

MINUTES
QUALITY IMPROVEMENT COMMITTEE
June 16, 2010
Airport Hilton
Oakland, CA 94621

**Planning Council Members
in Attendance:**

Daphne Shaw - Chairperson
Jennie Montoya
Susan Wilson
Monica Wilson
Walter Shwe
Karen Hart
Gail Nickerson

Planning Council Staff in Attendance:

Karen Hudson
Michael Gardner
Ann Arneill-Py

Others in Attendance:

Carole Marasovic
Cheryl A. Crose
Beryl Nielsen
Jeff Rackmil

Noting that a quorum was present, the Chairperson, Daphne Shaw, called the meeting to order at 8:30 a.m.

Planning Council Member Issue Requests

No requests at this time.

Welcome and Introductions

The Chairperson, Daphne Shaw, introduced herself and then the rest of the Quality Improvement Committee members and the audience introduced themselves.

Alameda County Behavioral Health Care Services

Jeff Raskmil, LCSW, Assistant Director of Child and Youth services, from Alameda County gave the committee a presentation on his county's quality improvement process.

His presentation covered the problems that were uncovered in the delivery of mental health services in Alameda County. He talked about how the county developed a new welcoming policy using the quality improvement process. The welcoming policy is designed to establish principles for welcoming strategies in the entire system. The principles are designed to focus on creating and maintaining an environment to support 7 core principles. They are –

- 1) Organization commitment to wellness, recovery, and resiliency.
- 2) Every door is the right door.
- 3) Creating a warm, engaging and safe place for all.
- 4) Be kind and respectful to everyone.
- 5) Committed to increasing cultural effectiveness throughout the system.
- 6) Initial and ongoing training and support to all levels of staff.
- 7) Continuous quality improvement.

Alameda County BHCS has developed a welcoming, recovery and resiliency oriented, integrated system of care based on the Comprehensive, Continuous, Integrated System of Care Model outlined by Dr. Minkoff and Dr. Cline.

The following principles define the core integrated interventions for each consumer as well as the job of each program to provide matched services to its cohort of consumers in the system of care. They are –

- 1) Co-occurring issues are an expectation, not an exception, and should be included in a welcoming manner in every contact.
- 2) The core of success in any setting is the availability of emphatic, hopeful, integrated, recovery and resiliency oriented relationships at any moment in time, and that continue over time.
- 3) Utilization of the four quadrant consensus model based on high and low severity of each disorder.
- 4) All relationships and programs have the right balance of support, reward, and expectation to promote integrated learning.
- 5) When multiple problems or issues are present, each problem must be considered primary, and skills to manage each are needed.
- 6) Interventions for each primary problem must be matched to phase of recovery, development maturation and stage of change.
- 7) There is no single correct intervention or program; each intervention must be matched according to the principles.
- 8) Similarly, successful outcomes for each problem are individualized according to the principles.

Analysis of Mental Health Board Workbooks

The committee received a report on the workbook project from Karen Hudson.

Karen reported that the first report has been received from Imperial County. She asked the committee what the next steps should be. She also touched on the training schedule and indicated that the plan was to have 22 counties trained by June 30th and it appeared that there would in fact be 20 trained. She explained there were some unavoidable changes and that the counties were allowed 4 months to respond back to the Planning Council.

Imperial was one of the pilot counties and had their training in February, 2010. Logistics are still a major concern and questions are still coming in. Overall responses have been very positive. Two counties have asked for extensions on the time allowed to report back and were granted an additional month. It is expected that all of the counties will be trained by the end of June, 2011.

Ann mentioned a content analysis of the data received broken down into small counties (maybe further dividing it into the real small counties), medium to large counties, and then the very large counties. Further breakdown within the content analysis by the different reporting categories and findings could be done. This could also be divided by age categories in the same region. Breaking it down by regions would hopefully make it more manageable. Trends may then be identified. A template for reporting would ensure consistency for all

counties. It was also mentioned that there would be a new workbook created that will measure new indicators as well as a new contract to provide training. This was mentioned as an agenda item for the next meeting in Sacramento. An online training, similar to the FPPC, was mentioned as a possible means of reaching the MHB. Here is that website –

<http://www.fppc.ca.gov/index.php?id=477>

Consumer Perception of Care Survey Methodology

Following a break, the committee received a report from the Department of Mental Health's Data Management and Analysis Unit on the Consumer Perception of Care Survey. The CPCS is a measurement of the perceived client satisfaction from services provided and changes in quality of life. These data must be reported back to SAMSHA.

The data must also be used in the department's yearly report back to the legislature. The quality of life scale and consumer satisfaction scale which was measured through the MHSIP. There are four primary focus groups. Children, transition age youth, adults and older adults are the groups.

The survey has been conducted twice a year even though it has only been required once a year. This was accomplished by 'convenience sampling' of a certain period when individuals received services. This approach is convenient and affordable while collecting a large quantity of data. The drawbacks are that only those persons receiving services during this period have an opportunity to participate and express their level of satisfaction.

Significant differences between the convenience sample and data in the CSI was recently discovered. Some target groups were under represented and some were over represented.

SAMSHA has been requesting that the state start using 'random sampling' similar to what other states have been doing. This would allow SAMHSA to compare different state's data. The data must be sufficient to satisfy their reporting requirements.

Meeting Evaluation and Future Agenda Items

The committee agreed that the material presented was informative and also that they would like follow ups on future agendas. The committee also thought that limiting the number of presentations afforded the committee more time to interact and discuss issues.

Suggestions for the October, 2010 meeting include having a presentation from Sacramento County Quality Improvement Department on their 'electronic health record' project; Ann's analysis of the workbook data; report on the next county workbook; a follow-up to the perception of care survey discussed today; and adding a new column to the issue matrix for race/ethnicity.