



PARTNERSHIPS FOR QUALITY

California's Statewide Quality Improvement System

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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

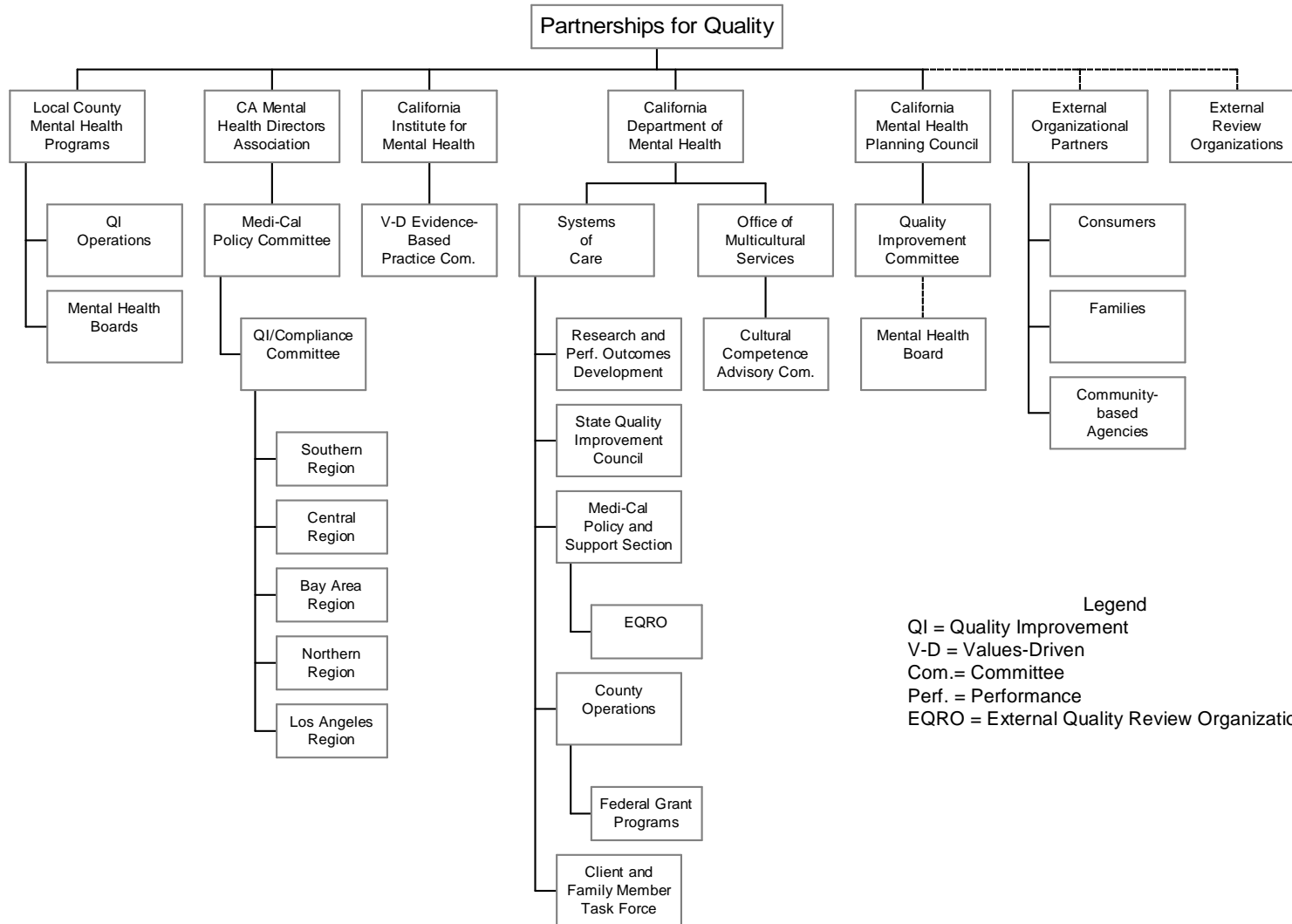
Systems of Care encompass the array of functions pertaining to California's Systems of Care for persons with mental illnesses. It develops, evaluates, monitors, and supports coordinated services that deliver care to adults and older adults who have serious mental illnesses and to children who have serious 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

Appendix A

**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