California Network of Mental Health Clients

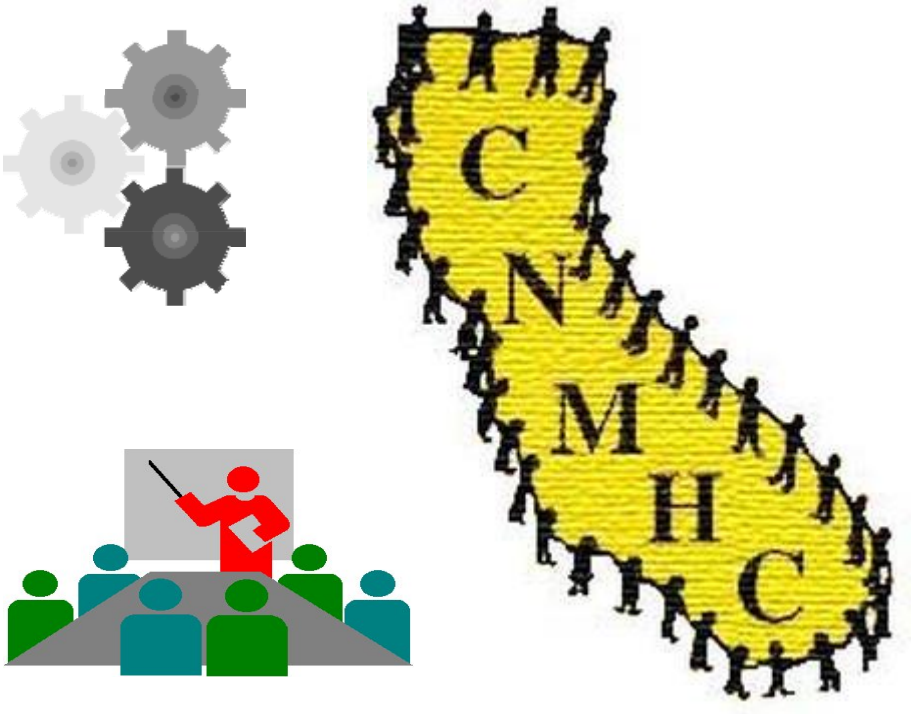
Presents

# QIC Manual

## For

## Quality Improvement Committee

Version 1.5.1




Project of the Far South Region

Compiled and Written by Kathi Stringer – April 10, 2005, Revised June 4, 2005

Edited by Georgette deFriesse

# Table of Contents

# Dedication

This QIC Manual is dedicated in recognition of Cheryl Thompson, an extremely effective and knowledgeable mental health attorney and a warrior for the clients that were involuntary hospitalized. In her attorney and advocate role she was intelligent, fearless, tenacious and most of all, compassionate to mental health clients. Tragically, Cheryl Thompson's transfer out of the Riverside county mental health courts was a colossal loss to all the mental health clients in Riverside County.

Kathi Stringer

## Forward – by Kathi Stringer
Director of the Far-South Region of the CNMHC

### Why
Often times it seems people that come to QIC meetings are lost or don't have a clue as to what is going on. In these cases members/visitors may drop out due to the frustration from lack of improvements. Or many feel like their presence doesn't make a difference because nothing ever changes, or if it does, it is at a snail's pace. Some feel like meetings are a place to vent and little else. However, we ARE encouraged with this new QIC manual, the first of its kind to get Mental Health Service improvements on the move and into action.

### When
During a NETWORK regional meeting in Orange County California in 2004, the suggestion of a QIC manual was voted in by the California Network of Mental Health Clients as their 2004/2005 Regional Project for a statewide tool, reference and guide to assist QIC members to have meaningful and knowledgeable participation in QIC meetings.

### Who
You! You can make a difference. Even if you read the contents of this manual and support your fellow members with a raise of hands with an informed choice, you can/will help make the future brighter for everyone.

### How
Show up at the monthly meetings! Your presence is a vital first step. You can also meet with other QIC members to discuss issues of concern during the week. Between QIC meetings, you can hold townhall-style meetings to brainstorm on how to improve upon the foundation of this manual. Remember that this manual is only a starting point. The possibilities are as endless as your imagination.

### Hopes/Goals
To change → "Nothing changes if nothing changes." Set your sights on well-defined goals and keep working towards them. When you feel discouraged, remember: There is always more than one way to get things done. This QIC manual is only a starting point to get you up and running!

## How to Use this QIC Manual

We'd like to get you up and running quickly as possible. In order to do that, this manual is split up into several sections. The more in-depth information is placed at the end of the manual.

To help make the written content easier to understand and to aid in the learning process, we make ample use of examples, charts and illustrations.

## Source

Part of the material in this manual was extracted from the State Department of Mental Health Website and from the State Quality Improvement Counsel, and other policy and procedures manuals written by State employees or contractors. Included are flow charts and step-models written especially for this manual along with flow charts from the State Department of Mental Health. *References are in "[ ]"*

Remember what the first Model-T Automobiles looked like compared to today's cars? Similarly, this is the NETWORK'S first QIC Manual, and this manual is just the beginning! There is a great deal of room for improvement as other members get excited and involved. Optimistically, individuals with different perspectives will add their contributions, and QIC Manual version 1.5.1 will continue to be revised. We hope this manual will inspire you and stir your imagination to the endless opportunities for performance improvement! Our number one goal is to insure "*Safety – Avoiding injuries to patients from the care that is intended to help them.*"

You are a pioneer in developing and beta testing the NETWORK'S first QIC manual! Congratulations and welcome aboard!

## *"Crossing the Quality Chasm"*

Quality Improvement and Accountability
Proposes six aims for quality improvement.

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**Safety –**

**Avoiding injuries to patients from the care that is intended to help them**

**Effectiveness –**

**Providing services based n scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and overuse, respectively)**

**Patient–centered –**

**Providing care that is respectful of and responsive to individual patient preferences, needs, and values guide all clinical decisions.**

**Timeliness –**

**Reducing waits and sometimes harmful delays for both those who receive and those who give care.**

**Efficiency –**

**Avoiding waste, including waste of equipment, supplies, ideas and energy.**

**Equity –**

**Providing care that does not vary in quality because of personal characteristics, such as gender, ethnicity, geographic location, and socioeconomic status.**

“The State Quality Improvement Counsel (SQIC) believes that these 6 aims of quality improvement can be very useful in generating new performance indicators.”

**California State Mental Health Quality Strategy [1]**

# Overview

## Why would a Quality Improvement Committee (QIC) procedure manual be helpful?

Many people do not have the slightest idea what a Quality Improvement Committee does. It may be that visitors and new members come to the monthly meetings, yet remain in a fog as to exactly how they can contribute to the process. It all seems very complex, so they sit in the meetings and try to 'wing it,' hoping for more clues from meeting to meeting. For this reason, many become discouraged or drop out. And who could blame them? Who would want to play a board game that is missing the instructions? One gets the feeling the rules and goals change depending on who is running the game. For this reason, the California Network of Mental Health Clients (CNMHC) voted to create a QIC manual as a step-by-step guide for clients to participate knowledgeably and effectively on the Quality Improvement Committees.

This manual will explain how performance improvement begins. It will explain State-to-County QIC policy & guidelines. It will help diminish the vagueness associated with the function of QIC. It will help explain and simplify complicated and confusing data. It will help explain the importance of collecting data that is accurate, appropriate, and which reflects the entire process. It will help identify resources available for brainstorming and problem solving. It can serve as a handbook and be used universally as a teaching aid.

## What is QIC?

- QIC = Quality Improvement Committee (QIC).
- Each county in California that has a Mental Health Plan (MHP) must have a Quality Improvement Committee.

## Why would QIC be important to you?

QIC will be of important to you if:

- You are interested in the quality of out-patient services
- You are interested in the quality of in-patient services
- You are interested in improving mental health services

## Who comes to a QIC meeting?

- Stakeholders: Mental health providers, beneficiaries, and parents, spouses, relatives, legal representatives, or other persons similarly involved with beneficiaries who have accessed specialty mental health services.
- Includes substantial involvement of a licensed mental health professional.

## What are the duties of QIC?

- QIC shall review the quality of *specialty mental health services* provided to beneficiaries by the Mental Health Plan (MHP). Most duties are outlined in the *Quality Improvement Program and the Quality Improvement Work Plan*. (QI Work Plan)
- QIC does MORE then make recommendations → QIC shall have an active involvement in planning, design and execution to the QI Program/Plan for monitoring quality of services. [13; 15]
- QIC shall have an active involvement in reviewing and revising the QI Work Plan as appropriate annually. [13; 15]
- Please note: It is imperative that QIC review the actual Quality Improvement Work Plan and NOT just an outline provided by the county.

## What types of things does QIC monitor?

- Conducts monitoring activities including but not limited to review of beneficiary complaints and grievances and fair hearings, provider appeals, and clinical records review. [13; 15]
- Monitors but not limited to → Service Delivery Capacity of the MHP, Accessibility of Services, Beneficiary satisfaction, MHP's service delivery system, continuity and coordination of care with physical health, provider appeals AND two (2) Performance Improvement Projects (PIP,s) [15; 17]
- Other areas as identified by staff and QIC members. [15; 17]

We Will Also Learn:

## How to Read a Report

Main Emphasis

You will receive many reports that are passed out in QIC meetings.

We will learn in this manual – What is IN the report and what is MISSING from the report – once you learn this, you will be half way there!

Before or after your ***first*** QIC meeting review the following list –

Bring – 

Bring this QIC manual.
Bring a note pad for taking notes
Bring a pen or pencil
And, you may also want to bring a highlighter.

## What to ask for:

- The current County Performance Improvement Work Plan
- The last QI performance Evaluation Sent to the State
- The last 3 months of QIC minutes.
- Any recent reports passed out at QIC meetings.

It not uncommon that some county departments will give incomplete information or just handout; an 'outline' of the QI Work Plan, or report, or whatever, to 'save you the trouble' of reading the actual plans or policies. However, be persistent in getting the actual plans and reports, because they are vital in your 'complete' understanding of this manual and how performance improvement works.

## Ask Questions

If something is not clear in a QIC meeting, such as a report, handout information, figures, etc., it is okay ask questions… and certainly, we encourage to ask questions. Gathering additional information usually begins with a question. Additionally, often times when a person asks a question, others also find the information useful. Take a chance and ask a question!

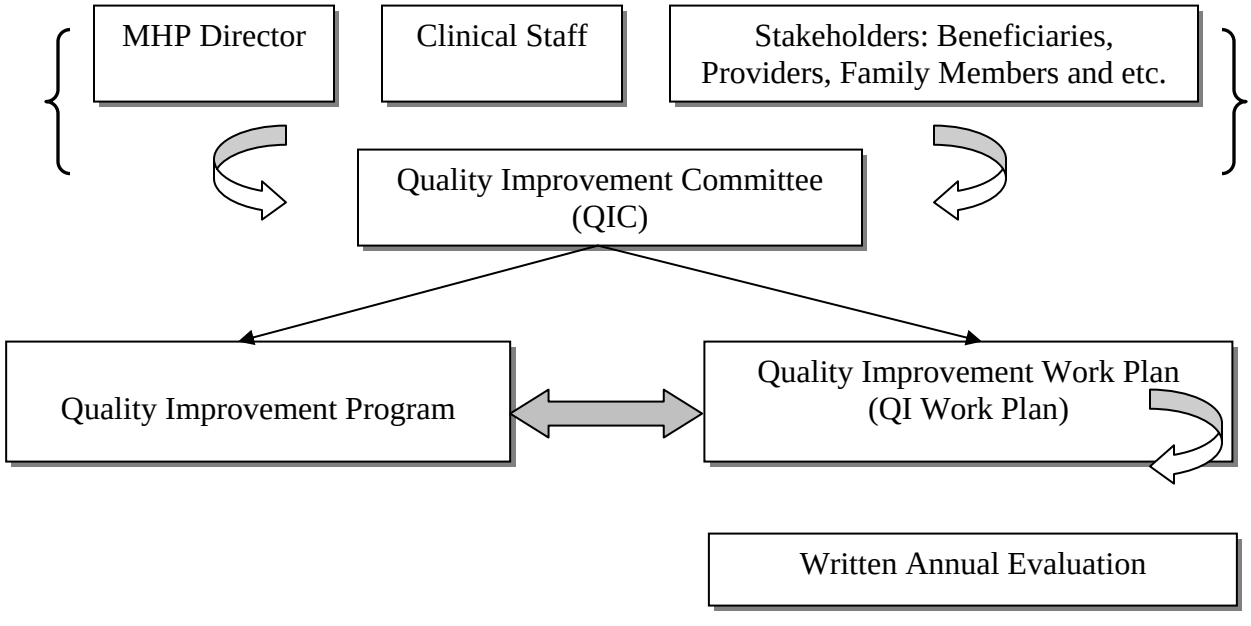
? = Information

# The Basics

## What is a Quality Improvement Program and Quality Improvement Work Plan?

MHP = Mental Health Plan
QIC = Quality Improvement Committee
QI Program = Quality Improvement Program
QI Work Plan = Quality Improvement Work Plan

## QIC Flow Chart




<u>Every Mental Health Plan (MHP) must have a QI Program AND a QI Work Plan</u> [15]
Each Mental Health Plan (MHP) shall have #1, a Quality Improvement Program AND #2, a Quality Improvement Work Plan. The QI Work Plan is only one part of the QI Program. The QI Work Plan helps to make sure that the delivery of Mental Health services is on track and getting good quality services to the beneficiaries.

<u>Quality Improvement Program</u> [15]
The QI Program shall have a written description in which structure and processes are clearly defined with responsibility assigned to appropriate individuals

1. The QI Program description will/shall be evaluated annually and updated as necessary.
2. The QI Program will/shall be accountable to the MHP Director.
3. A licensed mental health staff person will/shall have substantial involvement in QI Program implementation.
4. Stakeholders' → Mental health providers, beneficiaries, and parents, spouses, relatives, legal representatives, or other persons similarly involved with beneficiaries who have accessed specialty mental health services will/shall actively participate in the planning, design and execution of the QI Program.
5. The role, structure, function and frequency of meetings of the QIC and other relevant committees will/shall be specified.
6. The QIC will/shall oversee and be involved in QI activities, including performance improvement projects
7. The QIC will/shall recommend policy decisions; review and ***evaluate*** the results of QI activities, including performance improvement projects; institute needed QI actions; and ensure follow-up of QI processes.
8. Dated and signed minutes will/shall reflect all QIC decisions and actions.
9. The QI Program will/shall coordinate with performance monitoring activities throughout the MHP, but not limited to, beneficiary and system outcomes, utilization management, credentialing, monitoring and resolution of beneficiary grievances and fair hearings and provider appeals, assessment of beneficiary and provider satisfaction, and clinical records.
10. Review contracts with hospitals and with individual, group and organizational providers will/shall require:
    - Cooperation with the MHP's QI Program, and
    - Access to relevant clinical records to the extent permitted by State and Federal laws by the MHP and other relevant parties.

Quality Improvement Work Plan

The QI Program will/shall have an Annual QI Work Plan including the following:

- QIC oversees and examines all mandatory components of the MHP QI Work Plan.
- An annual evaluation of the overall effectiveness of the QI Program, demonstrating the QI activities, including performance improvement projects, have contributed to meaningful improvement in clinical care and beneficiary service, and describing completed and in-process QI activities, including performance improvement projects.
- Monitoring of previously identified issues, including tracking of issues over time.
- And, objectives, scope, and planned activities for the coming year, including QI areas and any additional areas required by the Centers for Medicare and Medicaid (CMS)
  - Monitoring → (1) Service Delivery Capacity of the MHP, (2) Accessibility of Services, (3) Beneficiary satisfaction, (4) MHP's service delivery system, (5) Continuity and coordination of care with physical health, (6) Provider appeals AND two (2) Performance Improvement Projects (PIP,s)
- Other areas as identified by staff and QIC members.

# QIC – What you need to know to get started –

Abstract: QIC must develop a QI Work Plan to look at six (6) State identified areas plus two (2) Performance Improvement Projects (PIP's) *in addition* to other areas of concern to QIC.

STATE IDENTIFIED AREAS [17]

1. Monitor Service Delivery Capacity of the MHP
2. Monitor Accessibility of Services
3. Monitor Beneficiary satisfaction
4. Monitor MHP's service delivery system
5. Monitor continuity and coordination of care with physical health
6. Monitoring of provider appeals.

PERFORMANCE IMPROVEMENT PROJECTS [17]

1. One Clinical
2. One non-Clinical

OTHER AREAS OF CONCERN TO QIC

Conducts monitoring activities including but not limited to review of beneficiary complaints and grievances and fair hearings, provider appeals, and clinical records review. [25]

## The Quality Improvement Committee (QIC) must have a QI Work Plan (=type of blueprint) that includes all of the following:

- An annual evaluation of the overall effectiveness of the QI Program, demonstrating that QI activities, including performance improvement projects, have contributed to meaningful improvement in clinical care and beneficiary service, and describing completed and in-process QI activities, including performance improvement projects.
- Monitoring of previously identified issues, including tracking of issues over time;
- Planning and initiation of activities for sustaining improvement, and;
- Objectives, scope, and planned activities for the coming year, including QI activities in each of six (6) areas – See Six (6) Mandatory Items to be monitored by QIC in the Chart on the next.
- Two (2) Performance Improvement Projects (PIP') – One clinical and one non-clinical.

# QIC Range of Duties and Discretion

## Quality Improvement Committee

Monitors & Plans, Design & Execute

- Service Delivery Capacity of the MHP
- Accessibility of Services
- Beneficiary satisfaction
- MHP's service delivery system
- Continuity and coordination of care with physical health
- Provider Appeals.

FOLLOW-UP
Monitoring of previously identified issues, including tracking of issues over time.

Planning and initiation of activities for sustaining improvement.

OTHER AREAS OF CONCERN TO QIC

Conducts monitoring activities including but not limited to review of beneficiary complaints and grievances and fair hearings, provider appeals, and clinical records review.

PIP's → Two (2) Performance Improvement Projects → 1 Clinical & 1 Non-Clinical

An annual evaluation of the overall effectiveness of the QI Program,

KAS

# Six (6) Mandatory Items to be monitored by QIC

QIC shall evaluate the analyzed data to identify barriers to improvement that are related to clinical practice and/or administrative aspects of the delivery system. First we'll discuss in detail the six areas to be monitored. Then starting on page 19, we'll explain the five steps that make up the protocol for monitoring these six areas.

## #1 Monitor for Service Delivery Capacity of the MHP

- ***Requirement:*** The MHP will/shall implement mechanisms to assure the capacity of service delivery within the MHP.
  ***Question:*** How many beneficiaries qualify for services?

- ***Requirement:*** The MHP will describe the current number, types and geographic distribution of mental health services within its delivery system.
  ***Question:*** What kinds/type of services are offered?
  ***Question:*** Where are the services offered?
  ***Question:*** How are the services geographically distributed?
  Example: There are too many of one type of service in an area but not enough in another.

- ***Requirement:*** The MHP will/shall set goals for the number, type and geographic distribution of mental health services.
  ***Question:*** What improvements/goals could be set for all the above?

## #2 Monitor Accessibility of Services

- ***Requirement***: Timeliness of routine mental health appointments.
  ***Question***: Are patients getting their appointments often as needed?
  Example: The patients' appointments are getting pushed out further do to some sort of problem(s).

- ***Requirement***: Timeliness of services for urgent conditions
  ***Question:*** Do patients that have urgent/emergency conditions receive timely service?

- ***Requirement: Access to after-hours care.***
  ***Question:*** Is there access/places to go during after-hours for care/treatment/crisis?

- ***Requirement***: Responsiveness of the Mental Health Plan's 24 hour, toll free telephone number.
  ***Question:*** How responsive is the Mental Health Plan (MHP) 24-hour toll free telephone number?

Example: Secret shopper can call and ask a series of questions and write down the responses and compare them with the notes written down in a log at the time of the call. Hint: Establish some mechanism to monitor accessibility/responses from the contact toll free telephone number.

## #3 Monitor Beneficiary Satisfaction

The MHP will/shall implement mechanisms to ensure beneficiary or family satisfaction. The MHP will/shall assess beneficiary or family satisfaction by:

- ***Requirement***: Surveying beneficiary/family satisfaction with the MHP's services at least annually
  ***Question:*** _____
- ***Requirement***: Evaluating beneficiary grievances and fair hearings at least annually; and;
  ***Question:*** _____
- ***Requirement***: Evaluating requests to change persons providing services at least annually.
  ***Question:*** _____
- ***Requirement***: The MHP will/shall inform providers of the results of beneficiary/family satisfaction activities.
  ***Question:*** _____

Fill in your concerns – brainstorm and use our references throughout the manual

## #4 Monitor MHP's service delivery system

AND meaningful clinical issues affecting beneficiaries, including the safety and effectiveness of medication practices.

- ***Requirement***: The scope and content of the QI Program shall reflect the MHP's delivery system and meaningful clinical issues that affect its beneficiaries
  ***Question:*** _____
- ***Requirement***: Annually the MHP shall identify meaningful clinical issues that are that are relevant to its beneficiaries for assessment and evaluation.
  ***Question:*** _____
- ***Requirement***: These clinical issues shall include a review of the safety and effectiveness of medication practices. The review will/shall be under the supervision of a person licensed to prescribe or dispense prescription drugs.
  ***Question:*** _____

- ***Requirement***: Other clinical issue(s) shall be identified by the MHP.
  ***Question:*** _____

- ***Requirement***: The MHP shall implement appropriate interventions when individual occurrences or potential poor quality are identified.
  ***Question:*** *When a quality problem is identified, is there a written corrective action plan put in process with goals, timetables, and a baseline against which to measure progress?*

- ***Requirement***: AT A MINIMUM the MHP shall adopt or establish quantitative measures to assess performance and to identify and prioritize area(s) for improvement.
  ***Question:*** *What indicators or figures are the MHP using to measure progress? Is there a clearly defined formula or method to measure improvement*? What formula is used to decide which areas is prioritized?

- ***Requirement***: Providers, consumers and family members shall evaluate the analyzed data to identify barriers to improvement that are related to clinical practice and/or administrative aspects of the delivery system.
  ***Question:*** *Is the MHP giving QIC enough information in the written reports to compare if there has been improvement based on prior reports?*

## #5 Monitor continuity and coordination of care with physical health care providers and other human services agencies.

- ***Requirement***: The MHP will work to ensure that services are coordinated with physical health care and other agencies used by its beneficiaries
  ***Question:*** _____

- ***Requirement***: When appropriate, the MHP will/shall exchange information in an effective and timely manner with other agencies used by its beneficiaries
  ***Question:*** _____

- ***Requirement***: The MHP will/shall monitor the effectiveness of its MOU (Memorandum of Understanding) with Physical Health Care Plans.
  ***Question:*** _____

## #6 Monitoring of provider appeals.

# Root Cause Analysis

## Getting to the Bottom of It!

Things happen. Often, the root causes of problems are not apparent. Hidden circumstances create confusion and cloud our understanding of a problem. However, there is a simple tool that we can use as a template to cut through the confusion.

The fancy term for this tool is referred to as "Root Cause Analysis" (RCA). Root Cause Analysis, or RCA, is a method of asking a series of "WHY" questions to help identify the root problem. Usually the magic number is about <u>five</u> "why" questions. Using an example from a quality adviser for APS Health Care, let's "drill down" and see how this works:

In reviewing hospital admissions, a spike of admits stood out. This brings us to our <u>first</u> "why" question:

1. "Why is there a spike in hospital admissions?"
   After some analysis and teasing out data, many of the extra admits seemed to have one thing in common: They came from areas that had rural zip codes. Ah ha! Now for our <u>second</u> "why" question:
2. "Why are all the extra admits coming from distant and rural places?" After some digging, it turned out this cluster of clients mostly used a vendor transport service. Which brings us to our third question:
3. "Why are the clients that use the transport service exposed to higher hospital admit rates?" It appears the transport service wasn't getting paid correctly and their billing was getting rejected much of the time. As a result, the transport company cut back on its service. This of course meant that clients were missing their mental health appointments and falling through the cracks. Ah ha! And this brings us to our <u>fourth</u> question:
4. "Why was the transport vender not being paid correctly and on time?" It was discovered that recently, the county payer system had assigned new payee codes to all of its venders. Apparently there was a mix-up in this particular vender's code. Now, for our <u>fifth</u> and final question:
5. "Why was the payee code not assigned correctly?" After some investigation, a procedure and process error was found in how the original codes were reassigned with new codes.

Because we looked for the root cause, we were able to identify the problem and implement corrective action. By asking a series of "why" questions, we were able to drill down and investigate further.

Did you happen to notice something else? RCA usually finds a *procedure* or *process* that is failing; it does not focus so much on an individual. In our next example, which happened to one of my clients recently, we are able to see the difference between *process* and *individual*.

Jenny was involuntary hospitalized in a psychiatric hospital. During her hospitalization, she was given a shot of medicine against her will and according to her father, she was over drugged and "the doctor just blows her off". Let's use the RCA series of five "why" questions to find out why Jenny was drugged against her will.

1. "Why was Jenny given a shot against her will?"
   Inpatient staff stated, "To help her relax."
2. "Why did Jenny need help to relax?
   Inpatient staff continued, "Because she was running up and down the halls and calling 911."
3. "Why was Jenny running up and down the halls and calling 911?" The night charge nurse, her social worker, and the social worker's supervisor didn't have a clue, because nothing was in Jenny's clinical record. It was now time to drill down and look more deeply. I contacted the hospital Risk Manager and I rephrased the question: "What precipitated the events of Jenny running up and down the halls and calling 911?" Nothing. I drilled down even more. "Did Jenny have any problems revolving around her medication that morning? It was indicated that about one hour before Jenny was running up and down the halls, she had declined to take her medication that morning. Which brings us to our next question:
4. "Why did Jenny refuse to take her medication that morning?" It turns out that Jenny was getting sick on her current dose of medication taken twice a day. She was about to refuse to take the medication but was ambivalent because she wanted to be treatment compliant. A compromise was reached between her and her doctor, and she was told she could take the medication 3 times a day in smaller doses. However, the next morning at med time, Jenny was asked to take the same dosage that made her sick. The doctor didn't live up to his side of the bargain. Jenny refused the higher dosage. Furthermore, she was likely to be invalidated further when staff indicated that if she didn't take it, she would be kept longer and, if needed, they would get a court order to have her involuntary medicated. Apparently Jenny dwelled on this for an hour and felt she wasn't being heard and agreements were not being honored. Her resentment and anxiety heightened until she was running up and down the halls. Which brings us to our fifth "why" question:
5. "Why didn't Jenny get her lower dosage of medication?"
   Because we weren't privy to the hospital policy we can only speculate why, and recommend corrective action in the following areas:
   - ◊ Frequent in-service training in communication with clients concerning agreements with staff and doctors.
   - ◊ Revise procedure manual to chart what precipitated a client's significant change in behavior.

The result of this RCA suggests that hospital policy and procedure have failed, along with in-service training. The focus was on a *system of policy and procedures*, not on the *individuals* involved in the incident. When identifying "root-gaps," (training and communication in this case) most times we find that we are in a better position to make sweeping improvements throughout the organization, rather than targeting a single individual. Thus the effectiveness of our effort has been multiplied.

## REPORTS [19, 20]

## Looking At Data – Is there a Concern?

- QIC looks at different items mandated by the state in the Quality Improvement Work Plan, and if necessary, plans, designs and executes a plan to correct and/or improve problem(s). The following 5-step protocol shall be followed for each of the Quality Improvement (QI) Work Plan activities (the six areas listed above on pages 14 through 16, not including mandated Performance Improvement Projects), to ensure that the MHP is monitoring the implementation of the QI activities:

### Protocol

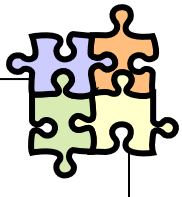
1. ***Requirement:*** Collect and analyze data to measure against the goals, or prioritized areas of improvement that have been identified.
   ***Question:*** _____
2. ***Requirement:*** Identify opportunities for improvement and decide which opportunities to pursue.
   ***Question:*** _____
3. ***Requirement:*** Design and implement interventions to improve its performance.
   ***Question:*** _____
4. ***Requirement:*** Measure the effectiveness of the interventions.
   ***Question:*** _____
5. ***Requirement:*** Incorporate successful interventions in the MHP as appropriate.
   ***Question:*** _____

## What to look for in a report: [19, 20]

Example → Beneficiary Grievances for the current year.

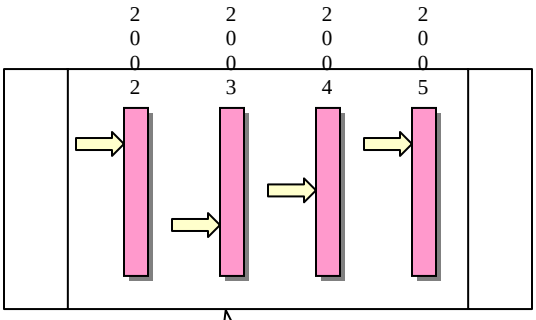
KEYWORDS

- Concern(s)
- Data
- Performance Measurement
- Indicator(s)
- Baseline
- Benchmark
- Domain (Used in PIPS)



Each domain has indicators.
Each indicator has measures.
Each measure has corresponding source data via surveys, empirical evidence or special studies. See Appendix E

## Indicators [19, 20]




Note: "/" same as "divide by"

### Is there at least one Concern?

Yes, I am concerned there are 150 grievances reported to QIC.
A concern needs to have corresponding data to develop an indicator

- Data #1 → 150 Beneficiary Grievances
- Data #2 → 2000 Beneficiaries in the system

Remember the Star Trek Indicators in Sickbay bobbing up and down?

$$\frac{\text{Data 1}}{\text{Data 2}} = \text{Indicator}$$

### Concerns can be developed into Indicators.

Once a concern is identified, using performance measurement from data sources develops an indicator.

### Performance Measurement

- **Is there a formula for performance measurement?**
  - **Yes** → Data #1 / Data #2 = Percentage of Unhappy Beneficiaries
- Data #1 (150 grievances) divided by Total number of beneficiaries in the system, 2000 beneficiaries = percentage of unhappy beneficiaries.
- 150/2000 = 7.5% unhappy beneficiaries. →

7.5% → Note: 7.5% is an Indicator

### Indicators

Once the Performance Measurement is completed (data#1 / data#2), we have developed an ***indicator***. In the case above, 7.5% is our newly developed ***indicator***.

Indicators by themselves don't mean as much as when we compare them with other indicators. Meaning is "7.5% of unhappy beneficiaries good or bad? We don't know. We need the last report to compare it with to see if 7.5% is higher or lower?

### Baseline

**Is there a baseline → in the last report? Are the indicators relevant to each other?**
Our ***baseline*** could be our indicator for last year's report.
For example, last year's report showed only 75 grievances. And of course, this year has 150 grievances. At first glance, it looks like there are twice as many grievances this year! However, last year's report with 75 grievances had 1000 total beneficiaries in the system, and this year we had a total of 2000 beneficiaries in the system. Now, lets do the following Performance Measurements that will develop our ***indicators*** to find out if last year's performance improvement report is different then this year's performance improvement report.

<u>Report #1</u> → Last year's report
75 grievances divided by 1000 beneficiaries = 7.5% of beneficiaries unhappy.
Last year's indicator = 7.5%

Report #2 → This year's report
150 grievances divided by 2000 beneficiaries = 7.5% of beneficiaries unhappy.
This year's indicator = 7.5%

RESULT: No change. In both years 7.5% of the beneficiaries were unhappy. In our example, our indicator from last year's report is NOT any different from the indicator in this years report. By comparing these two indicators, we can see there has NOT been any improvement in reducing the number of grievances. This is why it is important to compare one indicator with another indicator to make a determination if there has been ***performance improvement***.

**Problem: When there is no baseline/indicator (the last report)**
In these cases there is no method to compare progress. If this is the first report, it is very important to note that there is at least 1 indicator (can be a baseline if we wish) to compare and develop a baseline for the next report. Often times a previous report will have data WITHOUT an indicator, say data of 75 grievances. But 75 grievances is relative to what? We need one more data source (1000 beneficiaries that is not in this report). However, when the next report comes out, say 150 grievances, we can ask how many beneficiaries are in the system. When we get our data of 2000 beneficiaries in the system, we can now develop our NEW indicator. Now we have yardstick/baseline to make a complete comparison for the next report (data#1 / data#2 = indicator). We now have a new baseline/indicator ready for our next report when it comes out.

## Additional Data for Indicators

- Review reports carefully. Some reports would be much better to have more then 1 indicator. A good report will contain enough data to measure performance outcome. For example, lets look at a patient's rights grievance report that contains five (5) sources of data that we can use to develop indicators.

1. **Number of patients**
2. **Type of grievance**
   *Note: Perhaps some grievances are more severe then others. If most of the grievances were about excessive force and restraint one month, and then mostly about late/lost appointments the next month, that would make a difference on how you would view the report.*
3. **Which facility did the grievance come from?**
   *Note: This question is important. Lets suppose most the grievances came from a single facility one month and then split between 3 facilities the next month- this could make a difference on how you would view the report.*
4. **Current status of each grievance**
   *Note: Has the grievance been resolved?*
5. **Finally, the outcome of each grievance.**
   *Was the grievance resolved to the satifisation of the* beneficiary*? Was the grievance rejected from lack of evidence?*

6. As you can clearly see, additional data will tell us more about the quality of services being delivered.

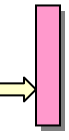
## Example – Measuring Access to Services

Because the county is the sole source for authorizing treatment, Medi-Cal beneficiary access (county wide) to services must be assured. Access to services is measured by <u>comparing the number of qualified beneficiaries with the actual beneficiaries that access the system.</u> This will give us an INDICATOR. For instance, a red flag could be raised if only 25% of the beneficiaries were served. It would be up to QIC to help figure out why. Are the services too far apart? Are services not available in many places? Is there a language or communication problem? Is the county understaffed? Is there a shortage of licensed professionals? These types of questions and problem solving are the concerns and duties of QIC. Lets take a look at how this if figured out below:

Noted: Divided-by is the same as using "/ "

Measure: Data#1 / Data#2 = Indicator
Measure: Numerator / Dominator = Percentage of Beneficiaries That Access System
Measure: = 100,000 / 400,000 = 25%
"Our Indicator for year 2005 is 25%"

$$\frac{\text{Data 1}}{\text{Data 2}} = \text{Indicator} = 25\%$$




$$\frac{\text{Numerator}}{\text{Dominator}} = \frac{\text{Number of Beneficiaries Accessing the System}}{\text{Qualified Beneficiaries To Receive Services}} = \frac{100{,}000}{400{,}000} = \text{25\% Accessing the System}$$

Note: Numerator and Dominator are often times are used for Performance Measurement Calculations to give us our Indicator

## More on Indicators [19, 20]

25 apples out of 100 apples are bad. Method → 25/100 is a performance measurement that indicates 25% of the apples are bad.

Everything begins with a CONCERN.

Lets say we have a question, which of course would be a *concern(s);* "Has there has been a reduction in the use of restraints?" We could look at our concern in 3 different ways. (1) "Has there been a reduction in the beneficiaries restrained?" AND, (2) "Has there been a reduction in the frequency each beneficiary has been restrained?" AND, (3) "Has there been a reduction in the time each beneficiary is in restraints?" Evidently, we have a concern for each of the following:

Is there a reduction of:

1. Number of beneficiaries in restraints?
2. Frequency beneficiaries are in restrains?
3. Time beneficiaries are in restraints?

Note: Each Result will be an Indicator and we will have 3 indicators

We need the following data for our performance measurements that will develop our indicators.

- Data #1 → Number of beneficiaries admitted to hospital → 300 clients admitted
- Data #2 → Number of beneficiaries restrained. → 40 clients in restraints;
- Data #3 → Total number of times beneficiaries were restrained. → 70 times;
- Data #4 → Total hours beneficiaries were restrained. → 350 hours.

Next: Performance Measurement results ARE our Indicators
Average beneficiary restrained per admit → Data #1 / Data #2 → 40/300 = 2.5%
Frequency each beneficiary in restraints → Data #3 / Data #2 → 70/40 = 1.75 av. freq.
Average length of <<added words>> time in restraints → Data #4 / Data #3 = → 350/70 = 5 hours

2.5 percent of all admitted beneficiaries were in restraints and;
Average = each beneficiaries restrained 1.75 times for 5 hours each restraint.

Indicator #1 = 2.5%
Indicator #2 = 1.75 av. frequency per client.
Indicator #3 = 5 hours av. duration per restraint.

Last and most important, compare this report with the last report. If the last report was the first one, it could act as a starting point or a baseline to compare and determine if there will be performance improvement in future reports.

Exercise – Lets develop some indicators and compare for Performance Improvement!

# PERFORMANCE IMPROVEMENT WORK SHEET

Concern → Data → Performance Measurement → Develops an Indicator → Compare to Last Report → Improvement?

| CONCERN | DATA | MEASURMENT | INDICATOR | LAST REPORT | IMPROVEMENT? |
|---|---|---|---|---|---|
| ***Question*** – Is all the required clinical information in the beneficiaries chart? | Data#1 5 charts failed inspection<br><br>Data#2 50 charts were inspected | Data #1 / Data #2 =<br>Or<br>5 / 50 = | 10% Failed | 13% Failed | 13%-10% =<br><br>3% Improvement |
| | | | | | |
| ***Question*** – Has there been a reduction in the number of seclusions in the county hospital this month? | Data#1 = _____ in Seclusion<br><br>Data#2= _____ admitted in the hospital | Data#1 / Data#2 =<br>Or<br>_____ | _____% Secluded | _____% Secluded | ? |
| | | | | | |
| ***Question*** – Has there been a reduction in the number of restraints in the county hospital this month? | Data#1 = _____ in Restraints<br><br>Data#2= _____ admitted in the hospital | Data#1 / Data#2 =<br>Or<br>_____ | _____% Restrained | _____% Restrained | ? |

ACTUAL SAMPLE REPORT To QIC

## #2 Monitor Accessibility of Services (State Required)

A verbal report was given for this state mandated item at a QIC meeting. The Quality Assurance person verbally indicated that 'secret shopper' test calls were done. Persons pretending to need mental health services from the County Mental Health Plan (MHP) called the county hotline (Central Access Team – CAT) for help. Later, the QI department looked at the logged test calls to compare them for how accurate the ACT operator took the information from the caller, AND examined the operator's responses to the caller.

### Reported Verbally to QIC

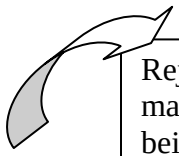
It was indicated in an email that reason verbal data was given to QIC is because this "is such a small and simple study." " *The point was, we made 17 test calls and she reported that 14 were logged by the program correctly and 3 were not. That was the report and what the state wants to know.*"

### Impression From this Report

What did we learn about ***performance improvement*** from this QIC verbal report? Not much. The report was relevant to nothing as presented. There was nothing in this report that applied ***performance measurements to develop an indicator for comparison to an earlier report***. The report did not mention an indicator from the data presented, nor did the report mention data or indicators from the last report. In fact, this report was out of compliance with the QIC Quality Improvement Work Plan. The QI Work Plan calls for analysis and measurements to set benchmarks and baselines to help prioritize QI projects. Now lets do some work with the verbal report to create an initial baseline for the next report.

Data#1 – 3 Calls Rejected
Data#2 – 17 Test Calls Made

Performance Measurement – 3/17 = 18%
18% is our new indicator



Rejection rates over 3% (3 out of 100) in many companies will result in the whole lot being rejected and require documentation for corrective action immediately.

***18% of the calls were rejected!*** This by most standards is a very high rejection rate. High rejection rates should always be addressed with Corrective Action and the action should be relayed to QIC. In this case, no one in the QIC was even aware there was an 18% rejection rate because of how the verbal report was presented. This is why a QIC manual can help members recognize problems; develop indicators for new baselines, discover failed tests from limited data and more.

## Consideration of a Subcommittee To Address A Concern(s)

Example of a Flow Model for a Sub-Committee

Review Report → Review Indicator → Examine Source Data → State Concern

### Proceed?

If NO, continue to monitor the issue for the time being.

If YES, Proceed to Consider Subcommittee

### Consider Subcommittee

Define Project from Concern → What do you hope to accomplish?
Collect Data → Surveys, Databases, Special Studies, etc
Develop Indicators from Data → *(Ex Data#1 / Data#2 = Performance Indicator)*
Compare/Judge Indicators

Proceed?

If NO, continue to monitor the issue for the time being.

IF Yes → Consider the following 4 Steps

| | |
|---|---|
| #1 Develop Improvement Strategy<br>• Identify Possible Solutions<br>• Evaluate Solutions<br>• Implement Corrective Action | #3 Institutionalize Improved Process<br>• Modify Policy & Procedure<br>• Communicate Changes to Affected Areas |
| #2 Evaluate Results<br>• Collect New Data<br>• Draw Conclusions | #4 Monitor To Hold Gains |

Please see following flow chart next Page

Remove this page and replace with the attached
Step Flow Chart

# Member Considerations & Tools

## Check Out the Minutes:

Each month you come to QIC minutes will be passed out from the last meeting. The minutes are a summary of what happened in the meeting. Things to look for in the minutes:

1. Do the minutes appear to be objective? Meaning, do they portray and capture the essence of the meeting or do the minutes portray the meeting in a slanted, distorted light i.e. too positive or to negative?
2. Are any important subjects that were discussed during the last meeting missing? Or is only one aspect of the report, say all the positive comments in the minutes and none of the negative points? Look for a ***balance***.
   Example: Say the minutes in one meeting stated a single sentence about an issue, "*Kathi indicated it would be helpful to know how many beneficiaries are in the system?*" In this case the essence of the issue was not at all apparent. Kathi had requested the data to measure against the number of beneficiaries that requested to change their provider because they were unhappy. Kathi had discovered a problem with a report that didn't have enough data to develop an indicator, and the minutes did not reflect this problem. These are the sorts of things to watch for in the minutes. The minutes should reflect areas that need improvement. In this case, the minutes did not reflect any need for improvement in this area.
3. ***Are all the unfinished items set aside for <u>action</u> completed?*** For example, a Quality Improvement (QI) staffer may share that a beneficiary is upset because their county doctor will only give them one week of medication at a time. And after going though 2 levels of grievances, the outcome may be something like this: "*It is county policy that this certain type of medication can only be prescribed for one week at a time.*" However, your county doctor may be giving you the same kind of medication one month at a time. So the is a big difference of information that may alert you to inquire further. At that point you may want to ask to see the county policy on medication for this type of medication. If your request is accepted (and it should be) then you will have an 'action item' on the minutes for follow-up to clarify the issue.
4. If for some reason the committee chair will NOT hear your concerns/corrections, consider stating the following for the record to be on the minutes, "I would like this on the record, the minutes appear to be bias, skewed, distorted and slanted."

## How to get new issues on the agenda.

- Put your request in writing and deliver it in person and have the person you deliver the request to sign a copy as a receipt.
- If you have Internet access, you could write an email to the QIC chair and CC a copy to all QIC attendees. This way you have a receipt of your request.
- You could mail your request by certified mail.
- You could call the QIC chair and request he/she add the agenda item(s). Write down your message, and the date and time of the request.

# Grievances / Actions / Appeals / State Fair Hearings

In the past beneficiaries had the option of asking QIC to review their complaints in the final stages of attempting to resolve the problem to their satifisation. However, all that has changed now. No longer can beneficiaries bring their problems to the QIC. The new changes are as follows: Complaints have been 'redefined' into 2 categories...i.e. Grievance and Action. Grievance has to do with rude staff, personality conflicts and etc. Action has to do with denial of services, medication, appointments → basically regulatory and money/payment issues. For example: [13, 15, 18]

## Grievance:

- Reception staff was laughing at me.
- Staff keeps hangs up on me every time I call.
- A staffer called me a 'sicko.'

## Action:

- I was seeing a doctor once a week and now they are making my appointments for once a month but I need to see a doctor once a week.
- I was getting Restoral for sleep and now they won't give it to me anymore.
- They say I don't need mental health services anymore and I know that I need them to keep from getting sicker.
- My son is mentally ill and I can't get services or help through the Mental Health Plan (MHP).

It begins with → a *Grievance* or an *Action*. Decisions of Grievances are final, but an Action can be contested with an appeal and if the appeal fails, you ask for a State Fair Hearing (SFH). This gives the beneficiary a total of 3 chances to resolve the problem with an Action. There are other options available if your Grievance or Action is ignored, or if your request is an emergency and you need things to be speeded up. Rather then explain the complexities in the next several pages; notes were extracted from each option available. In addition to the notes, there is a flow chart on the next page to help clear up the differences between Grievances and Actions. There are also flow charts developed by the State Department of Mental Health (SDMH) included on PAGE *29A – 29C* for reference.

Unhappy Beneficiary

G r i e v a n c e  o r  A c t i o n ?

**GRIEVANCE**
(i.e. personality conflict)
(rude staff and etc.)

**ACTION**
(services/money related)
(denial of services and etc.)

One Chance

Three Chances

One Level ONLY
Decision is Finial

Level One → (Initial Decision)
Level Two → (Appeal)
State Fair Hearing (SFH)

Results

Results

KAS

Quality Improvement Committee

Notice that all decisions on *grievances* are final. Especially for this reason there needs to be a method to separate and categorize all grievance decisions so that QIC and keep an eye on trends. Perhaps each category represents a data source to develop an Indicator.

**See also the attached:**

Grievance Process Flow Diagram (Page 33-A)
Appeals Process Flow Diagram (Page 33-B)
New Expedited Appeal Process Flow Diagram (Page 33-C)

## Quick Notes From State Manuals on Grievances, Actions, Appeals, and State Fair Hearings

### Grievances [16, 18, 25]

- Q: When does a verbal "bad hair day" remark transition into a verbal grievance? How do we decide of little grips have to follow a formal grievance process?
- A: "Grievance" means an expression of dissatisfaction about any matter other then an "action."
- Grievances must be resolved within 60 days. May be extended 14 days.
- MHP's must inform beneficiaries of their option to present evidence in person. CFR, 438.406(b)(2) requires that MHP's provide beneficiaries a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing.
- If grievance is a clinical issue, the decision maker must be a health care professional with the appropriate clinical expertise.
- Individual not involved in any previous level of review or decision-making.
- Beneficiaries may authorize another person to act in their behalf to use the grievance and appeal process.
- 2 level grievance review process is no longer required in the new grievance system.
- A grievance could generate an action if resolution is not rendered within the required timeframes. In this situation, the beneficiary could request a SFH. All other grievances would not quality for a SFH process.
- Grievances and appeals follow different processes.
- Possible subjects for grievances include, but are not limited to, the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights.
- Definition of "grievance" includes "quality of care"
- disposition of grievances and resolution of appeals
- An appeal is triggered through an action, while a grievance involves any dissatisfaction other than an action.

### Actions (Notices of Action) [16, 18, 25]

- MHP denies payment to the provider after the service has already been delivered to the beneficiary.
- Oral appeals must be followed up in writing and signed, or appeals do not go to resolution. MHP's must make every effort to assist written appeals.
- Beneficiaries may authorize another person to act in their behalf to use the grievance and appeal process.
- When an MHP or provider determines that a beneficiary does not meet the medical necessity criteria.
- Denies or limits authorization of a requested service, including the type or level of service;
- Reduces, suspends, or terminates a previously authorized service;
- Denies, in whole or in part, payment for a service;
- Fails to provide services in a timely manner, as determined by the MHP or;

- Fails to act within the timeframes for disposition of standard grievances, the resolution of standard appeals, or the resolution of expedited appeals.
- Grievances and appeals follow different processes.
- We have modified the definition of "action" to include unreasonable delays in services, or appeals not acted upon within the timeframes
- An appeal is triggered through an action, while a grievance involves any dissatisfaction other than an action.
- When an MHP denies or changes a provider's request for authorization of payment for services, the MHP must send the beneficiary a "Notice of Action" that tells the beneficiary about the MHP's decision, why the decision was made and what the beneficiary can do if the beneficiary doesn't agree. MHPs are now required to send Notices of Action in new situations: when the MHP denies or changes a provider's request for authorization after the beneficiary has already received the services, when the MHP doesn't provide timely services, and when the MHP doesn't complete its grievance or appeal process on time. DMH is working with the Departmetn of Health Services to prepare new Notice of Action forms to assist MHPs to meet these new obligations.

## Appeals [16, 18, 25]

- An appeal is a request for review of an ACTION
- When an MHP or provider determines that a beneficiary does not meet the medical necessity criteria.
- Denies or limits authorization of a requested service, including the type or level of service;
- Reduces, suspends, or terminates a previously authorized service;
- Denies, in whole or in part, payment for a service;
- Fails to provide services in a timely manner, as determined by the MHP or;
- Fails to act within the timeframes for disposition of standard grievances, the resolution of standard appeals, or the resolution of expedited appeals.
- Grievances and appeals follow different processes.
- Provide the enroll and his or her representative the opportunity, before and during the appeals process, to examine the enrollee's case file, including medical records, and any other documents and records considered during the appeals process.
- disposition of grievances and resolution of appeals
- An appeal is triggered through an action, while a grievance involves any dissatisfaction other than an action.

## State Fair Hearing (SFH) [16, 18, 25]

- When an MHP or provider determines that a beneficiary does not meet the medical necessity criteria.
- The MMC regulations require an ACTION to occur before a case can quality for a State Fair Hearing (SFH)
- **Q: What is a fair hearing?**
  **A:** It pertains to Medi-Cal grievance. If you feel that your Medi-Cal services have

been reduced or denied, your may make a request by contacting the Department of Social Services Fair Hearing Division. Your complaint will be heard through an administrative law judge. You may also apply for a fair hearing if you feel you have been mistreated in any way. You may also apply for a fair hearing if you feel you have been mistreated in any way. However, the administrative law judge primarily makes decisions regarding Medi-Cal services.

## What are Performance Improvement Projects? (PIP's)

The purpose of Performance Improvement Projects (PIPs) is to assess and improve processes, and thereby improve outcomes of care. What sets a PIP apart from a regular report is that PIPs must be designed and conducted in a methodologically sound manner. These projects are usually based on information such as enrollee characteristics, standardized measures, utilization, diagnosis and outcome information, data from surveys, grievance and appeals processes, etc. These projects are required by the State and can be of the MHP's choosing or prescribed by the State. [17, 23, 24, 27]

QIC must conduct 2 Performance Improvement Projects (PIP's) every year.

One must be clinical in nature
One must be non-clinical in nature

Each PIP begins with a STUDY QUESTION

Ex → "Will training inpatient hospital staff significantly reduce the number of times patients are put into restrains?"

In out study question above, it addresses the inpatient population enrolled in the Mental Health Plan (MHP). Also, there is a 'subset' population → the number of patients restrained are the SUBSET population.

> Addition Study Questions → "Does the location of the clinic(s) impact utilization of mental health services by Latino beneficiaries?) or, "Do the opening and closing hours of a mental health clinic have an impact on Older Adult Access?"

Next, to proceed with our Performance Improvement Project (PIP) we must measure performance at <u>two periods of time</u> to find out if improvement has occurred.

NOTE: The example below is an oversimplification of data required for a PIP.

1. First Period of Time → We develop an indicator(s) to compare the current number of times patients are being restrained.
2. Second Period of Time → We compare the indicator(s) in from our first period of time with our new indicators after inpatient training to find out if there has been a reduction in the use of restraints.

Now, as mentioned above, data from PIPs are looked at very closely before being considered valid. We do not take for granted that the data handed to us is good data. We look at how the data is gathered. We look at the how data is entered into forms while being gathered. We do this to assess for errors → Is a single person with training entering data, or are many people without training entering the data? If many people are entering data into charts without training, we cannot ignore the possibility of error. If we think there is a

possibility of error, we may go back further and do spot checks/audits of the patients' clinical charts instead of relying on running logs that keep track of subtotals. The reason valid data is important is because we use data for Performance Measurements to develop Indicators. Any verification of data will affect our Performance Measurement and ultimately, our Indicators.

## PIP's Knowledge in Depth

(You may want to review this section on PIP's after reading this QIC Manual)

When considering PIPs, areas called "Domains" are looked at. There are four areas of Domains: Structure, Access, Process and Outcome. The first three Domains, Structure, Access and Process should have a link to each other that affects the last Domain → Outcome. For example:

Structure = Inpatient resources, building design, and overcrowding due to building size.
Access = Are beneficiaries able to communicate in their language with staff?
Process = Was the diagnosis correct? Did staff treat the beneficiary with dignity?

Looking at Structure → Access → Process to affect Outcome

Outcome? = Was the beneficiary happy with services? Did the beneficiary improve?

Because there is a link between the first 3 Domains, any or all of them should affect the 4th Domain → Outcome.

Once the PIP's are complete, they are "Assessed to determine the Likelihood that Improvement is "Real" Improvement. One way to make this assessment is confidently calculating the degree to which an intervention is statistically "significant".

As you can see, PIPs can get complicated. For more information and protocol on PIPs, review Appendix G in the back of this QIC Manual. There is also much more information on PIPs that are beyond the scope of this QIC Manual because this subject be a booklet by itself. For more information on PIPs, please see the California State Department of Mental Health Website.

It has been found, in program evaluation literature, that "outcome measures", "measures", and" indicators" appear to be used interchangeably. (p. 326 State QI) However, we make the distinction between measures and indicators i.e. measures ***develop*** indicators.

3/6 is a Measure
.5. the answer. is our Indicator

# Other Items to Monitor

QIC must monitor previously identified issues
QIC must monitor beneficiaries' outcomes on grievances, appeals and State Fair Hearings.
QIC must monitor if MHP and providers are complying with applicable laws, regulations and State policies relating to patients' rights.
QIC could/should monitor the use of Seclusion and Restraints in each/all the County Contracted Hospitals with the MHP.

1. Monitor number of patients,
2. The number of times it happens to each patient, and,
3. The amount of time each patient is in Restraints and/or Seclusion

QIC will pass out many reports.
Notes here on items that you would like to see monitored or feel are of concern.

## QIC Reports

Is your QIC Inactive? Reactive/Passive? Or Active?

1. Inactive → Are some reports not getting done or ignored?
2. Reactive/Passive → Are some reports getting done only 'after' something negative happens or after getting cited for being out of compliance?
   Reactive = Reacts only after something happens
   Passive = Goes along with everything → nods, agrees, no questions
3. Active → (preferred) Reports are getting done according to the QI Work Plan AND because the QIC is looking ahead into areas of concern. QIC is fully active in the planning, designing and execution stages of the QI Work Plan.

## QIC Strategies to Address Concerns and/or Reports

1. You have concern about a report.
   Lets say you take a report home, and after looking at it closer, you have a 'concern.'
2. Get on the agenda.
   Request to get your concern about the report on the next QIC agenda for discussion. After a discussion, if your concern about a report is not satisfied, then;
3. Consider a QIC sub-committee.
   If your concern is not answered to your satifisation, request for a special sub-committee with other interested QIC members to address the concern and to examine the problem more closely and explore resolutions. (Perhaps designing a survey to identify the problems more closely.)
4. Write down the responses.
   If your concern is 'passed up' even though some people are interested in pursuing the problem, then write down the responses for a record.
5. Check the minutes.
   Next QIC, check the minutes to confirm your request for a subcommittee is logged. Also, if performance indicators about your concern are vague or ambiguous and you have followed protocol in QIC for intervention, consider looking to outside intervention to assist you in getting the problem resolved and/or correction action.

## QIC Meetings – Ideas and Organization

1. Checklist / Worksheet
   It is helpful to put all your QIC contents from each meeting into a folder with the meeting data. Items such as → the meeting agenda, minutes, meeting notification, reports and your notes.
2. Things to look for –
   Look at the reports that are handed out. Do they have at least 2 sources of data? Is the data sources used for performance measurement to develop an INDICATOR? Is the indicator compared to an indicator from the last report? If not, why not? After reviewing the report, do you have suggestions on how the report could be improved?

# - History -

[28]

## What is Medi-Cal?

The federal government designed a health care plan for low-income people in 1965 called Medicaid. In California, their version of Medicaid is called Medi-Cal, short for *California Medical Assistance Program*. Medi-Cal was originally designed for welfare recipients, but didn't include mental health specialty services. Although, mental health services that were provided at that time were reimbursed by Medi-Cal. Shortly thereafter in 1971, the Short-Doyle program was legislated as a part of Medi-Cal. The Short Doyle program is the mental health services component added into Medi-cal to make it more complete. There was major advantage for adding the Short-Doyle program into the Medi-cal benefits because the feds matched county dollars for the program.

For the accountants, things really changed around. There were now two (2) systems for PAYMENT. One was the original Medi-Cal, called Fee-for-Service/Medi-Cal (**FFS/MC**). The second was the new Short Doyle that became a PART OF Medi-Cal, and was called Short-Doyle/Medi-Cal (**SD/MC**).

Nearly 20 years later in 1989, Short-Doyle/Medi-Cal got another boost to include case management. Then in 1993, a whopper of extra services titled the Rehabilitation Option was added into Short-Doyle/Medi-Cal.

By the time the accountants had everything figured out, things got changed around again! In 1995, a neat little thing called a 'Freedom of Choice Waiver' came into the picture. A waiver is a request to the feds asking permission for California to do certain things their way as long as it doesn't' reduce the quality and delivery of care. California's new model for the delivery of mental health care was divided in to 3 phases. The 1st phase began with the initial waiver. In this waiver, the state requested counties to be responsible for authorization and payment of inpatient services rather then the Department of Health Services. Of course the Feds requested some rational that the counties can handle the job. Once the Feds were satisfied, the waiver was approved and became part of the Medi-Cal contract with the Feds. This initial and original waiver was called "Medi-Cal Psychiatric Inpatient Hospital Service Consolidation," and became the responsibility of each county Mental Health Plan (MHP).

Two years later in 1997, California was ready to kick-in Phase II of the new model to make Medi-Cal bigger and better at the county level for delivering mental health services. What

they did was throw professional mental health services into the renewed waiver. The consenting counties were now responsible for inpatient and also professional services. Of course in typical fashion, the modified waiver got a name change to – Medi-Cal Specialty Mental Health Services Consolidation. It was required of each county Mental Health Plan (MHP) that opt in, to put together a work plan that satisfied state and federal requirements. The feds viewed the MHP as a close resemblance of their version called, Prepaid Inpatient Health Plans (PIHPs). Of course, the two were very similar but not exact, which prompted California to also include those differences into their modified waiver. Currently out of the 58 counties in California, 55 of them have their own MHP. Each MHP became a special and unique entity that is responsible for Fee-for-Service/Medi-Cal and Short-Doyle/Medi-Cal claiming systems or as shortened in accounting circles, FFS/MC & SD/MC.

The sources of Medi-Cal funds are about 50-50. That is 50% from the Federal Government and 50% from the state of California. Since about half the funds come from the federal government, they have a say-so over how that money is spent. Therefore, many of the Medi-Cal rules (codes and regulations) for the delivery of mental health services are a direct result of the Code of Federal Regulations (CFR) by the Federal Government. In addition to the Federal Government's rules for the Medi-Cal, the state of California also has their rules. The end result is that the delivery of Medi-Cal is a combination of Federal and State rules.

## – Today –

### Medi-Cal Oversight

Starting from the top. The Feds require a 'single state entity' to be responsible for the Medicaid *transition of services into* Medi-Cal. That entity would be the California Department of Health Services (DHS). The Department of Health Services through inter-agency agreements, farms out the mental health portion of the Fed contract to the California State Department of Mental Health (SDMH). However, keep in mind, the Department of Health Services (DHS) has the ultimate responsibly to the Feds, meaning, DMH answers to DHS. It's another way of saying, 'the buck stops here.'

The federal government does their audits with the state, and the state does their audits with the Counties (contractors), and the counties do their audits with subcontractors.

### Who Delivers Medi-Cal Mental Health Specialty Services?

To being with, The California State Department of Mental Health (DMH) is responsible and oversees each county Mental Health Plan (MHP). Each Mental Health Plan (MHP) is referred to as the *contractor*. There are also *subcontractors*. However, subcontractors must be approved to participate in the local Mental Health Plan (MHP). Subcontractors are private individuals (treaters), or organizations (group of treaters) e.g. Riverside County Mental

Health Department is a Contactor, and Axiom Therapy Group is a privately owned subcontractor.

### What is the MHP?

MHP means Mental Health Plan. A Mental Health Plan stipulates how Medi-Cal mental health services are delivered to County *beneficiaries* that qualify for Medi-Cal.

## Why Do We Need A Quality Improvement Committee (QIC)?

As you may recall, we discussed that a wavier allows California to customize the delivery of the Federal Medicaid plan – California style, into Medi-Cal. The Feds also approved California's request to be a single source (no competition) for mental health services in the waiver. As you may imagine, the Feds needed some assurances that if California wanted to monopolize the mental health plan, there needed to be some mechanisms to protect the beneficiaries. Due to the waiver being approved, the Feds stipulated additional oversight was required. Part of this oversight came in the form of state and county quality improvement committees.

The state has a State Quality Improvement Counsel (SQIC), and each county mental health plan (MHP) has a Quality Improvement Committee (QIC). The primary function and duties of these committees is to give assurance to the Feds that the waiver does not affect the beneficiaries negatively.

Or course, the heavy weight in this series is the State QIC. The state QIC (SQIC) takes on a more proactive role in establishing data sources for performance measurement to develop meaningful indicators. SQIC has access to state electronic databases, and a wider range of performance measures in which to conduct special studies to create new data sources to develop new performance indicators. The SQIC also develops quality strategies on a wide platform that filters down to the lower level county Quality Improvement Committees (QIC).

QIC is mandated by the state to be made up of staff, providers, beneficiaries, family members, or other persons similarly involved with beneficiaries.

Appendix A

# Knowledge in Depth [19, 20]

**Domain**: the most global category within which to identify indicators, such as structure, access, process, and outcome.

**Concern**: the most salient issue to be addressed by measurement strategies; describes the desired goal of service provision; e.g. "Clients can access services that they need" states a "concern"

**Indicator**: something important to measure – the markers that could identify an indicator's target

Indicator development: must have normative validity. All stakeholders would agree that indicators reflect shared values about the ideal mental health system.

Stakeholders: Direct consumers, family members, advocates, local mental health directors, community agencies, mental health professionals, state agencies, including DMH.

Indicator Relationship: A good performance indicator has a relationship to and effect upon the other domains, e.g. structure, access, process and outcome.

Valid Indicator: Performance indicators can be referred to as valid when the link between structure, process, and outcome has been established.

Ex 1: Coordination of services, a structural variable, may be found to be associated significantly with decreased symptoms and increased functioning.

Ex 2: having bilingual and ethnic providers, a structural variable, may be associated with positive outcomes for multicultural populations.

In time indicators may need to change to more fully reflect increasing sophistication.

"performance outcome measure" the early authors (1990's) of the legislation were referring to the broader class of indicators now understood to include structure, access, and process indicators. Nowadays performance outcome measures is understood to mean performance indicators

**Measure (performance measurement)**: the mechanism used or data element identified to support a judgment on an indicator.

In general, ***indicators of quality care are identified***, ***benchmarks are established***, data is collected and ***performance against the indicators is measured***.

Specific instruments of data elements used to qualify or calibrate an indicator.

Because performance measurement is staff-intensive and data-intensive, it is imperative to select indicators that will yield the most information for continuous quality improvement.

Some measures use numerator and denominator for calculations via a data source. Performance measures included here may include measures calculated by the State (from encounter data or another data source), or measures submitted by the MCO/PHP.

State Quality Improvement Counsel –

Each Domain Has Indicators.

**Domains** **[19, 20]**

**Structure**

= resources and tools (human, physical, and organizational) need to provide good quality care.

= number of patients' rights advocates and their duties relates to structure.

= quality assurance activities relate to structure

**Access**

= how consumers and family members get into care.

= availability of culturally competent services e.g. language

= degree in which services are quickly and readily obtainable

= wide array of relevant services to meet individual needs

= number of persons in identified target populations served relates to access.

= percentage of resources used to serve children and older adults relates to access.

**Process**

= describes what happens during service provision. The word "appropriateness" if often used interchangeably with process

= individualized to address a consumer's strengths and weaknesses, cultural context, services preferences, and recovery goals.

= best match for client's needs.

1. level of care, e.g. inpatient or outpatient
2. chosen treatment of intervention, e.g. medication or therapy
3. service utilization, e.g. length of stay, number of sessions, and appropriate transitions.

**Outcomes**

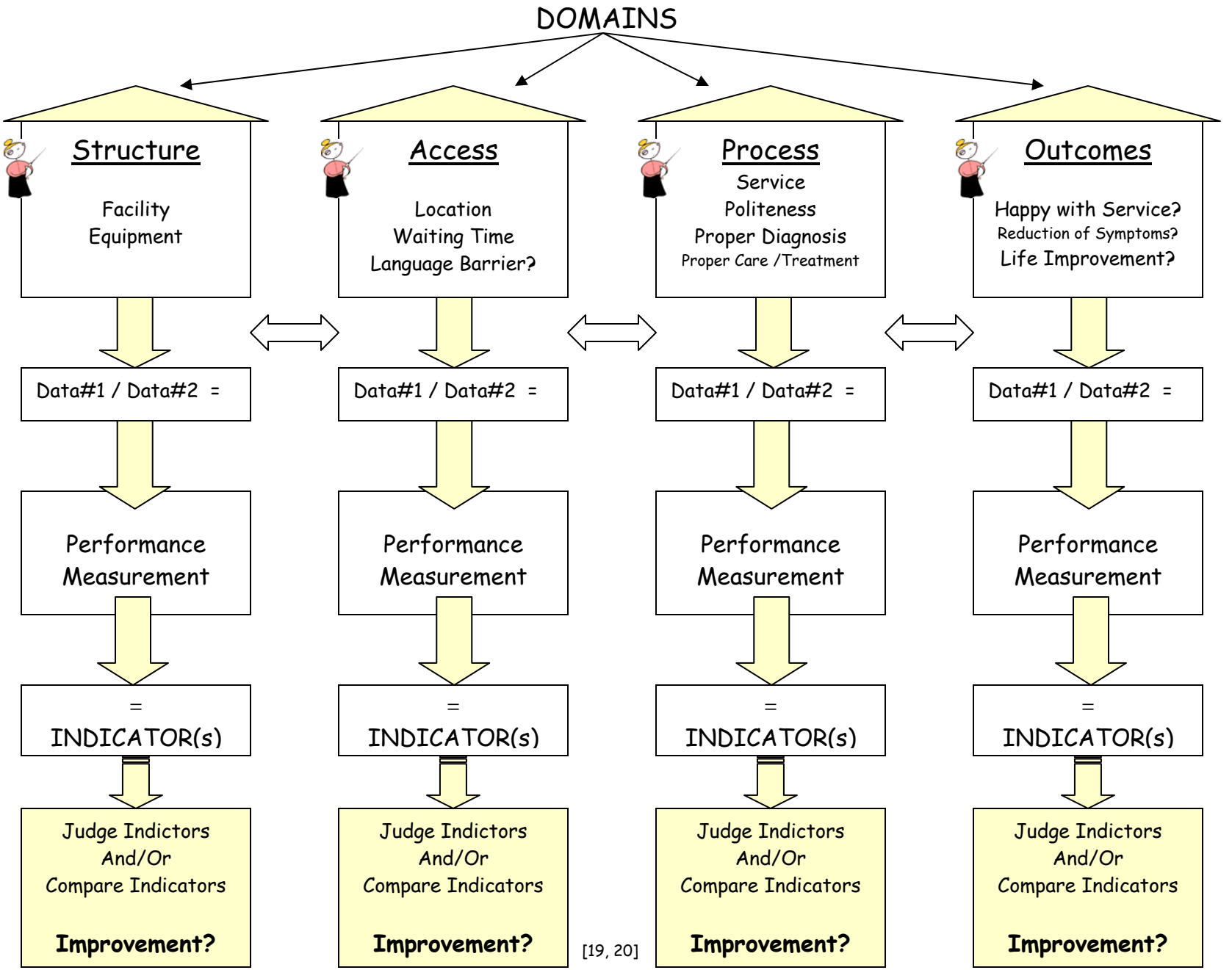
= the impact or care on health and well-being, the ultimate goal

= improvement or stabilization in a client's symptoms and functioning and in client satisfaction with quality of life, health status, and community integration.

**Cost-effectiveness** [used by CMHPC]

= ability to use resources efficiently to achieve positive outcomes, e.g. use crisis stabilization or crisis residential services instead of acute inpatient hospitalization.

There are 4 Domains → Each Domain has an impact toward Performance Improvement Outcomes




[19, 20]

NOTES

Appendix B

# Theoretical Perspective on Use of Words and Phrases

**PERFORMANCE** The way in which an individual, group, or organization carries out or accomplishes its important functions or processes.

**PERFORMANCE ASSESSMENT** Involves the analysis and interpretation of performance measurement data to transform it into useful information for purposes of continuous performance improvement.

**PERFORMANCE MEASURES** A gauge used to assess the performance of a process or function of any organization. Quantitative or qualitative measures of the care and services delivered to enrollees (process) or the end result of that care and services (outcomes). Performance measures can be used to assess other aspects of an individual or organization's performance such as access and availability of care, utilization of care, health plan stability, beneficiary characteristics, and other structural and operational aspect of health care services. Performance measures included here may include measures calculated by the State (from encounter data or another data source), or measures submitted by the MHP.

**PERFORMANCE IMPROVEMENT PROJECTS** Projects that examine and seek to achieve improvement in major areas of clinical and non-clinical services. These projects are usually based on information such as enrollee characteristics, standardized measures, utilization, diagnosis and outcome information, data from surveys, grievance and appeals processes, etc. They measure performance at two periods of time to ascertain if improvement has occurred. These projects are required by the State and can be of the MHP choosing or prescribed by the State.

**PATIENT ADVOCATE** A person whose job is to speak on a patient's behalf and help patients get any information or services they need.

**BENEFICIARY** The name for a person who has health insurance through the Medicare or Medicaid program.

**GRIEVANCE** A complaint about the way your Mental Health Plan is giving care. For example, you may file a grievance if you have a problem with the cleanliness of the health care facility, problems calling the plan, staff behavior, or operating hours. A grievance is not the way to deal with a complaint about a treatment decision or a service that is not covered.

Risk adjustment: process for adjusting performance indicators so comparisons among counties can be made. Without such adjustments that take into account differences among counties, direct comparison of counties' results is not possible.

Ex: counties with the lowest rate of employment of consumers also had the highest rates of unemployment for their general populations.

Examples of variables to be used for risk adjustment include client characteristics, socioeconomic conditions in each county, and fiscal resources available to fund mental health services. Caution: at this point, risk adjustment techniques are highly theoretical and experimental (provider profiling).

Risk adjustment is designed to eliminate differences among counties that cannot be attributed to delivery of mental health services.

### Data Sources

Data is pivotal to measurement and performance indicators must be linked to reliable, high quality data sources.

Special Studies [21]

There are many critical aspects of service delivery for which data sources are not readily available. Such concerns require special study to determine if they can be measured and if so, what benchmarks of performance are desirable. A special study is distinguished by the fact that additional research and analysis will be required before a performance indicator can be articulated.

## *Insights*

### Concept of Accountability

The main purpose for creating performance indicators is to facilitate oversight of county mental health programs by the Department of Mental Health (DMH), The California Mental Health Planning Council, and the local mental health boards and commissions. **[22]**

### Continue to Explore

The Quality Improvement Committee (QIC) must continue to explore relationships between the ***indicators*** and to understand variables that influences quality. [29]

Appendix C

# Law, Codes and Regulations [12]

## California Code of Regulations (CCR)
## Title 9; Division I; Chapter 11; § 1810.440

The MHP shall establish a Quality Management Program in accordance with the terms of the contract between the MHP and the department that includes at least the following elements:

(a) A Quality Improvement Program responsible for reviewing the quality of specialty mental health services provided to beneficiaries by the MHP that:
   1. Is accountable to the director of the MHP.
   2. Has active involvement in planning, design and execution from:
      A. Providers;
      B. Beneficiaries who have accessed, specialty mental health services through the MHP; and
      C. Parents, spouses, relatives, legal representatives, or other persons similarly involved with beneficiaries who have accessed specialty mental health services.
   3. Includes substantial involvement of a licensed mental health professional.
   4. Conducts monitoring activities including but not limited to review of beneficiary complaints and grievances and fair hearings, provider appeals, and clinical records review.
   5. Is reviewed by the MHP and revised as appropriate annually.

(b) A Utilization Management Program responsible for assuring that beneficiaries have appropriate access to specialty mental health services from the MHP that:
   1. Assures that the access and authorization criteria established in this chapter are met.
   2. Conducts monitoring activities to ensure that the MHP meets the established standards for authorization decision making and takes action to improve performance if necessary.
   3. Is reviewed by the MHP and revised as appropriate annually.

(c) A beneficiary documentation and medical record system that meets the requirements of the contract between the MHP and the department and any applicable requirements of state and federal law and regulation.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code.
Reference: Sections *5777,* 14683, and 14684, Welfare and Institutions Code.

Appendix D

# Acronyms & Descriptions

**CAC – Compliance Advisory Committee** [5]
Est. 2000.
Goal: Assess, clarify and improve DMH's program compliance function.
Meets 4 times per year
Chaired by Deputy Directory of the Program Compliance Division
Members reps: Providers groups, advocacy groups, CMHDA, clients and family members.

**CCAC – Cultural Competence Advisory Committee** [4]
Est. 1996 as Cultural Competence Task Force (CCTF)
Member reps: DMH, CMHDA, ethnic service managers, other experts, clients and family members.
Responsible for Cultural Competence Plan (CCP)

**CCP – Cultural Competence Plan**

**CMHDA – California Mental Health Directors Association** [7]
Not a state agency.
Mission: Link for performance measurement and local MHP quality improvement.

**CMHPC – California Mental Health Planning Council** [6]
Mandated by Federal and State law.
Advocate for Children and Adults
Oversight and accountability of public mental health system
Role for obtaining federal grant funding for California
Legislative mandate to establish performance outcome measures for system accountability
W&I 5772 grants CMHPC the authority to review, assess, and make recommendations of California's mental health system.
Has QIC subcommittee

**CFMTF – Client and Family Member Task Force** [3]
Est. 1996. 12 members. All clients and family members.
Meets 6 times per year
Advisory to the DMH Systems of Care Division

**CFR – Code of Federal Regulations**

**CMS – Centers for Medicare and Medicaid Services**
Federal agency responsible for Medicaid program

**DHS – State Department of Health Services**
Responsible for State's Medi-Cal program

**DMH – Department of Mental Health**

**EQR – External Quality Review** [9]

**EQRO – External Quality Review Organization** [8]

Makes annual presentation to SQIC on the effectiveness of State's Quality Strategy. Reviews each county MHP for quality, timeliness, access, and appropriateness of care

*Independent organization* per Section 438.354 and 438.358

Validates information to be accurate, reliable, free from bias, and in accord with standards for data collection and analysis.

**MCO – Managed Care Organization**

Managed care plans that provide comprehensive coverage under capitated contracts

**MEDS – Medi-Cal Eligibility Data Systems**

Electronic system that contains race, ethnicity and primary language

MHP's have access to this statewide information

**MHPC – Mental Health Boards and Commissions**

W&I code 5604.2 authorizes MHPC to engage in various oversight activities, such as evaluating the community's mental health needs, services, and facilities.

**MHP – Mental Health Plan**

**MMC - Medicaid Managed Care**

**MOU - Memorandum of Understanding**

**PIHP – Prepaid Inpatient Health Plans**

MHPs are considered PIHPs under federal rules

**SQIC – State Quality Improvement Counsel** [2]

Est. 1999. 20 members. 50% client and family members.

Meets 4 – 6 times per year.

Chapter 93, Statues of 2000, an omnibus Health Trailer Bill to the Budget Act of 2000, recognized the Quality Improvement Committee (QIC) in law and directed it to "establish and measure indicators of access and quality to provide the information needed to continuously improve the care provided in California's public mental health system."

**QIC – Quality Improvement Committee**

Appendix E

# Examples of Data Sources for Measurements [26]

- CSIS – Client and Services Information System: DMH's most current and comprehensive database. Includes both Medi-Cal and non-Medi-Cal clients
- MEDS – Department of Health Services Medi-Cal Eligibility Data System file
- Performance Outcome System – The California Performance Outcome System is a comprehensive set of testing instruments designed to collect outcome information on specific age groups of clients – Children/Youth, Adults, and Older Adults. Note – only if expected to receive services 60 days or longer due to more serious and persistent mental illness.
- County administration
- Cultural Competency Plans
- On-site reviews
- DMH Performance Outcome Data System
- DMH Ombudsman Office
- Medi-Cal Paid Claims
- CR/DC
- YSS & YSS-F Access Score
- Special Studies
- Various State Data Systems Collected for System of Care Counties
- State Hospitals – Various state data systems collected for system of care counties
- Group Homes – client information sheet
- Foster Homes – client information sheet
- Various state data systems collected for system of care counties
- Department of Social Services
- Special Education Non-public schools: State Department of Education
- Vital Statistics
- County Quality Improvement & Utilization Review Process
- MHSIP Consumer Survey
- QOL
- Department of Health Services Data
- Medi-Cal Pharmacy Claims Data

Appendix F

# Waivers [28]

1915(b) Freedom of Choice Waivers

**Initial Waiver**
Phase I, Medi-Cal Psychiatric Inpatient Hospital Services Consolidation
March 17, 1995 to September 5, 1997

**1st (renewed) Waiver**
Phase II, Modified and renamed Medi-Cal Specialty Mental Health Services Consolidation. Incorporated professional specialty mental health services.
September 5, 1997 to November 19, 2000

**2nd (renewed) Waiver**
Phase II, Incorporate Medicaid Managed Care (MMC) Regulations by 8/13/002 and effective 8/13/2003.
November 20, 2000 to April 27, 2003

**3rd (renewed - Current) Waiver**
Phase II,
April 28, 2003 to Expire April 27, 2005

**4th (proposed) Waiver**
Incorporated to reach full compliance with federal MMC regulations.
April 1st to March 31, 2007

3 Phases (for waivers)

Phase I – 3/17/1995 "Medi-Cal Psychiatric Inpatient Hospital Services Consolidation" at the county level

Phase II – 9/5/1997 Renewed, Modified and Renamed waiver to "Medi-Cal Specialty Mental Health Services Consolidation," again at the county level.

Phase III – On Hold. Final phase would be the transfer of risk for federal financial participation (FFP) through capitation or other risk arrangements.

The California's Medi-Cal mental health managed care program was designed to include three phases, to be put into operation over several years. – Authority sited – Freedom of Choice Act, CMS 1995

Appendix G

PERFORMANCE IMPROVEMENT PROJECT VALIDATION WORKSHEET
Final Protocol Version 1.0
May 1, 2002 [30]

Use this or a similar worksheet as a guide when validating MCO/PIHP Performance Improvement Projects. Answer all questions for each activity. Refer to the protocol for detailed information on each area.

ID of evaluator: _____ Date of evaluation: ___ /___ /___

| Demographic Information | | |
|---|---|---|
| MCO/PIHP Name or ID: | | Note: MCO/PIHP are MHP's in California |
| Project Leader Name: | | |
| Telephone Number: | | |
| Name of Performance Improvement Project: | | |
| Dates in Study Period: _____/_____/_____ to _____/_____/_____ | | |
| Type of Delivery System (check all that are applicable) | | |
| ____ Staff Model<br>____ Network<br>____ Direct IPA<br>____ IPA Organization | ____ MCI<br>____ PIHP | ____ Number of Medicaid Enrollees in MCO or PIHP<br>____ Number of Medicare Enrollees in MCO or PIHP<br>____ Number of Medicaid Enrollees in Study<br>____ Total Number of MCO or PIHP Enrollees in Study |
| Number of MCO/PIHP primary care physicians_____<br>Number of MCO/PIHP specialty physicians _____ | | |
| Number of physicians in study (if applicable) _____ | | |

| I. ACTIVITY 1: ASSESS THE STUDY METHODOLOGY | | | | |
|---|---|---|---|---|
| Step 1. REVIEW THE SELECTED STUDY TOPIC(S) | | | | |
| Component/Standard | Y | N | NA | Comments |
| 1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care and services? | | | | |
| 1.2. Did the MCO's/PIHP's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services? | | | | |
| 1.3. Did the MCO's/PIHP's PIPs over time, include all enrolled populations; i.e., did not exclude certain enrollees such as those with special health care needs? | | | | |
| Step 2:REVIEW THE STUDY QUESTION(S) | | | | |
| 2.1. Was/were the study question(s) stated clearly in writing? | | | | |
| Step 3:REVIEW SELECTED STUDY INDICATOR(S) | | | | |

| | | | | |
|---|---|---|---|---|
| 3.1. Did the study use objective, clearly defined, measurable indicators? | | | | |
| 3.2. Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? | | | | |
| Step 4:REVIEW THE IDENTIFIED STUDY POPULATION | | | | |
| 4.1. Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? | | | | |
| 4.2. If the MCO/PIHP studied the entire population, did its data collection approach capture all enrollees to whom the study question applied? | | | | |
| Step 5:REVIEW SAMPLING METHODS | | | | |
| 5.1. Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? | | | | |
| 5.2. Did the MCO/PIHP employ valid sampling techniques that protected against bias? Specify the type of sampling or census used: | | | | |
| 5.3. Did the sample contain a sufficient number of enrollees? | | | | |
| Step 6:REVIEW DATA COLLECTION PROCEDURES | | | | |
| 6.1. Did the study design clearly specify the data to be collected? | | | | |
| 6.2. Did the study design clearly specify the sources of data? | | | | |
| 6.3. Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? | | | | |
| 6.4. Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? | | | | |
| 6.5. Did the study design prospectively specify a data analysis plan? | | | | |
| 6.6. Were qualified staff and personnel used to collect the data? | | | | |
| Step 7:ASSESS IMPROVEMENT STRATEGIES | | | | |
| 7.1. Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? | | | | |
| Step 8:REVIEW DATA ANALYSIS AND INTERPRETATION OF STUDY RESULTS | | | | |

| | | | | |
|---|---|---|---|---|
| 8.1. Was an analysis of the findings performed according to the data analysis plan? | | | | |
| 8.2. Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? | | | | |
| 8.3. Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? | | | | |
| 8.4. Did the analysis of study data include an interpretation of the extent to which its PIP was successful and follow-up activities? | | | | |
| Step 9:ASSESS WHETHER IMPROVEMENT IS "REAL" IMPROVEMENT | | | | |
| 9.1. Was the same methodology as the baseline measurement, used, when measurement was repeated? | | | | |
| 9.2. Was there any documented, quantitative improvement in processes or outcomes of care? | | | | |
| 9.3. Does the reported improvement in performance have "face" validity; i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention? | | | | |
| 9.4. Is there any statistical evidence that any observed performance improvement is true improvement? | | | | |
| Step 10:ASSESS SUSTAINED IMPROVEMENT | | | | |
| 10.1. Was sustained improvement demonstrated through repeated measurements over comparable time periods? | | | | |
| | | | | |

Appendix H

# References and Reading


**Institute of Medicine**, 2001; "*Crossing the Quality Chasm" p.198*

This report from the committee on the Quality of Health Care in America makes an urgent call for fundamental change to close the quality gap, recommends a redesign of the American health care system, and provides overarching principles for specific direction for policymakers, health care leaders, clinicians, regulators, purchasers, and others.

**Department of Mental Health**, 2001; *Establishment of Quality Indicators for California's Public Mental Health System*

**Department of Mental Health**, 2004; *Medi-Cal Managed Mental Health Care Quality Strategy* [**1** – p. 6]; [**2** – p. 7]; [**3** – p. 8]; [**4** – p. 8]; [ **5** – p. 9]; [ **6** – p. 10]; [ **7** – p. 11]; [ **8** – p. 32]; [ **9** – p. 32]; [ **10** – p. 18]; [ **11** – p. 18-30]; [ **12** – p. 55] ; [ **13** – p. 71-74] ; [ **14** – p. 76-97] ; [ **15** – p. 98-101] ; [ **16** – p. 109-117] ; [ **17** – p. 148-149] ; [ **18** – p. 150-154] ; [ **19** – p. 193-342] ; [ **20** – p. 251-269] ; [ **21** – p. 269-270] ; [ 22 – p. 189-191] ; [ **23** – p. 286] ; [ **24** – p. 323-342]; [ **26** – p. 205-247]

**Department of Mental Health**, 2002; Medi-Cal Specialty Mental Health Services Consolidation Request for Waiver 11/20/2002 to 11/19/2004
[**28** – p. 1-71]

**Department of Mental Health**, 2004; FAQ About System of Care, Medicare and Medi-Cal, 1999

**Department of Mental Health;** CMS-2104-F
[**25** – p. 290-335]

**Department of Health and Human Services** – Center for Medicare and Medicaid Services
[**27** – p. 1-32]

**Federal Register**
[**29** – p. 3590]

**CMS** Glossary, Extracted 2004; http://www.cms.hhs.gov/glossary/

DMH State Quality Improvement Council (QIC), Marilynn Bonin, State QI Coordinator

**Department of Health and Human Services Centers** for Medicare & Medicaid Services
[**30**- PIP Protocol – Final Protocol Version 1.0 → May 1, 2002]


**About the Author:**

Kathi Stringer was self-employed from 1978 to 1996. Her company was a key supplier for Hughes Aircraft. In the course of her work she has designed Quality Control manuals to meet Military Specification MIL-I-45208A and MIL-105 Sampling Tables. She has experience in site source audits, corrective action, material review committees, form development, manual revisions and protocol development.