



**COUNTY OF LOS ANGELES
DEPARTMENT OF MENTAL HEALTH**



**PROGRAM SUPPORT BUREAU
QUALITY IMPROVEMENT DIVISION**

**QUALITY IMPROVEMENT
HANDBOOK**

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Director**

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TABLE OF CONTENTS

| | |
|--|----|
| INTRODUCTION | 1 |
| Historical Background | 2 |
| Vision, Mission, Values Statement..... | 5 |
| SECTION 1: QUALITY IMPROVEMENT PROGRAM | 6 |
| Structure and Functions | 6 |
| Responsibilities and Processes..... | 7 |
| Quality Improvement Work Plan Goals | 8 |
| Consumer/Family Satisfaction Survey and Performance Outcomes..... | 9 |
| Service Area Provider Directories | 10 |
| Figure 1 – Quality Improvement Structure | 11 |
| Figure 2 – Quality Improvement Service Area Structure–Representation | 12 |
| Figure 3 – Quality Improvement Service Area Structure–Providers | 13 |
| P&P 105.1: Quality Improvement Program Policy and Procedures..... | 14 |
| Quality Improvement Council Membership Roster | 18 |
| Quality Improvement Council and Cultural Competency Committee..... | 23 |
| Cultural Competency Committee Roster..... | 25 |
| SECTION 2: QUALITY IMPROVEMENT PROGRAMS IN ORGANIZATIONAL PROVIDERS | 26 |
| SECTION 3: QUALITY IMPROVEMENT AND PERFORMANCE OUTCOMES | 29 |
| STATS Summary | 29 |
| LAC-DMH State and County Performance Outcomes | 30 |
| CDMH Quality Improvement and Performance Outcomes..... | 30 |
| External Quality Review of Mental Health Plans: Performance Protocol.. | 31 |
| Department of Auditor–Controller Quality Improvement Protocol..... | 36 |
| Performance Outcomes and California Regulations | 37 |
| APPENDIX A: CDMH MEDICAL OVERSIGHT ANNUAL REVIEW PROTOCOL FOR CONSOLIDATED SPECIALTY MENTAL HEALTH SERVICES AND OTHER FUNDED SERVICES | |
| APPENDIX B: PARTNERS IN QUALITY | |

Introduction

Quality Improvement concepts challenge us to improve the quality of services provided through the County of Los Angeles Department of Mental Health (LAC-DMH) system of care. LAC-DMH is a Mental Health Plan (MHP) as defined by the California Department of Mental Health (CDMH), California Code of Regulations. The LAC-DMH Quality Improvement Program Policy and Procedure (P&P) 105.1 describes the structure and process of the Quality Improvement Program, which supports the Mental Health Plan (MHP) and is mandated by the Performance Contract with CDMH. As a shared responsibility with its' providers, the MHP holds a continuing commitment to maintain and improve the quality of its' service delivery system. It is the function of the Quality Improvement Program to support this commitment by establishing processes and performance outcomes for the continuous improvement of services. QI efforts facilitate and support recovery, resiliency and cultural competent client/family centered services, community-based services and field-based services "without walls". The mental health care Array of Services is monitored and measured in comparison to Service Area population demographics in order to identify and reduce disparities and set goals for capacity building cultural/linguistic needs, accessibility, outcomes, and quality.

LAC-DMH Quality Improvement activities are the responsibility of the Quality Improvement (QI) Division, under the auspices of the Program Support Bureau. The QI Division is responsible for coordinating and managing the Quality Improvement Program, and plans, designs, organizes, directs, and sustains the Quality Improvement Work Plan activities and initiatives of LAC-DMH. The Quality Improvement Work Plan identifies the goals and measurable objectives that are monitored and tracked for progress and improvement. Within the Quality Improvement Program is the Quality Improvement Council (QIC), previously known as the Performance Excellence Quality Improvement Council (PEQIC). The QI program has oversight responsibilities for activities throughout the Department in the following areas:

1. Reviewing and evaluating of QI performance results including general oversight of State and County mandated consumer satisfaction measures and internal services measures and indicators.
2. Identifying opportunities for quality improvement including information gleaned from performance measures, information Systems (IS) data as well as other opportunities. Sources include the Department's Risk Management; feedback from Service Area Quality Improvement Committees; periodic organizational data summaries, and audit /site review findings and recommendations.
3. Designing and tracking of quality improvement and Performance Improvement Projects (PIPs): as part of the External Quality Review Organization (EQRO) requirements, mandated by Title 42, QI Division coordinates, organizes, and supports PIPs from and throughout the organization.

4. Evidence Bases Practices (EBPs): QI Division reviews the use of EBPs. Its' responsibility in this area may include identification of new and upcoming best practices from inside and/or outside the Department.
5. Oversight of Departmental QIC activities including coordination with Service Area QIC activities.
6. Training: "Tools" of Continuous Quality Improvement and related quality skills are not traditional management skills. QI Division in collaboration with the Training Division has responsibility to support and coordinate training in these tools throughout LAC-DMH.
7. Formal reporting on the effectiveness of QI processes through the development and completion of the Annual QI Work Plan Evaluation Report and the State and County Performance Outcomes Report.

Historical Background

It is important to note that the goals of the "Presidents New Freedom Commission on Mental Health – Transforming Mental Health Care in America" (2003), the Institute of Medicine's (IOM's) "Crossing the Quality Chasm" (2001), and the SAMHSA/CMHS, NASMHPD Research Institute (NRI) National Outcome Measures (NOM's) have served to guide the LAC-DMH direction and selection of Performance Outcomes and goals for improved quality. This national perspective has provided a valuable framework for transformation of the system through measurable indicators that were identified by consumers and other stakeholders throughout the Nation as having universal meaning and significance for improving the lives of the persons we serve.

The following is an excerpt from the President's New Freedom Commission on Mental Health:

"In his charge to the Commission, President Bush directed its members to study the problems and gaps in the mental health system and make recommendation for immediate improvements that the Federal government, State governments, local agencies, as well as public and private health care providers, can implement."

"The [Commission's] Interim Report concluded that the system is not oriented to the single most important goal of the people it serves – the hope of recovery. State-of-the-art-treatments, based on decades of research, are not transferred from research to community settings. In many communities, access to quality care is poor, resulting in wasted resources and lost opportunities for recovery. More individuals could recover from even the most serious mental illnesses if they had access in their communities to treatment and supports that are tailored to their needs."

"The Commission identified the following six goals that are the foundation for transforming mental health care in America. The goals are intertwined. No single step

can achieve the fundamental restructuring that is needed to transform the mental health care delivery system.”

- Goal 1: Americans understand that Mental Health is essential to overall health
- Goal 2: Mental Health Care is Consumer and Family Driven.
- Goal 3: Disparities in Mental Health Services are eliminated.
- Goal 4: Early Mental Health Screening, Assessment, and Referral to Services are common practice.
- Goal 5: Excellent Mental Health Care is delivered and research is accelerated.
- Goal 6: Technology is used to access Mental Health Care and information.

Electronic copies are available and can be downloaded at:

<http://www.mentalhealthcommission.gov/reports/FinalReport/toc.html>

In 2001, the IOM report “Crossing the Quality Chasm: A New Health System for the 21st Century” examined the quality of the healthcare system in the United States. The Quality Chasm report developed a framework and strategies for improvements in quality and indentified six aims for high quality healthcare and ten rules for the redesign of the healthcare system.

The Six Aims are:

Safe—avoiding injuries to patients from the care that is intended to help them.

Effective—providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and overuse, respectively).

Patient-centered—providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.

Timely—reducing waits and sometimes harmful delays for both those who receive and those who give care.

Efficient—avoiding waste, including waste of equipment, supplies, ideas, and energy.

Equitable—providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic locations, and socioeconomic status.

The Ten Rules to Guide Redesign of Health Care are:

Care based on continuous healing relationships. Patients should receive care whenever they need it in many forms, not just face-to-face visits. This rule implies

that the health care system should be responsive at all times (24 hours a day, every day) and that access to care should be provided over the internet, by telephone, and by other means in addition to face-to-face visits.

Customization based on patient needs and values. The system of care should be designed to meet the most common types of needs but have the capability to respond to individual choices and preferences.

The patient as the source of control. Patients should be given the necessary information and the opportunity to exercise the degree of control they choose over health care decisions that affect them. The health system should be able to accommodate differences in patient preferences and encourage shared decision making.

Share knowledge and the free flow of information. Patients should have unfettered access to their own medical information and to clinical knowledge. Clinicians and patients should communicate effectively and share information.

Evidence-based decision making. Patients should be safe from injury caused by the care system. Reducing risk and ensuring safety require greater attention to systems that help prevent and mitigate errors.

Safety as a system property. Patients should be safe from injury caused by the care system. Reducing risk and ensuring safety require greater attention to systems that help prevent and mitigate errors.

The need to transparency. The health care system should make information available to patients and their families that allows them to make informed decisions when selecting a health plan, hospital, or clinical practice, or choosing among alternative treatments. This should include information describing the system's performance on safety, evidence-based practice, and patient satisfaction.

Anticipation of needs. The health system should anticipate patient needs, rather than simply reaction to events.

Continuous decrease in waste. The health system should not waste resources or patient time.

Cooperation among clinicians. Clinicians and institutions should actively collaborate and communicate to ensure appropriate exchange of information and coordination of care.

Institute of Medicine. (2006). *Improving the quality of health care for mental and substance-use conditions*. Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders, Board on Health Services. Washington, DC: The National Academies Press.

Vision, Mission, Values Statement

The purpose of the LAC-DMH Quality Improvement Program is to ensure and improve the quality and appropriateness of mental health care services in conformance with established local, State, Federal service standards and national state-of-the-art mental health care practices and evidence-based practices. The Departmental Quality Improvement Council and Service Area Quality Improvement Committees provide opportunities to: Identify quality improvement issues and projects within the service areas; foster an environment where quality improvement activities can be discussed; identify possible best practices; and ensure performance standards are upheld according to the Departments' Vision, Mission, Values and performance objectives.

| <u>Department of Mental Health Vision, Mission and Values</u> | |
|---|--|
| Vision | Partnering with clients, families, and communities to create hope, wellness, and recovery. |
| Mission | Enriching lives through partnerships designed to strengthen the community's capacity to support recovery and resiliency. |
| Values | <p>Integrity: We conduct ourselves professionally according to the highest ethical standards.</p> <p>Respect: We recognize the uniqueness of every individual and treat all people in a way that affirms their personal worth and dignity.</p> <p>Accountability: We take responsibility for our choices and their outcomes.</p> <p>Collaboration: We work together toward common goals by partnering with the whole community, sharing knowledge, building consensus, and sharing decision-making.</p> <p>Dedication: We will do whatever it takes to improve the lives of our clients and communities.</p> <p>Transparency: We openly convey our ideas, decisions and outcomes to ensure trust in our organization.</p> <p>Quality and Excellence: We identify the highest personal, organizational, professional, and clinical standards and commit ourselves to achieving those standards by continually improving every aspect of our performance.</p> |

Section I: Quality Improvement Program

Structure and Functions

The Quality Improvement (QI) Division is under the direction of the Deputy Director for the Program Support Bureau (PSB). The QI Division is responsible for coordinating and managing the Quality Improvement Program, which plans, designs, organizes, directs, and sustains the quality improvement activities and initiatives of the County of Los Angeles, Department of Mental Health (LAC-DMH). The structure and processes of the QI Program are defined in the Department's program Policy, 105.1 and were developed to ensure that the quality and appropriateness of mental health services meets and exceeds local, State and Federal established standards. The QI Program is also designed to support QI oversight functions for both directly operated and contracted providers for the County's public mental health system, with a focus on a culture of continuous quality improvement processes and excellence.

The QI Division includes the Data Unit, which is specifically responsible for data collection, analyses and reporting for planning and measuring progress towards goal attainment including outcome measures in support of improved: service capacity, accessibility, consumer/family satisfaction, staff cultural competency, penetration and retention rates, continuity and coordination of care, clinical care and other identified outcomes. The QI Division and Data Unit staff coordinate with the Department's Standards and Quality Assurance Division and those Bureaus and Units directly responsible for conducting performance management activities throughout the Department that include but are not limited to: client and system outcomes, beneficiary grievances, fair hearings, clinical care, clinical records and reviews, appeals on behalf of consumers and providers, accessibility and timeliness of services, and Performance Improvement Projects (PIPs). The analyses and management of data is used as a key tool for performance management, decision making and QI work plan goal development, paying particular attention to the data for use in monitoring the system for improved services and quality of care.

The LAC-DMH Quality Improvement structure is formally integrated within several key levels of the service delivery system. The Department's Countywide Quality Improvement Council (QIC) meets monthly and consists of representation from each of the eight (8) Services Areas and Countywide programs, including consumers and/or family members, practitioners from directly operated and contracted agencies, Cultural Competency Committee representatives, and other QI stakeholders. At the Service Area level, all Service Areas have their own regular Service Area Quality Improvement Committee (SA QIC) meetings and the SA QIC Chairpersons are standing members of the Departmental Countywide QIC. There is also a Countywide Children's QIC. At the service provider level, all directly operated and contracted organizational providers, maintain their own Organizational QIC. In order to ensure that the QI communication feedback loop is complete, all Service Area organizational providers are required to participate in their local SA QIC. This constitutes a structure supportive of effective QI performance and involvement of directly operated and contracted providers, the Service

Areas, the Quality Improvement Council, and the Departments' management structure. Lastly, there is a communication loop between the SA QIC and the respective Service Area Advisory Committee (SAAC). The SAACs provide valuable information for program planning and opportunities for program and service improvement. It is used as a key venue for consumer/family member input at the SA QIC level.

The Departmental Countywide QIC is chaired by the Program Support Bureau, District Chief, for the Quality Improvement and Training Divisions. It is Co-Chaired by the Regional Medical Director from the Office of the Medical Director. The District Chief for the Quality Improvement Division also participates on the Southern California QIC, the Statewide QIC, and the LAC-DMH STATS.

The LAC-DMH Cultural Competency Coordinator is under the Program Support Bureau, Planning Division, and is also the Chairperson for the Departmental Countywide QIC, Cultural Competency Committee. Directly operated and contract providers are required to adhere to the Departmental Cultural Competency Plan. This structure facilitates system wide communication and collaboration for attaining the goals set for the provision of improved culturally competent services.

Responsibilities and Processes

The QI Program works in collaboration with Bureaus and Units, responsible for performance management activities, to develop the Annual QI Work Plan and monitor the established measurable goals, for the system as a whole. The Quality Improvement Program consists of dynamic processes that occur continuously throughout the year and requires that interventions be applied based upon collected and analyzed information and data. This also requires collaboration with IS staff and resources whenever possible. The QI Program processes can be categorized into seven (7) main categories, which include: Service Delivery Capacity, Service Accessibility, Beneficiary Satisfaction, Clinical Issues, Performance Improvement Projects, Continuity of Care and Provider Appeals.

The QI Division is also responsible for the formal reporting on the effectiveness of QI processes through the development and completion of the Annual QI Work Plan Evaluation Report and the Annual State and County Performance Outcomes Report. The State and County Outcome measures were initiated in January 2008. These measures include access and timeliness of services, and a focus on persons discharged from acute psychiatric inpatient hospitals. The ultimate goal of the QI measures and evaluation process is to ensure a culture and system of continuous self-monitoring and self-correcting quality improvement strategies and best practices, at all levels of the system.

The Departmental Countywide QIC systematically and formally exchanges quality improvement information, data, and performance updates on QI goals and performance improvement projects. The Departmental QI Program also engages and supports the SA QICs in QI processes related to the Work Plan, specific PIPs, and other QI projects

at the SA level. In turn, SA QICs provide a structured forum for the identification of QI opportunities and action designed specifically to address the challenges and barriers encountered at the SA level and that may exist as a priority in a SA. SA QICs also engage and support Organizational QICs that are focused on their internal Organizational QI Program and activities. The Organizational QICs also monitor internally to ensure performance standards are met for: accessibility, consumer/family satisfaction, clinical care, coordination of care, complaints and grievances and other QI matters as needed. (See P&P 105.1 and Organizational Providers' Quality Improvement Program – QI Handbook, Section 2.)

Quality Improvement Work Plan Goals

The QI Program reassesses and revises, as appropriate, the Annual Quality Improvement Work Plan Goals focusing on performance outcomes. QI Work Plan Goals are revised in accordance with new requirements as related to quality improvement and outcomes measurement. The Work Plan Goals are reported as measurable objectives with numerators and denominators. Baseline data is provided and longitudinal comparisons over time are reported in the Annual QI Work Plan Evaluation Report. A one page summary of the QI Work Plan Goals is also prepared annually and is included in the Annual Evaluation Report. With the clear understanding that Service Delivery Capacity and Service Accessibility are intrinsically intertwined, QI goals and measurements often reflect this inherent connectivity and equally integrate cultural competency measures as appropriate.

Monitoring of Service Delivery Capacity is the first section of the QI Work Plan and includes measures for improved penetration and retention rates for populations identified as underserved and/or populations with identified unmet service delivery needs. Data is prepared Countywide and by Service Area for Population Demographics for age, race/ethnicity, and gender. Data is also prepared by Medi-Cal Populations and Federal Poverty Level Populations to identify (gap analysis) needs accordingly. Goals are set relative to Threshold Languages and data is prepared as is Language Capacity data to address the need for translated consumer/family materials and interpreter services. Goals are also set for core cultural competencies including Interpreter core competencies. Cultural Competency Plan requirements are integrated into the Quality Improvement Work Plan to ensure relevant cultural competency and linguistic standards are appropriately addressed. Relevant data is also prepared by the Quality Improvement Program and Data Unit for distribution via the Service Area Provider Directories.

Monitoring Accessibility of Services is the second section of the QI Work Plan and includes measurable outcomes for access to after-hours care, responsiveness of the ACCESS 24/7 Toll-Free Line and consumer/family satisfaction in survey reporting of service availability at convenient times and locations. This data is used in conjunction with Service Delivery Capacity data and information from the Service Area Provider Directories to improve the systems ability to respond to increasing demands for accessibility, especially as related to underserved populations.

Monitoring Consumer Family (Beneficiary) Satisfaction is the third section of the Quality Improvement Work Plan and includes comprehensive data collected from the Statewide Performance Outcomes that aggregates data on client/family survey evaluations of mental health services. The QI Work Plan contains measureable goals for consumer/family satisfaction survey response rates, overall satisfaction, staff sensitivity to cultural/ethnic background, written materials are available in preferred languages, and service availability at convenient times and locations as reported for Accessibility of Services. Additionally, QI Work Plan measureable objectives are included for monitoring beneficiary grievances, appeals, and Fair Hearing processes and Change of Provider Requests.

Monitoring Clinical Care is the fourth section of the QI Work Plan and the Office of the Medical Director is represented on the Quality Improvement Council via the Council Co-Chair who coordinates with the Quality Improvement Council and reports on clinically related quality improvement activities including effectiveness of medication practices and participation in Statewide Quality Improvement Performance Improvement Projects.

Monitoring Continuity of Care is the fifth section of the QI Work Plan and includes measureable objectives concerning participation in the Post Hospitalization Outpatient Access (PHOA) STATS measure and Statewide Quality Improvement Performance Improvement Project for reducing re-hospitalizations for acute psychiatric hospital care. Lastly, the QI Work Plan contains monitoring goals pertaining to provider appeals and resolution of issues and/or complaints.

Consumer/Family Satisfaction Surveys and Performance Outcomes

The QI Division and Data Unit have the responsibility of administering the Consumer/Family Satisfaction surveys in Clinic Outpatient and Day Treatment Programs that receive mental health funding from the LAC-DMH. The surveys are administered in all of the eight (8) Service Areas of the LAC-DMH. Summary Reports are prepared upon completion of the survey process which includes data sharing and collaboration with the California Performance Outcomes System and the Performance Outcomes & Quality Improvement (POQI) Unit of the CDMH. The existing partnership that is between the Counties and the CDMH POQI is critical to the successful application of this web-based statewide reporting system that is also linked to national database networks for mental health care service delivery performance measures and outcomes. In addition to Overall Satisfaction, Subscale Domains and Service Area specific data, the Quality Improvement Division uses selected items from the survey to measure satisfaction with other areas of performance as related to service convenient locations, convenient times, staff sensitive to cultural/ethnic background, services provided in preferred language, medication information provided, and important other consumer/family perception content. This information is used to identify areas for improvement and for specific quality improvement activities.

Service Area Provider Directories

The Service Area Provider Directories are prepared and updated periodically by the QI Division and Data Unit to support the Departments effort to inform and ensure timely access to available services and to provide Service Area specific data to assist in developing quality improvement activities to reduce disparities.

The Service Area Provider Directories for 2010 contain County directly operated and contract providers by Service Area including address, contact information, language capability, services by type including age groups served and special populations served, Service Area population demographics, map locations, Service Area Threshold languages and other user friendly information. Other population demographics are provided to the Service Areas to assist with identifying gaps and needs in services and areas to focus on for quality improvement.

Electronic copies are available and can be downloaded at:

<http://psbqi.dmh.lacounty.gov/data.htm>

In addition to Policy and Procedure 105.1, key documents for use by the Quality Improvement Program include: The Quality Improvement Work Plan, the Annual Quality Improvement Work Plan Evaluation Report, The State and County Performance Outcomes Report, the Service Area Provider Directories, the Service Area and Countywide Population Demographics including Cultural Competency Plan and linguistic data/information, the Quality Management Handbook, The Departmental Quality Improvement Council Minutes, and the Quality Improvement Work Plan Implementation Status Reports.

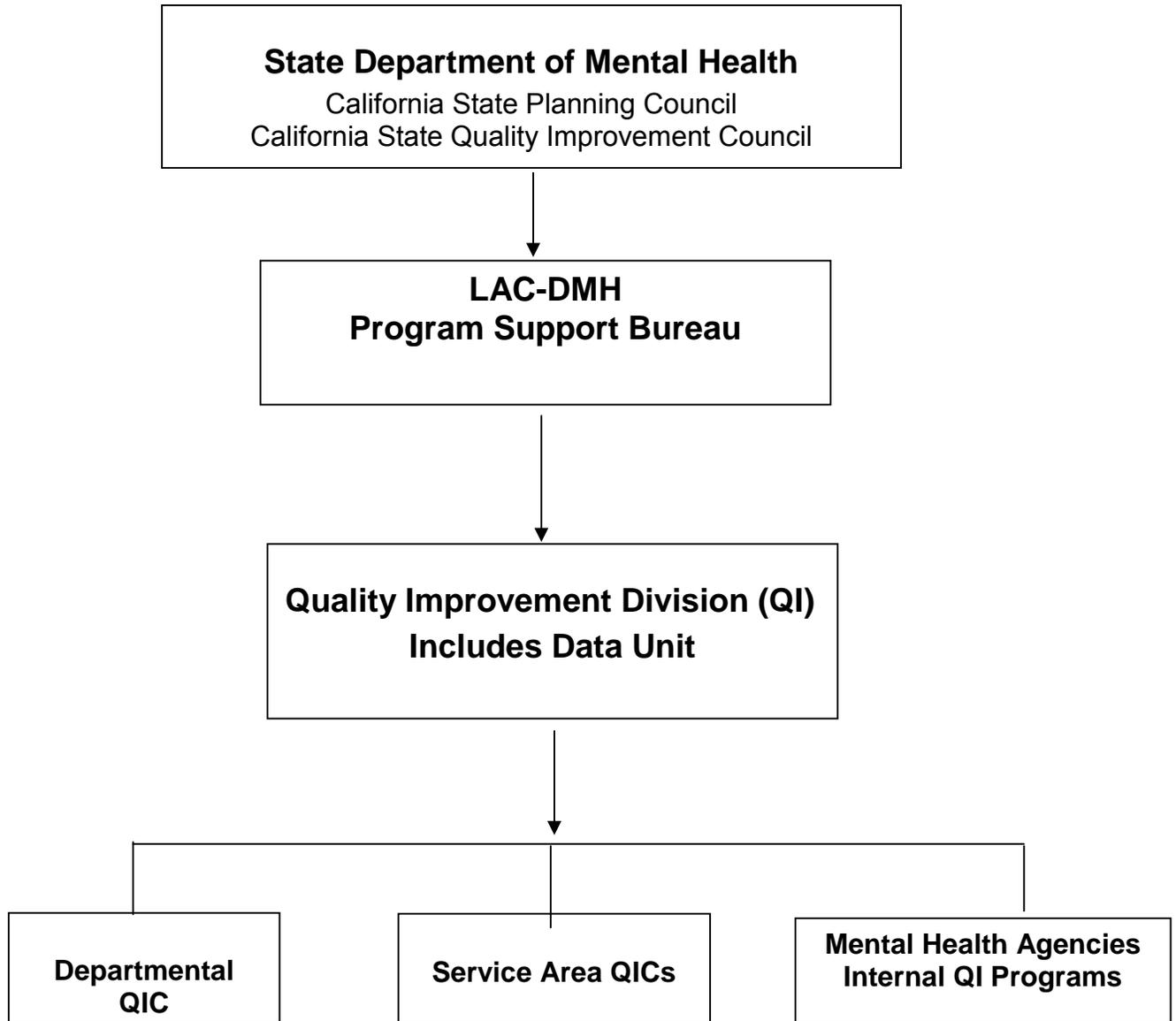
Electronic copies are available and can be downloaded at:

<http://psbqi.dmh.lacounty.gov/qi.htm>

The following figures illustrate the structure of the Quality Improvement Program as it relates to the State Department of Mental Health and County of Los Angeles Department of Mental Health, Countywide Programs.

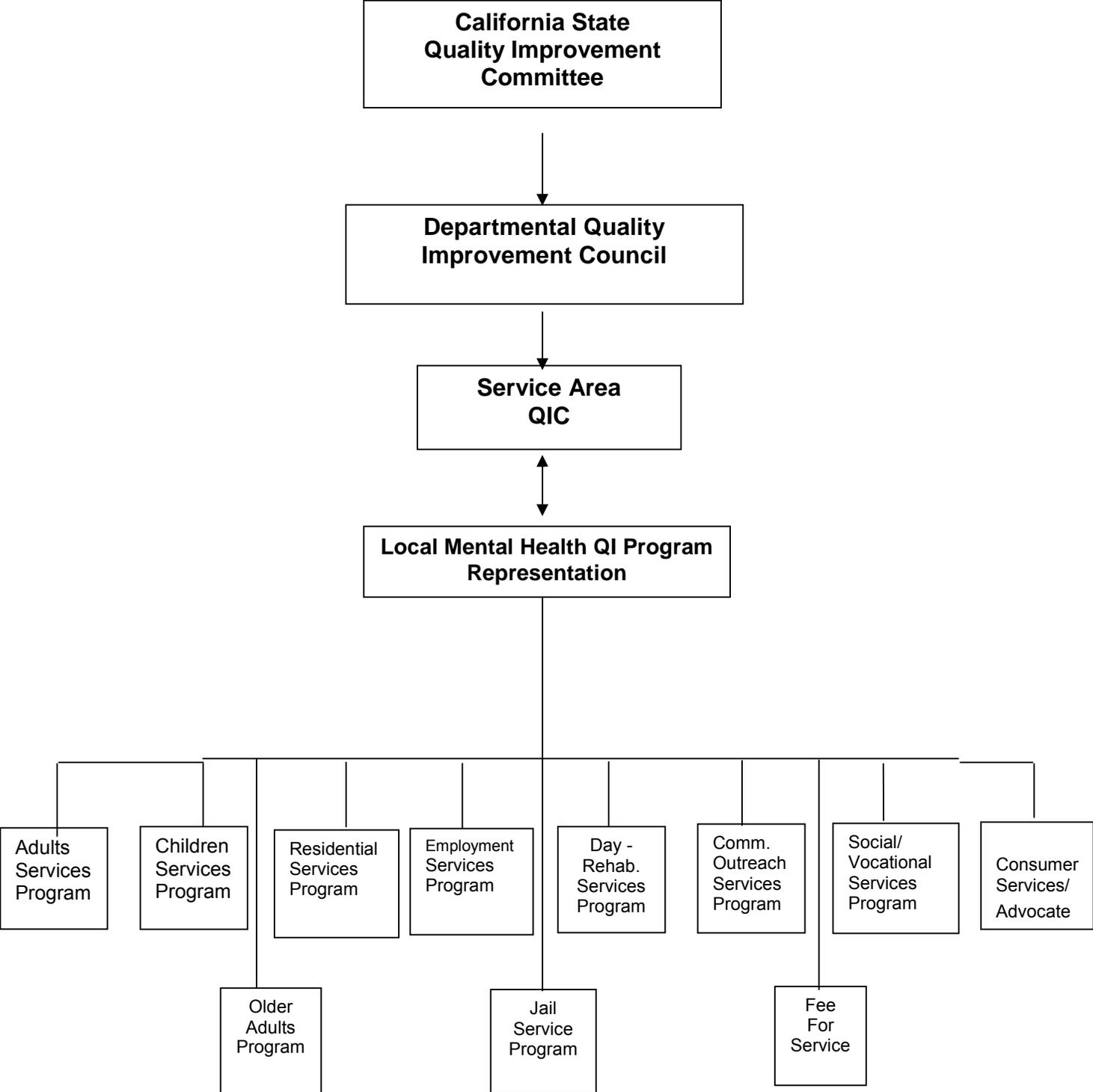
Quality Improvement Structure

Figure 1



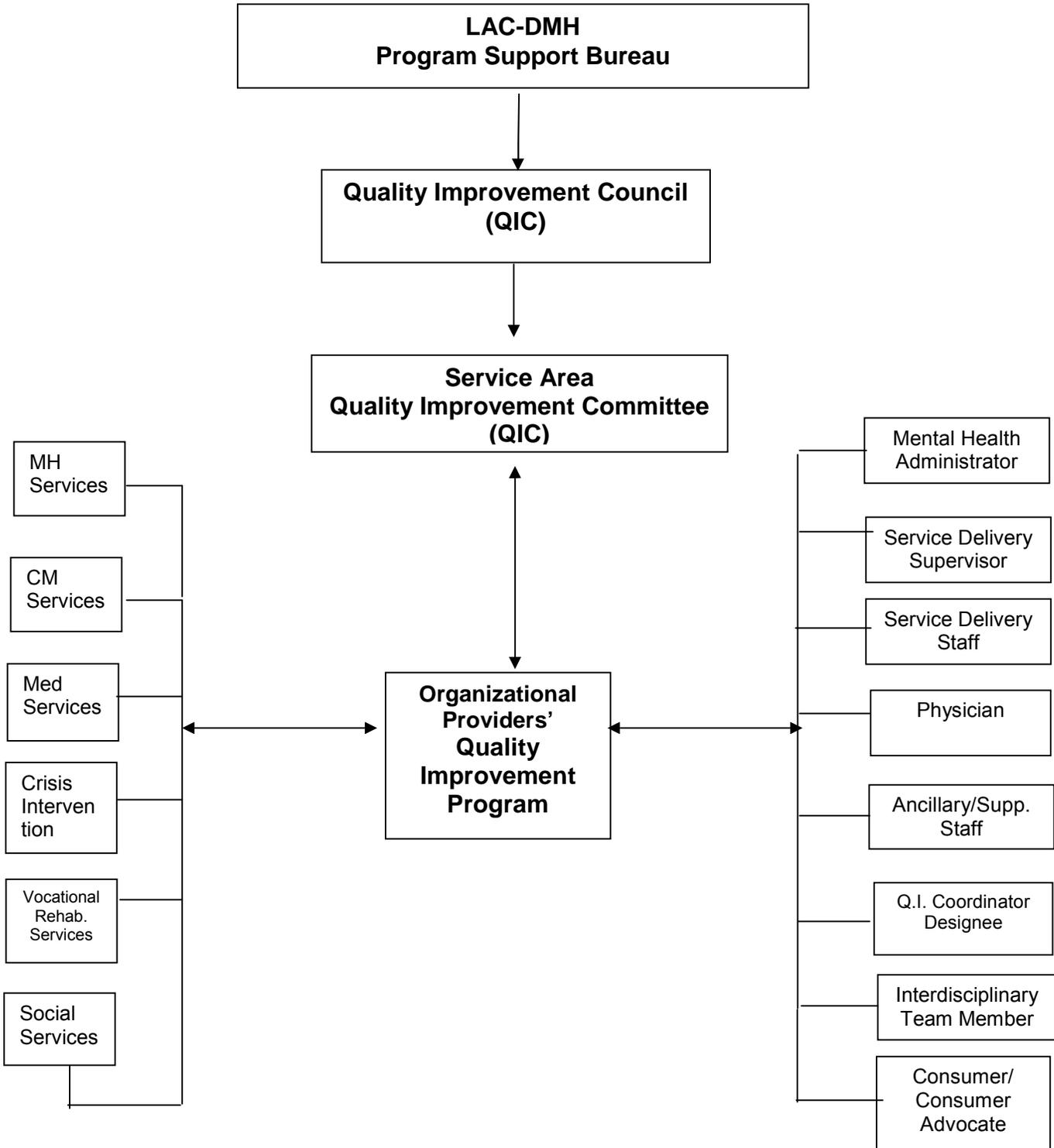
Quality Improvement Service Area Structure – Representation

Figure 2



Quality Improvement Service Area Structure – Providers

Figure 3





DEPARTMENT OF MENTAL HEALTH POLICY/PROCEDURE

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| SUBJECT QUALITY IMPROVEMENT PROGRAM POLICY | POLICY NO. <p style="text-align: center;">105.1</p> | EFFECTIVE DATE <p style="text-align: center;">02/15/06</p> | PAGE <p style="text-align: center;">1 of 4</p> |
| APPROVED BY: <div style="text-align: center;"> Director </div> | SUPERSEDES | ORIGINAL ISSUE DATE | DISTRIBUTION LEVEL(S) <p style="text-align: center;">2</p> |

PURPOSE

- 1.1 To ensure that the quality and appropriateness of care delivered to clients of the mental health system meets or exceeds the established local, State, and Federal service standards.
- 1.2 To define the structure and process of the Quality Improvement (QI) Program within the Department of Mental Health (DMH).
- 1.3 To comply with standards set by the State Department of Mental Health through the Medi-Cal Performance Contract.

DEFINITION

- 2.1 Quality Improvement is a customer focused program involving leadership, management, and clinic staff to create and sustain a culture of continuous improvement and total involvement.
- 2.2 The DMH QI Program has a shared responsibility with its contract providers. It has a commitment to maintain and improve the quality of its service and delivery infrastructure. The QI Program shall support this commitment by establishing processes for continuous improvement of services. This includes processes for resolving service and system issues through systematic evaluation and the implementation of feedback loops, matched to available resources.

POLICY

3.1 Management Responsibilities

- 3.1.1 The QI Program shall be accountable to the Director of the Department.
- 3.1.2 The QI Program shall be under the general auspices of the Director of the Program Support Bureau, who shall direct program responsibility and ensure compliance with Departmental QI practices. This includes, but is not limited to, compliance with all mandated QI programs, as well as Departmental policies and procedures which impact the quality of care.



DEPARTMENT OF MENTAL HEALTH POLICY/PROCEDURE

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| SUBJECT: QUALITY IMPROVEMENT PROGRAM POLICY | POLICY NO. <p style="text-align: center;">105.1</p> | EFFECTIVE DATE <p style="text-align: center;">02/15/06</p> | PAGE <p style="text-align: center;">2 of 4</p> |
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PROCEDURE

4.1 The Departmental QI Program shall:

- 4.1.1 Be administered by a licensed mental health professional.
- 4.1.2 Coordinate with the Bureaus/Units who conduct performance monitoring activities throughout the Department including, but not limited to, client and system outcomes, fair hearings, resolution of beneficiary grievances, clinical issues, provider appeals, assessment of beneficiary and provider satisfaction, and clinical record review.
- 4.1.3 Have overall responsibility for such additional activities as:
 - Liaison to the Quality and Productivity Commission;
 - Policy Review and Forms Committees; and
 - Employee Recognition.
- 4.1.4 Develop an annual QI Work Plan that includes the following:
 - An evaluation of the overall effectiveness of the QI Program, demonstrating that QI activities have contributed to meaningful improvement in clinical care and client services;
 - A description of completed and in-process QI activities, including performance improvement projects;
 - Monitoring of previously identified issues;
 - Planning and initiating activities for sustaining improvement; and
 - Developing goals and monitoring planned activities in the following six (6) areas:
 - ◆ service delivery capacity and organization;
 - ◆ service accessibility;
 - ◆ beneficiary satisfaction;
 - ◆ the service delivery system and meaningful clinical issues affecting beneficiaries;
 - ◆ continuity and coordination with other human service agencies; and
 - ◆ provider appeals.
- 4.1.5 Identify and implement at least two performance improvement projects annually, one clinical and one non-clinical, in accordance with Title 42, Code of Federal Regulations (CFR), Section 438.240(a)(2).
- 4.1.6 Support local Service Area/Countywide Quality Improvement Committee (QIC) structure and processes. Staff assigned to the QI Program shall:



DEPARTMENT OF MENTAL HEALTH POLICY/PROCEDURE

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|--|---------------------------------------|--|----------------------------------|
| SUBJECT: QUALITY IMPROVEMENT PROGRAM POLICY | POLICY NO. 105.1 | EFFECTIVE DATE 02/15/06 | PAGE 3 of 4 |
|--|---------------------------------------|--|----------------------------------|

- participate in local Service Area and Countywide (QIC) meetings;
- review and respond to issues and/or recommendations raised by the local QICs;
- assist local QICs in determining and developing performance improvement projects relevant to local issues; and
- provide information and support to local Service Area and Countywide QIC chairs on problem/issue resolution.

4.1.7 Disseminate information that will enable service providers throughout the system to be in compliance with quality of care requirements.

4.1.8 Distribute the QI Work Plan to all Short-Doyle/Medi-Cal Organizational Providers (directly operated and contract). All inpatient programs shall develop their own quality improvement plan, which must comply with relevant State and local requirements.

4.1.9 Provide appropriate recommendations, via a feedback loop, to the DMH Planning Division and Service Area planners.

4.2 Departmental Quality Improvement Committee

4.2.1 The Department’s QIC shall be known as the Performance Excellence Quality Improvement Council (PEQIC). PEQIC shall:

- oversee and be involved in QI activities, including performance improvement projects;
- recommend policies;
- review and evaluate the results of QI activities, including the performance improvement projects;
- institute needed QI actions;
- ensure follow-up on QI processes; and
- review the Department’s QI Work Plan.

4.2.2 PEQIC shall meet at least quarterly and the minutes shall reflect all decisions and actions. Signed and dated minutes shall be maintained for a minimum of three (3) years.

4.2.3 PEQIC shall consist of practitioners, consumers, and family members who shall have an active role in the planning, design, and execution of QI activities.

4.3 Service Area/Countywide QICs



DEPARTMENT OF MENTAL HEALTH POLICY/PROCEDURE

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|--|---------------------------------------|--|----------------------------------|
| SUBJECT: QUALITY IMPROVEMENT PROGRAM POLICY | POLICY NO. 105.1 | EFFECTIVE DATE 02/15/06 | PAGE 4 of 4 |
|--|---------------------------------------|--|----------------------------------|

4.3.1 Local Service Area QICs shall be composed of at least one (1) staff from every organizational provider within the Service Area, as well as family members and clients. Since Countywide QICs represent specific groups, such as children, the composition shall be appropriate to the represented body.

4.3.2 Local Service Area QICs and Countywide QICs shall:

- meet at least quarterly;
- select a chair/co-chair;
- discuss pertinent issues related to areas identified in Section 4.1.4 of this policy;
- develop and implement feedback loops to organizational provider staff regarding quality of care issues and problem resolutions discussed at the QIC; and
- maintain minutes that reflect all decisions and actions. The minutes shall be signed and dated and be maintained for a minimum of three (3) years.

4.4 Organizational Provider QIC

4.4.1 All organizational providers, directly operated and contracted shall have a QIC.

4.4.2 The QIC shall meet at least quarterly, or more frequently based on agency need.

4.4.3 The QIC shall maintain minutes that reflect all decisions and actions. The minutes shall be signed and dated and be maintained for a minimum of three (3) years.

4.4.4 The QIC shall monitor the following areas to ensure quality of care:

- service accessibility;
- beneficiary satisfaction;
- the service delivery system and meaningful clinical issues affecting beneficiaries;
- coordination of care with other human service agencies; and
- beneficiary grievances.

4.5 Utilization Review

4.5.1 Each organizational provider shall establish a Utilization Review (UR) process within the agency.

4.5.2 Utilization Review shall be part of the organizational provider's quality improvement program and under the umbrella of the Quality Improvement Committee.

REVIEW DATE This policy shall be reviewed on or before February 2011.

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
Program Support Bureau
Quality Improvement Council
Attendance on:

| MEMBERSHIP ROSTER | | | |
|--|--|--|-----------------|
| Name, Title, Email Address, & Phone Number | Entity Represented | Participant / Representation | Initials |
| Albert Thompson (213) 251-6522 | DMH Empowerment & Advocacy Division | QIC Member | |
| Alex Medina amedina@childguidance.org (818) 739- 5324 | Service Area 2 Child Family Guidance Center | SA 2 QIC Co-Chair QIC Member | |
| Alyssa Bray, MA, LMFT abray@oyhfs.org (323) 443-3152 | Service Area 4 Optimist Youth Homes and Family Services | SA 4 QIC Co-Chair QIC Member | |
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GUEST ROSTER

Please sign in!

| Name, Title, Email Address, & Phone Number | Entity Represented | Participant / Representation | Initials |
|---|---------------------------|-------------------------------------|-----------------|
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Quality Improvement Council and Cultural Competency Committee

The Cultural Competency Committee is a committee of the Quality Improvement Council and reports at each Departmental Quality Improvement Council meetings providing progress reports and forwarding issues requiring attention. The Quality Improvement Council and the Cultural Competency Committee share a substantial cross fertilization of membership representation to ensure that strategies, efforts and activities are coordinated to reduce disparities and improve cultural and linguistic competencies including staff training and workforce development. This collaboration also ensures that relevant cultural competent and linguistic standards are incorporated in the annual QI Work Plan as required and that Service Area Provider Directory information is organized to include ethnic, cultural, linguistic and other culture specific information including demographic population data.

QI Work Plan goals and activities intended to address disparities and cultural competency gaps in the system include measurable objectives for: penetration rates; retention rates; consumer/family satisfaction rates for service time and location; consumer/family satisfaction for materials/information available in their language; cultural, linguistic, and interpreter staff training; post-hospitalization outpatient access (within 7 calendar days); cultural competency organization assessment goals; and, other identified objectives (See QI Work Plan).

The LAC-DMH is currently drafting a new Cultural Competency Plan to address the new Cultural Competency Plan Requirements recently issued by CDMH early in 2010. The Planning Division plans to complete the new document later this year.

The following are working definitions that are used by the Cultural Competency Unit and the Quality Improvement Program:

Access – availability of medically necessary managed care specialty mental health services to Medi-Cal beneficiaries who need them in a manner that promotes, provides the opportunity for, and facilitates their use. This access, by treatment setting is indicated by penetration rates by age, gender, ethnicity and diagnostic category that are reflective of the Medi-Cal beneficiary population.

Client Culture – Mental health clients bring a set of values, beliefs and lifestyles that are molded, in part, by their personal experiences with a mental illness, the mental health system and their own ethnic culture. When these personal experiences are shared, mental health clients can be better understood and be empowered to effect positive system change.

Competence – acquisition of knowledge, skills, and experience necessary for the development and implementation of mental health interventions adaptive to the different groups served (Cross et al, 1989. Towards a Culturally Competent System of Care: A Monograph on Effective Services for Minority Children who are Severely Emotionally Disturbed Volume I).

Culture – the integrated pattern of human behavior that includes thought communication, actions, customs, beliefs, values and institutions of a racial, ethnic, religious or social group. Culture defines the preferred ways for meeting needs (Cross et al, 1989). A particular individual's cultural identity may involve the following parameters among others: ethnicity, race, language, age, country of origin, acculturation, gender, socioeconomic class, disabilities, religious/spiritual beliefs and sexual orientation.

Cultural Competence – a set of congruent practice skills, knowledge, behaviors, attitudes, and policies that come together in a system, agency, or among consumer providers and professionals that enables that system, agency, or those professionals and consumer providers to work effectively in cross-cultural situations. (Adapted from Cross et al, 1989).

Culturally Competent Mental Health Agency – an agency that acknowledges and incorporates at all levels the importance of culture, the assessment of cross-cultural relations, vigilance towards the dynamics that result from cultural differences, the expansion of cultural knowledge, and the adaptation of services to meet culturally-unique needs.

Threshold Language – A language identified on the Medi-Cal Eligibility Data System (MEDS) as the primary language of 3,000 beneficiaries or five percent of the beneficiary population, whichever is lower (in an identified geographic area). Title 9, CCR. Section 1810.410 (f) (3).

**LOS ANGELES COUNTY- DEPARTMENT OF MENTAL HEALTH
PROGRAM SUPPORT BUREAU
QUALITY IMPROVEMENT COUNCIL
CULTURAL COMPETENCY COMMITTEE
MEMBERSHIP ROSTER**

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Section 2: Quality Improvement Programs in Organizational Providers

Organizational Providers' Quality Improvement Program

- Each Organizational Provider (directly operated and contractor) will develop and implement a QI Program.
- The purpose of the Organizational Providers' QI Program is to:
 - define the scope and activities of the QI Program;
 - foster an environment where quality improvement activities can be discussed;
 - identify possible best practices to use by the local provider;
 - ensure that performance standards are upheld according to the Department's mission statement, philosophy, and objectives.
- Each Organizational Provider will have a description of their QI program. The description will be reviewed annually and updated as necessary.
- A licensed mental health staff person will have substantial involvement in the QI Program.
- Each Organizational Provider will keep a copy of the current Departmental Quality Improvement Work Plan and Service Area's QI minutes.
- All Organizational Providers will have a minimum of one QI member participating in its respective SAQIC, and the representative will be responsible for reporting relevant data to the SAQIC, as well as the Organizational Providers' QIC.

Utilization Review

- Each Organizational Provider shall establish a Utilization Review (UR) process within the agency.
- Utilization Review shall be part of the Organizational Provider's Quality Improvement Program and under the umbrella of the Quality Improvement Committee.

Organizational Providers' Quality Improvement Committee

- Each QIC shall elect a Chair or Chair and Co-Chair.
- The QIC shall meet at least quarterly, or more frequently based on agency need.

- The QIC shall maintain minutes that reflect all decisions and actions. The minutes shall be signed and dated and be maintained for a minimum of three (3) years.
- The QIC shall monitor the following areas to ensure quality of care:
 - service accessibility;
 - beneficiary satisfaction;
 - the service delivery system and meaningful clinical issues affecting beneficiaries;
 - coordination of care with other human service agencies; and
 - beneficiary grievances.
- The chairperson provides necessary support by:
 - facilitating the QIC meetings, including preparation of the agenda;
 - conducting QIC meetings at least quarterly;
 - ensuring that issues related to quality are the primary focus of the meetings;
 - ensuring issues referred by the Utilization Review Committee are reviewed;
 - ensuring that high risk clients and/or quality of care issues referred to the QIC are discussed. Referrals of high risk individuals may include but are not limited to the following areas:
 - risk of homelessness or out of home placement;
 - attempted or contemplated suicide;
 - frequent crisis/emergency room visits;
 - violent behavior;
 - non-compliance cases;
 - multi-clinic users/clinic shoppers;
 - overseeing or appointing someone for activities of recording, preparation, distribution and maintenance of minutes.

QIC Members Functions and Responsibilities

- The QI Committee members' responsibilities include, but are not limited to the following:
 - regular attendance at meetings and active participation in QIC activities;
 - review and analysis of information from data sources;
 - problem assessment, identification, selection and study;
 - development of valid clinical criteria;
 - recommendation for corrective actions to the service area manager;
 - monitoring effectiveness of corrective actions;
 - problem evaluation and reassessment; and
 - dissemination of information from the SAQIC meetings to managers and staff at their programs and providing information to the SAQIC

regarding special issues and/or communications from their program.

- The QIC members serve as resource persons to the staff of their agency for problem assessment, identification, selection, study, corrective action, monitoring, evaluation and reassessment according to each committee member's respective area of practice.
- The QIC develops and implements feedback loops to staff regarding quality of care and problem resolution discussed at the SAQIC.
- The QIC develops service benchmark/thresholds relative to the provider's quality indicators.
- The QIC recommends QI decisions based on an on-going review of clinical and service activities, processes, and outcomes.

QIC Meeting Agenda and Minutes

- An agenda should be prepared in advance of each meeting and distributed to the members before the meeting.
- The agenda should cover such topics as:
 - Introduction
 - Old business
 - Sub-committee reports
 - Update from Departmental Quality Improvement Council (minutes posted on Departmental QI website)
 - Special reports/presentations
 - Scheduling of meetings
 - Occasional case presentation
 - Suggestion of items for the agenda of the next meeting
 - Specified time allotted for each agenda item
- Meetings of the QIC are documented and distributed to members.
- Each QIC will determine who will maintain the meeting agenda, minutes, and attendance records. Such records should be retained for three years. It is recommended that each local mental health provider also maintain QIC minutes on site. Minutes are subject to audit by State review teams.

Section 3: Quality Improvement and Performance Outcomes

LAC-DMH STATS (Strategies for Total Accountability and Total Success)

The STATS (Strategies for Total Accountability and Total Success) process involves structured monthly meetings that are chaired by the Chief Deputy Director, with active participation by the Executive Management Team (EMT), District Chiefs and Program Heads. Office of STATS analysts conduct a preliminary analysis of performance indicators relative to established targets or benchmarks and prepares an agenda and questions to help focus the formal session. During the STATS meetings, the EMT reviews relevant performance data and, as necessary, strategizes with clinical program and administrative managers to develop specific action plans designed to improve performance. Follow-up is an integral part of the process, with program-specific reports provided to monitor follow-through on action plan commitments and to measure performance improvement over time.

At its inception in May 2007, the DMH STATS process focused on three core operational process metrics:

- **Direct Services** – Percent of staff time spent on direct services.
- **Benefits Establishment** – Percentage of clients with benefits.
- **Claim Lag Time** – Percentage of claims entered within 14 days of date of service.

Since that time, the following indicators have been introduced to the STATS process and reviewed at the monthly meetings:

- **Medi-Cal Approval** Percent Indicator and **Medi-Cal Revenue Capture**. These indicators help assure that an improvement in timeliness of claim submission doesn't come at the cost of quality of data entry and revenue capture.
- **Post-Hospitalization Outpatient Service Access** Indicator. Facilitates linking clients to outpatient services within seven days after discharge from the hospital.
- **Quality Assurance (QA) Claiming** Indicator. Indicator to assure that QA programs are in place to assure regulatory accountability and compliance. This has resulted in previously unrealized revenue capture.
- **Full Service Partnership (FSP) Baseline Completion** indicator. Monitors and enhances the completeness and quality of the FSP client's outcome data.
- **Full Service Partnership Reduction in Homelessness** Indicator
- **Co-Morbid Substance Abuse (Dual Diagnosis) Assessment Indicator**
- **Claiming by Plan Indicator**. Allows for high level tracking of MHSA service transformation and monitoring for claiming / service delivery anomalies.
- Indicators tracking centralized Administrative Support functions including Timeliness of (1) **Rendering Provider Processing** (CIOB), (2) **Certification List Request Processing** (Human Resources) and (3) **Performance Evaluation Completion** (Executive Management Team).

For each metric, data is aggregated at the department level, by Service Area and by individual programs. Programs are measured against specific targets, which are

established by LAC-DMH, as well as against their peers. The STATS program also provides extensive didactic and lab-based training, mentoring, as well as numerous supplemental reports in order to enhance the skills and ability of managers and supervisors to use data to help monitor and improve their programs.

As each metric has been introduced to the STATS process, substantial performance improvements have been noted in every relevant operational or clinical domain. Examples include: a 16% increase in staff Direct Service levels and 18% increase in claim submission timeliness over the first 2 years; an increase in annual revenues of approximately \$3 Million / year; and a 12% increase (to 97%) of consumers showing clear evidence of assessment for co-morbid substance abuse in the first six months since introduction of that metric.

LAC-DMH State and County Performance Outcomes

The LAC-DMH Performance Outcomes were selected consistent with the State Performance Outcomes System by an interdisciplinary team of stakeholders including representatives from directly operated and contracted providers, the Office of the Auditor-Controller, and other involved stakeholders. The team was developed in 2007 and subsequently selected these measures to: support existing consumer/family initiatives and performance outcome measures; foster cost neutrality; reduce duplicative efforts; and, create opportunities for partnering with providers for Quality Improvement purposes. Additionally, a brief survey was developed for field and school based mental health care service settings, hereafter referred to as “Field Based”. The team also recommended the inclusion of performance measures for timely access to services for persons discharged from psychiatric inpatient hospitals and residential treatment facilities/institutional settings. Lastly, the team recommended that CY 2008 be solely dedicated to establishing baseline data for the selected measures and that quality improvement initiatives be directed at improving mental health care service performance measures and outcomes. The State and County Performance Outcomes Report (August 2009) can be downloaded at <http://dmh.lacounty.gov/qi.htm>

CDMH – Quality Improvement and Performance Outcomes

Consistent with its commitment to the quality and improvement process, CDMH revised the performance outcome data collection instruments to ensure that quality indicators of specific relevance to California’s public mental health system would be measured, and to ensure data comparability with national quality benchmarks. Through the assistance of a Performance Outcomes Steering Committee, with representation from the California Mental Health Planning Council (CMHPC), California Mental Health Directors Association (CMHDA), county program management, county evaluation/quality improvement personnel, and consumer and family members, DMH adopted the most recent version of the national Mental Health Statistics Improvement Program (MHSIP) Consumer Survey, as well as the Youth Services Survey (YSS) for Youth and Youth Services Survey for Families (YSS-F). Additionally, Performance Outcomes Steering Committee members recognized the importance of collecting quality of life data as a mental health outcome for adults, as well as older adults, and advocated for the

development of two somewhat different Quality of Life (QOL) measures, tailored to the specific needs of each population. Collectively, these instruments assess consumers' perceptions of quality and outcomes of care, and are currently being used for broad-based evaluation of California's community-based mental health services. All instruments are currently available in English and Spanish, and translations of the surveys into other languages are underway in order to accommodate the language needs of California's diverse mental health consumer population.

An additional improvement was the use of on-line, internet-based data capture methods that allow direct key-pad data entry and provides a paper-form scanning and verification option for larger volume direct data submission. This new data entry and submission technology provides flexibility for system users, while increasing data uniformity and accuracy.

Data that are transferred to CDMH via the new technology are housed in a single database, and are therefore quickly available for centralized data analysis, and for return to counties for local processing. Quick data analytic turn-around time allows CDMH, other oversight entities, and interested stakeholders to maintain a "pulse" on the mental health system's performance, and to make administrative decisions/apply quality improvement strategies in a timely manner.

CDMH continues to perceive the performance outcomes measurement process as being tied to a continuous quality improvement process and, consequently, data elements and methods of evaluation are necessarily subject to change. As such, this new technology provides low-cost flexibility to accommodate changes over time.

CDMH envisions applicability of the system to numerous future data capture endeavors. These include performance outcome indicators derived through national stakeholder processes (e.g., requirements for Federal Block Grant Performance Partnership reporting), collaborative performance measurement activities between DMH and other State departments, (e.g., Department of Rehabilitation, Department of Alcohol and Drug Programs, etc.) and special studies designed to evaluate specialty mental health programs and/or integrated system services for targeted mental health populations (e.g., Children's System of Care, Older Adult System of Care, etc.).

Electronic copies are available and can be downloaded at:

<http://www.dmh.ca.gov/POQI/History & Legislation Introduction.asp>

External Quality Review of Mental Health Plans: Performance Protocol

In response to recent changes in Medicaid managed care regulations, the CDMH must provide for annual external quality review of the quality, outcomes, timeliness of and access to services provided by (County) Mental Health Plans (MHPs). Specifically, MHPs must gather data for the calculation of Performance Measures (PMs) designated by CDMH. These PMs must be annually validated and reviewed by an External Quality Review Organization (EQRO).

The purpose of mental health care PMs is to assess and improve care processes and thereby improve outcomes of care. In order for such measures to achieve real improvements in care, and for interested parties to have confidence in the reported improvements, PMs must be designed, conducted and reported in a methodologically sound manner. To achieve this goal, this PM Protocol identifies procedures for an EQRO to use in its validation of MHP PMs.

In California, MHPs claim Federal Financial Participation (FFP) on a cost basis. Claims are submitted to CDMH based on services delivered. CDMH pays the county claims and uses approved claims data to calculate performance measures for each MHP. Therefore, in order to validate the accuracy of the PMs, the EQRO will need to validate both the processes and information used by CDMH to develop and calculate the performance measures, and the MHP information systems upon which this data is based. This means that the review of performance measurement activities contained in this protocol will take place at both CDMH and the MHPs.

The EQRO will objectively assess quality, outcomes, timeliness of, and access to the services provided by California's MHPs that contract with the CDMH to provide Medi-Cal specialty mental health services to Medi-Cal eligible individuals. To make this assessment, the EQRO will conduct annual external quality reviews that include but not limited to:

- Assessment of DMH-specified performance measures
- Assessment of MHP-selected Performance Improvement Projects, which are studies designed to assess and improve care processes and thereby improve outcomes of care
- Periodic evaluation of selected aspects of each MHP's ongoing internal Quality Improvement system and annual review of each MHP's progress on any related plans of correction
- Review of each MHP's health information system capability to meet the requirements of the Medi-Cal specialty mental health services program
- Review of each MHP's most recent compliance review performed by the CDMH Program Compliance Division, Medi-Cal Oversight Unit, and each MHP's progress on any related plans of correction.

It will also be necessary to verify that the MHP is in compliance with the required elements for a health information system in Medicaid managed care regulations and to develop an appropriate Information System Capabilities Assessment (ISCA) protocol for the MHPs that will include the validation of encounter data. This ISCA protocol will be used to assess the MHP's Information System in future years.

The purpose of the PM Protocol is to assist the EQRO to accomplish the following:

1. Review of the data management processes of DMH and the MHPs.

2. Evaluation of the translation of captured data into actual statistics by DMH.
3. Verification of the DMH-specified PMs to confirm that the reported results are based on accurate source information.
4. Verification that MHPs are in compliance with the basic required elements for a health information system under 42 CFR 438.242.
5. Development of an MHP ISCA protocol for DMH approval.

The protocol consists of three phases of tasks: Pre-Onsite, Onsite, and Post-Onsite activities. Each of these phases will apply to both DMH and each of the MHPs. For each of these phases, the PM Protocol specifies outcomes or objectives and lists the activities to be performed. Methods of evaluation are suggested and tools and worksheets are provided throughout the PM Protocol and as attachments.

Pre-Onsite activities involve:

1. Communicate with DMH to ensure that the EQRO understands:
 - The measures to be validated.
 - The methodology(ies) DMH has used to calculate and report the performance measures.
2. Develop schedules and preparing DMH and the MHP for onsite activities:
 - Communicating with the identified DMH and MHP contact person.
 - Indicating, in writing, to DMH and the MHP the EQRO's requirements for the conduct of the assessment including anticipated time on-site, space needs and preliminary data and documentation needs.
 - Communicating the EQRO's policies and procedures with respect to safeguarding confidential information.
 - Identifying, prior to the site visits, probable key staff to be interviewed.
3. Identifying the appropriate stakeholders to be involved in the development of an appropriate assessment protocol for assessing an MHP's underlying information system (IS), and/or reviewing the results of any prior assessment that has been done for an MHP.

Onsite Activities include activities onsite at both DMH and at individual MHPs. They focus on: 1) validating the data for performance measures by DMH through observation of documentation or procedures; and (2) verifying that the MHP is in compliance with the required elements for a health information system and gathering the information

necessary in Year One to develop an appropriate MHP “Information System Capabilities Assessment” (ISCA) protocol which will include validation of the encounter data upon which the MHP’s claims are based. These activities include:

For DMH:

1. Reviewing and assessing the procedures DMH has in place for integrating eligibility and claims information.
2. Evaluating processes used by the DMH to produce PMs, e.g., calculating denominators and numerators.

For the MHP:

1. Reviewing the procedures the MHP has in place for collecting and/or integrating mental health service, financial, eligibility and service provider information, covering service-related data, from internal and external sources.
2. Verifying that the MHP currently has an Information System that meets the basic required elements of a health information system as described in 42 CFR Section 438.242.
3. Working with the MHP and other stakeholders to develop an appropriate ISCA protocol.

To accomplish these activities, the EQRO reviews DMH and MHP policy and procedure manuals and documents, observes required activities, and conducts interviews with key DMH PM staff and MHP staff such as Information Systems, Fiscal and Quality Improvement staff.

Post-Onsite Activities focus on the analysis of the data and information obtained through Pre-Onsite and Onsite activities, and submission of the validation report, the MHP ISCA protocol and supporting documentation to DMH following its format and time frames. These activities include:

1. Evaluating gathered information and preparing a report of preliminary findings on the validation of PMs and the status of each MHP’s compliance with the required basic elements of a health information system.
2. Submitting reports of preliminary findings identifying areas of concern to DMH and the MHPs.
3. Submitting a draft ISCA protocol to DMH and the MHPs.
4. Evaluating DMH and MHP comments concerning the preliminary findings and the draft ISCA protocol to assure accuracy and completeness of findings.
5. Evaluating gathered information and preparation of findings for DMH.
6. Submitting reports and the ISCA protocol to DMH.

The EQRO will prepare a report annually on each MHP that comprehensively assesses the overall performance of the MHP in providing mental health services to Medi-Cal beneficiaries. The individual reports on MHPs will utilize the EQRO's own assessment of each MHP in light of the review components described above. The EQRO will also prepare an aggregate report for the State based on the information gained in the assessments of the individual MHPs.

The EQRO will provide up to four hours of technical assistance and consultation for each MHP annually. The intent of this activity is to meet the individualized quality improvement needs of each MHP and to maximize the utility of the external review activity as a quality improvement learning experience.

Electronic copies are available and can be downloaded at:

http://www.dmh.ca.gov/Laws_and_Regulations/docs/EQRO_contract/APS%20EXHIBIT%20A%20Attach1%20&%202.pdf

Department of Auditor–Controller Quality Improvement Protocol

The Countywide Contract Monitoring Division of the County of Los Angeles, Department of Auditor–Controller completes contract compliance reviews for program and fiscal contract monitoring. Their review methodology includes Quality Improvement for:

1. Does your Agency have a QI Program? If so, please attached your Program description.
2. Who administers the QI program and what are their credentials? Attach a copy of any licensed.
3. Does your Agency have a copy of the LA County DMH QI Work Plan? If so, please show us your copy.
4. Does your Agency attend the DMH Service Area QIC meetings at least quarterly? If so, list the staff and dates they attended for the last two quarters.
5. Does your Agency review charts to ensure compliance and quality of care? If yes, please provide us with a copy of your utilization review tool/form and expected criteria.
6. How often and how many charts are reviewed during this process?
7. Does your Agency communicate the results of the chart reviews to therapists and supervisors? If so, explain the process.
8. What is the process for communicating results on an organizational level to management? What organizational changes have been made as a result of your QI Program?

Performance Outcomes and California Regulations

WELFARE & INSTITUTIONS CODE
DIVISION 4. MENTAL HEALTH
PART 1. GENERAL ADMINISTRATION, POWERS AND DUTIES
OF THE DEPARTMENT
CHAPTER 2. PLANNING, RESEARCH, EVALUATION AND QUALITY
ASSURANCE
(Effective June 30, 1991)

4031. The State Department of Mental Health shall to the extent resources are available, do all of the following:

- (a) Conduct, sponsor, coordinate, and disseminate results of research and evaluation directed to the public policy issues entailed in the selection of resource utilization and service delivery in the state.
- (b) Make available technical assistance to local mental health programs incorporating the results of research, evaluation, and quality assurance to local mental health programs.
- (c) Implement a system of required performance reporting by local mental health programs.
- (d) Perform any other activities useful to improving and maintaining the quality of state mental hospital and community mental health programs.

4032. The department shall, when appropriate, give and receive grants and contracts for research, evaluation, and quality assurance efforts.

4033. (a) The State Department of Mental Health shall, to the extent resources are available, comply with federal planning requirements. The department shall update and issue a state plan which may also be any federally required state service plan, so that citizens may be informed regarding the implementation of, and long-range goals for, programs to serve mentally ill persons in the state. The department shall gather information from counties necessary to comply with this section.

4040. The State Department of Mental Health may conduct, or contract for, research or evaluation studies which have application to policy and management issues. In selecting areas for study the department shall be guided by the information needs of state and local policymakers and managers, and suggestions from the California Conference of Local Mental Health Directors.

4041. The department shall serve as a clearinghouse for information on research and evaluation studies relevant to mental health. The department shall review and disseminate the results of local, state, and national research and evaluation studies that have important implications for mental health policy or management.

APPENDIX A

SECTION A ACCESS

IN COMPLIANCE INSTRUCTIONS TO REVIEWERS COMMENTS

CRITERIA

| | IN COMPLIANCE | Y | N | COMMENTS |
|---|---------------|---|---|---|
| <p>1. Does the Mental Health Plan (MHP) provide beneficiaries with a current list of its providers upon first receiving a Specialty Mental Health Service (SMHS) and thereafter upon request?</p> | | | | <p>NOTE: How does the MHP ensure that this requirement is met?</p> <ul style="list-style-type: none"> Review provider list and issuance upon first receiving a SMHS and upon request. Does the MHP have Policies and Procedures (P&Ps) to address this? |
| <ul style="list-style-type: none"> <u>CFR, Title 42, Section 438.10(f)(3)(6)(i)</u> <u>CCR, Title 9, Chapter 11, Sections 1810.360(d) and 1810.110</u> | | | | <p>OUT OF COMPLIANCE:</p> <ul style="list-style-type: none"> No evidence that the MHP is providing a current provider list to beneficiaries upon first receiving a Specialty Mental Health Service. Evidence reviewed indicates the MHP does not provide a current provider list upon request. |
| <p>Documentation: (List document(s) reviewed that demonstrates compliance and provides specific explanation of reason(s) for in compliance or out of compliance.)</p> | | | | |
| <p>2. Regarding the provider list:</p> | | | | <p>NOTE: When reviewing larger counties, a regionalized provider list is ok. The provider list can include organizational, group, and individual providers.</p> <ul style="list-style-type: none"> At a minimum, the services are to be categorized by psychiatric inpatient hospital, targeted case management, and/or all other SMHS. |
| <p>2a. Does the list contain the names, locations, and telephone numbers of current contracted providers in the beneficiary's service areas by category?</p> | | | | |

SECTION A **ACCESS**

IN COMPLIANCE

COMMENTS

Y N

CRITERIA

| 2b. | | | Does the provider list include alternatives and options for cultural/linguistic services? | <p>NOTE: Refer to MHP's Cultural Competence Plan Requirements (CCPR) for the definition of ethnic, racial, culture-specific specialties.</p> <ul style="list-style-type: none"> Review provider list and check for cultural/linguistic services on list. Look for ethnic specific providers. |
|--|--|--|---|---|
| 2c. | | | When applicable, does the provider list identify providers that are not accepting new beneficiaries? | <p>NOTE: The MHP may use means other than the provider list to identify providers that are not accepting new beneficiaries.</p> |
| <ul style="list-style-type: none"> <u>CFR, Title 42, Section 438.10(f)(6)(i)</u> | | | | <p>OUT OF COMPLIANCE:</p> <ul style="list-style-type: none"> The provider list does not contain the names, addresses, telephone numbers, cultural/linguistic alternatives and options. The provider list does not contain minimum required categories. No means to identify providers who are not accepting new beneficiaries |
| <p>Documentation: (List document(s) reviewed that demonstrates compliance and provides specific explanation of reason(s) for in compliance or out of compliance.)</p> | | | | |
| 3. | | | Is there evidence that the MHP is making efforts to include culture-specific providers and services in the range of programs offered? | <p>NOTE: Does the MHP have evidence of mechanisms in place to track progress for the inclusion of culture-specific providers and services in the range of programs offered? Tracking may include increases or reductions in culture-specific providers.</p> |
| <ul style="list-style-type: none"> <u>CFR, Title 42, Section 438.206(c)(2)</u> <u>CCR, Title 9, Chapter 11, Section 1810.110(a)</u> <u>DMH Information Notice No. 02-03, Enclosure, Page 20</u> | | | | <p>OUT OF COMPLIANCE:</p> <ul style="list-style-type: none"> No evidence the MHP is making efforts to include culture-specific providers and services |

SECTION C **BENEFICIARY PROTECTION**

INSTRUCTIONS TO REVIEWERS
COMMENTS

IN COMPLIANCE
Y N

CRITERIA

| | | | NOTE: Review the procedures in place. |
|--|--|--|--|
| 1. | Regarding notice to the Quality Improvement Committee (QIC) and subsequent action: | | |
| 1a. | Does the MHP have procedures by which issues identified as a result of the grievance or appeal processes are transmitted to the MHP's QIC, the MHP's administration or another appropriate body within the MHP's organization? | | |
| 1b. | When applicable, has there been subsequent implementation of needed system changes? | | |
| • | CCR Title 9, Chapter 11, Section 1850.205(c)(7) | | <p><u>OUT OF COMPLIANCE:</u></p> <ul style="list-style-type: none"> • The MHP does not have procedures in place. • Evidence procedures not being followed • Implementation of needed system changes not taking place |
| <p>Documentation: (List document(s) reviewed that demonstrates compliance and provides specific explanation of reason(s) for in compliance or out of compliance.)</p> | | | |
| 2. | Does the MHP maintain a grievance and appeal log(s) that contains, at least, the following entries? | | <p><u>NOTE:</u> Verify information is present for each grievance and appeal.</p> |
| 2a. | The name/identifier of the beneficiary. | | |
| 2b. | The date of receipt of the grievance/appeal. | | |
| 2c. | The nature of the problem. | | |
| • | CCR, Title 9, Chapter 11, Section 1850.205(d)(1) | | <p><u>OUT OF COMPLIANCE:</u></p> <ul style="list-style-type: none"> • NFP • Log(s) does not contain this information on all grievances and appeals. |

SECTION H QUALITY IMPROVEMENT

**IN COMPLIANCE INSTRUCTIONS TO REVIEWERS
Y N COMMENTS**

CRITERIA

| | | | |
|---|--|--|---|
| 1. | Is the QIC involved in or overseeing the following QI activities? | | NOTE: Review minutes for evidence of each activity described in a-d. |
| 1a. | Recommending policy changes. | | |
| 1b. | Reviewing and evaluating the results of QI activities. | | |
| 1c. | Instituting needed QI actions. | | |
| 1d. | Ensuring follow-up of QI processes. | | |
| • | <u>CCR Title 9, Chapter 11, Section 1810.440</u> | OUT OF COMPLIANCE: | |
| • | | • NFP | |
| • | | • There is no evidence that the QIC is involved in and overseeing activities described in a-d. | |
| Documentation: (List document(s) reviewed that demonstrates compliance and provides specific explanation of reason(s) for in compliance or out of compliance.) | | | |
| 2. | Regarding the annual QI work plan: | | The following information applies to items a-b: |
| 2a. | Does the MHP evaluate the effectiveness of the QI program and show how QI activities have contributed to improvement in clinical care and beneficiary service? | | NOTE: Review the QI work plan. |
| 2b. | Does the MHP incorporate relevant cultural competent and linguistic standards in the annual QI work plan? | | |

SECTION H QUALITY IMPROVEMENT

**IN COMPLIANCE
Y N**

**INSTRUCTIONS TO REVIEWERS
COMMENTS**

CRITERIA

| | | | |
|-----|--|--|--|
| 4. | Does the QI work plan include goals and monitoring activities and is the MHP conducting activities to meet the following work plan areas? | | <p><u>The following information applies to items a-c:</u></p> <p><u>NOTE:</u> MHP should have baseline statistics with goals for the year.</p> |
| 4a. | <p>Monitoring the service delivery capacity of the MHP as evidenced by:</p> <p>1) A description of the current number, types, and geographic distribution of mental health services within the MHP's delivery system.</p> | | |
| | 2) Goals are set for the number, type, and geographic distribution of mental health services. | | |
| 4b. | <p>Monitoring the accessibility of services as evidenced by:</p> <p>In addition to meeting statewide standards, goals have been set and mechanisms have been established to monitor the following:</p> <p>1) Timeliness of routine mental health appointments.</p> | | <p><u>NOTE:</u> Review P&Ps.</p> <ul style="list-style-type: none"> • Goals should be set for 4b. (1-4). • Mechanisms for monitoring should be in place for 4b. (1-4). • Does the MHP test call its toll-free number for 4b. (1-4)? |
| | 2) Timeliness of services for urgent conditions. | | |
| | 3) Access to after-hours care. | | |
| | 4) Responsiveness of the 24/7 toll-free number. | | |

SECTION H **QUALITY IMPROVEMENT**

IN COMPLIANCE
Y N

INSTRUCTIONS TO REVIEWERS
COMMENTS

CRITERIA

| 4c. | Monitoring beneficiary satisfaction as evidenced by: | | | | | | <p><u>The following information applies to items 1-6:</u></p> <p><u>NOTE:</u> How are providers informed?</p> |
|-----|--|--|--|--|--|--|--|
| | 1) Annual survey of beneficiary satisfaction. | | | | | | |
| | 2) Annual evaluation of beneficiary grievances and fair hearings. | | | | | | |
| | 3) Annual review of requests for changing persons providing services. | | | | | | |
| | 4) Providers are informed of the results of the beneficiary/family satisfaction surveys. | | | | | | |
| | 5) Completion of a consumer satisfaction survey in the threshold languages. | | | | | | <ul style="list-style-type: none"> Refer to DMH Information Notice No. 02-03, Enclosure, Page 19 for Question 4c. 5. and 6. |
| | 6) Satisfaction surveys, in each threshold language, indicated that, at least, 75% of the respondents had access to written information in their primary language. | | | | | | |
| 4d. | Monitoring the MHP's service delivery system as evidenced by: | | | | | | |
| | 1) Relevant clinical issues, including the safety and effectiveness of medication practices, are identified? | | | | | | |

APPENDIX B



PARTNERSHIPS FOR QUALITY

California's Statewide Quality Improvement System

May 2005

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Table of Contents

| | |
|--|----|
| What is Quality? | 1 |
| Quality Assurance versus Quality Improvement | 3 |
| Roles and Responsibilities of Partners for Quality | 4 |
| California Department of Mental Health | 4 |
| Systems of Care | 4 |
| Medi-Cal Policy and Support Section | 6 |
| Office of Multicultural Services | 10 |
| Local County Mental Health Programs | 11 |
| Quality Improvement Operations | 11 |
| Mental Health Boards and Commissions | 14 |
| California Mental Health Directors Association..... | 14 |
| Quality Improvement/Compliance Subcommittee | 14 |
| California Institute for Mental Health..... | 14 |
| California Mental Health Planning Council | 15 |
| Quality Improvement Committee | 15 |
| External Review Organizations | 16 |
| Joint Commission on Accreditation of Healthcare Organizations (JCAHO)..... | 16 |
| Department of Justice (DOJ) Civil Right Division, Special Litigation Section | 16 |
| Department of Finance Office of State Audits and Evaluations..... | 16 |
| Little Hoover Commission (LHC)..... | 17 |
| Bureau of State Audits..... | 17 |
| Protection and Advocacy, Inc. (PAI)..... | 17 |
| External Consumer, Family and Professional Organizational Partners..... | 17 |
| Future Projects | 18 |
| Appendix A..... | 19 |

The California Mental Health Planning Council (CMHPC) is mandated in federal and state statute to provide oversight of the public mental health system. As a part of this responsibility, it convened a work group to study the State's quality improvement activities. This paper describes quality improvement system functions and oversight roles. It also describes the roles and responsibilities of each group in the public mental health system involved in quality improvement activities. The last section discusses future activities that the CMHPC proposes to undertake regarding this project.

What is Quality?

What is quality? Is quality in healthcare something different or unique? How do we recognize or measure quality? Are there special concerns in thinking about quality in mental healthcare systems? And what is value? What is the relationship between quality and value?

These seemingly simple questions are, in truth, difficult to answer. The Oxford English Dictionary defines quality as "the degree of excellence or superiority that an object or service possesses." Although this may be helpful as a starting point, it does not entirely answer the questions posed above.

In the late 1960s, Avedis Donabedian from the University of Michigan, School of Public Health, developed a definition of healthcare quality that has been the prevailing paradigm for most of the last half of the 20th Century. He defined three essential components of quality, which included structure, process, and outcome. Structure refers to the various preconditions of providing healthcare—often literally referring to the physical structure, as well as other resources required to provide services. Process refers to the actual provision of care and implies the importance of the experience of the client. Lastly, outcome refers to the actual impact or change brought about as a result of healthcare interventions.

Donabedian recognized that outcomes are extremely difficult to measure and perhaps were the most problematic of this tripartite definition. In more recent years, and probably influenced by the managed care initiatives in this country, access came to be identified as a fourth essential component of quality, one that Donabedian had not anticipated. One could argue that access is embedded within structure, process, and outcome, but it has become such a critical component of quality that it is frequently addressed separately.

Managed care has challenged and redefined quality in many ways. Derived largely from an economic model or perspective, the prevailing model for quality has become:

$$\text{Value} = \frac{\text{Quality}}{\text{Cost}}$$

This equation suggests that as quality increases value also increases and that increasing cost without changes in quality can quickly erode value. The algebraic conversion of this equation makes quality a product of cost multiplied by value, and it may accurately depict how quality factors into the healthcare market and purchasing decisions.

By the mid-1990s, it became increasingly clear that the American healthcare system was rapidly failing and that neither the Donabedian paradigm nor the managed care economic

model was producing the experience of quality in healthcare that the American public both wanted and deserved. In 2001, the Institute of Medicine (IOM) issued its report entitled, *Crossing the Quality Chasm*, in which it proposed a new paradigm for healthcare quality. The IOM defined quality as “the degree to which health services for individuals and populations increase the likelihood of desired healthcare outcomes and are consistent with current professional knowledge” (p. 232). The IOM identified six core aims and stated that healthcare could be experienced as:

- ◆ Safe
- ◆ Timely
- ◆ Effective
- ◆ Efficient
- ◆ Person and family centered
- ◆ Equitable

This approach has engendered a tremendous amount of interest and positive response from multiple stakeholders in American healthcare and is quickly moving to replace the Donabedian model as the new prevailing and defining paradigm.

In 2002 the American College of Mental Health Administration (ACMHA) began to explore how this new approach could apply and be relevant to concerns about quality in mental health systems. Building upon that initial work, the California Department of Mental Health’s (DMH) State Quality Improvement Council (SQIC) convened a workgroup to explore how the quality chasm model could be used as a core framework for evaluating quality in the State’s mental health system. In order to make the IOM’s six aims relevant, a small group of stakeholder representatives developed the following modified definitions of each aim:

- ◆ Safe
Services are provided in an emotionally and physically safe, compassionate, trusting, and caring treatment/working environment for all clients, family members, and staff.
- ◆ Timely
Goal-directed services are promptly provided in order to restore and sustain clients’ and families’ integration in the community.
- ◆ Effective
Up-to-date, evidence-based services are provided in response to and respectful of individual choice and preference.
- ◆ Efficient
Human and physical resources are managed in ways that minimize waste and optimize access to appropriate treatment.
- ◆ Person and Family Centered

A highly individualized, comprehensive approach to assessment and services is used to understand each individual's and family's history, strengths, needs, and vision of their own recovery, including attention to the issues of culture, spirituality, trauma, and other factors. Service plans and outcomes are built upon respect for the unique preferences, strengths, and dignity of each person.

◆ Equitable

Access and quality of care do not vary because of client or family characteristics, such as race, ethnicity, language, age, gender, religion, sexual orientation, disability, diagnosis, geographic location, socioeconomic status, or legal status.

These new definitions seem to resonate well with stakeholders and have been endorsed by the SQIC as a model for moving forward and evaluating quality and performance within the California mental health system. The challenge that remains is the development of indicators, measures, and data to help evaluate performance and improvement over time within these six aims.

Although all the aims are essential and interrelated, one stands alone in its primacy: being person and family centered. Donald Berwick, MD, from the Institute for Healthcare Improvement, has emphasized that the aims alone are not sufficient and that they must be kept in context. The ultimate measure of quality lies in the experience of individuals and communities. This is as true for the mental healthcare system as it is for the general healthcare system: the ultimate defining experience and determination of quality lies with the individual and family receiving care and services. A critical component of being person-centered is the ability to respond sensitively and competently to the linguistic preferences and cultural context of multi-cultural and diverse communities in their interaction with the mental health system. Taking steps to establish systems-level accountability is important; however, it is essential to incorporate a person- and family-centered approach to care and the evaluation of quality in all healthcare delivery.

Quality Assurance versus Quality Improvement

Quality assurance is usually associated with monitoring compliance with regulations. It provides a floor or minimum standard for achieving a basic level of quality in the public mental health system. Examples of quality assurance activities would be performing chart reviews to ensure that clinicians have written progress notes in charts when they provide mental health services or verifying that a licensed mental health professional has signed a client's treatment plan. The Medi-Cal Managed Care On-site Reviews that the Department of Mental Health (DMH) conducts are also quality assurance activities.

Quality improvement is a process whereby a mental health provider continuously works to enhance the quality of its mental health services above the basic level of quality achieved by its quality assurance activities. Quality improvement is achieved by setting goals and objectives, developing performance indicators to measure the objectives, and collecting data on system performance. The results are then analyzed and fed back to program planners and service providers so that services can be modified, if necessary, so they better achieve the program's goals. Other tools that are used for quality

improvement are focus groups and various special studies to review aspects of programs that cannot be measured using quantitative data.

Roles and Responsibilities of Partners for Quality

Figure 1 provides an organization chart identifying all the major entities that have a role in quality improvement in the State's public mental health system.

California Department of Mental Health

The Department of Mental Health provides leadership of California's mental health system and ensures through partnerships the availability of effective, efficient, culturally competent services. This goal is accomplished by advocacy, education, innovation, outreach, understanding, oversight, monitoring, quality improvement, and the provision of direct services. The DMH has oversight of a public mental health budget of more than \$3 billion and provides services in four broad areas:

- ◆ System leadership for state and local county mental health departments
- ◆ System oversight, evaluation, and monitoring
- ◆ Administration of federal funds
- ◆ Operation of four state hospitals and inpatient psychiatric programs in two state prisons

The next section describes units of the DMH that have responsibilities that relate to quality improvement functions.

Systems of Care

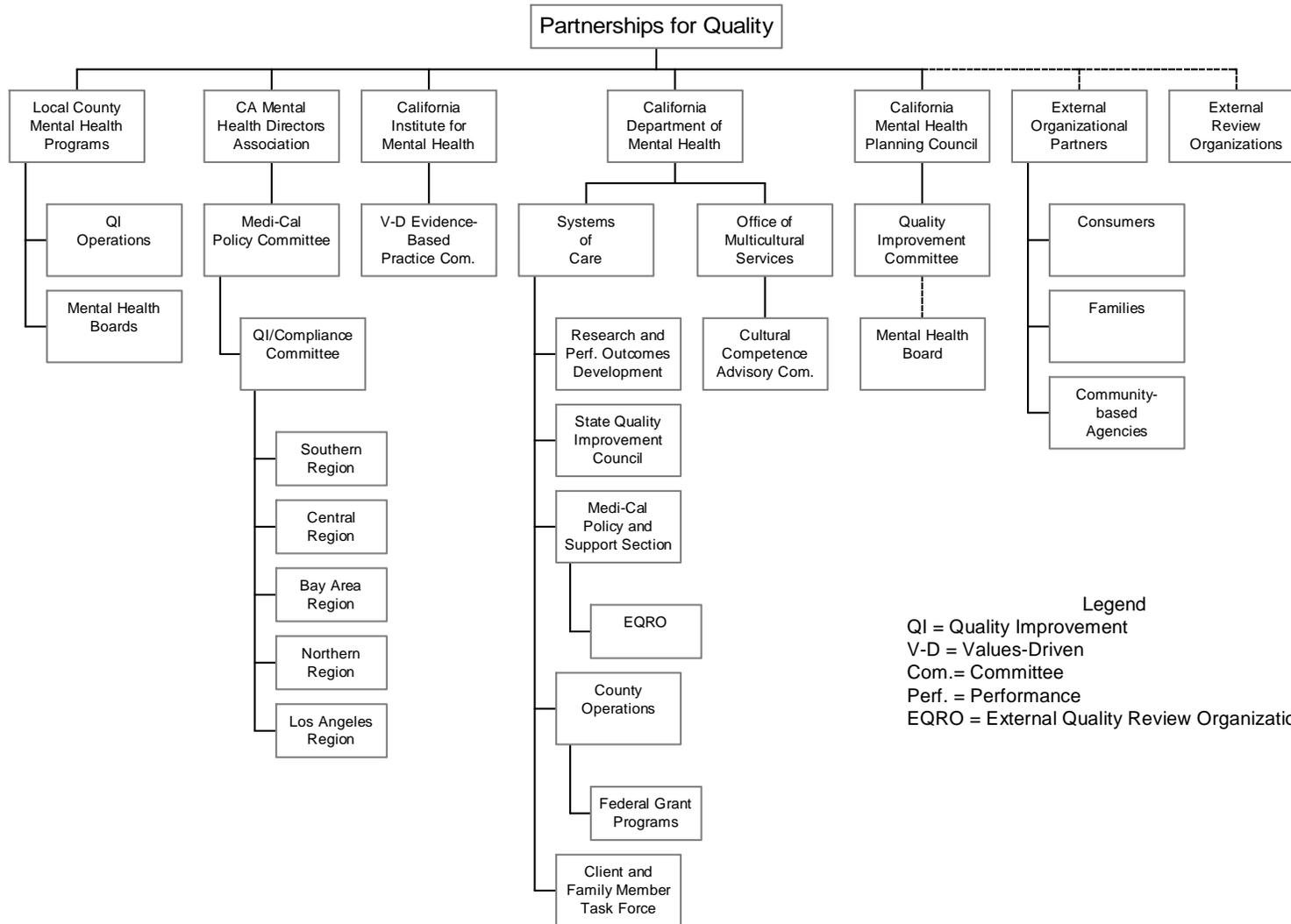
Systems of Care encompass the array of functions pertaining to California's Systems of Care for persons with mental illnesses. It develops, evaluates, monitors, and supports coordinated services that deliver care to adults and older adults who have serious mental illnesses and to children who have serious emotional disturbances. It also does planning, development, and evaluation for public mental health programs. It includes a number of units that perform quality improvement functions. It also has several advisory groups that report to it that have quality improvement responsibilities.

Performance Outcomes and Quality Improvement Development

The Research and Performance Outcomes Development unit is responsible for planning and implementing California's statewide public mental health performance outcome systems. These systems are the result of a collaborative effort between the DMH, the CMHDA, and the California Mental Health Planning Council (CMHPC). The goal of California's performance outcome system is to facilitate a process whereby mental health clients and their families receive the highest quality and most effective services in a manner that both empowers and respects them as individuals.

State Quality Improvement Council

The State Quality Improvement Council (SQIC) states that its mission is "to assure a collaborative, accessible, responsive, efficient, and effective mental health system that is culturally competent, client and family oriented, and age appropriate by the



implementation of quality improvement methodologies.” It was recognized by statute in Welfare and Institutions Code Section 5614.5 in 2000; however, it had been established administratively in 1999. The statute specifies that it shall include representatives of the CMHPC, local mental health departments, consumers, family members, and other stakeholders. In addition, the statute specifies the type of performance indicators that should be developed, including those measuring structure; process, which is comprised of access, appropriateness, and cost-effectiveness; and outcomes.

The SQIC is also part of the DMH’s process for complying with the quality improvement requirements of the Medi-Cal Managed Care Waiver. Much of the work that the group did during its first years focused on the administrative data sets, such as the Medi-Cal Claims data, and analyzed access to Medi-Cal services. The SQIC also has three work groups that perform special studies on issues that require working with more than administrative data sets:

- ◆ The Inpatient Treatment Review Work Group
- ◆ The Community Mental Health Services Work Group
- ◆ The IOM *Crossing the Quality Chasm* Work Group

The Inpatient Treatment Review Work Group completed a special study on the rate of rehospitalization at 30 days and 180 days post-discharge. This study reported on statewide data and studied rehospitalization rates in ten counties from fiscal year 1993-1994 to 1999-2000. That committee is now focusing on utilization of inpatient services by African Americans. The Community Mental Health Services Work Group conducted a special study on the timeliness of follow-up appointments after initial routine outpatient assessments. The IOM *Crossing the Quality Chasm* Work Group adapted an innovative paradigm for quality improvement developed by the Institute for Medicine to apply to the mental health system.

Medi-Cal Policy and Support Section

The Medi-Cal Policy and Support Section has as its major responsibility oversight and quality assurance in the implementation of the Medi-Cal managed care program. Each county contracts with the DMH to provide medically necessary specialty mental health services to its beneficiaries. Provision of Medi-Cal services is governed by state regulations in Title 9, California Code of Regulations, Division 1, Chapter 11. The Medi-Cal Policy and Support Section provides policy clarification to the mental health plans and information notices that relate to quality improvement issues and cultural competence requirements. This Section is also responsible for drafting the Medi-Cal Managed Care Waiver related to freedom of choice under which the State of California operates its Medi-Cal program. In addition, the Medi-Cal Policy and Support Section is responsible for implementing new federal Medicaid regulations promulgated by the Centers for Medicaid and Medicare Services in June 2002 and January 2003 that require the DMH to implement new quality improvement processes for the Medi-Cal program.

External Quality Review Organization

One new requirement in the Medicaid regulations is establishment of external quality reviews to enhance the DMH’s ability to evaluate the quality improvement programs of

each Mental Health Plan (MHP). The Medi-Cal Policy and Support Branch is responsible for implementation of this new requirement. Through a Request for Proposal process, the DMH selected APS Healthcare (APS) as the External Quality Review Organization (EQRO).

The EQRO will objectively assess quality, outcomes, timeliness of, and access to the services provided by California's MHPs that contract with the DMH to provide Medi-Cal specialty mental health services to Medi-Cal eligible individuals. To make this assessment, the EQRO will conduct annual external quality reviews that include:

- ◆ Assessment of DMH-specified performance measures
- ◆ Assessment of MHP-selected Performance Improvement Projects, which are studies designed to assess and improve care processes and thereby improve outcomes of care
- ◆ Periodic evaluation of selected aspects of each MHP's ongoing internal Quality Improvement system and annual review of each MHP's progress on any related plans of correction
- ◆ Review of each MHP's health information system capability to meet the requirements of the Medi-Cal specialty mental health services program
- ◆ Review of each MHP's most recent compliance review performed by the DMH Program Compliance Division, Medi-Cal Oversight Unit, and each MHP's progress on any related plans of correction

The EQRO will prepare a report annually on each MHP that comprehensively assesses the overall performance of the MHP in providing mental health services to Medi-Cal beneficiaries. The individual reports on MHPs will utilize the EQRO's own assessment of each MHP in light of the review components described above. The EQRO will also prepare an aggregate report for the State based on the information gained in the assessments of the individual MHPs.

The EQRO will provide up to four hours of technical assistance and consultation for each MHP annually. The intent of this activity is to meet the individualized quality improvement needs of each MHP and to maximize the utility of the external review activity as a quality improvement learning experience.

Because of the unique nature of the Medi-Cal managed mental healthcare system, calculation of performance measures is done by the DMH using claims data obtained from the MHPs. Thus, in order to assess MHP performance fully, the EQRO will review and assess various DMH data systems and processes in addition to the MHP's systems for reporting claims data. The EQRO will prepare an annual report that comprehensively assesses the overall performance of the DMH in this capacity.

The first year of reviews will utilize protocols for validation of performance measures and performance improvement projects and an information system assessment instrument developed by the DMH in addition to any review protocols or instruments developed by the EQRO for use in other areas of the review. In subsequent years, the EQRO will work with the DMH, MHPs, and other stakeholders to edit as necessary protocols and information system assessment instruments developed by the DMH to maximize their

effectiveness in collecting pertinent information to meet regulatory requirements and to adapt their content to the California public mental health system.

In order to accomplish these goals successfully, the EQRO will be required to work closely with the DMH Contract Administrator and other key DMH staff as needed to plan and coordinate activities. The EQRO will also be expected to attend up to four statewide meetings annually to provide training and technical assistance on the external quality review process to MHPs and other stakeholders. Periodic status reports will be required by the DMH.

County Operations

From a broad perspective, the primary goals and objectives of the DMH County Operations Sections include assisting and supporting California's county-organized local mental health programs in meeting their programmatic goals to provide high quality public mental healthcare. This assistance and support occurs primarily through established collaborative relationships with ongoing close communications between County Operations staff and the administrative staff of each local mental health program. In its day-to-day functioning, County Operations staff provide consultative and technical assistance services to local mental health programs in a wide variety of subject areas from Medi-Cal specialty managed mental health services to the Substance Abuse Mental Health and Services Administration (SAMHSA) Block Grant and from contract monitoring to policy, fiscal, and regulatory issues. It also performs the following functions related to quality improvement:

- ◆ Advocating for and contributing to the DMH's efforts in promoting and embedding cultural competency and the recovery vision within county mental health programs
- ◆ Facilitating timely and accurate county program reporting, including Cultural Competence Plan annual updates, annual beneficiary grievance summary reports, and Annual Quality Improvement Work Plans
- ◆ Assisting county mental health programs in achieving quality improvement goals, such as coordinating and providing consultative services to counties during their strategy development and implementation of plans of correction as well as other corrective measures

The sections are currently developing their conception of their role with the EQRO. It envisions that it may perform some of the following functions for the DMH:

- ◆ Providing technical assistance to counties to promote the overall state quality improvement framework
- ◆ Complementing APS's role in external quality review
- ◆ Being liaison between counties, the DMH contract administrator, and APS. County Operations functions as the primary conduit for communications and relationships with the counties
- ◆ Identifying, coordinating, and providing telephone and onsite pre-visit and follow-up

- ◆ Assisting counties to understand requirements and to implement Performance Improvement Projects

Federal Grant Programs

The DMH is responsible for securing and ensuring the continuation of federal grant funds. All tasks related to the administration of federal funds, such as utilization review, quality management, and cost reporting and settlement are included in this category. Two such federal programs are the Substance Abuse and Mental Health Services Administration (SAMHSA) Block Grant and the Projects for Assistance in Transition from Homelessness (PATH) formula grants.

The Center for Mental Health Services, which is part of SAMHSA, awards the Community Mental Health Services Block Grant to states each fiscal year. In fiscal year 2004-05, California is receiving \$54.4 million, which is allocated to the 58 county mental health programs. The block grant is used to provide comprehensive community mental health services to children with serious emotional disturbances and adults and older adults with serious mental illnesses. The block grant funds are allocated through both a competitive process and an annual allocation process to the counties. Counties submit applications to the DMH for the programs that they intend to fund with their SAMHSA allocation. The DMH assures the quality of the SAMHSA block grant programs operated by county mental health programs by conducting program performance reviews. DMH policy is to evaluate each county mental health program on-site every three years, and staff provide technical assistance to programs on an ongoing basis. These performance reviews assure that programs are providing only allowable services to the specified target populations, that the services described in the application are being provided, and that measurable objectives are being met. If there is a need for corrective action, a plan of correction is required from the program within 30 days of receipt of the program review.

The DMH is also awarded federal PATH formula grants that fund community-based outreach, mental health and substance abuse referral and treatment, case management and other support services, as well as a limited set of housing services for persons with mental illness who are homeless. During fiscal year 2004-05, the State will receive approximately \$6.7 million to fund programs in 37 counties. Counties receiving PATH funds must annually develop a service plan that describes each program and the services and activities to be provided. PATH programs also report outcomes relative to achievement of their objectives. The DMH conducts program performance reviews of PATH-funded programs every two years. These reviews include determining whether the services provided are consistent with the approved application, that the appropriate target population is being served, and that treatment modalities used are those that will be most effective with homeless persons who have a mental illness. DMH review staff also conduct chart reviews and interview clients.

Client and Family Member Task Force

The Client and Family Member Task Force was established prior to the implementation of Medi-Cal managed mental healthcare inpatient consolidation. Its original goal was to provide for more meaningful consumer and family member involvement in advising on this process. It has evolved into having a broader purview in advising the DMH and the CMHDA on client and family member involvement.

The Client and Family Member Task Force has adopted the following Mission Statement:

In order to promote a better quality of life for all mental health clients, the Client and Family Member Task Force will assist in the development of an effective, culturally competent, comprehensive, community-based service delivery system. This is accomplished by advising and supporting the Department of Mental Health and the California Mental Health Directors Association by advocating for clients and family members.

With the publication of final federal Medicaid Managed Care regulations in June 2002, the State's Medi-Cal managed mental healthcare program had significant changes that it had to implement, especially to its quality improvement activities. The Client and Family Member Task Force, along with the CMHDA, was involved in consulting with the DMH on the potential effects of these regulatory changes.

Office of Multicultural Services

The purpose of the Office of Multicultural Services (OMS) is to work with state and local leaders to eliminate disparities in mental health accessibility, to eliminate inappropriate care, and to improve quality of care to racially/ethnically diverse communities in California. The mental health system has not kept pace with the diverse needs of racial and ethnic populations in our State. Multicultural communities are underserved or inappropriately served. Although local MHPs are charged to serve Medi-Cal beneficiaries, there are still many barriers to care, especially for California's Latinos and Asian Pacific Islanders. In 1997 the DMH issued the first Consolidation of Medi-Cal Specialty Mental Health Services—Cultural Competence plan requirements, which established standards and plan requirements for achieving cultural and linguistic competency. Each MHP is required to develop a cultural competence plan consistent with standards in three major areas: access, quality of care, and quality management. The purpose of issuing these standards and plan requirements was to assist MHPs in creating a more responsive and accessible system for Medi-Cal beneficiaries for the delivery of quality and cost-effective specialty mental health services.

Cultural Competence Advisory Committee

The Director of the Department of Mental Health established the Cultural Competence Advisory Committee (CCAC) as an advisory group to the Office of Multicultural Services. It is also required in the Medi-Cal Managed Care Waiver. CCAC provides critical support to the DMH for consultation and leadership for the development and ongoing direction of California's cultural competence programs and the development of standards and policy recommendations to address elimination of mental health disparities. CCAC is made up of multicultural consultants representing various stakeholder groups as well as representatives from the CMHDA, mental health consumers, family members, community-based program representatives, and University affiliates.

Currently, the OMS is working on the third revision of the requirements in the Consolidation of Medi-Cal Specialty Mental Health Services Cultural Competence Plan to reflect recent research in the field and new federal mandates. Appendix A contains a brief description of the requirements in the Cultural Competence Plans. The OMS has

completed the reviews of this year's Cultural Competence Plan Requirements annual submissions. The OMS continues to work with the SQIC to track penetration and retention rates and quality of care special studies. In partnership with the SQIC, significant disparities in access to care for the California Latino population were identified. Selected counties are required to complete Latino Access studies to help improve Latino penetration rates. The OMS continues to work with DMH Program Compliance regarding cultural competence and language standards. The OMS also participates in statewide training and workforce development strategies. For example, the OMS, in partnership with the University of La Verne and other community partners, has completed an evidence-based research tool and accompanying curriculum to assess the cultural competence training needs of mental health providers and training programs. The OMS also provides ongoing collaboration with state hospitals to improve services to multicultural clients.

Local County Mental Health Programs

Counties are the primary providers of public mental health services in California for Medi-Cal and non-Medi-Cal clients. Realignment of mental health services required counties to serve target populations—seriously mentally ill adults, seriously emotionally disturbed children, and persons in acute psychiatric facilities—to the extent resources are available. Counties may choose to contract for all or part of administration and clinical services, including MHPs for Medi-Cal. Whether operated directly by the county or by contract, the MHP must operate according to state and federal Medi-Cal eligibility, service, and benefit standards. Counties generally provide services through a mix of services operated directly by the county or contracted for with community-based organizations.

Quality Improvement Operations

Any discussion of quality improvement (QI) from the county perspective must begin with an acknowledgement that each county has charted a unique course for behavioral health service delivery and for how that county's values and resources are incorporated into its QI processes. But, there are factors of commonality that are present to some extent in all county programs. The most consistent factor is the need to adapt to change. In the past ten years, the expectations for county QI programs have changed with implementation of the Rehabilitation Option, Systems of Care, Medi-Cal managed care consolidation, on-site reviews, and new federal Medicaid regulations. Through these changing paradigms, the roles of county QI programs have changed. Although rules and task requirements change, county QI programs do not cease performing one set of tasks and initiate another set of tasks. Rather, they now have to perform both sets of tasks. No requirement ever seems to go away. Traditional requirements are simply incorporated differently into new paradigms.

An example of how a traditional requirement has evolved is provided by quality assurance reviews on both inpatient and outpatient service records. The requirement to review medical records has changed little over time, particularly for inpatient programs. However, clinical documentation must now meet more exacting standards, and the traditional record review practice of simply finding problems has not proved to be a particularly effective means of eliminating record errors. This realization caused county

QI staff to recognize that lack of skills rather than bad staff behavior was the primary documentation problem. As a result, county QI programs have adopted a continuous quality improvement approach to record reviews. This approach is much more effective in correcting documentation problems than simply returning a record and requesting corrections. Now QI staff develop specific curriculum and teach clinical staff how to document services correctly. Development of this educational process enhanced the policy development role of county QI programs. County QI programs have had to develop local interpretations of more general state standards or quality indicators in order to develop documentation training programs for staff. For example, certain data are required for an assessment, but county QI programs must articulate when formal assessments are to be completed, by whom, and what the specific content of the assessment must be.

Another factor common to all county QI programs is that changes to clinical programs and most changes to fiscal programs directly or indirectly affect county QI operations. The DMH conducts two different types of reviews: clinical programs are reviewed through Medi-Cal on-site reviews, and fiscal operations are reviewed through a cost report audit process. These reviews are conducted by two different groups of state staff that clearly have a very different focus and work plan, very different time frames, and result in very different outcomes. Although these reviews remain distinct at the state level, these same tasks have become more blended at the county level. County QI operations and fiscal operations have become more interdependent. A traditional review activity done by county QI staff is matching progress notes with billing, which is very similar to the fiscal staff activity of matching billing with the existence of progress notes. County fiscal staff also maintain staff and contractor records that county QI staff require in their expanding roles of staff development and contractor monitoring. Each unit now maintains records that the other unit needs to rely on in its work, and both units need to be assured of the accuracy and completeness of the other's records. To develop this local partnership between county QI and fiscal programs has required clarification of tasks and expectations and development of policies, procedures, and standards that has enhanced the overall county QI program.

Another traditional task of county QI operations is to translate and incorporate new and existing rules, regulations, and interpretations made by outside entities into that county's quality assurance process and to assure that the county consistently attains and maintains at least minimal levels of compliance with all requirements. Systems of Care are an example of a new program that had to be implemented for which local QI processes had to be developed. This proved an interesting assignment because of its ambiguity. The role of Systems of Care program staff was to develop new programs that served more individuals and increased revenue, and the role of county QI staff was directed more toward development of managed care practices. The county QI role in managing care had two parts: at the county provider level, the county QI program was to be the keeper of the census, so it was charged with development of processes to discharge those recipients that no longer required services; and, at the level of the community-based agencies, its role was to assure compliance with requirements, including QI. Many counties were unable to develop structures to adequately manage care because 1) county QI staff had no real clues where to start; 2) staff resources were being shifted toward service program development; and 3) QI operations lacked sufficient computers or

software programs. These problems created a management gap because rigid traditional county QI rules were replaced with new interpretations aimed mostly toward increasing availability of service and increasing federal financial participation to counties. County QI programs were placed in a very awkward position of having diminished authority to manage processes while still being held responsible for the outcomes of those processes.

This trend toward increased federal financial participation led to increased scrutiny by the Office of the Inspector General of the federal Health and Human Services Agency. It resulted in counties' developing an enhanced awareness of compliance requirements and created a constant need to know exactly where the county is and is not in compliance with federal and state standards. Most counties relied, to at least some extent, on their seasoned QI staff to take steps necessary to prevent or mitigate the potential for a federal audit. Counties began to develop compliance plans that would both establish the means to meet evolving federal requirements (or, more importantly, their evolving interpretations) and establish new "rules" for guiding county business practices. QI then became a greater part of each county's business function. That is, each step of each process would now have to satisfy specific business rules that most often centered on billing practices and ethical concerns. For example, traditional QI activities had centered on the existence of required documentation within a set time frame. In contrast, documentation must now be much more specific about the service that is delivered and why the client requires that specific service. To assure documentation meets these much higher standards requires that counties train staff and assist programs to incorporate higher standards into core program values. Providing higher quality services is not seen as simply additional tasks staff must do—providing higher quality services is simply the way business is done. County QI operations are the driving force behind this effort.

The most recent change affecting county QI programs is the new federal Medicaid managed care regulations, which became effective in August 2003 and had to be implemented by county MHPs by June 30, 2004. Each county had to alter its business plan to accommodate these new requirements. One new requirement is that an External Quality Review Organization (EQRO) conducts an annual review of each county's Medical operations. A description of EQROs is provided later in the paper. The advent of this new program added responsibilities for QI staff in many counties, who now have to coordinate these reviews, including assembling all the needed documentation, making available all the staff that need to participate in the review, and setting up the focus groups.

The most important aspect of the new requirements is that counties must develop and implement quality improvement projects, referred to as Performance Improvement Projects (PIPs). The discipline required for developing PIPs forces a clear review of practices, development and use of databases for decision-making, and documentation of a clean trail to show that a viable quality improvement process is in place. The most important feature of a PIP is that the process requires analysis of the findings for further clinical or fiscal program development. In carrying out a PIP, county MHPs will benefit from county QI staff's historical knowledge, specific analytical skills, and network connections with knowledgeable persons outside the county. This new process will further broaden the role for county QI programs.

Mental Health Boards and Commissions

Every county mental health program is required to have a mental health board or commission (MHB/C), which is appointed by the county governing body. MHB/Cs are comprised of consumers, family members, mental health professionals and providers, and members of the general public. MHB/Cs are responsible for reviewing and evaluating the community's mental health needs and advising the governing body and the local mental health director on any aspect of the local mental health program. Two of their statutory duties relate directly to quality improvement activities:

- ◆ Submit an annual report to the governing body on the needs and performance of the county's mental health system (WIC Section 5604.2(a)(5))
- ◆ Review and comment on the county's performance outcome data and communicate its findings to the California Mental Health Planning Council (WIC Section 5604.2(a)(7))

California Mental Health Directors Association

Quality Improvement/Compliance Subcommittee

The California Mental Health Directors Association (CMHDA) Quality Improvement/Compliance Committee is a subcommittee of the CMHDA Medi-Cal Policy Committee within the CMHDA governance structure. Through the committee structure of the CMHDA, the Quality Improvement/Compliance Committee receives assignments and reports to the CMHDA Governing Board. The Quality Improvement portion of the committee was created in 2003 to pull together the regional Quality Improvement Work Groups (BayQIC, Central QIC, SoQIC, NorQIC and collectively CALQIC), which have existed for many years and are comprised of county Quality Improvement Coordinators. The charge of the Quality Improvement subcommittee was expanded in February 2004 to include compliance issues. The CMHDA Quality Improvement/Compliance Committee has the following objectives:

- ◆ To provide a direct contact/feedback loop between county QI staff and CMHDA to support county QI personnel in obtaining direction on issues with statewide impact
- ◆ To assist the larger CMHDA committee structure in policy direction on quality improvement issues from the perspective of the CMHDA to the DMH
- ◆ To assist in the development of the review protocol for Medi-Cal On-site Reviews
- ◆ To provide guidance to county mental health compliance officers

California Institute for Mental Health

The California Institute for Mental Health (CIMH) is a non-profit 501(c)(3) with a unique role in California's Quality Improvement System. The CIMH's mission is to "promote excellence in mental health services through training, technical assistance, research, evaluation, and policy development." It accomplishes many far-reaching activities with key constituents in California, including local county mental health directors and their staff, the DMH, mental health consumers, family members, community-based agencies, and other partners. The CIMH is a provider of training, technical assistance, policy

development, and research and evaluation in emerging areas/topics on mental health that help make a difference for local county mental health directors and their staff, local boards/commissions, as well as other interested stakeholders. It works to improve quality as a bridge between research and practice, assisting local programs to implement evidence-based practices and providing evaluation of services. The CIMH also promotes research of local best practices. It has developed a strategic plan, *Toward Effective Mental Health Practices: A Strategic Plan to Incorporate Values and Science into Practice*. This plan frames the CIMH's efforts to improve quality of care in California's public mental health services and to promote the values of resiliency, recovery, and cultural competence.

California Mental Health Planning Council

The California Mental Health Planning Council (CMHPC) is established in federal and state statute to provide oversight of the public mental health system. The CMHPC, a multicultural consumer, family, provider, and advocate organization with the following mission:

- ◆ To provide oversight to the DMH regarding accessibility, availability, and accountability of the State's mental health system
- ◆ To advocate for accessible, timely, appropriate, and effective services, which are culturally competent, age and gender appropriate, strengths-based, and recovery-oriented
- ◆ To educate the public and the mental health constituency about the current needs for public mental health services and ways to meet those needs

Quality Improvement Committee

The overarching focus of the CMHPC's statutory mandate relates to oversight of the public mental health system. A very substantial aspect of that mandate relates to reviewing and approving performance indicators and using data to evaluate the performance of county mental health programs. The CMHPC has had a committee that focuses on quality improvement issues since 1997. The CMHPC has charged the committee with the following responsibilities:

1. Formulate the CMHPC's position on issues before the State Quality Improvement Council
2. Formulate the CMHPC's positions on implementation of performance outcome systems for county mental health programs and state hospitals
3. Monitor the adequacy of the DMH's oversight of the public mental health system
4. Monitor county performance by developing projects using performance indicators for programs funded by realignment funds and the Mental Health Services Act
 - ◆ Continue the model of working with mental health boards and commissions to obtain their interpretation of performance indicator data for their counties

5. Review the performance of Medi-Cal Mental Health Plans by periodically reviewing the results of managed care on-site reviews and external quality review reports
6. Review state hospital performance

External Review Organizations

Not all efforts to improve the quality of mental health services come from groups within the mental health system. A number of organizations outside the mental health system's Quality Improvement Partnership have responsibilities for reviewing and reporting on the performance of the mental health system. This section will highlight those organizations:

Joint Commission on Accreditation of Healthcare Organizations (JCAHO)

The mission of JCAHO is to continuously improve the safety and quality of care provided to the public through healthcare accreditation and related services that provide performance improvement in healthcare organizations. Among its activities, it evaluates and accredits psychiatric hospitals, nursing homes, and behavioral healthcare organizations. JCAHO has maintained state-of-the-art standards that it develops in consultation with healthcare experts, providers, measurement experts, purchasers, and consumers. Its comprehensive accreditation process evaluates an organization's compliance with these standards and other accreditation requirements.

Department of Justice (DOJ) Civil Rights Division, Special Litigation Section

The Civil Rights of Institutionalized Persons Act (CRIPA) authorizes the Attorney General to conduct investigations and litigation relating to conditions of confinement in state or locally operated institutions, including mental health facilities. The Special Litigation Section investigates covered facilities to determine whether there is a pattern or practice of violations of residents' federal rights. The Section has focused on significant problems, such as inadequate education in facilities serving children and adolescents. It has also been active in enforcing the rights of institutionalized persons with disabilities to receive adequate habilitation and active treatment and to be served in the most integrated setting appropriate to their needs. The Section has conducted a review of the programs for children and adults at Metropolitan State Hospital.

Department of Finance, Office of State Audits and Evaluations

The Department of Finance is part of the State's Executive Branch and is one of the State's control agencies. One of its principal functions is to monitor and audit expenditures by state departments to ensure compliance with law, approved standards, and policies. The Department's Office of State Audits and Evaluations (OSAE) performs most of those tasks. Its general responsibility is to supervise matters concerning the State's financial and business policies, including all Executive Branch audit functions. The Department's broad oversight responsibilities result in a wide range of work being conducted, including financial audits, performance audits, information technology audits, internal control audits, compliance audits, consulting, quality assurance reviews, and budgetary reviews.

Little Hoover Commission (LHC)

The LHC is an independent state oversight agency created to investigate state government operations and to promote efficiency, economy, and improved service. The LHC selects topics to study that come to its attention from citizens, legislators, and other sources. Unlike fiscal or performance audits, LHC studies look beyond whether programs comply with existing requirements, instead exploring how programs could and should function. The LHC produces in-depth, well-documented reports that serve as a basis for crafting reform legislation or making administrative changes.

Bureau of State Audits

The Bureau of State Audits promotes the efficient and effective management of public funds and programs by providing to citizens and government independent, objective, accurate, and timely evaluation of state and local government activities. Under the direction of the Little Hoover Commission, the Bureau meets the needs of state government for periodic audits of organizations, programs, and services to promote sound fiscal and administrative policies for the government of the State. It also conducts financial and performance audits as directed by statutes and other government audits requested by the Joint Legislative Audit Committee.

Protection and Advocacy, Inc. (PAI)

PAI is a nonprofit agency that provides legal and other advocacy assistance to people with disabilities, including persons with psychiatric disabilities. Many of its advocacy activities serve a quality improvement function. For example, it addresses serious, recurring, and systemic rights violations and problems through focused litigation efforts and amicus curiae briefs. It also investigates incidents of abuse and neglect of persons with disabilities. Its investigative activities also focus on incidents that are serious and systemic and involve failures of other agencies to adequately carry out their own investigative responsibilities.

External Consumer, Family and Professional Organizational Partners

While having no statutory or formal administrative role in the statewide quality improvement process, a number of organizations are central to the consumer-family-professional partnership at the statewide level. When the Quality Improvement Partnership is developing activities or policies that affect service delivery to consumers, their families, and community-based agencies involved in service provision, communication with these organizations can be helpful. At the local level, processes to involve these stakeholders in policy development and service provision issues are routine and enhance the quality of the final product. At the local level, both statutory and discretionary appointments assure input from these stakeholders. Consumers and families are statutorily required appointments to the Mental Health Boards/Commissions; however, conflict of interest provisions prohibit county employees and contract providers from being appointed. The Local Mental Health Director does have the ability to appoint representatives from community-based agencies to the County Quality Improvement Committee, which can assure their input, as well as appointing additional consumers and family members. At the statewide level, the Quality Improvement Partnership can derive similar benefits in terms of improved policy development by establishing communication

links with key external organizational partners representing consumers, family members, and community-based organizations.

Future Projects

1. Conduct a survey of all the groups identified in the paper performing quality improvement activities to analyze communication and liaison relationships
2. Determine how to use the Institute of Medicine's Six Aims as framework for State's quality improvement system
3. Update the paper to reflect the passage of the Mental Health Services Act and the existence of the Oversight and Accountability Commission
4. Examine more closely the nature of county quality improvement operations, including the balance of workload between compliance activities versus quality improvement activities

**California Department of Mental Health
Office of Multicultural Services**

Cultural Competence Plan Requirements Purpose: To establish standards and plan requirements for county MHPs to achieve cultural and linguistic competency under consolidation of specialty mental health services. The intent of issuing Cultural Competence standards and requirement is 1) to create a more responsive and accessible system for Medi-Cal beneficiaries for the delivery of quality and cost-effective specialty mental health services; and 2) to reduce disparities and improve services in access and quality of care with a focus on multicultural communities. The Office of Multicultural Services is responsible for establishing and implementing plan requirements, for reviewing progress, and for providing leadership and policy direction.

| DMH Cultural Competence Plan- Improving Quality of Care for Multicultural Communities | | | |
|--|--|--|--|
| Required to do Cultural Competence (CC) County Plan Self- Assessment | Part I Populations Assessment Utilization of mental health services by Medi-Cal population by ethnicity, age, gender, and primary language | Part II Organizational and Service Providers Assessment, Administrative direction, Human Resources assessment, language capacities, QI of care | Part III <ul style="list-style-type: none"> • Annual Updates submissions • CC indicators in DMH Compliance Protocol |
| Standards | Access | Quality Improvement | Quality Management |
| 3- Standards set for cultural and linguistic competence | Demonstrate evidence culturally and linguistically accessible services | Ensure accurate and appropriate clinical decisions | Appropriateness & Outcome |
| Total number and focus areas of indicators under each standard. | 6- Language access 5- Written Materials 4- Responsiveness of mental health services | 1- Consumer Family Role 5- Competent Evaluation, Diagnosis, Treatment and Referral Services 1- Client Culture | 1- Penetration & Retention 2- Capacity of Service 1- Continuous Quality Improvement Plan |
| Total Number of Measures | 27 Measures | 13 Measures | 10 Measures |