Fiscal Year 2011-2012

Quality Review Council

October 2011

The Mental Health Plan shall have a written Quality Improvement Program, in which structure and processes are clearly defined with responsibility assigned to appropriate individuals.

Contents

Introduction

Quality of services is a system-wide concern, far-ranging in scope, and is addressed at all levels of the organization. Quality is an organizational priority. Through it, and driven by federal, state and local mandates, we establish system-wide standards of care and organizational goals. The quality improvement process provides a means for organizational self-assessment, as well as assessment by consumers and families, of how well we are meeting our goals, and it provides a context for service redesign when problems are identified or goals are not met. In short, our quality improvement process is an essential system tool for the collection and analysis of system data, which permits a reliable assessment of system performance, as well as a process by which performance may be improved.

As required in the Managed Care Contract with the State Department of Mental Health (SDMH), Exhibit A, Attachment 1, Appendix A, Part B, each County Mental Health Plan (MHP) shall have an annual written Quality Improvement Work Plan (QIWP) to describe the MHP's Quality Improvement (QI) Program, and to provide guidelines for evaluating the overall effectiveness of the QI Program. The responsibility for Quality lies with the Department Executive Leadership. The responsibility for executing the QI Program rests with the QI Manager and the staff of the Department's QI Services. The execution of QI activities involves staff at all levels and in all areas of the Department. QI activities are inclusive of the collection and analysis of data, the identification of potential quality issues, the monitoring of previously identified issues of concern (and the tracking of these over time), the planning and initiation of procedures designed to address issues of concern, monitoring for resultant improvement in quality and for sustainment of improvement, and the establishment of objectives, scope and planned activities for the coming year. The QIWP must demonstrate how QI activities will contribute meaningfully to improvement of clinical care and services provided to MHP beneficiaries.

The Santa Clara County Mental Health Department's QIWP is consistent with the Department's Vision, Mission Statement and Values, as well as with our philosophical approach to care as we transition our service delivery to the Wellness and Recovery model. It is developed along the guiding principles of the Committee on the Quality of Healthcare in America, established in their Institute of Medicine 2001 report, *Crossing the Quality Chasm*. In this report, the Committee affirms that all healthcare services should be safe, effective, consumer-centered, timely, efficient and equitable. All these parameters are integral components of our QIWP. In addition, SDMH mandated activities are completed by our Quality Improvement Services staff and are identified in the QIWP.

The QIWP is approved and published by Executive Leadership within the Department on an annual basis. Input from QI Services staff, as well as from the Quality Review Council (see below) is sought, and necessary to the development of the QIWP. The QIWP is distributed to County service providers, and to Contract Agency service providers.

Mission Statement and Guiding Principles

The Mission Statement of the Santa Clara County Department of Mental Health is:

To assist individuals in our community affected by mental illness and serious emotional disturbance in achieving their hopes, dreams and quality of life goals. To accomplish this, services must be delivered in the least restrictive, non-stigmatizing, most accessible environment within a coordinated system of community and self-care, respectful of a person's family and loved ones, language, culture, ethnicity, gender and sexual identity.

Our Vision is to foster a mental health system that is successful in helping to ensure that Santa Clara County residents in need of public mental health services are:

- Physically and emotionally healthy, happy and thriving
- In a safe and permanent living situation
- Part of a loving and supporting social network
- Involved in meaningful school, work, and daily activities
- Free from trouble or causing harm to others
- Safe from harm from the environment or others

Our Vision and Mission Statement promote our Values. We believe without reservation that:

- All people have the right to mental health and well-being
- All people must be treated with fairness, respect, and dignity in a culturally and linguistically competent way
- With effective treatment and support, recovery from mental illness is achievable
- Consumers will actively participate in their own recovery and treatment goals
- Consumers and their families will be at the center in the development, delivery, implementation, and evaluation of their treatment
- The system of care must have a structure and process for ensuring access to needed services for potential and current consumers
- All people must have access to the highest quality and most effective integrated services

Evaluation of QI Work Plan FY2010-2011

The QI Work Plan for FY2010-2011 had the following major initiatives and targeted and statewide initiatives identified:

Major Initiatives:

- ***Family and Children System Re-Design,*** Responsible Manager: Sherri Terao, Division Director
- ***Authorization to Initiate 5150 Holds (MHD Policy 412-416)***, Responsible Manager: Michael Meade, M.D., System Medical Director
- ***Performance Measures,*** Responsible Manager: Dean Wiley, LPT Division Director.

Targeted and State Mandated QI Activities:

- ***Quality Improvement Services***
- ***Physician Quality***
- ***Performance Improvement Projects***
- ***Quality Review Council***

Following is a summary evaluation of the initiatives.

FAMILY AND CHILDREN SYSTEM RE-DESIGN

The F&C redesign work group has made substantial progress during FY2010-11. A macro design for the system has been developed that includes "Service flow standards" (e.g., access, initial services, initial and ongoing assessment, understanding, family-driven, youth-guided intervention planning, implementation and evaluation of intervention plan and increased natural supports and improved developmental progress) as well as "Interventions by Treatment Targets" in order for the system to properly address mental health diagnoses with appropriate evidence based practices (objective a). The development of the system redesign was greatly influenced by the results of the Santa Clara County Mental Health Department Family & Children Services Division Gap Analysis recently completed by California Institute for Mental Health (CIMH). The purpose of the gap analysis was to inventory the current system of care, identify service gaps and identify strategies that would streamline services and improve treatment outcomes (objective b). In addition to these accomplishments, the F&C redesign work group was tasked with conducting brief tests, or Plan-Do-Study-Act cycles based on the Model for Improvement. One example of a PDSA "test" was to pilot discharge coding criteria amongst the different County and Contractor programs in order to determine the utility of specific coding elements. The test results were helpful in developing a finalized list of discharge criteria and codes. An additional benefit to implementing the model for improvement method was the engagement of clinicians and staff in the process of developing the coding structure (objective c). During FY2010-11, there was also significant progress made on objective d. The F&C redesign workgroup reviewed multiple assessment and outcome tools and developed a tiered approach to categorizing potential assessment tools for use across the F&C system. The work group recommended the identification of one, overarching outcome measurement tool for the entire F&C system as well as additional assessment tools that would assist with understanding and identifying specific mental health conditions and diagnoses (e.g., in order to inform progress related to treatment targets).

AUTHORIZATION TO INITIATE 5150 HOLDS

The process of revising the authorization process for designating which staff may initiate 5150 holds continues. By December 31, 2011, the process will be complete, and only those with valid 5150 Authorization cards will be designated by the Mental Health Director to initiate 5150 holds in Santa Clara County. Training will be ongoing for those seeking authorization, conducted through the Learning Partnership. Both live four hour trainings, and on-line training courses (currently in development) will be available for initial authorization, and to renew authorization (due five years after the initial authorization). The authorization procedure may be found in Mental Health Department policy # 412-416.

PERFORMANCE MEASURES

The Performance Learning Measures Dashboard was tested with small teams of participants who are actively involved in the Department's System Redesign. The results of the testing where used to modify and enhance the current set of process and outcome measures being reported on the dashboard. Production of the monthly dashboard began in August of 2011. All sites are now receiving a dashboard for at least one of their programs. In September of 2011 sites were trained on how to use the dashboard for performance and quality improvement of service delivery.

The next steps are to explore how the dashboard can be electronically distributed to our sites. This is a modification to the plan to purchase an interactive reporting tool. The modification is to house the interactive tool as part of the Electronic Data Warehouse project funded by Capitol Facilities and Technology dollars of the Mental Health Services Act. In addition, the Performance Measures Dashboard Committee continues to meet and has begun the process of determining what will be the Phase Two dashboard measures.

QUALITY IMPROVEMENT SERVICES

The Department is required to monitor 15 specific quality improvement services items. Continuing on the work from the previous year, the Department has refined the goals and targets for each area and generated actual data for FY2009-10, when available. As mentioned last year, the 15 specific items will eventually be quantified in a data dashboard, which is a core element of the Performance Measurement Initiative mentioned earlier. Work on this initiative continues and will follow the basic model of: Collect and analyze data to measure against the goals; Identify opportunities for improvement and decide which to pursue; Design and implement interventions to improve performance; Measure effectiveness of the interventions; and Incorporate successful interventions.

PHYSICIAN QUALITY

The quality improvement medication monitoring chart review is conducted on an ongoing basis throughout the year, by a pharmacist specialist, under the leadership of the two medical directors. The goal is to ensure evidence based psychiatric treatment is provided to clients with mental illness.

In FY 2010-11, three recommendations were made in the physician quality area.

1. Discussion of the report results at Psychiatric Practices Committee and Quality Review Council.

   Met. The results of the medication monitoring chart review are widely disseminated and discussed several times a year at several forums including Psychiatric Practices meeting, psychiatry department meetings, and quality review council meetings.

2. Obtaining 100% of the consent forms for all psychiatric medications

   Almost met. Signed consent forms are obtained in 89% of the approximate 1100 charts audited. The lack of a consent form does not necessarily mean that consent was not obtained as the risks and benefits are often already documented in the medical records. The physicians may just forget to give the form to the patient to sign or the patients may not be willing to sign a consent form, at that moment in time. In retrospect, it may be more reasonable to set the goal of obtaining consent forms at 90%.

3. Perform the AIMS in 80% of the clients on typical antipsychotics and symptomatic clients on atypical antipsychotics

   Met. AIMS were obtained in 82% of the patients who meet the above criteria.

PERFORMANCE IMPROVEMENT PROJECTS

The IMD Assaultive Behavior non-clinical Performance Improvement Project

The IMD PIP team has met regularly over the past year to 1) define a study group, 2) explore a variety of potential interventions, 3) select and implement one intervention during which time standardized data collection for the study group has taken place, and 4) repeat the facility-wide data collection from which a baseline was established one year ago. The intervention chosen was the use of non-tradition techniques such as DBT, yoga, meditation and aroma therapy. Resident selection was based on the commission of multiple assaults in the three months prior to testing the intervention. Data collection consisted of quantitative information on frequency of attendance at the non-traditional therapy groups and qualitative information on level of participation and engagement and possible relationship between participation and frequency of assaults. The PIP team has met once since the intervention began and will meet to go over results at the end of the two month pilot. Data from the pilot will be looked at along with facility-wide data which the PIP team will evaluate and interpret at the conclusion or the PIP.

Statewide EPSDT clinical Performance Improvement Project

Our largest provider of children's services (EMQ Families First) continues to work on modified coordination of service. They have implemented a program to determine if improved case coordination/care management and authorization practices result in greater efficiencies, reduced overall cost and improved outcomes. The results of the work have indicated

significant cost saving without impacting clinical outcomes. Clients continue to do well in the program and continue to rate the program very highly. The department is moving toward widespread implementation of the model.

QUALITY REVIEW COUNCIL. Meetings occur every two months. The QRC met to discuss the following:

II. Announcements:

a) EPSDT/CAEQRO Updates (Ongoing)
b) MHD Personnel Changes (Ongoing)

III. Objectives, scope, and planned activities

1) Service Delivery Capacity

a) Update on QIWP-24 Hour Care Initiative (Oct. 2010)
b) Stability and Medical Necessity (April 2011)

2) Accessibility of Services

a) Delayed appointments after inpatient discharge (Aug2011)

3) Beneficiary Satisfaction

a) FY2009-10 Grievance and Appeals (Dec 2010)
b) State Consumer Survey Status (Feb 2011)
c) Client Survey (Apr/Jun/Aug2011)

4) Continuity and Coordination of Care with Physical Health Care Providers and Other Human Services Agencies

a) Report on new County health clinic in Milpitas (June 2010)
b) Client co-pay and share of cost issue. (June 2010)

5) Service Delivery System and Meaningful Clinical Issues Affecting Beneficiaries

a) FY2011-12 Clinical Record Review (Aug2011)
b) Update on QIWP & Quality Improvement Services (Aug/Oct/Dec2010, Feb/Apr/Jun/Aug2011)
c) Update on QIWP-PIPs (Aug/Oct/Dec2010, Feb/Apr/Jun/Aug2011)
d) Issue Rule: 30 days from service provision to completing a progress note (Aug/Oct 2010, Apr2011)
e) FY2010-11 Clinical Records Review (CRR) Process (Aug/Oct/Dec 2010, Feb/Apr/Jun/Aug2011)
f) FY2009-10 QI Annual Report (Aug 2010)
g) EHR/E-Signed Process (Aug/Oct/Dec2010, Feb/Apr/Jun2011)
h) Documentation Manual (Apr/Jun/Aug2011)
i) Treatment Plan Review and Development (Aug/Oct2010, Apr2011)
j) TCP (Aug2011)

k) SDMH Letter and Notices (Ongoing)
l) SCCMHD Policies and Directives (Ongoing)
m) Update on QIWP-Physician Quality
n) NewItem: Data Dashboard (Oct 2010)
o) NewItem: Mission Statement (Oct/Dec2010, Feb/Apr2011)
p) Issue Policy: 5150 Policy Changes
q) New Item: Abbreviation List (Oct 2010)
r) Issue CRR: Report format usefulness to users

6) Provider Appeals

IV. Consumer Affairs

a) Various Issues reported (Ongoing)

Major Initiatives for the Mental Health Department FY2011-12

Family and Children System Re-Design, Responsible Manager: Sherri Terao, Division Director

This redesign initiative is being undertaken in response to the dual need of transforming the system while also gaining efficiencies to respond to broad reduction in resources—in other words, to increase the effectiveness of services for persons served as a means of maximizing increasingly limited resources.

The Redesign Team has prepared the following DRAFT mission statement:

> *"Guided by the vision and mission of the Mental Health Department, to redesign the Family and Children's to ensure culturally appropriate, family-centered, efficient and effective services and supports are consistently provided to children and their families so they may live safely at home in their communities, thrive in school and/or employment, and achieve their hopes and dreams, both individually and as a family."*

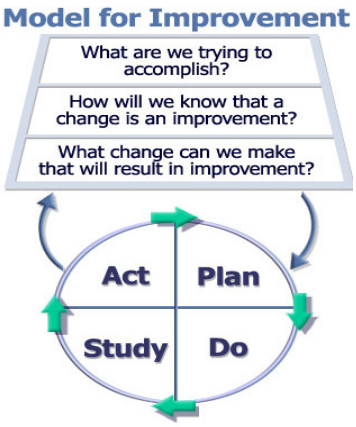
The key goals of this initiative are:

- a) Improve effectiveness and efficiency of services in order to: keep more youth at home, keep more youth in school, keep more youth out of Juvenile Hall, reduce the recidivism of youth, and reduce out-of-county placements and increase in-county services for youths;
- b) Reduce restrictiveness and stigma while enhancing family centeredness of services and the service system;
- c) Develop a coordinated system of community and self-care that reflects a person's family and loved ones, language, culture, ethnicity, gender and sexual identity and involves all generations of the family;

- d) Develop and adopt regular measurement of outcomes, including life functioning and other client strengths to support timely identification of and action on improvement opportunities, as well as to improve transparency of system performance;
- e) Reduce barriers to access and improve penetration rate of services, particularly to diverse ethnic and cultural communities;
- f) Adopt leadership and management models that build business competencies that support achieving and sustaining high levels of system performance; and,
- g) Increase partnering between the county and providers to support system improvement.

The QI Work Plan activities and evaluation methods for FY10-11:

- a) Develop a broad 'macro' design for the system, as well as addressing care processes at a micro-system level to ensure that individual care processes are supported by well-designed daily operations within a well-designed agency structure that dictates the broader environment in which those operations function
- b) Use the results of the performance gap analysis, a project contracted out by the MHD to the California Institute of Mental Health (CIMH)
- c) Use the "Plan-Do-Study-Act (PDSA)" Model for Improvement, in which answers to the following questions guide the planning, implementation, evaluation and follow up actions: What are we trying to accomplish? How will we know that a change is an improvement? What change can we make that will result in improvement?



- d) Will in the following sequence: select relevant design elements; cross-walk re-design activities and plans with the MHSA objectives, program development, etc.; summarize identified needs; evaluate model programs and their elements; evaluate assessment/outcome tools (Delphi Process); review continuum of care (by CiMH) through gap analysis & review of existing studies; select model elements for over-arching design/architecture; select assessment/outcome tools; identify "innovations" to be funded by MHSA for redesign needs; coordinate the redesign plan with the MHSA activities (e.g. WFET, PEI, etc.); implement assessment tool(s); and, implement selected elements of the new design.

Authorization to Initiate 5150 Holds (MHD Policy 412-416), Responsible Manager, Michael Meade, M.D., System Medical Director

The Lanterman-Petris-Short Act ("The LPS Act") (WIC § 5000 et seq.) in part establishes a uniform, state-wide, civil commitment scheme for the involuntary detention of individuals with mental health disabilities at specific hospitals designated by the County Board of Supervisors on recommendation of the Local Mental Health Director, and approved by the California State Department of Mental Health.

Only those persons identified in Section 5150 of the WIC may initiate a 5150 detention. All peace officers have statutory authority to initiate 5150 holds. The Director of the Mental Health Department for Santa Clara County holds the authority to designate other individuals as having the authority to initiate 5150 detentions.

The key goals of this initiative are:

- Provide a comprehensive training on how to initiate a 5150 training to all persons designated by the Director of the Mental Health Department to be granted authority to initiate 5150 holds.
- Provide 5150 Hold Authorization Cards to persons designated by the Director and who successfully complete the training and an pass a written test.
- Identify the names of persons designated by the Director on the SCCMHD website.

The QI Work Plan activities and evaluation methods for FY10-11:

- Monitor that there are sufficient trainings for persons seeking expertise on 5150 holds and having a need to obtain an authorization card. And grant cards to persons that pass the training class test.
- Monitor that persons holding 5150 Hold Authorization Cards are identified on SCCMHD website.

Performance Measures, Responsible Manager, Dean Wiley: LPT Division Director.

Issues driving the efforts of this initiative range from macro or community-level needs to those of individual client served by the system. These issues include: Agencies, programs and individual providers system-wide are committed to improving client outcomes and require performance measures in order to reliably achieve that improvement; To effectively manage outcomes, leadership and management must be able to see: 1) system-level performance, including overall value and service provided to the community; 2) program performance, including effectiveness with specific client cohorts, and 3) client specific-outcomes; Leadership, middle managers and supervisors require information to determine level of performance and to identify opportunities for improvement; Currently available data can inform performance measures related to processes but is limited in terms of informing outcomes; County rules and regulations require the contractors be evaluated in order to either extend existing contractors or establish new contracts; Current data technology system

development should influence and be influenced by performance measures; Client and family members need more input into services, at all levels; A variety of internal and external stakeholders are expecting/demanding greater transparency around reporting of the system's performance to ensure their constituents are being effectively served; Establishment of measures will be most effective if done in collaboration with contract agencies that will be responsible for gathering required data inputs and responding to the reported performance measures.

The Performance Measures Development Committee mission is to develop a dashboard of measures of client outcomes, financial performance, operational efficiency, and organizational capacity. These measures must support leaders and managers in the complex challenge of:

- Aligning vision and mission with customer requirements and day-to-day work.
- Managing and evaluating business strategy
- Monitoring operation efficiency improvements
- Building organizational capacity
- Communicating progress to all employees and stakeholders

The key goals of this initiative are:

- Support improved outcomes at the individual client level, program level, system level and community level
- Support performance reporting to Mental Health Board and other internal and external stakeholders
- Support performance management by executive team, middle manages and supervisors through qualitative and quantitative measurement of experience of care that enables greatest possible effectiveness of services
- Support provider performance evaluation for contracting/extensions and oversight.

The QI Work Plan activities and evaluation methods for FY10-11:

- Develop a dashboard of outcome and process measures to be published monthly
- Develop/purchase interactive reporting tool that allows flexible inquiry by agency leadership and program managers.

Targeted Areas and State Mandated Quality Improvement Activities

Quality Improvement Services - Responsible Manager: David Guerrero, QI/UR Manager

For each of the following QI target areas and State mandated QI activities, data are collected and analyzed over time, then used to measure outcomes against established goals and objectives. A Quality Dashboard provides a snapshot of these data, and trends them over time. Opportunities for improvement are identified, and implemented. Outcomes and recommendations for improvement are reported in the Annual QI Work Plan report.

1. **Service Delivery Capacity** – **i)** determination of how many consumers are served in various levels of care in terms of how many consumers the system is designed to accommodate.
2. **Accessibility of Services** (including efforts to mitigate cultural and ethnic disparity) - **ii)** determination of ease and timeliness of accessibility to various levels of service, **iii)** determination of ease of access for consumers with special needs, including language, culture, visual and hearing impairment, and co-morbid developmental or substance use problems, **iv)** responsiveness of after-hours services and urgent care services, and **v)** responsiveness of the 24/7 toll free Call Center number in all 5 threshold languages.
3. **Beneficiary Satisfaction** - includes **vi)** monitoring of consumer and family satisfaction, **vii)** monitoring the problem resolution process, and **viii)** monitoring for trends in the Grievances, Appeals, and Expedited Appeals process.
4. **Mental Health System and Clinical Issues** - includes monitoring **ix)** the safety and effectiveness of medication practices, **x)** the critical incident reporting process (timeliness of notification and intervention), **xi)** any changes made to service delivery as the result of critical incidents, **xii)** staff satisfaction, and **xiii)** trends in Notices of Action.
5. **Continuity and Coordination of Care with other Agencies** - includes **xiv)** monitoring coordination with physical health care, drug and alcohol services, and regional center services, and identifying opportunities for improvement
6. **Provider Satisfaction** - monitoring **xv)** provider satisfaction, and identifying trends and areas of needed improvement

FY2011-12 Objective: The Department will continue to refine the measurement of, analysis, and monitoring of the 15 specific items, identified above and in the following Table. Work will continue to make the data accessible in a data dashboard format. The Quality Improvement work plan activities will progress using the following model:

- Collect and analyze data to measure against the goals
- Identify opportunities for improvement and decide which to pursue
- Design and implement interventions to improve performance
- Measure effectiveness of the interventions
- Incorporate successful interventions.

Table 1

SERVICE DELIVERY

1. Determination of how many consumers are served in various levels of care in terms of how many consumers the system is designed to accommodate.

Goal: 100% Capacity by mode of service.

	FY2009-10 Actual	**FY2010-11 Target**	**FY2011-12 Target**
Crisis	54%	100%	100%
Outpatient	Not Available (NA)	100%	100%
IMD	Not Available (NA)	100%	100%
Acute	95%	100%	100%

Conclusion/Recommendation: Comparison of CBOs and County capacity is complicated because workload at County sites is based on 65% productivity for staff. Individual performance of County sites varies significantly.

ACCESSIBILITY OF SERVICES (includes efforts to mitigate cultural and ethnic disparity)

2. Determination of ease and timeliness or accessibility to various levels of service.

Goal: 100% of new admissions will receive services within 14 days of admission.

% of new admissions receiving services within 14 days of admission	FY2009-10 Actual	**FY2010-11 Target**	**FY2011-12 Target**
Cantonese	50% (2/4)	75%	100%
English	50% (902/1821)	75%	100%
Mandarin	55% (6/11)	75%	100%
Spanish	39% (125/317)	75%	100%
Tagalog	50% (5/10)	75%	100%
Vietnamese	67% (63/94)	75%	100%
Other	52% (55/105)	75%	100%
TOTAL	49% (1158/2362)	75%	100%

Conclusion/Recommendation: Access for Spanish-speaking clients appears to be more difficult based on these percentages.

3. Determination of ease of access for consumers with special needs, including language, culture, visual and hearing impairment, and co-morbid development or substance use problems.

Goal: 100% of clients with special needs identified at first contact will receive services.

	FY2009-10 Actual	**FY2010-11 Target**	**FY2011-12 Target**
Language	100%	100%	100%
Culture	Not Available	100%	100%
Deaf	100%	100%	100%
Blind	Not Available	100%	100%
2nd DX DD	Not Available	100%	100%
2nd Dx SA	100%	100%	100%

Conclusion/Recommendation: Development of measures for certain categories is still in development.

Monitoring:

4. Responsiveness of: after-hours services and Urgent Care services

Goal: Urgent Care office will operate 7 days a week throughout the year.

	FY2009-10 Actual	FY2010-11 Actual	**FY2011-12 Target**
Urgent Care office operates 7 days a week.	Yes	Yes	Yes

Conclusion/Recommendation:

Monitoring:

5. responsiveness of the 24/7 toll free Call Center number in all 5 threshold languages

Goal: Call Center line is responsive in 5 threshold languages 24/7.

Goal	FY2009-10 Actual	**FY2010-11 Target**	**FY2011-12 Target**
% Call Center line is always responsive in all 5 threshold languages.	Not Available	100%	100%

Conclusion/Recommendation:

BENEFICIARY SATISFACTION

6. Monitoring of consumer and family satisfaction.

Goal: 100% of Consumer Perception Surveys will be returned for analysis.

	FY2009-10 Actual	FY2010-11 Actual	**FY2011-12 Target**
Youth and Family	NA	100%	100%
Adult	NA	53%	75%
Older Adult	NA	38%	70%

Conclusion/Recommendation:

7. Monitoring the problem resolution process.

Goal: 80% of Appeals, Expedited Appeals, and Grievances will be resolved within regulation timelines.

	FY2009-10 Actual	**FY2010-11 Target**	**FY2011-12 Target**
Appeals: 45 days	100% (1/1)	80%	80%
Exp. Appeals: 3 days	NA	80%	80%
Grievances: 60 days	88% (44/50)	80%	80%

Conclusion/Recommendation:

8. Monitoring for trends in Grievance, Appeals, and Expedited Appeals Process.

Goal: Conduct analysis of Appeals, Expedited Appeals, and Grievances at QRC annually.

	FY2009-10 Actual	**FY2010-11 Target**	**FY2011-12 Target**
Once a year G&As will be analyzed for trends.	**51** A, EA&Gs reported to SDMH and discussed at QRC (Dec. 2010)	To be completed	To be completed.

Conclusion/Recommendation

SYSTEM AND CLINICAL ISSUES

Monitoring:

9. The safety and effectiveness of medication practices.

Goal: Conduct an annual medication monitoring program

	FY2009-10 Actual	**FY2010-11 Target**	**FY2011-12 Target**
Medication Monitoring program implemented	Yes; see QI Workplan for specifics	Yes; see QI Workplan for specifics	Yes

Conclusion/Recommendation:

Monitoring:

10. The critical incident reporting process (timeliness of notification and intervention).

Goal: 100% of Incident Reports will be reviewed by Administrative staff.

	FY2009-10 Actual	**FY2010-11 Target**	**FY2011-12 Target**
% of incidents reported to MHD Administration	*100%; Review of IRs indicates all were signed by appropriate staff.*	100%	100%

Conclusion/Recommendation:

Monitoring:

11. Any changes made to service delivery as the result of critical incidents.

Goal: 100% of changes recommended as a result of critical incidents will be implemented.

	FY2009-10 Actual	**FY2010-11 Target**	**FY2011-12 Target**
% of changes recommended as result of CI that were implemented.	100%; PIP projects	100%	100%

Conclusion/Recommendation: Source of information requires process development.

Monitoring:
12. Staff satisfaction

Goal: Conduct a staff satisfaction survey annually.

Goal	FY2009-10 Actual	FY2010-11 Actual	**FY2011-12 Target**
Once a year, a staff satisfaction survey will be conducted.	No	No	To be completed.

Conclusion/Recommendation: Survey examples being reviewed by Deputy Director.

Monitoring:
13. Trends in NOAs

Goal: Conduct analysis of NOAs at QRC annually.

Goal	FY2009-10 Actual	FY2010-11 Actual	**FY2011-12 Target**
Annually SCC will analyze NOA trends at QRC.	No	No	To be completed

Conclusion/Recommendation:

CONTINUITY AND COORDINATION OF CARE WITH OTHER AGENCIES

14. Monitoring coordination with physical health care, drug and alcohol services, and regional center services, and identifying opportunities for improvement.

Goal: Conduct regular meetings on coordination issues with SARC, DADS, and Ambulatory Care

	FY2009-10 Actual	FY2010-11 Actual	**FY2011-12 Target**
SARC	Yes	Yes	To be completed
DADS	Yes	Yes	To be completed
Amb Care	Yes	Yes	To be completed

Conclusion/Recommendation:

PROVIDER SATISFACTION			
15. Monitoring provider satisfaction, and identifying trends and areas of improvement. **Goal: 1) Annually, there will be a contract provider satisfaction survey conducted, 2) System managers will meet quarterly to identify issues that are raised in the Morale Committee.**			
	FY2009-10 Actual	FY2010-11 Target	FY2011-12 Target
Annually Contracts conducts provider satisfaction survey.	Not Available	Not Available	To be completed
Morale Committee	Not Available	Not Available	To be completed
Conclusion/Recommendation Contracts Unit is conducting survey.			

Other QI Work Plan activities and evaluation methods for FY2011-12 include:

1. Clinical audits
2. Administrative reviews
3. Consumer complaints and grievances
4. Incident reports
5. Clinician transfer logs
6. State mandated satisfaction measures
7. Assessment of the QI program

Additionally, QI Services undertake many other activities identified in Attachment 1 to this report.

Physician Quality - Responsible Manager, Tiffany Ho, MD, Outpatient Medical Director

Context: In 2003, the Food and Drug Administration (FDA) required a warning on diabetes risk for second generation antipsychotics. The American Diabetes Association and American Psychiatric Association recommended glucose and lipid testing for all patients starting to receive second generation antipsychotics.

Review of public sector data from three states: California, Missouri, and Oregon, showed the absolute rates of baseline testing were quite low; on average, less than 30% of second generation antipsychotic treated patients received baseline serum glucose and less than 15% received lipid testing. We aim to significantly improve the rate of metabolic monitoring to improve health outcomes.

The following are the goals proposed for FY2011-12.

1. Obtain weight in 80% of clients prescribed certain psychiatric medications that could affect weight.

2. Obtain lipid testing in 80% of clients prescribed certain psychiatric medications that could affect lipid profile.

3. Obtain glucose testing in 80% of clients prescribed certain psychiatric medications that could affect glucose level.

4. Obtain signed consent forms in 90% of clients prescribed psychiatric medications.

Performance Improvement Projects

A minimum of two Performance Improvement Projects are conducted annually by the Santa Clara County Department of Mental Health. Performance Improvement projects are chosen based on State guidelines. For FY2011-12 the identified projects are:

1. Statewide EPSDT clinical Performance Improvement Project - responsible manager is Deane Wiley. Monitoring method is through EPSDT utilization data.
2. The IMD Assaultive Behavior non-clinical Performance Improvement Project - responsible manager is Sheila Yuter.

Quality Review Council - Responsible Manager, David Guerrero

The Santa Clara County Department of Mental Health Quality Review Council (QRC) is a standing body, composed of representatives selected system-wide and charged with the responsibility to provide recommendations to Executive Leadership regarding the QI Work Plan and QI activities. The Council is chaired by the QI Services Manager, who reports to the Mental Health Department Medical Director. Council members represent the following entities: Mental Health Plan administration, pharmacy services, direct service provider agencies, the Santa Clara County Mental Health Board, and Consumer, Family and Mental Health advocates. The QRC meets bimonthly. The following issues have been identified for focus in FY2011-12.

1. Consumer grievances and mental health advocacy issues
2. Consumer and family satisfaction
3. Serious incidents and critical issues related to consumer care and system breakdowns
4. Quality and continuity of care, transfer of responsibility for services between one provider to another
5. The fostering and establishment of the recovery and wellness model throughout the system of care

6. Compliance with oversight agency mandates
7. Annual evaluation of overall QI Services effectiveness

The specific roles and responsibilities of the QRC are:

1. Ensure implementation of Quality Improvement Plan, and encourage stakeholder participation at all levels in QI activities.
2. Participate in the development of corrective action recommendations based upon findings from quarterly quality or other reviews; forward the recommendations to Executive Level MHP management.
3. Assist in identifying and prioritizing areas needing improvement using stakeholder input and reports provided by the Decision Support Program and other Information Resources.
4. Review and make recommendation to Executive MPH management about quality improvement project proposals.
5. As directed by Executive MHP management, facilitate implementation of quality improvement proposals.
6. Integrate the findings of reviews, reports, and other information submitted as part of QI monitoring, including:
    a) Quality monitoring
    b) Case record review
    c) Outcomes measurement
    d) Consumer satisfaction
7. Assess the effectiveness of actions taken and review documented outcomes.
8. Make necessary recommendations to Executive MPH management.
9. Facilitate communication of QI activities among Staff, Management, Consumers and Executive management.

Executive Management's Role in Quality

The Executive MHP management ultimately decides what the QI objectives will be for Santa Clara County Mental Health Plan and how available resources are to be allocated in realizing these objectives. In evaluating QI results, information and recommendations received from the QRC, executive management may take one of the following courses of action:

1. Decide that conditions are satisfactory and take no further action;
2. Decide that conditions warrant further monitoring but that no immediate action is required;
3. Decide that conditions warrant immediate attention but can be addressed through simple corrective action; or
4. Decide that conditions warrant immediate attention and would be best addressed through work team or standing committee of the QRC.

Quality Feedback

The Santa Clara County Mental Health Plan provides its service recipients, governing body, personnel, and other stakeholders with clear, concise, and timely information regarding all aspects of its QI process. On an annual basis, the agency will make available to all stakeholders a report of its findings from its QI process. As applicable, the Santa Clara County MHP will also submit summary results of its planning and evaluation processes to the governing body. This is the responsibility of the Director of Mental Health. Additionally, pertinent data gathered from the outcome measurement system and other QI processes are distributed annually to all service providers.

The Annual Evaluation of the Quality Improvement Program also summarizes findings in the following areas:

- Ongoing nature of quality management activities
- Comprehensive involvement of all departments and services
- Effectiveness of CQI action plans
- Effective use of agency resources and fiscal costs involved

Attachment 1

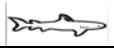
Quality Improvement Program Activities

The following is a comprehensive list of items the QI Program provides, monitors, tracks and evaluates on an annual basis.

1 Clinical record review of county and outpatient contractors for compliance with established documentation standards and appropriateness of care
2 Administrative review of outpatient county and contractor providers for compliance with established standards
3 Fee-for-Service Contractor Clinical Record Review
4 Mentoring Program
5 Assistance on EPSDT Audits
6 Assistance on Compliance directed Audits
7 Outpatient site certification per SDMH requirements
8 Documentation training
9 Documentation technical assistance
10 Approval of TBS authorizations employing established standards
11 Approval of Day Treatment Intensive/Day Rehabilitation authorizations employing established standards
12 Participation at RISC Meeting
13 Processing of grievances and appeals from consumers
14 Processing of license waiver requests for staff who have not yet obtained licensure
15 Processing of MHRS certifications
16 Processing of mid-level credentialing
17 Processing of fee-for-service credentialing
18 Medicare Application Processing
19 NPI Related Processing
20 5150 Authorization Processing
21 Documentation Workgroup
22 QRC Assistance
23 CALQIC / BAYQIC Representation
24 TCP Assistance/Participation
25 TCP Form Workgroup
26 Provision of UniCare new user applications and computer setups

FY2010-11 Accomplishments: Quality Improvement Program Activities

ACTIVITY:	**FY2010-11 ACCOMPLISHMENTS**
1 Clinical Record Reviews (CRR) – All staff	QI Reviewed 733 charts for FY2010-2011 CRR.
2 Administrative Reviews (AR) – All staff	QI conducted 35 off-site county/contractor AR's for FY 2010-2011.

ACTIVITY:	FY2010-11 ACCOMPLISHMENTS
3 Fee-For -Service Reviews (FFS) - Michele, Cheryl	QI reviewed 13 Providers. – 38 charts for FY2010-11.
4 Mentoring : Contractors =2; County =6	Mandatory mentoring for those sites with over 5% disallowance in FY 2010-11 CRR. 
5 EPSDT Audits (County)	None in FY 2010-11
6 Special/Comp Audits — All Staff	Org #1 =130; Org #2= 86; Org #3 = 14
7 Site Certifications -Mary(Lead), Michele, Cheryl	Conducted 25 off-site contractor inspections. Presently inspecting 6 County sites for certification. 10 County sites due for certifications in FY2011-12.
8 Documentation Training – All Staff	QI conducts 6 Documentation Trainings each calendar year. Conducted mandatory documentation training for county HCPMs and Leads in July, August 2010.
9 Documentation Assist – All Staff	QI available 5 days/week for e-mails and phone calls to assist county and contract staff with documentation questions.
10 TBS Authorizations-Cheryl, Mary, Bob	QI reviewed 483 Treatment Plans in order to authorize TBS in FY2010-11.
11 DTI/DR/Conc urrent Services Authorizations – Taraneh (Lead); Michele	Processed 2094 DTI/DR and concurrent authorization requests in FY 2010-11
12 RISC Meeting	Cheryl attends Friday morning RISC Meetings in the role of County MH over sight representative for TBS.
13 Grievances and Appeals - Bob, Michele, Mary and Cheryl	QI facilitated 41 grievance resolutions and 6 appeals resolutions in FY 2010-11
14 License Waivers ASW, MFTI & Ph.D (w/Mgr.) -Taraneh	QI processed 250 waiver requests
15 MHRS Certifications - Taraneh	QI processed 80 MHRS certifications
16 Mid-Level Credentialing - Taraneh	QI processed several applications

ACTIVITY:	FY2010-11 ACCOMPLISHMENTS
17 FFS Credentialing w/Mgr - Mary	QI reviewed 52 FFS Credential Applications in FY 2010-11
18 Medicare Applications – Taraneh, Michele, Jackie, Lily	New QI project since 7/2011. for QI. MDs at Short-Doyle clinics have to be registered for Medicare billing to occur. Lily keeps list of doctors who need initial applications.
19 NPI – Taraneh, Lily	QI processed 1500 NPI
20 5150 Training and Authorization Card Issuance – Jackie, Bob, Taraneh (back-up)	QI processed 435 applications for 5150 course. All were certified in FY2010-11
21 Documentation Workgroup	County and Contractor group that worked along with QI on updating the Documentation Manual. Completed February, 2010.
22 Quality Review Committee (QRC) - Facilitated by David	6 meetings per FY. All QI staff present.
23 CALQIC/BayQic	QI Coordinators did not attend CalQic Conference due to budget constraints. BayQic meetings not attended in FY 2010-11
24 TCP - All staff	QI participates in bi-monthly F&C and A/OA redesign. QI attends Ops meeting re: TCP once per month. QI staff has attended TCP trainings for F&C and A/OA. QI involved in learning about TCP model from its inception.
25 TCP Form Workgroup – Michele, Domingo Facilitated by David	Meetings began 8/3/11; held every 2 weeks; Workgroup created a template of TCP Treatment Plan &Treatment Plan Update form; Assessment up for review. Changes for the purpose of inter-weaving TCP into our system of care.
26 Unicare Provider Entry - Lily	Processed 1500 unicare entries of Drs, staff, and clerical so county and contract clinics can add to their individual teams. New hires and transfer staff from both county and contractors are included in the above unicare entries for FY 2010-11.