on the percent of calls where client information was documented.
- AH (91%) and BH (91%) demonstrated similar performance on the percent of calls showing identified presenting problem.

In a review of June 2017 data where BH performed better than AH (Attachment 3E.13):

- BH (94%) performed better than AH (80%) on the percent of non-English calls where language interpreter services were offered.
- BH (93%) performed better than AH (80%) on the percent of calls where the agent's requested the caller's name.
- BH (93%) performed better than AH (89%) on the percent of calls showing identified presenting problem.
- BH (100%) performed better than AH (80%) on the percent of calls showing identified substance abuse issues.
- BH (80%) performed better than AH (78%) on the percent of calls where client information was documented.

In a review of June 2017 data where AH performed better than BH (Attachment 3E.13):

- AH (100%) performed better than BH (80%) on the percent of calls where the agent provided a SMHS referral.
- AH (100%) performed better than BH (93%) on the percent of calls showing demonstrated respect for the caller.
- AH (57%) performed better than BH (50%) on the percent of calls showing identified medical needs.

Outcomes Data for Crisis versus Referral – May and June 2017 ***(Attachment 3E.15a and 3E.15b****):*

The outcomes data was reviewed for Crisis versus Referral calls for May and June 2017. For both May and June 2017, there **were higher ratings for Crisis Calls compared to Referral calls for the outcome measures related to "SMHS Referrals provided", "Identifying Presenting Problem" and "Identifying Medical Needs"**. On the contrary, **the ratings were lower** for both May and June 2017 for **Crisis calls** compared to Referral calls on the outcome measure related to **"Demonstrated Respect/Customer Service**", For all other outcome measures, results were inconsistent between May and June. It is important to continue to track these differences for FY 17-18. These differences in results between Crisis and Referral calls were closely reviewed with ACCESS Management. One of the important steps taken by ACCESS was to implement the Skill Sets/Workgroup Protocols for the Day and Mid Shifts in August 2017 (***Attachment E.9***) to ensure Agents have the specialized skills needed for the Skill Set assigned to provide appropriate SMHS referrals and timely access to clinical care, culturally responsive services, and complete accurate documentation pertinent to the calls handled.
Call Agents are scheduled by skill sets / work groups in order to improve customer service and more efficiently respond to the ACCESS Center toll free telephone lines. A Skill set/work group is a scheduled number of Call Agents who answer a specific category of skills based calls defined by choices made by the callers on the Interactive Voice Recording (IVR). This allows the Call Agent to focus on the skills necessary to meet the skill based request, rather than having to frequently alternate between different types of skill based needs. The skill set/work group members sit close to one another to allow for intra-group communication to facilitate the sharing of information, updating information, responding to repeat callers and identifying trends and obstacles in the moment. The proximity also allows supervisors to assist with intragroup warm transfers, and better manage call volume. Examples of skill sets/work groups can include: Crisis; Information and referral; which can be separated into Spanish only and other languages.

Objectives for the Skill Set implementation are :

1. To schedule a sufficient number of Call Agents with the appropriate skills to the skills-based work group to answer the expected workgroup call volume on each shift.

2. To have skill based work group Call Agents share information with the monitoring supervisor and skill set/ work group colleagues. For example: informing them of an expected call back; informing them of changes to resources.
3. To have the Call Agent be responsible for each call from the beginning of the call to the end unless it is determined that the needs of the caller or the needs of other callers are better served by transferring the call.
4. To have the monitoring supervisor determine whether the Call Agent should warm transfer a call to another member of the same skill set/work group, for example if they have an additional skill such as a specialized language that would better meet the needs of the caller.
5. To have the monitoring supervisor determine whether the Call Agent should warm transfer a call to another work group. For example the Call Agent in the Crisis group could transfer an Information/Referral skill based call to the information/referral work group.

ACCESS Center reviewed the calls received by Skill Set for Jan-June 2017 (***Attachment E.16***) that showed the differences in the percentage distribution for Crisis versus Referral calls for After Hours versus Business Hours. As seen in the pie charts, for both Q1 and Q 2 of CY 2017, ACCESS received **a larger percentage of crisis calls (47% and 48%) during After Hours** compared to **Business Hours (31% and 30%).** For Referral Calls, the percentage was **higher for Business Hours for both quarters of CY 2017 (27% and 26%) compared to After Hours (7% and 8%).** The percentage of general information and other calls received were very similar for After Hours and Business Hours. This data was used to guide the Skill set assignment for staffing Business Hours initially to examine the impact before implementing this for the After Hours.

STEP 9: ASSESS WHETHER IMPROVEMENT IS "REAL" IMPROVEMENT

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

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

Data cycles clearly identified when measurements occurred. For example, on a weekly basis the QA reviews were completed by the ACCESS supervisors and on a monthly basis the QA Checklists were sent to QID for scanning. The data analysis was completed on a monthly basis and outcomes data was shared with the PIP teams on a monthly basis. Factors that influence comparability of the initial and repeat measures for FY 16-17 are changes in the evaluation criteria for documentation, one of the outcome measures where the criteria were expanded to include 3 additional criteria. Three new outcome measures were added from the checklist for monitoring and tracking starting May 2017.

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?

Similar processes were used each month to rate the QA Checklist by the ACCESS Center supervisors. All supervisors were trained on the QA Protocols including the Quality Reference Standards for rating the checklist for the audio recordings of calls reviewed and during the baseline period from July-Sep 2017, calls were evaluated based on the basic training but not to give individualized feedback to the Agents so as to determine baseline behavior as much as possible. This also allowed supervisors to become more familiar with the evaluation process before addressing training issues with Agents. They also addressed any technical and logistical challenges to resolve any technical and logistic challenges. Calibration meetings were held on a regular basis where supervisors reviewed calls to discuss calls reviewed and review inter-rater reliability. Supervisors also completed the Customer Service Evaluation Form in addition to the QA Checklist to provide evidence and explanation for example, why a particular outcome measure was "Not Applicable" to evaluate on a specific call. These were reviewed by QID and ACCESS to ensure data reported was accurate in reporting the outcomes data and on completing the CSE along with the QA Checklists to describe comments related to why a call was rated as "Not Applicable".

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

A total of 96 ACCESS Call Center agents were trained on the QA Protocol between March 9, 2016 and May 17, 2017. There was improvement in processes as evidenced by: the Addition of new Resource Information to the Electronic Resource Directory (ERD) for IHSS insurance coverage for mental health services, Formalized Instructions regarding documentation for calls with unknown DOB, Focused review of barriers with documentation on IBHIS by CIOB, and other improvements in place via PDSA cycles. In addition**,** as described earlier, there was quantitative improvement in the outcome measures listed below between the first Quarter of FY 16-17 and the last Quarter of FY 16-17. These are:

1. The percent of non-English calls where **language interpreter services were offered increased from 84% to 86%.** Compared to QI, there was an initial 5 PP increase in Q2, 11 PP increase in Q2. However, there was a 9 PP decline in performance between Q3 (96%) and Q4 (86%) due to high call volume in May, staffing shortage for both supervisors and staff that resulted in a small overall PP increase of 2 PP in Q4. The expected achievement was 10 PP.
2. The percent of calls showing **demonstrated respect for the caller increased from 95% to 96%.** Compared to QI, there was an initial increase of 4 PP in Q1 and 3 PP in Q2. However, a 2 PP decline in performance between Q3 (98%) and Q4 (96%) occurred due to the same reasons explained above that resulted in a small overall increase of 2 PP for Q4 compared to Q1. The expected achievement was 5 PP.
3. The percent of calls where the caller's information **was documented increased from 60% to 77%.** The expected achievement was 10 PP. On this measure, compared to baseline, there was a significant improvement for Q2 by 17 PP, a 11 PP increase in Q3, and a 17 PP in Q4. In Q4, the evaluation criteria for documentation were expanded to make this more stringent. Despite this change, the PP increase was most significant for this measure.
4. On the Test Calls study findings for CY 2016 versus CY 2017 YTD, there was a **11 PP increase from 63% to 74% on the measure related to caller's name was requested**, a **2 PP increase on the measure related to reported satisfaction with ACCESS Agent from 84% to 86%.** These findings indicate parallel improvement related to the implementation of the PIP and focused efforts on performance in these areas. Since the satisfaction

reported here on this measure is directly related to the caller's satisfaction in contrast to the PIP QA review ratings by supervisors' indicative of their perceptions of satisfaction using objective QA referencing standards, these findings are promising and indicate impact on actual consumer satisfaction and not originating from only a proxy measure.

The two test call study measures also included improvement for the first two Qs of CY 2017 compared to CY 2016 showing that the PIP implementation impacted the performance. However, for calls logged there was decline in performance for CY 2017 YTD compared to the PIP measure related to documentation. Due to these contrary findings, a focus group was conducted with ACCESS Agents that revealed interesting reasons for these differences. In order to address the barriers identified during this focus group, ACCESS has already implemented two interventions – issuing a memo regarding documentation related to unknown demographics, implemented Skill Sets from Aug 2017 to address differences in improvement for Crisis versus Referral calls and also based on the call volume for the specific skill set.

- Describe the "face validity," or how the improvements appear to be the results of the PIP interventions.
- Discussion of PDSA cycles by supervisors in the ACCESS Center staff meeting and calibration meetings have shown quantitative improvements in the outcomes tables in subsequent months. This shows that the rating criteria has face validity since agents and supervisors attending the monthly PIP meetings have repeatedly voiced their appreciation of the QA checklist process and how it has helped their understanding of customer service at the ACCESS center.
- 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?)

The quantitative improvements have been listed under Question # 6. Overall, on 3 of the 5 outcome measures tracked for FY 16-17 for this PIP, there was improvement indicative of the effectiveness of interventions implemented including the QA reviews and feedback to Agents and other related interventions via PDSAs to address barriers identified. The improvement was especially significant on the measure related to documentation which had a lower percentage rating (60%) at baseline compared to the other measures (=>84%). On the other two measures where no improvement was noted – a) Demonstrated respect/customer service – there was steady improvement in Q2 and Q3 but there was a decline in Q4 and b) caller's name was requested – there was there was steady improvement in Q2 and Q3 but there was a decline in Q4. The decline in Q4 was related to the high call volume due to May is Mental Health Campaigns, and staffing shortage both supervisors and staff. In other words, these measures too were reflective of improvement barring these system issues in Q4.

The plan for monitoring and sustaining improvement will require the continuation of the QA Protocol and Non-Clinical PIP to track improvement on the four new outcome measures monitored from Q4 of FY 16-17 and the impact of interventions recently implemented including Skill Sets in Aug 2017 and proposed implementation of new Call Center system in FY 17-18. The MHP plans to continue this PIP over the next FY until the next EQRO review in Sep 2018 to report progress based on these interventions and also with the refined measurements for some of the existing measures related to documentation of calls and SMHS Referrals starting for July 2017 calls (where only Crisis and Referral Calls that focus on SMHS will be included in the outcomes data reported). This will facilitate the review of consistent outcomes data with similar methodology and measurements including the new random sampling implemented in August 2017.

From a Qualitative perspective, ACCESS Management, supervisors, and Agents shared their personal impressions that the PIP process and feedback on the outcomes data was valuable. The PIP has resulted in improved processes and interventions outlined earlier. The Agents reported they became more

aware of how their work can impact consumer care related to cultural responsiveness and quality clinical care and how documentation is critical to enable access to critical information about the consumer when subsequent calls are received. The ACCESS Center will benefit greatly from the continued implementation of this PIP into the next fiscal year by continuing to track and monitor the outcomes on a regular basis with the new interventions recently implemented and the proposed New Call Center application to be implemented in FY 17-18.