Improving Clinical Practice

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Improve Clinical Practice

Mark Blockus, Director of Practice Improvement, National Council for Community Behavioral Healthcare, Contact: MarkB@thenationalcouncil.org

Services and clinical practices of the highest quality are vital to the recovery of people with mental illnesses and addictions. And efforts to improve services and practices are the assurance that quality care is at the heart of an organization.

Practice improvement is often about shifting from customary care to evidence-based and promising practices that focus on prevention, recovery, and resiliency. It is about using science to achieve outcomes that enhance the lives of people with mental illnesses and addictions and lead to meaningful social inclusion. It is about patient and family focused treatment that is culturally and linguistically appropriate.

While practice improvement is clearly about the direct services and supports provided by clinicians to consumers, improvement is dependent upon an organization having in place operations and processes that support staff — operations and processes that create learning environments where knowledge is shared, outcome data drives change, staff accomplishments are showcased, and emerging leaders are nurtured.

Improvement often encompasses the integration and coordination of services. For example, mental health and freedom from addictions doesn’t exist apart from general good health. Effective consumer/clinician relationships are dependent upon workforce recruitment, development, and retention activities. And continuity between levels of care positively affects consumer engagement and adherence to treatment.

Technology increasingly offers important opportunities for practice improvement. Electronic health records can save time, reduce errors, and create system transparency. Clinical screening tools, functional rating scales, and clinical decision supports can be embedded in electronic health records. Technology allows us to more easily monitor outcomes and benchmark performance. And technology creates opportunities for practitioner to practitioner and consumer to consumer sharing and learning.

In this issue of National Council Magazine devoted to Improving Clinical Practice, we’ve tried to capture the many dimensions of improvement efforts — from technology to improving access and retention, from integrated care to consumer-led services, and from early identification of mental illnesses and addictions to measuring outcomes. We share lessons learned from member organizations as well as from National Council practice improvement initiatives.

We hope you find National Council Magazine useful. And that you take advantage of the array of business and clinical practice improvement resources we offer — National Council Live webinars; the bi-weekly Technical Assistance Update Newsletter; our practice improvement projects; our learning communities; and our expert consultations. We’re dedicated to helping you improve mental health and addictions services — let me know how the National Council can be most helpful.
The Intersection of Policy and Practice – An Opportunity for Action

Linda Rosenberg, MSW, President and CEO, National Council for Community Behavioral Healthcare

The Surgeon General, the President’s New Freedom Commission, and the Institute of Medicine reports have helped Americans understand that there are effective treatments that make recovery from mental illnesses and addictions possible. And the trade press is filled with articles about the efforts of National Council member organizations to provide the most effective treatments, introduce innovation, and improve care. In this issue of National Council Magazine devoted to “Improving Clinical Practice” you’ll read about the improvement initiatives and service accomplishments of member organizations from around the country.

When I joined the National Council, we committed to being the strongest possible advocacy voice on behalf of member organizations, the nation’s community-based mental health and addictions service organizations and the adults and children served by these organizations. Our focus on advocacy – mental health and addictions legislation, policies and regulations that protect and expand access to adequately funded, effective treatment, rehabilitation and support services – is complemented by our efforts to enable member to member learning and to offer members practice improvement resources and technical assistance. And over this past year the National Council has provided leadership in several key areas — integration and coordination of behavioral and general healthcare; mental health services to returning veterans; continuity of care between levels of service; access, retention and adherence to treatment, and workforce and leadership development.

Most recently, our assertive advocacy efforts and our commitment to service excellence culminated in the introduction on October 17, 2007 of landmark legislation, the “Community Mental Health Services Improvement Act” by Senators Jack Reed (D-RI) and Gordon Smith (R-OR) in the United States Senate.

Provisions of The Community Mental Health Services Improvement Act (S.2182) include:

• Creating a new federal grants program to support co-locating primary care services at community mental health facilities funded at $50 million in FY 2009 and authorized through FY 2013.

• Integrating treatment for mental health and substance abuse co-occurring disorders funded at $14 million in FY 2009, $20 million in FY 2010 and authorized through FY 2013.

• Improving the workforce through grants for the recruitment and retention of mental health professionals funded at $10 million in FY 2009 and authorized through FY 2013.

• Enhancing behavioral health education and training of para professional staff through a new grants program funded at $4 million in FY 2009 and authorized through FY 2013.

• Establishing a new $20 million federal grants program to finance infrastructure costs for telecommunications technology supporting tele-psychiatry and patient education at community behavioral health facilities located in rural and other medically underserved areas.

• Requiring the Secretaries of the HHS and DVA collaborate with the Office of the National Coordinator of Health Information Technology and SAMHSA to develop and implement a plan for ensuring that various components of the National Health Information Infrastructure address mental health and substance abuse provider needs supported by $10 million in funding in FY 2009.

• Commissioning a paperwork reduction study to be submitted to Congress no later than a year after enactment that evaluates the combined paperwork burden of safety net behavioral healthcare programs funded at $550,000.

• Directing a nationwide analysis and submission of a report to Congress of the compensation structure of professional and paraprofessional behavioral health personnel as compared with that of other health safety net and private sector employers also funded at $550,000.

What You Can Do

Charles Ingoglia, the National Council’s Vice President, Public Policy and our entire team are conducting a comprehensive lobbying effort supporting S.2182 in the U.S. Senate and in the House when a companion bill is introduced there. We are working very hard to explain the importance of the provisions of S.2182 and value of community treatment and rehabilitation services to every Congressional office we can reach.

But no matter how hard and smart we work in Washington, S.2182 and other measures good for consumers and communities have little chance of advancing without strong support from back home – including the support of National Council Magazine readers.

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“Getting well takes time and money and there are no shortcuts. And improving practice demands opportunities and resources. The Community Mental Health Services Improvement Act promises both. You can help make promises realities – take action now!”

Only you can contact your Senators, Representatives and their staffs to let them know that you support S.2182. And only you can help generate critical support from leaders and organizations in your state and local communities that your Senators, Representatives and their staffs will recognize as important voices in the political process.

**Step 1: Contact Your Senators, Representatives and Staff**

Everyone reading National Council Magazine should take a few minutes in the next day to write to their two U.S. Senators asking them to cosponsor S.2182 and send it off to Washington by fax and e-mail. Template letters are available on our website at www.TheNationalCouncil.org. Once our House bill is introduced, you should do the same with your U.S. Representative.

Besides writing a strong letter, you should follow-up with a phone call to the Senator or Representative’s Legislative Director to ask them to make sure the issue gets proper focus by the staff person responsible for health care, mental health and related issues.

We ask that you forward copies of your letters – and the responses that you receive – to us so that we can use them here when we visit these offices and know what they are saying when they respond to you.

Further, we urge you to meet personally with your Senators and Representative when they are back home to ask them to cosponsor S.2182 and its House companion and support its passage – or do so here in Washington. Bring key allies with you who will resonate with the Senator or Representative based on party, issue interests, background, and other considerations.

**Step 2: Inform, Educate and Mobilize Key State and Local Leaders and Groups**

Just as the National Council will be reaching out to a broad range of national organizations for support of S.2182 and its House companion bill, you can conduct similar outreach to important leaders and organizations in your state and on a local basis. Effectively informing, educating, developing, and mobilizing these allies is a critical success factor in bringing the provisions of S.2182 to fruition.

Specifically, we urge you to sign up the following kinds of organizations:

- State legislative caucuses
- Local government (mayors, counties, cities, etc.)
- Law enforcement (police, sheriffs, judges, prosecutors, etc.)
- Business (State and local Chambers of Commerce, economic development groups, etc.)
- Church leaders and culturally diverse organizations
- Civic groups (United Way, League of Women Voters, Rotary, etc.)
- Low income advocacy groups (Salvation Army, AMVETS, homelessness coalitions, etc.)
- Veterans (VFW, American Legion, Vietnam Veterans of America, etc.)
- Medical (medical associations, physician specialty societies, hospitals, medical centers, etc.)
- Academia (medical, social science, public policy, etc.)
- State and local chapters of mental health and addictions advocacy associations (Mental Health America, NAMI, etc.)

This exercise may prove to be one of the most effective things the behavioral healthcare community can do to reach out to other key interests to lend their support for our issues within the legislative and political processes.

**Results**

Results that we can produce together through this two-step process include:

- A strong group of Senate cosponsors for S.2182 and its House companion
- Awareness of the legislation among staff members in both Senate and House
- Hundreds of state and maybe even thousands of local organizations and leaders across the country supporting the bill
- Enhanced capacity for advocacy for mental health and addictions services at the national, state and local levels as a result of new and strengthened relationships with key political constituencies and leaders

Getting well takes time and money and there are no shortcuts. And improving practice demands opportunities and resources. The Community Mental Health Services Improvement Act promises both opportunities and resources. You can help make promises realities – take action now!
National Council Provides Recommendations for Bridging Gaps Between Inpatient and Outpatient Settings

Charles Ingoglia, MSW, Vice President, Public Policy, National Council for Community Behavioral Healthcare

Millions of Americans experience schizophrenia or other serious mental illnesses and the most vulnerable period in their recovery is the transition from hospital to local, community-based services. Yet nearly 50% of individuals with mental illnesses who are discharged from inpatient care and referred to community-based treatment, fail to make the transition.

The National Council and its members are deeply concerned about the significant human, social, and financial consequences of this interruption and discontinuation in mental healthcare. Individuals with mental illnesses who discontinue care upon discharge from inpatient settings can find themselves in crisis, ending up in emergency rooms or even jails.

Hospitals and community-based organizations need uniform standards, education, and better collaboration to ensure that patients with schizophrenia who fail to continue treatment following hospital discharge are not forgotten. Seeking to stem the tide of patients who are “lost in transition” every day, in December 2006, the National Council assembled a 24-member independent panel of experts to develop a consensus approach to coordination between inpatient and outpatient settings and engage people with mental illness in continued care. The panel included representatives from leading accrediting bodies and hospital and community treatment organizations, as well as patients, family members, researchers, state authorities, and psychiatric leaders.

Summary of Experts’ Recommendations to Improve Continuity of Care

The National Council expert panel’s recommendations to address the gap in care between inpatient and outpatient settings were released in April 2007. These recommendations, which span the administrative, professional, and human elements required to ensure complete continuity of care, include the following:

• Encourage collaborations between hospitals and community-based organizations.
• Use a quality improvement approach to enhance continuity of therapy by benchmarking a performance and outcomes standards at the organizational level.
• Ensure all patients have a level of care management for the transition from inpatient to community including reimbursable care management services by all payers.
• Focus on the “Pull Model” of transition from inpatient to outpatient care by involving community providers in the transition before patients get discharged.
• Align accreditation standards that address and improve continuity of therapy.
• Educate patients and their families on importance of maintaining a personal health care history.

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Many people with mental illness are ‘falling between the cracks’ when shifting from an acute inpatient setting into the community, often stopping the recovery process altogether. Interruptions of treatment interfere with recovery and prevent people from being able to function as contributing members of their community.

Joseph Parks, MD
Medical Director, Missouri Department of Mental Health
Member of the National Council’s Expert Panel on Continuity of Care
• Promote more thoughtful use of inpatient services to reduce emergency room use and an eventual decrease in the number of hospitalizations.

• Share data about mental health services with appropriate organizations in usable and timely ways.

• Involve patients and their advocates in all levels of system delivery and evaluation.

Continuity of Care: Systemic Benefits
Continuity of care supports patient recovery and re-entry into the community and has a positive, measurable impact on the healthcare delivery system in terms of the following:

• Reduced incidence of use of emergency room services by people with schizophrenia or other serious mental illnesses

• Access to appropriate treatment settings

• Enhanced efficiencies across the discharge planning process

The National Council will continue to work with member organizations and other stakeholders to disseminate the expert panel’s recommendations, and to support implementation of the recommendations through practice improvement initiatives (see article on page 9).

Continuity of therapy is a vital component of quality care for people with serious mental illnesses and must be given more attention by consumers themselves, family members, advocates, providers, administrators, and researchers alike.

Charles Ingoglia is Vice President of Public Policy for the National Council for Community Behavioral Healthcare. He directs the federal affairs function and oversees policy and practice improvement outreach to more than 1,300 member organizations across the nation. He also serves as adjunct faculty at the George Washington University Graduate School of Political Management. Prior to joining the National Council, Ingoglia provided policy and program design guidance, including the review of state Medicaid Waiver applications and other HHS regulations, to the Center for Mental Health Services at the Substance Abuse and Mental Health Services Administration under the U.S. Department of Health and Human Services.
Lost in Transition: Lessons from the Virginia Tech Tragedy

Tammy Seltzer, JD, Director of State Policy, National Council for Community Behavioral Healthcare

“One can’t help but wonder if the April 2007 tragedy at Virginia Tech could have been avoided if the shooter, Cho Seung-Hui, had received court-ordered treatment. It’s easy to blame flaws in the mental health care system for Cho’s failure to receive treatment, but the real issue is a failure to communicate — the failure of the criminal justice, public mental health, and university counseling services to communicate with each other and for all of these entities to communicate with Cho and his family.”

Two years prior to America’s most deadly shooting on the campus of Virginia Tech University in April 2007, a Virginia judge found that the gunman, Cho Seung-Hui, met the legal standard for commitment to a hospital or outpatient setting. Although the judge found Cho to be an “imminent danger” to himself, he ordered Cho to receive outpatient services — services that Cho tried three times to access at the university’s counselling center, but never received.

• Imagine how different things might be today — for 33 young people and their families — if Cho’s case had played out this way:
  - The court that committed Cho to outpatient care received assurance that a specific provider was able to treat Cho immediately.
  - The court order named a specific provider and contained a follow up date for the provider and Cho to report back to the court.
  - Provider staff reached out to Cho’s family to ask for their assistance in developing an appropriate treatment plan for Cho, much like the successful plan that was put in place at his high school.
  - The provider, the university’s counseling center in this case, promptly moved Cho from intake to treatment.
  - The court had a community liaison who contacted Cho to find out whether he was receiving treatment and acted swiftly to name an alternative community provider if the university counseling center did not meet his needs.

If we are to stem the tide of those, like Cho, who are “lost in transition,” then we need better communication, collaboration, and coordination of treatment and services. Providers must have adequate resources and staff to attend commitment hearings and conduct mobile outreach with individuals in need of treatment to ensure a solid hand-off from court to treatment. Once a court is involved, the judge must have a mechanism to ensure that the individual is receiving treatment and that any barriers are addressed.

How can we stem the tide of students and other individuals in need of mental healthcare who are lost in transition? Here are a few basics to consider.

Focus on Prevention
Ensure that young adults have ready access to necessary mental health services and are encouraged to take advantage of these services before a crisis occurs.

Use providers to train staff, students, resident advisors, campus police, and others who come into contact with students. Everyone should be familiar with the signs of mental illness and suicide risk, know how to access services in the community, and how to respond in an emergency situation.

Be Prepared for Emergencies
Ensure that communities have a range of emergency and crisis services available 24 hours a day, 7 days a week.

Providers can make available crisis lines and mobile crisis units to evaluate and stabilize a young person in crisis, and support to individuals who must be transported to emergency rooms when they are not safe to remain in the community.

Make Sure Everyone Works Together
Ensure that the different systems — justice, law enforcement, mental health providers, and schools — are working together so that the young person is not “lost” between systems.

Providers can attend commitment hearings, make contact with the patient and family, share their expertise with the court, and know what the court expects from them. Providers can work with hospitals to ensure that a workable treatment plan is in place before the individual is discharged — and work with the individual and family to smooth the transition from hospital to community.

Scarce resources often result in long waiting lists for community-based programs. States must ensure that providers have sufficient resources to address the full range of community needs, from prevention programs to crisis services to long-term care.

In the end, the Virginia Tech tragedy is not about needing a new law or about blaming one system or another. It’s about talking to one another. It’s about providing sufficient resources. It’s about working together to ensure that no one is lost in transition.

Tammy Seltzer, JD, is the Director of State Policy for the National Council. She focuses on the coordination of federal and state policy, and has special expertise and interest in children and criminal justice issues. Seltzer has given technical assistance to states and mental health advocates on a variety of issues involving children’s mental health, such as funding for home- and community-based services to reduce reliance on institutional care.
Primary Care and Behavioral Health Coordination Learning Collaborative

Barbara J. Mauer, MSW CMC, MCPHealthcare Consulting and Senior Consultant, National Council for Community Behavioral Healthcare

Since 2002, the National Council for Community Behavioral Healthcare and its member organizations have played a leadership role in improving clinical care through integrated behavioral health and primary care initiatives. The National Council’s current Primary Care-Behavioral Health Collaborative Project is yet another step toward ensuring that comprehensive, effective healthcare for mind and body is available to all those with serious mental illness. The project reflects the increasing importance of collaborative care in regional and national dialogues and begins to answer the need for more structured clinical improvement approaches in this arena.

The learning collaborative model that the National Council has adopted for this project is based on 20 years of pioneering work by the Institute for Healthcare Improvement and the application of that work in the Health Disparities Collaboratives sponsored by the Health Resources and Services Administration. The National Council’s Primary Care-Behavioral Health Collaborative Project started in January 2007 with four sites — each site is a partnership between a community behavioral healthcare organization and a community health center. The second phase of the project expanded to an additional eight sites in September 2007. This project will continue as a systems improvement activity and we will create and disseminate toolkits based on learning and materials from the sites.

The Need for Clinically Sound Collaborative Care

More than 30 studies in the U.S. and abroad, conducted since 1990, document that systematic collaborative care is more effective than usual primary care for depression.

An article in the Annals of Internal Medicine (September 2007) reported that most primary care practitioners do a good job of diagnosing and beginning treatment for depression, but do less well in following up with treatment over time — less than half of patients completed a minimal course of medications or psychotherapy. The lowest quality of care occurred among those with the most serious symptoms, including those with evidence of suicide or substance use. A major learning was that, “Right now PCPs don’t have the tools necessary to decide which patients to treat and which to refer on to specialized mental healthcare.”

Recent reports that the population with serious mental illness has an average life span that is 25 years less than that of the general population also point to the need for collaborative care.

A 2007 National Council survey of community behavioral organizations revealed that while 91% of respondents place high or medium priority on increasing the quality of general medical healthcare for their clients, only one in two providers has the capacity to provide any treatment for those conditions, and one in three has the capacity to provide the services onsite. The most common barriers to providing general medical services were problems in reimbursement (72.1%), workforce limitations (68.4%), physical plant constraints (60.8%), and lack of community referral options (55.8%).

Project Goals

The goals of the National Council’s Primary Care-Behavioral Health Collaborative Project are to

- Increase ability of primary care clinics to screen for bipolar, addictions, and suicide risk as a part of depression screening.
- Increase capacity of primary care clinics to provide proactive follow-up and management of patients identified with depression.
- Increase community mental health organizations’ provision of psychiatry training and clinical support for primary care, to enable a more comprehensive stepped care model.
- Establish processes for ongoing communication regarding collaborative care between primary care and community mental health organizations, including:
  - Protocols for referral of individuals with bipolar disorder and suicide risk from primary care clinics to community mental health organizations, to assure seamless transition from primary care to specialty mental healthcare.
• Return of stable patients to primary care follow up as appropriate.
• Establish shared methods for medical management of patients treated in community mental health settings who are at risk for metabolic syndrome.
• Increase capacity of both primary care and community mental health organizations to document and track care processes and performance.

The work is grounded in the National Council’s Four Quadrant Model, which has been adopted widely as the foundation for initiatives in collaborative care.

There is always a boundary between primary care and specialty care and there will always be tradeoffs between the benefits of specialty expertise and of integration. Stepped care is a clinical approach to assure that the need for a changing level of care is addressed appropriately for each person — a person may begin receiving services in Q1 and need specialty mental health/substance abuse services (Q II) or specialty medical services (Q III). Those who need specialty mental health/substance abuse services and medical services as well as primary care (Q IV) have a critical need for collaborative care. The National Council’s collaborative care project is intended to result in a stepped care model that the behavioral health and primary care agencies agree upon and implement in daily practice.

Self-identified Barriers to Clinical Improvement

In order to be successful at clinical practice improvement, any organization must have a planned approach to change and assuring improvement. Prior to the learning session, a self-assessment tool was completed by each of the eight sites convened in September 2007. Identified the following barriers to clinical improvement and the use of data:

• Lack of staff follow through in implementing procedural changes, implementation does not match plan, failing to carry out the Check-Act part of the Plan-Do-Check-Act (PDCA) cycle, not following up to make sure changes implemented were effective and have resulted in better outcomes.
• Staff overload/crisis oriented, busy schedules, not enough time to focus, new electronic health record.
• Finite IT resources to design and write programs to generate reports for additional EHR programming.
• Real time access to data, treatment outcome data not readily available.
• Design and implementation of screening, collection, and analysis techniques that are not burdensome.
• Difficulty sharing medical records between MH and PC, one party as an EHR, the other not.
• Too many meetings, full schedules, attendance at meetings a problem.
• Too much autonomy of providers, lack of buy in.
• Lack of systematic measures for tracking and program improvement.
• Inconsistent use of screening tools and gathering of data.
• Inefficient communication.
• Not including all provider levels in process, improvements don’t fit actual workflow.
• Weakly defined action steps, who is responsible for details and deliverables.

The Four Quadrant Clinical Integration Model

Non specific due dates.

This list is probably applicable to clinical practice improvement initiatives in every setting—the learning collaborative project has tools to help sites overcome barriers to improvement, and the toolkits that emerge will assist many other organizations in improving care. If you are thinking about starting a clinical practice improvement initiative of any kind, use this list to assess whether these barriers exist and to develop strategies to address them.

The Learning Process

The National Council project, using a learning collaborative model, convened primary care and specialty mental health teams in an initial learning session. The teams generally were composed of the medical director of the primary care clinic, the medical director of the community mental health organization, the person who serves as the mental health care manager in the primary care setting (either a primary care or mental health employee who sees patients and tracks their care), and one other person selected by the two organizations.

At the learning session, teams received clinical education materials and training, reviewed project measurement requirements, and planned their
Introducing Mental Health First Aid

Lea Ann Browning McNee, Outreach and Development Officer, National Council for Community Behavioral Healthcare

Fear is generally the root of most stigmas. The stigma surrounding mental illnesses in the United States is no different: fear of not understanding the problem, fear of doing or saying the “wrong” thing and fear of not knowing what to do when someone needs help.

Today, we recognize First Aid as the help administered to an ill or injured person before medical treatment can be obtained. Mental Health First Aid is the help provided to a person developing a mental health problem or experiencing a mental health crisis. The first aid is given until appropriate professional treatment is received or until the crisis resolves. It gives primary care providers, educators, businesses, and others in the public a tool and a resource to help overcome the fear.

The National Council is adapting the well-researched Mental Health First Aid program for the American public. Our vision is that by the year 2025, Mental Health First Aid certification will be as common and as well-known as CPR and other first aid certifications.

The Certification Program
Mental Health First Aid is a 12-hour certification course originally designed to increase the skill of primary care providers in helping a person cope with a mental health crisis. Developed in 2000 by Betty Kitchener and Professor Tony Jorm with the aim to improve the mental health literacy of Australians, it is now auspiced by ORYGEN Research Centre at the University of Melbourne, Department of Psychiatry. The program has since been replicated in six countries, including Scotland, Great Britain, and Canada.

The National Council will bring Mental Health First Aid to the United States by training our member organizations — community-based providers of mental health and addictions services— to lead and manage certification programs in their communities. Slated to launch in May 2008 in approximately six locales, Mental Health First Aid Programs will be active in at least 30 communities by the end of 2009. As provider organizations already connected with other healthcare groups, community leaders, advocates and families, National Council members are uniquely positioned to educate their communities, promote the certification program and to provide effective, culturally-relevant training across broad audiences. The National Council will also work with members to offer Mental Health First Aid to key audiences — primary care professionals, educators, college leaders, human resource professionals, faith leaders, and family members.

Mental Health First Aid certification, which must be renewed every three years, provides trainees with the skills, resources and knowledge to provide short-term intervention for an individual experiencing a mental health problem. Participants will learn to assess the situation, to select and implement appropriate interventions, and to help the individual in crisis connect with appropriate professional care. The course covers a range of common disorders and potential crises such as helping someone who is having a panic attack, is suicidal, or has experienced an addictions relapse.

I’m so pleased the National Council has taken the lead in bringing Mental Health First Aid to the United States. This program will help us achieve so many critical objectives: from educating our communities and fighting stigma to serving as a valuable public policy tool.

— Don Miskowiec, President, North Central Behavioral Health Systems, Inc., LaSalle, IL

As the Outreach & Development Officer for the National Council, Lea Ann Browning McNee creates new programs that connect education to policy and practice priorities. Before joining the National Council, she oversaw the external relations programs of the National Mental Health Association. She currently serves as adjunct faculty at the George Washington University Graduate School of Political Management. To learn more about Mental Health First Aid, contact her at LeaAnnBM@thenationalcouncil.org
The National Council launched a practice improvement initiative focused on improving access to and retention in care for persons with mental illness in August of 2007. This project is based on an approach used by industry, and more recently embraced by healthcare organizations, that recognizes that consumers are served by an organization’s processes—the series of action steps taken to convert inputs into outcomes. It is estimated that 85% of the problems that organizations have in serving consumers are caused by the organization’s processes, and that the failure to make improvements are most likely operational failures.

Why Focus on Access and Retention?
In December 2006, the National Council convened an Expert Roundtable comprising representatives of the mental health community—consumers, family members, inpatient and outpatient provider organizations, state mental health authorities, and accrediting organizations to develop recommendations to improve continuity of treatment for persons transitioning from inpatient to outpatient treatment systems. This Expert Roundtable developed a series of nine consensus recommendations to improve continuity and to ensure that treatment is seamless and continuous for consumers (see article on page 3).

The Access and Retention Initiative represents the National Council’s initial response to these recommendations as embodied in concrete action to improve the status quo. This initiative seeks to make it easier for consumers to access care and to improve the ability of staff to engage clients. It is our belief that these improvements will also enhance treatment retention and medication adherence. It makes sense to us to apply the concept and tools of performance improvement to the problems of access and retention.

How Does the Initiative Work?
Through a competitive Request for Proposals process, four community-based behavioral healthcare organizations were chosen to participate in this intensive, year-long change process. The organizations are the Carlsbad Mental Health Center in Carlsbad, New Mexico; LifeWorks NW in Portland, Oregon; Northside Mental Health Center in Tampa, Florida; and Sweetser in Saco, Maine.

For 12 months, the sites will form a collaborative to engage in a series of structured activities designed to advance their improvement work as rapidly as possible. Participating organizations come together for “Learning Sessions”—in-person, conference calls, discussion groups, exchange of printed reports—where they clarify the science, plan their own tests of change, and learn from each other’s efforts. The term “Learning Session,” although now fixed in our jargon, can be deceptive. The participants not only learn from the experts, but work closely with them and with each other to refine the science of improvement.

While all changes do not lead to improvement, all improvement requires change. The National Council for Community Behavioral Healthcare. He directs the federal affairs function and oversees policy and practice improvement outreach to more than 1,300 member organizations across the nation. He also serves as adjunct faculty at the George Washington University Graduate School of Political Management. Prior to joining the National Council, Ingoglia provided policy and program design guidance, including the review of state Medicaid Waiver applications and other HHS regulations, to the Center for Mental Health Services at the Substance Abuse and Mental Health Services Administration under the U.S. Department of Health and Human Services.

The most fundamental aspect of the Access and Retention Initiative is measurement. Measuring the progress toward our aims is fundamentally important to achieving those aims. Throughout the Initiative, the focus will be on results with a strong, early emphasis on establishing performance measurement systems within participating institutions. Results depend on the performance of numerous planned, structured tests of change while collecting data to learn from those tests. The ideas being tested are in general already proven in the literature, successfully used elsewhere, and supported by experts in the field.

The National Council has retained MTM Services—David Lloyd, Randy Love, Scott Lloyd, and Bill Schmiter—to serve as the faculty for this project. This team combines the data collection and analysis, as well as the clinical and organizational change expertise necessary to lead the participating sites to improve their processes, and in turn increase access to and retention in care.

Charles Ingoglia is Vice President of Public Policy for the National Council for Community Behavioral Healthcare. He directs the federal affairs function and oversees policy and practice improvement outreach to more than 1,300 member organizations across the nation. He also serves as adjunct faculty at the George Washington University Graduate School of Political Management. Prior to joining the National Council, Ingoglia provided policy and program design guidance, including the review of state Medicaid Waiver applications and other HHS regulations, to the Center for Mental Health Services at the Substance Abuse and Mental Health Services Administration under the U.S. Department of Health and Human Services.

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Primary Care and Behavioral Health Coordination, continued from page 7

Initial approach to achieving the project goals. Training topics included:

- IMPACT model and tools
- STABLE toolkit (bipolar)
- Suicide risk and substance use assessment
- Rapid Cycle Improvement
- Performance measures
- Tools for planning and reporting

Over a six-month period, the teams submit periodic reports and participate in three conference calls with the project faculty and all other project participants. The teams reconvene in a final learning congress to present their accomplishments, data, learning and tools to one another.

Measurement of Results
In the Rapid Cycle Improvement model, measurement is essential to determine whether an implemented change results in a quantifiable improvement.

The project has 15 core performance measures necessary to evaluate the quality of care being provided. Each site begins with a baseline assessment of the measures in use, and must provide a final report at the end of the project.

1. Percent of patients screened annually for depression in primary care*
2. Percent of primary care patients with depression with PHQ-9 on initial evaluation, 4-6 weeks, 12 weeks, 6 months*
3. Percent of patients treated for depression who were assessed, prior to treatment, for the presence of current and/or prior manic or hypomanic behaviors**
4. Percent of patients diagnosed with depression or bipolar disorder with evidence of an initial assessment that includes an appraisal for risk of suicide**
5. Percent of patients diagnosed with depression or bipolar disorder with evidence of an initial assessment that includes an appraisal for current or past alcohol or chemical substance use**
6. Percent of primary care patients with major depressive or bipolar disorder meeting severity/complexity criteria for specialty mental health services (as established by state and local payors) referred for specialty mental healthcare*
7. Percent of patients referred to mental health specialty care who attend initial visit*
8. Average time to initial visit after referral to mental health specialty care*
9. Average number of contacts (phone and in person) between primary care and specialty mental health to coordinate care
10. Percent of patients with bipolar disorder with evidence of level of function evaluation at the time of the initial assessment and again within 12 weeks of initiating treatment**
11. Percent of patients with bipolar disorder with evidence of monitoring for weight twice within the initial 12 weeks of treatment**
12. Percent of patients with bipolar disorder who were assessed initially for their symptom complex and then assessed for change in their symptom complex within 12 weeks of initiating treatment**
13. Percent of patients treated for bipolar disorder with evidence of screening for hyperglycemia within 16 weeks after initiating treatment with an atypical antipsychotic agent**
14. Percent of patients treated for bipolar disorder with evidence of an assessment for hyperlipidemia within 16 weeks after initiating treatment with an atypical antipsychotic agent**
15. Percent of primary care patients with diagnosis of depression meeting remission criteria at 12 weeks, 6 months*  
* From Center for Quality Assessment & Improvement in Mental Health, 2006
** From STABLE (Standards for Bipolar Excellence), 2006

On completion of the year-long learning collaborative, the National Council will compile and disseminate learnings from the pilot sites to improve clinical practice in providing integrated care.

Participants in the National Council’s Primary Care-Behavioral Health Learning Collaborative

Phase I
- Behavioral Health Network/ Holyoke Health Center, Inc. (Springfield, MA)
- Behavioral Health Resources/ Primary Health Care, Inc (Des Moines, IA)
- Cowlitz County Guidance Association/ Cowlitz Family Health Center (Longview, WA)
- South Central Montana Regional Mental Health Center/Deering Community Health Center / Yellowstone City – County Health Department (Billings, MT)

Phase II
- Austin Travis County Mental Health & Mental Retardation/Community Care Services Department (Austin, TX)
- Colorado West Regional Mental Health Inc./ Summit Community Care Clinic (Frisco, CO)
- Community Counseling Services/ Horizon Health Care, Inc (Huron, SD)
- Heritage Behavioral Health Center/Community Health Improvement Center (Decatur, IL)
- Highline West Seattle Mental Health Center/High Point Medical and Dental Clinic Puget Sound Neighborhood Health Centers (Seattle, WA)
- LifeStream Behavioral Center, Inc./Thomas E. Langley Medical Center (Leesburg, FL)
- North Range Behavioral Health/ Sunrise Community Health, Inc. (Greeley, CO)
- Porter-Starke Services, Inc./Hilltop Community Health Center, Inc. (Valparaiso, IN)

Barbara Mauer is a nationally known expert in behavioral health and primary care integration. She has more than 15 years of experience in this field and is a managing consultant for MCPP Healthcare Consulting in Seattle, Washington and a National Council senior consultant. She offers consulting services to public and private sector health and human service organizations on integration as well as strategic planning, quality improvement, and project management. Mauer has authored many papers and books on behavioral health and primary care integration.
Process Improvement in Addictions Treatment

Dave Gustafson, Ph.D., Director, National Program Office of The Network for the Improvement of Addiction Treatment (NIATx)

The addiction treatment field is working hard to meet policy and regulatory requirements to implement evidence-based practices—interventions that have been scientifically proven to promote positive client outcomes.

In health services research, the gold standard for testing and proving evidence-based practices is the randomized controlled trial (RCT). Yet randomized controlled trials are time-consuming and expensive, and evaluate effectiveness only at a global level. Process improvement offers a complement to randomized controlled trials, helping service providers test evidence-based practices in their own unique settings. Over the past decade, businesses and healthcare organizations have used process improvement successfully to improve performance outcomes. Broadly defined, process improvement is a method developed and tested within the field of continuous quality improvement (CQI) that uses Plan-Do-Study-Act (PDSA) Cycles to improve organizational processes. Organizations can use PDSA Cycles to set improvement targets, pilot test changes, and analyze outcomes using demonstrated performance measurement tools.

Through rapid-cycle testing, we can obtain new knowledge in five days or five weeks—rather than five years.

Through PDSA or “Change Cycles,” NIATx members take a concept and test it in a specific environment. An organization accomplishes improvement by taking an idea, trying it out in a very small context, determining why it succeeds or fails, and then trying it again in another rapid-cycle test. The NIATx process improvement methodology can be generalized to other organizations that desire to improve their own real-world processes quickly. Along the way, NIATx member organizations are proving the effectiveness of key practices that can be implemented on a broad scale. Through rapid cycle testing, we can obtain new knowledge in five days or five weeks—rather than five years.

Since NIATx began in 2003, member organizations have been building an evidence base for practices that they know work, and have been learning how to implement proven treatment methods in their unique clinical settings. NIATx is now promoting the rapid adoption of evidence-based practices among treatment providers through two exciting new initiatives. First, in partnership with the Treatment Research Institute (TRI), NIATx serves as the national program office for Advancing Recovery: State and Provider Partnerships for Quality Addiction Care. Funded by the Robert Wood Johnson Foundation, Advancing Recovery is designed to promote the use of evidence-based practices by treatment providers through innovative partnerships between providers and single state agencies. This initiative is expected to improve clinical and administrative practices that impede the use of evidence-based practices.

Another initiative is Strengthening Treatment Access and Retention—State Implementation (STAR-SI) funded by the Center for Substance Abuse Treatment. This program builds on the findings of NIATx members who have substantially increased client access and retention

As the National Program Office Director, Dave Gustafson provides overall leadership to the NIATx initiative. Gustafson is also director of Wisconsin’s Center of Excellence in Cancer Communications Research (funded by the National Cancer Institute), and a research professor in the College of Engineering at the UW-Madison. He founded the Center for Health Systems Research and Analysis, a multidisciplinary research center on the UW campus, best known for its research on improving healthcare quality.

References
A critical question for community behavioral healthcare organizations is “What is the primary day-to-day focus of the direct care and support/admin staff — the processes used in service delivery OR delivering services to consumers/families?”

The answer can be identified by using the following data points:

1. Review the agendas for the management team/clinical team meetings during the past six months.

2. Identify the number of agenda items that were focused on internal challenges with the service delivery process (i.e., documentation is not being completed by staff and turned in within the submission standard, support staff are not assisting direct care staff adequately, etc.)

3. Identify the number of agenda items that were focused on the actual delivery of services to consumers (i.e., the number of consumers waiting for service, how many, in which service/unit/program and an action plan to solve the access to care problem, etc.)

4. Percentage the number of service delivery process agenda items compared to items on the agenda focused on actual delivery of services to consumers.

Using this measurement model fifteen years ago when I became a manager/supervisor at a community behavioral health organization, we learned that only 6% of the agenda topics were focused on actual delivery of services to consumers while 94% of the agenda topics focused on internal challenges with the service delivery process.

What has become apparent during the 15 years since, during which I provided consultation to more than 400 CBHOs, is that internal “noise levels” created by the re-occurring challenges with service delivery processes create barriers to timely and effective change. The noise levels demand that managers, supervisors, and staff stay focused on and commit a high percentage of energy and creativity to “the process” rather than directing much needed attention to delivering more timely and quality services.

Below is a typical list of ongoing seemingly never-ending system process noise generators within CBHOs:

- Documentation timeliness and completeness
- Documentation quality
- Direct care and support staff roles that create high levels of discontent
- Quality improvement model of the need to create the perfect change solution that everyone must agree with versus using a continuous quality improvement action plan change model that supports timely implementation and on-going evaluation based modifications to the process as needed
- Non-standardized clinical/support staff flow processes
“Noise levels” created by the re-occurring challenges with service delivery processes demand attention to “the process” rather than to the more critical delivery of timely and quality services.

- Non-standardized documentation models/styles
- Access to care flow/processes
- Lack of computer skills and data/information to support objective decision-making
- High level of “emoting” by staff when presented with any change requirement
- Lots of ideas about changing the organization, but relatively low/no implementation of actual change

If any of the top ten noise generators identified above claim re-occurring attention of your center’s management team and staff, then the following suggested intervention solutions might be helpful:

1. Implement a 70% super majority decision-making process in all meetings of the management and unit/program teams to facilitate more effective organizational decision-making to address the noise generators. A 70% vote model used by each team has proven to effectively solve the challenge of a few staff members creating ongoing barriers to service delivery system change.

2. Create quality documentation improvement training programs that provide specific instruction for direct care staff on how to write more objective, effective, and quality documentation. Bill Schmelter, Ph.D., MTM Services and National Council Consultant, and I are collaborating on a book for spring 2008 publication by the National Council that focuses on the concept of “What we do – what we write.” We have found nationally, that direct care staffs are providing very important and quality interventions to consumers; however, the documentation being recorded in the charts does not support the level of quality and interventions being provided. Specific curricula are available to address this workshop based training need that uses current documentation in each CBHO’s charts as the focus of instruction.

3. Create flow charts of current service delivery processes to provide a more objective awareness of the redundancy/re-work designed into the current processes. Scott Lloyd, MTM Services and National Council Consultant, has experienced an interesting phenomenon when developing flow charts for CBHOs. When support staff/direct care staff are asked to identify process flows without managers present, the process flows are very different and in many cases in conflict with the workflow charts created by managers for the same processes. It seems that support staff/direct staff have adapted the process to their identified needs while the managers more often reflect the “Policy and Procedure” version. These process flow variances create system noise that can only be resolved when the actual practice is aligned to the envisioned practice.

In summary, the ability to reduce service process noise levels is proportionate to the efforts by management teams to measure current processes, identify appropriate solutions, make decisions about which solutions need to be implemented, and implement process change.

David Lloyd, author of How to Deliver Accountable Care, has facilitated the development and implementation of compliance-based management accountability initiatives with more than 400 community behavioral health organizations, regional medical centers, and primary care practices throughout the United States. He has been a featured presenter at numerous national, regional, state, and local workshops and conferences. He is the founder and president of MTM Services based in Raleigh, North Carolina and is a senior consultant for the National Council. For consulting arrangements, contact MarkB@thenationalcouncil.org.
Experts Speak

The Role of Psychiatric Core Measures in Transitioning from Hospital to Community Care

Frank A. Ghinassi, Ph.D., Chair, Technical Advisory Panel, Hospital-Based Inpatient Psychiatric Services Performance Measurement Initiative; Kathleen McCann, R.N., Ph.D., Director of Clinical and Regulatory Affairs, National Association of Psychiatric Health Systems

Inpatient, hospital-based psychiatric core measures are now being pilot tested in an exciting and groundbreaking performance measurement effort in behavioral health. And, while these measures are designed for use within the hospital setting, they will also provide valuable quality of care information and treatment planning leadership to enhance care continuity with community mental health settings. Of particular interest will be those measures that deal with the transition from hospital to community care – one of the most critical and challenging steps in a patient’s journey toward recovery.

About the Core Measures Initiative
At the start of 2007, pilot testing began through the “Hospital-Based Inpatient Psychiatric Services Performance Measurement Initiative.” This project was brought to The Joint Commission by the National Association of Psychiatric Health Systems, the National Association of State Mental Health Program Directors, and the NASMHPD Research Institute, Inc., with the support of the American Psychiatric Association (see www.naphs.org/quality for background). Together our organizations are working – with input from all affected stakeholders, including consumers, families, providers, researchers, and others – to identify and implement a test set of core performance measures that meet the rigorous standards used to develop core measures for heart failure and other general healthcare conditions.

A diverse and active Technical Advisory Panel is now overseeing the project. The widespread commitment of all stakeholders to participating in the development process, the willingness of providers to invest the human and financial resources needed to test these measures, and the enthusiasm of the involved pilot facilities to join in the leadership of this core measure development have been extraordinary. More than 190 hospitals – private and public from 40 states – are now participating in the HBIPS pilot test.

How Community Providers Will Benefit from HBIPS
While the initial core measures are focused on inpatient hospital care, the entire process has been designed with the expectation that many of the concepts may ultimately be useful to all levels of care.

For the first time, data will be comparable across the public and private sectors
Up to this point, there has been a great deal of data collection — an important first step — but with little or no ability to compare data across systems. While there was interest in many of the same measures, common definitions and standardized data collection methodologies that were widely supported by diverse stakeholders were lacking — thereby limiting the ability of data to provide risk adjusted benchmarks and improve practice. The core measures initiative will provide consistency in operational definitions — vetted and approved by diverse constituencies. All clients, families, and providers will benefit from this step toward a common language.

The core measures initiative puts behavioral health on equal footing with general health
This project will give psychiatric inpatient providers behavioral health data that is on a par with the core data (e.g. on heart failure) that general hospital and community health colleagues have available. Making the case that core measures can be compared across all types of inpatient treatment settings and that they are using standardized operational definitions will be easier as a result of this project.

In particular, two of these core measures will help hospitals improve the dialogue about patient care with the community services that receive patients transitioning from these settings. Core measures on timely communication for continuity at discharge and on use of multiple within-class medications will help to ensure transition to community outpatient providers with the data required to continue effective treatment.

Continuity Measure (HBIPS 5)
“Provision of discharge assessment and after-care recommendations, in a timely manner, to responsible community health providers upon discharge” is a measure that was chosen by the stakeholder panel for a number of reasons. Communication between levels of care is critical for both client safety and continuity of care. Many clients may not be able to fully report to their next healthcare provider their course of hospitalization or discharge treatment recommendations. The aftercare instructions given to the patient at discharge may not be available to the next level of care provider at the client’s initial intake or follow-up appointment.

In developing this measure, the Technical Advisory Panel felt that it was incumbent on hospital providers to ensure that this data is available to the next level of care. The TAP decided to standardize elements of what information clients should bring. This measure specifies that – prior to the aftercare appointment – inpatients leave the hospital with a brief referral summary that includes all of these elements:

- 5 axial discharge diagnosis.
- Current list of all medications with accurate dosing information.
- Next level of care treatment recommendations.

Documentation as to the reason for the current hospitalization is sent to the next level of care, which can be the prescribing clinician, the
prescribing outpatient entity, or the treating clinician or entity (in the absence of medications) prior to the aftercare appointment.

The measure will look to see that every hospital record is reviewed by the hospital for completion. As hospitals use this standardized measure, community mental health organizations and other community providers should feel the impact of improved communication more and more.

**Multiple Medication Use (HBIPS 4)**

“Patients discharged on multiple antipsychotic medications” is a measure that is intended to make this information an explicit part of the discharge summary for all hospital inpatients. This measure evaluates the proportion of inpatients discharged on two or more antipsychotic medications without one of several acceptable clinical rationales outlined in the discharge summary.

According to the Joint Commission, research studies have found that 5% to 18% of outpatients and 50% of inpatients treated with an antipsychotic medication concurrently receive two or more antipsychotics (Stahl, Grady, 2004). Studies have also found that, compared to treatment with a single antipsychotic agent, use of multiple antipsychotics for schizophrenia or other major psychiatric disorders is generally associated with more severe side effects and generally not associated with better clinical outcomes (Ananth, Gunatilake, 2004).

There are exceptions to practice guidelines recommending monotherapy, which are reflected in this core measure. For example, some patients who have failed multiple, adequate trials of monotherapy may benefit from the addition of a second agent (Learner, et. al., 2000). In an era of short hospital stays, a patient may be started on a new antipsychotic medication but discharged before the prior agent can be tapered off (Ananth, Gunatilake, 2004). Thus, clinically appropriate rationales for multiple antipsychotics include: 1) the patient has failed multiple adequate trials of monotherapy; or 2) the inpatient physician intends that one or more antipsychotics be tapered off following discharge.

The goal of measuring this information is to ensure that hospitals send providers in the next level of care a very clear picture of the intended plan for continuing use of antipsychotic medications. This information is intended to be an explicit part of the discharge summary.

The HBIPS core measures initiative is moving behavioral health on to an equal footing with general healthcare in terms of data collection and reporting. The primary goal of this project is to have a positive impact on the quality of patient care through standardized measurement, benchmarking, and greater transparency of practice decision-making – both within the hospital and as individuals are discharged and move to receiving community services.

**The Psychiatric Core Measures**

The five candidate measures in the psychiatric core measure set address quality-related dimensions of inpatient, hospital-based psychiatric care:

1. Assessment of potential risks, previous trauma, existence of substance abuse, and client strengths
2. Restraint use
3. Sedation use
4. Patient discharge on multiple antipsychotic medications
5. Provision of discharge assessment and aftercare recommendations to responsible community health providers upon discharge

Throughout 2007, psychiatric hospitals have been testing these measures. For details on the project, visit www.jointcommission.org (look under Performance Measurement Initiatives).

Frank A. Ghinassi is Vice President, Quality and Performance Improvement at Western Psychiatric Institute and Clinic of UPMC Presbyterian Shadyside. He is an Assistant Professor in the Department of Psychiatry at the University of Pittsburgh School of Medicine and serves as the principal investigator on a research grant aimed at studying the effectiveness of mental healthcare for Medicaid recipients in Allegheny County. He is a frequent presenter at national professional meetings and conferences.

Kathleen McCann is the director of clinical and regulatory affairs for the National Association of Psychiatric Health Systems. She provides clinical consultation to more than 600 member psychiatric health system facilities in the areas of clinical programming, performance improvement, and regulatory compliance. She serves as the NAPHS liaison to the Hospital Based Inpatient Psychiatric Systems core measurement development project.
It is easy to believe that most lawsuits against healthcare providers are the result of too many lawyers bringing frivolous claims and jurors run amok. However, because lawsuits sometimes accurately identify failures in quality care, we can learn from the patterns that are evident after analysis of a large body of cases. Over time, the allegations in categories of cases repeat from one case to the next. In fact, despite unique circumstances in each case, it is striking how similar the allegations are about deficiencies in clinical mental health care.

Because the costs in bringing a lawsuit can be quite high, many cases actually resulting in litigation involve serious injuries. Lawyers are more likely to bring claims when there are serious injuries because the greater the injury, the higher the potential for large settlements or jury awards.

The best clinical risk management is simply the process of providing the best quality care possible. The best use of a center’s risk management dollar is to concentrate on those areas of clinical practice most likely to result in serious injuries and lawsuits.

The most frequent lawsuits against community mental health centers are for:
1. Sexual misconduct with patients
2. Suicide malpractice
3. Patient’s violent acts with another patient at a center facility or with third parties

Except for the sexual misconduct claims, these cases almost always involve an allegation of some type of failure in adequately assessing or monitoring the patient’s condition. The mental health expert witnesses often assert that an assessment was based on incomplete information that could have been obtained with reasonable diligence or that the provider was not thorough enough because factors that should have been considered were not. Additionally, we often see allegations that an assessment was not done when it was important to do one.

Community mental health center management should design procedures to ensure that adequate information is available for staff doing assessments. It is especially important that the assessor have access to and be trained to consider the center’s own relevant records.

Sometimes access to relevant information is difficult because it is buried in a thick chart and time constraints present a barrier to reading the whole chart. Separate, easily accessible sections on a computer network for those areas most important to quality care and presenting the highest risk of lawsuits could alleviate this concern. These computer sections could document suicidal and violent behavior, the treatment provided over time, and whether the treatment was effective. Furthermore, they could document the baseline and historical data, such as lab test reports and physical exam information that are required for decisions about medication prescriptions. Descriptions about side effects and whether the medication was effective could also be included.

Other mental healthcare provider records usually contain information important to an assessment but are not always easily and quickly available. Consider entering into agreements with other local providers such as hospitals, physicians groups, and associations as well as other clinics to expedite the availability of their relevant records.

Sometimes other providers make their records available but not all relevant records are obtained. For instance, if an emergency room doctor refers a patient for crisis

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Associations have long played a unique and critical role in how American communities have addressed problems, promoted civic engagement, and served the public interest. Associations are “common ground” for cooperation and collaboration among vendors/providers who otherwise compete with each other.

Quality improvement through education, benchmarking, member services, and advocacy is a core activity for associations. Associations can be a key partner in state and national efforts to foster best practices and a culture of competence and quality. Many associations strive to be a non-governmental vehicle to address quality through a variety of strategies. Understanding the opportunities and challenges for deploying these quality improvement strategies will help association leaders and their members develop durable partnerships with payers, policy makers, and consumers.

**Association Strategies to Improve Quality**

- Benchmarking or measuring key indicators of performance and outcomes such as productivity, financial ratios, staffing patterns, no-show rates, or client satisfaction and functioning.
- Setting industry norms through a common vision, values, and code of ethics.
- Sharing effective processes that support quality and “make it easier to do the right thing.”
- Standard-setting through credentialing, expert opinion, guidelines, and protocols.
- Fostering communication among payers and providers regarding quality, cost, and access.
- Raising awareness of how to differentiate quality through “sell-right” strategies.
- Sponsoring training, development, and consultation services.
- Facilitating knowledge transfer and replication of innovations and best practices.
- Convening vendors and providers on joint projects that link products and services in the “supply chain.”
- Advocating removing regulatory barriers that interfere with quality.
- Advocating for reimbursement methods that support and reward quality and best practices.

The Minnesota Association of Community Mental Health Programs, Inc. (MACMHP) mission is “improving quality through education, member services and public policy advocacy.” The following examples show how we’ve creatively used association strategies to foster quality improvement. Similar activities are sponsored by other associations nationwide.

**A Model Benefit Set and Performance Measurement.**

Minnesota’s mental health system transformation focused on public and private sector services and the interaction between them through the Minnesota Mental Health Action Group. A key initiative was to develop an evidenced-based “model benefit set” that goes beyond traditional outpatient and inpatient benefits to include intensive, intermediate-level services typically available only to public sector consumers. With both public and private payers committed to the model benefit set, services and programs would need to be adjusted to meet the multiple quality expectations of employed commercial clients, poor, disabled consumers and the interests of the employer-purchasers, the local sheriff, or the hospital emergency room. For the Association’s provider members, this approach broadened the payer mix to support services that require sufficient volume to be sustainable. For consumers and family, it supported earlier intervention before disability and deterioration and all the related social consequences.

The state association with state leaders, consumer advocates, and private healthplan executives involved the MMHAG are also moving ahead with a project to establish common methods to assess quality and performance indicators for multiple payers and funders. The Minnesota Association role in these efforts, as a founding member of the MMHAG steering committee and various workgroups, arises from its mission and a strategic goal set by its board to improve coverage of intensive non-residential services for continuous, coordinated care built on high quality standards.

**New Connections for Telehealth**

This is another Minnesota Association-sponsored project to use high quality televideo conferencing for client clinical services, professional education, and administrative meetings. The project involves a combination of activities that tap into association expertise:

- Fundraising to secure financing and local match for equipment grants and staff.
- Negotiating group purchasing arrangements to leverage best prices and services.
- Training staff in the use of telehealth equipment.
- Advocating with public and private payers regarding reimbursement methods.
- Exploring business opportunities and new ways to use the telehealth capabilities.

Some lessons in quality from the Minnesota Association’s experiences are:

- Quality requires that multiple activities work together to yield the best outcomes, even when component services are supplied by multiple providers/vendors.

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stabilization or inpatient care because of suicidal behavior, the hospital should provide its records relevant to the decisions as a reference for further care and medication. QA committees should audit charts to monitor whether all relevant records are obtained in time.

All possible sources of relevant information should be contacted. As appropriate to the specific case, patients should be asked to give permission for the assessor to confer with such sources as family, friends, police, and primary care physicians who may be prescribing psychiatric medication.

Center management should also design systems to ensure that assessments are sufficiently thorough. For example, charts we have reviewed in suicide malpractice cases more often than not contain only minimal documentation of the consideration of suicide risk. Often the documentation is limited to comments about whether the patient denies suicidal ideation and includes a plan that does not consider why the patient should be believed. Consideration of the lethality of past suicide attempts is only infrequently documented.

Consider adopting protocols for assessments such as those described in The Harvard Medical School Guide to Suicide Assessment and Intervention (Jossey Bass, 1999). The lethality of past suicide attempts could be analyzed in relation to the risk for success of the attempt and the probability of rescue. For instance, a suicide attempt with a firearm after checking into a hotel alone without telling anybody has a high risk of success and a low chance of rescue.

When doing the initial assessment it is also important to plan the need for reassessments. Appropriate assessments should be done when a patient first presents for care, when discharged, when there is a significant change in clinical status, and on the occurrence of any suicidal or violent behavior.

The Mental Health Risk Retention Group offers professional and general liability and directors and officers insurance as well as a wide variety of risk management materials for the community mental health industry.

Ronald Zimmet is general counsel to the Mental Health Risk Retention Group. He is the featured speaker in the company’s risk management video and audio presentations. He writes a column on risk management for Behavioral Healthcare magazine. He is a trial lawyer and provides risk management consulting for mental health centers.

Nicholas Bozzo is the president of the Mental Health Risk Retention Group and the managing director of Negley Associates. He has many years of experience in insurance industry management.

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Quality improvement is not a top-down process — it involves paying attention to how things work on the ground and how services interact as well as focus on workflow efficiencies and the customer experience.

Often public mental health programs, piloted with grant funding, are unable to be sustained and replicated because they have not been positioned to live in the world of reimbursement-based financing; and often real world payers have not been able to relate to the innovative services developed with grant funds. Services need to be designed and developed from the start to meet the quality standards and interests of multiple payers and consumers.

Compliance and quality improvement are interrelated; however, compliance is a minimum goal, not an excellence goal. Compliance is a key foundation on which to build interest and consensus for broader quality initiatives.

A focus on quality improvement adds credibility to the association’s traditional advocacy efforts—that associations can both advocate and implement is a powerful combination.

Associations undoubtedly face many challenges in fostering quality. The information and communications technology needed for collaboration and dissemination of quality practices is expensive — collaboration software, listserves, online learning, web meetings, televideo conferencing, benchmarking surveys, and data reports. Increasing diversification and specialization by providers requires increased association staff capacity, yet there are resource constraints. And, fragmented funding silos fracture and frustrate efforts to improve quality.

Despite the challenges, associations’ focus on quality is critical to efforts to shorten the time lag from science to practice in a range of initiatives from primary care and behavioral health integration to dual diagnosis treatment. Through leadership, convening, and sharing of practical ideas, associations can bring a practical emphasis on how best practices can operate on the ground.

Ron Brand is Executive Director of the Minnesota Association of Community Mental Health Programs, Inc., a position that he has held since 1990. In this capacity he is involved with public policy advocacy, education, and member services. Previously, he worked in a community counseling center, in substance abuse treatment, as a school psychologist, and for a private foundation focused on organizational development and community care. Brand has a Masters degree in psychology from the University of Minnesota.
Performance Measurement

Benchmarking for Best Practices

Paul M. Lefkovitz, Ph.D., President, Behavioral Pathway Systems

The measurement of organizational performance has become ubiquitous in behavioral health settings. Its acceptance as a management tool has been facilitated by commitment to mission, marketplace dynamics, and regulatory mandates. Yet behavioral health leaders often report that such data has limited impact on organizational performance. In spite of commonly held beliefs that performance data should stimulate ongoing improvement, in many behavioral health settings, performance data does not inform organizational vision and does not drive key management decisions.

Why is this? Consider this — how helpful would a thermometer be as a measure of your health if you did not know that 98.6°F was “normal?” In the absence of context, your measured temperature would not provide information — it would just be a number. The same applies to behavioral health performance data. In the absence of context, no-show rates, access, productivity, cost per unit of service, and other performance metrics are simply numbers—they do not serve to inform.

Benchmarking provides the vital context that transforms numbers into actionable information. Benchmark metrics, most often provided in the form of percentile rankings, reveal exactly how your organization is performing in comparison to others. This leads to the identification of relative strengths and opportunities for improvement. Concrete evidence pointing to organizational performance that is lagging in particular areas readily calls most leaders to action.

In addition to illuminating opportunities for improvement, benchmarking offers insights as to how to improve. A technique known as process benchmarking uses benchmark data as a vehicle to identify potential best practices. Process benchmarking is based on a very simple premise — top performing organizations employ different methods than others and it is those unique methods that account for their high level of performance. Process benchmarking is an investigative technique that systematically compares the methods used by top performers with those used by others. Tactics that distinguish between top performers and others may be regarded as potential best practices.

Behavioral Pathway Systems, an organization that specializes in benchmarking, developed the process benchmarking methodology. BPS has conducted numerous process benchmarking workshops around the country to identify potential best practices. Electronic audience polling technology is used to lend anonymity and efficiency to the exercises. An interesting feature of process benchmarking is that the findings are quite sensitive to regional differences. Potential best practices in one geographic area may not exhibit similar promise in other localities.

Another noteworthy characteristic of process benchmarking is that the findings are frequently unexpected. That is because recognized and popular tactics are already widely adopted by most organizations. The methods that actually prove to separate top performers from others are often subtle and little-known, representing the “leading edge” of best practice.

For example, in conducting process benchmarking exercises in the area of access to services (length of time to be seen for initial session), it was found that organizations that generally eschew the use of voicemail were five times more likely to reside in the “top performer” group. Also, top performers were much more likely to limit the control clinicians have over their schedules. In addition, top performers were considerably more likely to have a Utilization Review process in place to manage the “back end” of the access process (excessive no-shows, therapist cancellations, etc.).

In the area of staff retention, top performers were found to be over twice as likely to establish procedures to ensure that individuals have a clear understanding of the job characteristics and hurdles before being hired. Top performers were also more likely to actively encourage supervisors to give positive feedback to staff regularly. In addition, organizations with high staff retention were more likely to have an employee newsletter that comes out at least quarterly.

In the absence of context, no-show rates, access, productivity, cost per unit of service, and other performance metrics are simply numbers — they do not serve to inform. Benchmarking provides the vital context that transforms numbers into actionable information.

These findings represent a small sample of what was learned in BPS process benchmarking workshops. They are presented as illustrations of the technique and should be regarded with appropriate caution. These findings have not been replicated sufficiently to allow for generalization across all geographic regions and types of settings.

In summary, benchmarking represents a powerful management tool that brings static performance data to life and facilitates ongoing organizational improvement. Interest in benchmarking is on the rise and its broader use within the behavioral health field should prove to be highly beneficial.

Paul M. Lefkovitz, Ph.D., a licensed clinical psychologist, is president of Behavioral Pathway Systems. He has been an active contributor to professional literature and presents regularly at regional and national conferences. He serves as chair of the Joint Commission Behavioral Health Care Professional and Technical Advisory Committee. Dr. Lefkovitz is active on the boards of behavioral health advocacy associations at the local, regional, and national levels.

Tracer Methodology Offers Burke Center a Qualitative Assessment Option

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As part of its Shared Visions-New Pathways® accreditation process, the Joint Commission on Accreditation of Healthcare Organizations introduced an onsite process, the tracer methodology. Tracer methodology involves the tracking of care recipients’ experiences throughout the entire organization, and is used to assess organizational systems and processes that drive care.¹ Since 2005, Burke Center, a community mental health and mental retardation center in Deep East Texas has used this process as a quality improvement tool.

With services being provided in more than 40 sites spread out over 12 counties encompassing 10,000 square miles, Burke Center has encountered challenges in assuring that programs implement processes consistently and that changes are communicated effectively. This was in fact identified as a need for improvement in our most recent Joint Commission accreditation survey. Recognizing the limitations to traditional auditing and monitoring in identifying shortfalls, Burke Center used tracer methodology as a means to assess consistency and quality in programs and areas in need of organizational improvements.

A tool was developed to help assess important aspects of service delivery and included assessment, treatment planning, service delivery, medical needs, and other areas requiring special attention, such as the use of behavior management plans. The tool also served as a prompt to follow up on issues that staff had struggled with in the past, such as assessing for nutritional risk and identifying the need for integration of care in mental health and substance abuse. Although the tool was useful as a prompt and in recording information, this process does not lend itself to measurement, a tradition in quality improvement. The merit of the process lies not in measurement but in how the individual’s needs are assessed, how problems to be treated are identified, and the means by which these needs are addressed. Questions such as “Why did you choose to work on this?” are asked. Thoroughness, timeliness, and appropriateness of the documentation are reviewed. Follow up over time of critical issues in an individual’s treatment is explored.

Most important, staff are given the opportunity to identify not only what they did but why they did it, thus reinforcing the larger purpose of the processes. While reviewing the care (still all in hard copy at our organization), use of the correct, most recent forms and procedures is also assessed. Staff are given the opportunity to ask questions, offer suggestions on improvements, and identify inefficient processes.

Following completion of the tracers, all findings are compiled onto a spreadsheet, under headings of program, issue, action needed, and status of action. Over the ensuing months, action plans based on tracer findings are identified and implemented, and the following years’ tracers identify if the actions taken were effective. The process is used to analyze how Burke Center as a whole approaches care and provides services.

The process has helped the Burke Center
• Identify training needs of staff.
• Assess effectiveness of past trainings.
• Assess effectiveness of communication throughout the organization.
• Providing a venue for staff to ask questions and make suggestions.
• Identify inefficient or laborious processes.
• Afford staff the opportunity to become familiar with the Joint Commission accreditation process.

Tracer methodology affords a qualitative, interactive assessment of services, as opposed to traditional audit and measurement activities.

¹ Tracer Methodology: Tips and Strategies for Continuous Systems Improvement, Joint Commission Resources, 2004
Client-Directed, Outcome-Informed Approach Produces Results for Community Health and Counseling Services

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Joanne is a 47 year-old woman diagnosed with bipolar disorder. When Community Health and Counseling Services began case management with her, she had been in mental health services most of her adult life, and was frequently suicidal. She was in despair, and felt helpless to change it. Charlotte, her case manager, had recently been trained in our Client-Directed, Outcome-Informed clinical approach, which provides a strengths-focused recovery pathway. She asked Joanne to complete a brief measurement tool rating how well she had been doing in the previous week on four scales. Joanne rated herself a 0.8 out of a possible 40, indicating serious distress. Charlotte wanted to validate Joanne’s distress, but she also knew from her training that it would likely be more effective to focus on Joanne’s heroism in the face of such adversity.

Accordingly, she pointed out that Joanne was clearly having a tough time, but she couldn’t help but notice that in the interpersonal area of the measure, she was doing just a little bit better. Charlotte asked how that could be, given that everything else was so distressing for her. Joanne told her that she had been suicidal again the night before, and had discussed it with her husband. He encouraged her by telling her that she was a strong woman, that he loved her, and found her delightful. She disagreed with him, but wanted to be the woman her husband saw her as.

Charlotte and Joanne discussed what it means to be a strong person, which led to Joanne’s decision to start an exercise program. She couldn’t see herself as an emotionally strong woman, but she decided to at least become physically strong. They went to a women’s gym, where Charlotte accompanied and supported Joanne, with permission from the owner, until Joanne felt comfortable to go there by herself. One year later, she had built muscle, lost weight, and was no longer suicidal. She was ready to end her case management services. Charlotte remarked that she would not have thought to have that initial conversation with Joanne or known how to capitalize fully on her strengths, prior to her training in CDOI.

Joanne and Charlotte’s experience together is not unusual at CHCS these days. CDOI de-emphasizes model and technique, as well as so-called “evidence-based practices,” in favor of attending to the factors that research has shown to be most important — bringing out the heroism in clients, and the quality of the helping relationship.

Working with clients through their preferred method (called the client’s theory of change) and measuring client self-report of progress at regular intervals with real-time feedback to both clients and clinicians, allows us to partner with clients to note early, small signs of progress or deterioration.

Thus we are in a position to make immediate adjustments in our approach to maximize the likelihood of a successful outcome. The clinical conversations engendered by the use of the measures provide a roadmap to rapid recovery. The use of measurement tools, in combination with our clinical judgment and the continuing input of the client and of others concerned about the client’s well-being, provide a vehicle for determining the efficacy of continuing services. Thus, we are able to closely tailor services to the specific needs of the client, and to make services accountable both to clients and payer sources. This approach is called “practice-based evidence” and was developed by Drs. Barry Duncan and Scott Miller at the Institute for the Study of Psychotherapy (www.talkingcure.com).

Since implementing CDOI four years ago, CHCS has reduced length of stay by an average of 60% across programs, the percentage of long term clients in our community support program by 49%, and our client no show and cancellation rates by 30%. Implementation of this approach enabled us to confidently assure our clients that recovery is not just a possibility, but a probability, and it ensures that we are accountable in our use of public funding for mental health services.

CDOI was initially developed for use with an outpatient psychotherapy population. CHCS is the first agency in the world to apply this approach systematically to community support services and group home programs. We are now developing an initiative in which a network of consumers, including those incarcerated, and both inpatient and outpatient providers, join together to bring a collaborative, focused, recovery approach to an entire community.
Family Services of Western Pennsylvania Improves Services with the Toyota Model

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The Toyota Production System is a well-known approach to enhancing quality in industrial organizations. Family Services of Western Pennsylvania in Pittsburgh, PA has adopted TPS as a strategy to improve delivery of behavioral health and other social services.

Family Services of Western Pennsylvania is a $21 million agency with 425 employees and operates 35 social service programs in clinical, residential and community settings in a multi-county area. Consequently, this dispersed and diverse agency requires quality enhancement strategies that are not static and that can be adapted to a multi-faceted workplace.

Family Services received funding for the intensive training required for its TPS implementation from the Jewish Healthcare Foundation, which has adapted the Toyota model as Perfecting Patient Care® and uses it in health care settings to train nurses, physicians, and quality managers in improving quality. Family Services attended a system wide orientation conducted by the foundation, followed by targeted training of 25 key individuals from all sectors of the agency. After subsequent training of agency staff by a newly hired quality improvement manager, the quality department created an organizing model called Values in Practice teams to operate inter-agency quality improvement projects. These teams adopt a practice change challenge and seek a better way to conduct the targeted practice by using the four rules of the Toyota model.

1. All work is highly specified as to content, sequence, timing, and outcome.
   Each time a team is formed around a problem to be solved; its initial activity focuses on identifying the existing need, value, goal and/or expectation related to the issue of focus. The team determines what the current condition is and what factors have led to it by collecting available metrics to understand the situation.

2. Every customer connection must be direct and there must be an unambiguous yes or no way to send requests and receive responses.
   The team identifies all people, locations, and steps that occur during the process that is being examined. They draw these steps on a chart, showing connections among them while soliciting confirmation from individuals who participate in the process that the documentation of these connections is accurate.

3. The pathways for every product and service must be simple and direct.
   This rule serves as a guiding discipline in redesigning a work process and involves exploration of how to simplify the targeted process to add value to the customer and to decrease waste. This activity redefines long held beliefs and challenges staff to look at old processes in new ways and discover alternatives for themselves.

4. Any improvement must be made in accordance with the scientific method under the guidance of a teacher at the lowest possible level in the organization.
   The organization flattens the customary authority structure to enable individuals who are closest to an activity to propose change. Since the team includes those who are involved in and familiar with the process, they are able to specify the actions that need to be taken and may address the problem without seeking approval from traditionally higher authorities. The caveat to this process is that the team must test their proposed solutions and use data from this scientific approach to clarify if the chosen solution improves the process and if the goal is achieved.

At Family Services, Quality Council is a committee representing staff from all service sites, foster parents, and individuals receiving services. The Council provides oversight and coordinates activities for continuous quality improvement. Part of the Council’s function was the implementation of a full evaluation plan of the TPS process. Components of the evaluation involve tracking the results of the TPS training, recording the number of staff across the agency that is involved in a VIP team, and monitoring the outcomes to assure that the procedures are effective.

To promote problem-solving using this method, the agency is publicizing specific team activities and results across the agency through feature articles in the agency’s weekly e-newsletter as well as formal team presentations at quarterly staff meetings.

Family Services has eleven early success stories with several VIP teams that have conducted projects during the past ten months. These projects have included, streamlining training procedures, improving the process for credentialing, using technology to collect daily work hours in the vocational workshop, and reducing wait time for psychiatric service appointments.

In a recent team, the central intake system of the outpatient department was revamped to allow for customers who are requesting appointments to talk “live” with an intake worker, reducing by days the length of time it takes for an individual to be scheduled for an appointment.

Successes such as these have a positive and sometimes immediate impact on the quality of service delivery and customer satisfaction. The implementation of TPS has engaged staff and stakeholders throughout Family Services in working together to identify goals for quality improvement and enhancement.
QI Scoring Tool Changes the Mindset and Performance at Fellowship Health Resources

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Fellowship Health Resources, which serves approximately 3,000 clients in seven states, has a Quality Improvement and Corporate Compliance Department, through which it imposes its expectations of unwavering excellence. Responsible for implementing the organization’s quality improvement plan in over 50 sites, the department consists of a director, manager, northeast region specialist and southeast region specialist. The team continually reviews and improves upon the organization’s systematic framework. It is through the program evaluation process that the team has the ability to formally, and in more detail, review each program’s performance. This has evolved over the years into a more streamlined, data-driven process by which programs are held accountable for individual performance ratings.

In previous years, the program evaluation process consisted of a visit to each FHR program site on a semi-annual basis by a member of the QI Team. Utilizing a checklist itemizing FHR policy and best practice standards developed by the QI Team, a review of client records, medications, funds, and the environment of care was conducted. At the end of the visit, findings were reviewed with the program director. A narrative report was then developed outlining trends noted during the review. This process had been in place for some time and was received well by program staff. However, among the many downfalls of the narrative report was that without actual data outlining performance, the QI Team was unable to precisely assess performance.

The Program Review Scoring Tool was developed in September 2005 and uses internal and external benchmarks, as well as regulatory and best practice standards, to evaluate performance. Specifically for the PACT program model, a Fidelity Scale was added to the Scoring Tool integrating regulatory standards through the Dartmouth Assertive Community Treatment Scale. The premise of this Excel-based tool was to attach a compliance rate to each program to better track performance over time. During the pilot process, the benchmark compliance rate was set for 85%. The tool is separated into sections which all hold varying amounts of weight to the overall score. Sections related to the client record piece of the scoring tool include psychiatric, medical, assessment, treatment planning, and progress notes. A score is calculated for each section, which also must meet the 85% compliance rate. Should a program achieve a score below benchmark, a follow-up review from the QI Team would take place within the next three months to assess progress with the established Corrective Action Plan.

Initial reaction from program staff during the pilot phase of the scoring tool was that of apprehension, which negatively affected the introduction of the new program review process. Though the review process itself did not change, program directors were unhappy with the idea of a “grade” attached to each review. The QI Team worked closely with programs, educating staff on how the tool operates and why it is important to collect performance data. During the first reviews following implementation of the new scoring tool, the average compliance score was 90%, exceeding the required 85% compliance benchmark. Following each review, program staff was consistently pleased with the newly developed tool. There evolved a more competitive spirit among peers to achieve the highest score. Those programs that meet or exceed the benchmark score receive a certificate for posting within the program, along with recognition in the agency newsletter and website.

In 2007, the FHR Program Review Scoring Tool has yielded an average score of 96%. The benchmark compliance rate has increased to 90%, and the individual scores will soon become a part of the staff performance evaluation process for program directors.

Jefferson Center Uses Senior Reach to Proactively Reach Older Adults with Mental Health Needs

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The aging of the U.S. population in the United States is expected to have a major impact on general health service and costs and increase the need for mental health services. Early intervention for older adults will minimize the need for more costly and intensive services. However, many older adults with mental health needs do not self refer and are reluctant to access traditional mental health services so they do not come to the attention of the mental health and aging service delivery systems that could help them at an early stage of distress. It is more compassionate to manage care for these older adults when effective and less costly services are delivered in a proactive manner rather than waiting for more serious symptoms to develop.

Jefferson Center for Mental Health and The Mental Health Center serving Boulder and Broomfield Counties partnered with Seniors’ Resource Center to develop the Senior Reach program. The program is in five counties with approximately 116,000 older adults.

Senior Reach was designed using research-based Gatekeeper models from

Continued on page 24
Managing the therapeutic encounter as an event in time is mission critical for all behavioral healthcare providers and high no-show/late cancel rates frustrate both the community service and business goals of the organization. The inability to fill a scheduled appointment due to a no-show or late cancel means lost access to care for the community and, depending upon how your service is financed, a lost revenue opportunity.

Maumee Valley Guidance Center is a regional behavioral healthcare provider serving the residents of Defiance, Fulton, Henry, and Williams counties of northwest Ohio. It features a progressive behavioral healthcare environment involved in research on adults with severe mental disabilities as well as in implementing advanced electronic medical records systems. Maumee was experiencing a 37-38% no-show/late cancel rate for psychiatry and outpatient counseling and a 50% no show/late cancel rate for nursing outpatient visits. We spent numerous meetings over a significant period of time trying to understand and impact this phenomenon.

Invariably our discussions centered on consumer behaviors. Serving a large regional population of adults with severe mental disability, our explanations focused on non-compliant behaviors and other issues — all revolving around the characteristics of the populations we serve. Consequently, we spent hours on strategies to change consumer behaviors. Groups focusing on non-compliant behaviors, patient education, and other strategies made little to no impact on the problem.

In our earlier research, we found that a 20-minute wait was within the tolerance range for most clients. The first client in reception was seen first and customer support representatives notified physicians if their second client was a no show. The physician then has the option to extend the first client’s 30 minute session or utilize the time for paperwork support to service. Considering the complexity of many of our clients, both physician and client value the additional time if available. Billable productivity increased by 13%.

With a new perspective on scheduling, we’ve increased access, created greater flexibility in meeting our clients’ evolving treatment needs, increased productivity, and correspondingly captured more revenue as well as reduced our frustration with client behaviors seldom within our immediate control.

However, in practice, access actually increased and clients and therapists have greater flexibility with “working clients in” when crises arise. Wait times also decreased, enabling clients to receive a scheduled appointment earlier on from date of intake. Our earlier research indicated that a critical indicator of no show behavior from intake to first appointment was the time span between these two events. No show behavior doubled when the time between intake and first therapy session went beyond ten working days.

Medication management clients, seen in half hour appointment blocks, are now scheduled two on the hour. Research into patient wait time tolerance suggested that a 20-minute wait was within a tolerance range for most clients. The first client in reception was seen first and customer support representatives notified physicians if their second client was a no show. The physician then has the option to extend the first client’s 30 minute session or utilize the time for paperwork support to service. Considering the complexity of many of our clients, both physician and client value the additional time if available. Billable productivity increased by 13%.

With a new perspective on scheduling, we’ve increased access, created greater flexibility in meeting our clients’ evolving treatment needs, increased productivity, and correspondingly captured more revenue as well as reduced our frustration with client behaviors seldom within our immediate control.
approach of brief, focused therapy, and the privacy of assessment in
their homes.

Senior Reach is a SAMHSA grant project and has rigorous data requirements for
producing outcomes described in the section for pertinent data. We have had
significant (p<.05) outcomes using this Senior Reach treatment model in:

• Reduction in indicators of depression
• Improvement in hopefulness – optimism about the future
• Reduction in social isolation

To date, 86% of referrals from the community have accepted services and
4,000 people in the community have been trained on the needs of older adults.

Senior Reach has resulted in better overall services to older adults in the com-
community, good research-based outcomes, less fragmentation in service delivery,
more people in the community who understand the special needs of seniors, a
spirit of volunteerism to be the “eyes and ears” in the community to assist older
adults, and better intra-agency collaboration.

More information can be obtained from www.senioreach.org and a DVD
about the program to share with your community is available by e-mail to
vickir@jcmh.org.
Measuring our success in recovery requires those of us in mental health service delivery to be more accountable to our communities and to demonstrate the difference we make in the lives of the people we serve.

The Mental Health Center of Denver received the Community Provider of Excellence Award from the National Council for Community Behavioral Healthcare in 2005 for implementing integrated, evidence-based approaches to recovery.

The “Denver Approach,” which encompasses training, education, social, and arts programs, as well as employment and other rehabilitative services, aligns with MHCD’s operational definition of recovery: “Recovery is a non-linear process of growth by which people move from lower to higher levels of fulfillment in the areas of sense of safety, hope, symptom management, satisfaction with social networks, and active/growth orientation.” (1)

In keeping with its progressive recovery-focused philosophy, MHCD has developed a “360-degree” process of recovery measurement, using environmental, clinical, and client-specific individual indicators. The outcomes measurement process is proving to be a critical component in instituting system change and promoting consumer recovery successes for MHCD.

Using Data to Inform System Change

The intent of MHCD’s measurement process is to improve clinical practices, rather than to evaluate performance. Measurement is based on a formative and summative process that creates a constant loop of client recovery information while providing empirical feedback toagency leaders.

Sample Outcomes from the MHCD Recovery Markers Inventory (RMI)

(Based on 44 new intakes)

Compared to their situation at intake:

- 36.6% of the consumers had an improvement in their employment situation 1 year later
- Almost half of the consumers (47.6%) had an improvement in their active/growth orientation 1 year later
- 37% of the consumers had an improvement in their symptoms 1 year later

As clinicians, we have historically used anecdotal data to inform clinical practice to promote recovery outcomes for consumers. With Recovery Markers, we now have longitudinal, empirical data to support our clinical judgment and decisions.”
assist in system transformation. The process promotes recovery at multiple levels within the mental health system (consumers, clinicians, managers, and directors) and from multiple viewpoints (consumers and clinicians).

**Tools for Holistic Measurement of Recovery and Provider Effectiveness**

To gather a holistic view of mental health recovery, MHCD developed state-of-the-art tools to assess recovery from the perspective of both the clinician and the consumer. Psychometrics of these four recovery tools were established using Item Response Theory (IRT) techniques and have proven to be highly reliable. (2)

Initially, new consumers are administered a **Recovery Needs Level (RNL)** assessment, which rates them on a variety of clinical criteria. The RNL assesses a consumer’s current status and progress in achieving his or her recovery goals. It then assigns the consumer to one of four levels of service corresponding to where their need is the greatest. For instance, a consumer may have high needs in symptom management but have low need in housing. MHCD administers the assessment at three and six months after admission, and every six months thereafter to match the consumer’s needs and keep him/her moving forward in recovery.

Every two months, case managers complete a **Recovery Markers Inventory (RMI)**, which rates each consumer’s progress based on his or her own goals in six survey areas: employment, education/learning, active/growth orientation, symptom interference, engagement, and housing. This tool is effective in identifying consumers who are having more difficulty than others and in determining in which areas they need more help. (3)

Approximately every six months, consumers rate their own perceptions of their mental health recovery using a **Consumer Recovery Measure (CRM)**. The CRM is a 15-item survey which includes questions regarding active/growth orientation, hope, symptom interference, sense of safety, and social networks. Likert-type responses are measured on a 0 (strongly disagree) to 3 (strongly agree) scale. Clinicians receive regular reports of consumer perceptions of progress in the various domains to help them to be more responsive to consumer needs. (4)

The **Promoting Recovery in Mental Health Organizations (PRO)** tool is utilized once a year to provide consumer evaluation of how the overall MHCD environment supports his or her recovery. Consumers interview peers to assess MHCD staff, including case managers, therapists, psychiatrists, front desk staff, rehabilitation staff, and residential staff. In addition to serving as a general needs assessment, the PRO survey was designed to help gain an understanding of what staff
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Follow the leader

The Mental Health Center of Denver is a private, not-for-profit, community mental health care organization providing comprehensive, recovery-focused services to more than 6,500 residents in the Denver metro area each year. The CEO, Dr. Carl Clark, was formerly the Medical Director of MHCD. In 1993, Dr. Clark was chosen as NAMI’s Exemplary Psychiatrist of the Year and in 2000, he was elected Professional Man of the Year by the Colorado Business Council. Dr. Clark is also Assistant Clinical Professor at the Department of Psychiatry at the University of Colorado School of Medicine and the Second Vice-Chair of the National Council for Community Behavioral Healthcare’s Board. P. Antonio Olmos-Gallo, PhD is the Director of Evaluation and Research at MHCD. He is also an adjunct professor at the Department of Psychology, University of Denver, where he teaches graduate level statistics and research design.

1 MHCD Recovery Committee (2004)
3 A partial credit Rasch model was applied, suggesting good model fit (N = 2,108), including: Individual Response Theory (IRT): person reliability = .75, item reliability = 1.00; Classical Test Theory (CTT): reliability = .78
4 A Rasch Rating Scale model was applied, suggesting good model fit (N = 525), including: IRT: person reliability = .83, item reliability = .86; CTT: reliability = .86
5 The PRO survey is in its pilot phase, where a trained consumer survey team is currently collecting data. Expected completion March 2008
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How Consumers **STEP UP** to Design a Truly Recovery-based Mental Health System

Daniel Fisher, MD, PhD, Executive Director, National Empowerment Center

Recently there have been spirited discussions among consumers about what we want to propose as a basic change in the mental health system. Several of us have proposed that legislation be passed to ensure that every state and every community have reliable funding for consumer-run support and advocacy groups similar to the independent living centers for people with other disabilities. I liked the idea, but then I started to worry that those centers would be marginalized or co-opted as long as the mental health system remains narrowly medical. I have concluded, and have preliminary support from other leaders, that as consumers, we need to redesign the whole system and society from the bottom up, based on our lived experiences with mental health issues. I believe that only by having a vision of a truly recovery-transformed system and society, will we ever see lasting and genuine change.

In 2007, 27 statewide consumer organizations and three National Technical Assistance Centers united to form a broad-based national consumer group called the National Coalition of Mental Health Consumer/Survivor Organizations (www.ncmhcsso.org). With this newfound unity and strength, the Coalition needs a national agenda.

The President’s New Freedom Commission mapped out the bold new vision of “a future when everyone with a mental illness would recover.” The Commission went on to state that this vision could best be carried out by transforming the system to a consumer-driven system based on recovery. I want to see us carry out the vision but it is yet to be truly supported. Only piecemeal solutions have been attempted. To transform the system to a recovery-based one, C/S/Xs (consumers/survivors/ex-patients) will need to almost completely redesign it.

An example of the failure of piecemeal solutions lies in the use of peer support specialists. Most people concur that peer support is a vital component of the spirit of recovery. Accordingly, Georgia led the charge among states to make peer support a reimbursable service. In order for the system to accept peer support as a service, it made severe changes to the concept of peer support and recovery. Recovery was broken down into a set of institutionalized steps. The first step is that a person has to accept that he or she is mentally ill. The condition is then defined as a permanent deficit resulting in a chemical imbalance. In that manner, the medical model is reinforced and recovery becomes just another term for remission.

Secondly, for peer specialists to be reimbursed, supervision needs to be carried out by “qualified mental health professionals,” which means by traditionally trained clinicians who have little understanding of peer support or recovery. Instead of validating the importance of lived experience, this type of supervision turns peers into junior clinicians. The first indication of this pitfall was revealed to me at a progressive mental health enter in California several years ago. The administrator proudly introduced me to 13 newly hired peer specialists. I was shocked to learn however that each was primarily checking people’s medication and had no opportunity to share their personal experiences. We agents of change should not underestimate the skill with which the system is able to preserve the status quo by absorbing the language of peer support and recovery into its existing structure. That is why we are proposing a genuine transformation of the system, which is designed and carried out by persons with the lived experience who identify as C/S/Xs.

**A consumer-driven system means one which is guided by people with a lived experience. We know better than anyone else what helps and what hurts in our recovery. Every significant administrative body in mental health needs to have significant participation by Consumers/Survivors/Ex-Patients.**
What Would a Consumer-driven, Transformed, Recovery-based System Look Like?

First and foremost, a consumer-driven system means one which is guided by people with a lived experience. We know better than anyone else what helps and what hurts in our recovery. For too long we have tried to educate decision makers. The time is coming when we will need to be those decision makers. This means that every significant administrative body in mental health needs to have significant participation by C/S/Xs.

A useful acronym for the changes that need to be made is **STEP UP:**

Consumer-Driven Services, Training, Evaluation & Policy: United for Power

**S:** Services and supports need to be consumer-driven

**T:** Training needs to be consumer-driven

**E:** Evaluation and research needs to be consumer-driven

**P:** Policy and planning needs to be consumer-driven

These changes need to be accompanied by a shift in the understanding of the problems known as mental illness and the best way to help people recover.

Those of us with a lived experience have been constructing a new paradigm over the last 35 years. We need to be the people who define these problems based on our experience, not on some outdated textbook. We need to instill hope at the very outset of a person’s recovery journey.

The consumer movement started as a civil rights movement to right the wrongs that are perpetrated against people labeled with mental illness. In the last 15 years, this has also become the recovery movement. Instead of describing the problems as mental illness, we who experience these problems prefer terms such mental health issues or life changing experiences. Dr. John Weir Perry described these as periods of reorganization of the self at the deepest levels. Underlying all these new descriptions is an understanding that if people are surrounded by people who believe in them and connect on the most human of levels, then these periods of change are opportunities for growth.

Viewing these periods as opportunities instead of symptoms of an illness means that there is meaning in unusual thoughts and behavior. It means that these unusual aspects of the person need to be understood and incorporated, not removed and eliminated. Young people today are particularly turned off by the concept of stamping out mental illness as shown in the Icarus Project’s materials.

A few of the innovative projects, which C/S/Xs have already piloted, are:

- Five peer-run crisis respite — the Rose House in New York is the most developed with a drop-in center, crisis respite for up to 5 people (at 1/5th the cost of a hospital), outreach to people’s homes at times of crisis, and a warmline.
- Self-determination accounts in Florida, headed by consumer Patrick Hendry, which give decision-making power to the C/S/Xs.
- The Consumer Quality Initiative, a peer-run evaluation team in Massachusetts (www.cqi-mass.org).
- Peers working as peer specialists (they are setting up their own national group, National Association of Peer Specialists or NAPS) and a variety of other jobs such as peer bridges.
- Drop-in centers and recovery centers in almost every state and county.
- Consumers working as personal care assistants for their peers in Oregon.
- National Coalition of Mental Health Consumer/Survivor Organizations (www.ncmhcso.org) with 27 statewide networks as members.

**Next Steps**

- C/S/Xs and advocates need to seriously discuss what we would like to see in a redesigned system and society. We need to enter into discussions about the future we want. We need to share and pool the best information, experience and ideas we have for a new recovery-based system.
- We need to take that knowledge and principles to the public and draw them into the need for a bottom up change. We need to overcome the discrimination and discrediting we are subjected to by the media.
- We need to collectively develop a comprehensive new set of proposals to genuinely transform this system. This would be a type of national C/S/X white paper.
- We should use that white paper an advocacy tool and educate decision makers, media, and public at every organizational level.
- We could pick the top 2-3 recommended steps and push for success in those first.
- Carry out all these steps with as broad-based participation as possible to ensure “nothing about us without us” but also recognize the advantage of working through a national consumer group such as the National Coalition of Mental Health Consumer/Survivors.

Daniel Fisher is a psychiatrist who has recovered from schizophrenia. He is a role model for others who are struggling to recover, and was a member of the White House Commission on Mental Health. He is presently Executive Director of the National Empowerment Center and a practicing psychiatrist at Riverside Outpatient Clinic, Wakefield, MA. Dr. Fisher conducts workshops, gives keynote addresses, teaches classes, and organizes conferences for consumers/survivors, families, and mental health providers to promote recovery of people with labeled with mental illness by incorporating the principles of empowerment. He has been featured on many radio and television programs, including CNN Special Report. He is the recipient Mental Health America’s Clifford Beers Award and the Bazelon Center for Mental Health Law’s advocacy award.
Community Collaboration Helps to Target Early Detection and Intervention for Psychosis

Donna Downing, MS, OTR/L, Director of Training, Early Detection and Intervention for the Prevention of Psychosis Program; Elizabeth Spring, RN, BSN, MS, Deputy Director, Michigan Prevents Prodromal Progression

There is a unique treatment research program in Portland, Maine called the Portland Identification and Early Referral Program, PIER. PIER’s mission is to identify young people between the ages of 12 and 25 who might be at risk for psychosis in the Greater Portland area, and then offer appropriate treatment. In August 2006, the Robert Wood Johnson Foundation recognized PIER, under the direction of Dr. William McFarlane, for its pioneering work in the field of early intervention for psychosis by awarding a significant grant to replicate the program in other locations in the U.S.

Following an application process, four sites were chosen in April 2007 to replicate the PIER Program in Sacramento, California; Salem, Oregon; Washtenaw County, Michigan; and Glen Oaks, New York. PIER and the four other sites are now part of a replication study known as the Early Detection and Intervention for the Prevention of Psychosis Program or EDIPPP.

PIER’s outreach effort to educate community members was based on initiatives developed in Australia, Norway, and Denmark — where the focus was to interrupt the progression of schizophrenia and other severe psychotic disorders. PIER’s goal was to improve outcomes and prevent the onset of the psychotic phase of those illnesses. The Australian and Norwegian initiatives identified stakeholders outside of the mental health system who could participate in early detection and show commitment to the effort. Stakeholders were recognized as people who were in a unique position to identify young people demonstrating the early mental changes predictive of a developing psychosis. Stakeholders were also “the general public.” The PIER team made the assumption that certain groups of professional and lay people spent more time with teens and young adults, and would therefore notice early symptoms and respond more quickly.

Most participants have been on low-dose medications, but overall, their symptoms have subsided as they and their families have learned to keep stress low and identify early signals of symptom recurrence. Research has been an important component of the program because much still needs to be learned about the early phases of illness, what works in terms of interventions, and what individuals and their families need. The result is that the majority of young people who have participated in the program have stayed in school, refused to take subsequent calls, and instead, would quickly make referrals.

PIER has been designed to respond quickly to referrals and to partner with young persons and their families from the start — through the intake assessment process and then through various client-centered psychosocial interventions, such as family psychoeducation, counseling, supported education, and supported employment. When appropriate, clients have also had occupational therapy assessments to better understand cognitive and functional difficulties — results and recommendations are then shared with the family and treatment team.

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Psychotic illnesses are disabling and expensive. It has been estimated that the cost to society can be higher than $10 million over the course of an individual’s lifetime, especially if they have schizophrenia.

Starting in December of 2000, the multi-disciplinary PIER team began educating community stakeholders about the early signs of psychosis. Psychotic illnesses, such as schizophrenia, are known to be disabling and expensive in multiple ways. There is a tremendous cost to individuals with these illnesses, as well as to their families and communities, e.g., lost productivity, increased family stress, increased physical illnesses, diminished self-esteem, increased dependency, repeated need for hospitalizations, inability to maintain friendships, and difficulty attaining life goals, such as completing school and working. It has been estimated that the cost to society can be higher than $10 million over the course of an individual’s lifetime, especially if they have schizophrenia. When we consider that psychosis can derail a young person’s life permanently, it is hopeful to think that offsetting an illness process early in its development is possible.

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It was reasoned that if specific community professionals were offered information and support, collaborative relationships between them and the PIER staff would develop and lead to early referrals of “at risk” youth. The community education presentations and outreach activities were designed to give specific information about early signs of psychosis, to network with community members outside the mental health system, and to demystify and destigmatize mental illness. These trainings offered important information about the biology of the brain, which raised awareness about brain disorders versus personality disorders. They also offered resource and referral suggestions for stakeholders. The result of PIER’s outreach was that school professionals, teachers, health professionals, parents, and mental health practitioners became familiar with PIER’s message, knowledgeable about the importance of making early referrals as a deterrent to disability, and learned how to make referrals.

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graduated, held jobs, maintained relationships, participated in extra-curricular activities, and set goals for the future.

The M3P (Michigan Prevents Prodromal Progression) Program is one of the EDIPPP replication sites and is located in the diverse community of Washtenaw County, Michigan. M3P prepared for outreach activities by completing a community mapping tool, which allowed it to prioritize efforts.

Community outreach started in the spring of 2007 and to date, has reached seven public high schools, six middle schools, several primary care physicians and nurse managed clinics, the local community college, as well as two major universities and two major health systems. In most instances, outreach to a school involves a minimum of two to three visits, first with the counselors or social workers, followed by the administrators and teachers, and frequently, a request to meet with various student groups. Outreach efforts have extended beyond the schools to include student advocacy centers, churches, multicultural groups, the local National Alliance for Mental Illness chapter, police, campus security staff, resident assistants, the local health department, veteran services, and county administrators.

Part of M3P’s strategy is to create extensive and inclusive outreach opportunities. Outreach targets include any professional or community group that encounters those aged 12 to 25. When reaching out to a wide variety of community members, it is important to tailor the information presented, including the development of “leave behind” materials. For example, what one would present to a group of teachers or counselors would be different from what is presented to hospital staff, students or the police. The most effective leave behind material has been the “youth brand” bookmark, which includes the early warning signs of early psychosis and program information. When crafting a message, M3P considers the age of the target population, as well as the circumstances under which the community group encounters them. The community response to date has been remarkable. A local school principal has requested weekly M3P onsite office hours for support and screening of students. This is a model that truly focuses on health promotion and secondary prevention services.

PIER’s community outreach has helped school professionals, teachers, health professionals, parents, and mental health practitioners became knowledgeable about the importance of making early referrals as a deterrent to disability.

M3P is a replication site, and therefore uses the same content for its outreach materials and messages to audiences that PIER and the other program sites use. An important part of the research is to better understand what messages work with what audiences in different communities, especially in culturally diverse communities. The EDIPPP “youth brand” bookmarks are visually appealing and carry simple messages about getting help early and recognizing the early warning signs that “something’s not quite right.” To date, these bookmarks have been instrumental in helping community members of all ages gather basic information about the importance of dealing with symptoms early, along with going to the website to gather further information.

If most citizens can understand that there are very early signals that point to brain changes, then perhaps more individuals will get help early and avoid a major mental illness.

Donna Downing, M.S., OTR/L is Director of Training for the EDIPPP Study, overseeing the clinical functions of each replication site. She served as the first team leader of the PIER Program, from 2000-2006. She has worked in various psychiatric in-patient and community settings throughout her career and has taught at the university level. Her area of expertise is Family Psychoeducation.

Elizabeth Spring, R.N., B.S.N., M.S., Deputy Director of M3P, has training and expertise in health promotion, prevention, engaging at risk populations and program development and implementation. She is also a part-time faculty member at Washtenaw Community College, teaching mental health nursing and has an adjunct appointment at the University of Michigan School of Nursing.

**EARLY SIGNS OF PSYCHOSIS**

In combination...
- Being fearful for no good reason
- Jumbled thoughts and confusion
- Feeling “something’s not quite right”
- Declining interest in people, activities, and self-care
- Hearing sounds/voices that are not there
- Trouble speaking clearly

Don’t ignore the early symptoms! www.preventmentalillness.org
Youth

Improving Engagement with Youth and Families when Treating Mental Health Difficulties

Samira B. Ali, MSW, Advocate Supervisor, Court Appointed Special Advocate; Mary A. Cavaleri, PhD, LCSW, Post Doctoral Fellow, Mount Sinai School of Medicine; Mary M. McKay, PhD, LCSW, Professor of Psychiatry and Community Medicine, Mount Sinai School of Medicine

Evidence-based phone and in person engagement strategies which aim to reduce potential barriers to care have resulted in about 448 more children attending treatment and decreased the number of treatment dropouts.

Background

Service underuse is a major problem confronting the child and adolescent mental health system, as indicated by a set of studies in which 11% to 36% of youth in need of treatment were not engaged in services1,2 while 35% to 75% of the children who were initially engaged in treatment dropped out prematurely3,4. Service underutilization appears to be particularly pronounced among children of color5,6, especially if they are impoverished7, despite the fact that their risk of being afflicted with mental health difficulties is greater than that of Caucasian youth of higher socioeconomic status8,9. Consequently, only a small fraction of children and adolescents with mental health difficulties receive adequate care, and ethnic minority youth from low-income families are particularly unlikely to receive needed services8.

Impediments to Service Utilization

Research investigating the disparity between service need and utilization has revealed an association between service underuse and multiple child, parent, and family-level factors ranging from the child’s gender, parental pathology, and low socioeconomic status9-14, to perceptual factors such as parental mistrust, concerns about stigma, and fears of losing custody of their children or being blamed for the child’s illness15-18 to larger logistical and provider barriers including transportation, childcare difficulties, waiting lists, and insufficient/lack of insurance17,19. Low-income children and families of color are thought to be particularly apt to experience perceptual barriers such as stigma, mistrusting providers, and being blamed for their child’s difficulties19,20, and to instead utilize alternate sources of care instead of formal mental health services21.

Engagement Strategies

In spite of this, multiple service delivery efforts which address these barriers to care appear to be effective at improving service use, especially among youth of color. For example, intensive phone engagement and letter reminders for appointments in the initial stages of treatment have been shown to be effective for engaging families and decreasing rates of premature termination22-24. Particularly, phone engagement is most beneficial when the conversation goes beyond intake procedures and discusses potential difficulties and past experiences in similar settings25. Moreover, research indicates that community representatives serving as advocates for the family have been involved in an attempt to decrease the stigma of seeking help26,27.

In addition, Dr. Mary McKay and colleagues have developed a series of evidence-based engagement strategies delivered by telephone and in person which identify and discuss negative perceptions and prior experiences with mental health providers and care; explore and aim to reduce potential barriers such as time constraints, transportation and childcare issues; clarify the roles of the agency and mental health providers; and establish a foundation for a collaborative relationship between provider and family25,26,28-31. The use of these techniques has been associated with an average increase of 14% in the rate of attendance at child mental health intake appointments across 12 agencies serving predominantly low-income children and families of color (the equivalent of 448 more children attending treatment)29, as well as decreasing the number of treatment dropouts29.

Yet although these engagement strategies have shown much promise, delivering these techniques in real world settings has been difficult because there is relatively little guidance given to providers as to how to administer these interventions32. Moreover, there is a severe lack of systematic dissemination methods within the field in general33,34, and child mental health in particular35. Thus, in addition to implementing successful evidence-based strategies, transporting such methods throughout the child mental health system presents multiple challenges.

In closing, it is clear that youth and families are encumbered by a vast array of logistical, perceptual, and provider impediments, which in addition to child, parental, and family-level factors, results in the underutilization of mental health services for youth. Therefore, it is imperative that effective interventions which improve service use be disseminated throughout the child mental health system in order to improve the health and well-being of children with mental health difficulties.
Samira Ali, MSW is a Supervisor for Court Appointed Special Advocate in New York City. She is also a research assistant with Dr. Mary McKay's research lab. Her research interests include HIV interventions for adolescents and high-risk populations, barriers to mental health care, and increasing services to children in foster care.

Mary A. Cavaleri is currently a Post Doctoral Fellow at Mont Sinai School of Medicine. She holds a PhD in Clinical Social Work from New York University, where she has studied barriers to health and mental health services among vulnerable populations including inner-city youth, families of color, and adults afflicted with HIV.

Dr. McKay is a Professor of Psychiatry and Community Medicine. She directs a large research lab focused on inner-city mental health services research and family and community-based prevention and intervention research. Her research lab currently consists of approximately 65 staff members, almost exclusively staff of color with substantial expertise in conducting community-based research. Dr. McKay is also the recipient of two career scientist awards from the National Institute of Mental Health. Dr. McKay is also the Assistant Director of Social Work in Psychiatry at the Mount Sinai School of Medicine.

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25. McKay, M.M. Collaborating with consumers, providers, systems and communities to enhance child mental health services research in Collaborative Research to Improve Child Mental Health Services. Edited by Hoagwood K, in press.
It is our responsibility as community behavioral healthcare providers to assure that resources allocated to our system are maximized to deliver the highest volume and quality of services feasible. At North Central Behavioral Health Systems, process improvement is an ongoing effort that has demonstrated positive achievement of fiscal, operational, and clinical service quality objectives.

In conjunction with implementation of an electronic health record, North Central measured the three interrelated variables of cost, quality, and access. Many providers have achieved two of the three variables, but few show mastery of all three — some providers may achieve the ability to deliver high quality services but at a high unit cost. Then the provider has long waiting lists, which limits access to those quality services.

At North Central, our leadership team challenged this conventional wisdom, understanding that controlling only 2 of the 3 variables was not sufficient to achieve operational goals identified in our strategic plan. And we were able to influence and control all three variables by utilizing an EHR.

**Cost**
Our return on investment analysis focused on a review of four functional areas that could be measured quantitatively and have a direct impact on cost: productivity, human resources, finance, and compliance. In North Central’s EHR implementation and use, analysis of standard performance benchmarks revealed that the cost variable was controlled and unit costs were significantly reduced within an environment of increased client satisfaction.

**Quality**
The current healthcare environment has an expectation of immediate responses to one’s needs. The EHR has enhanced the quality of care at North by generating the ability to have an immediate response to any clinical issue.

Clinical staff have identified that treatment is more collaborative when the EHR is updated immediately and staff can review consumer progress provided by all treatment providers involved in the consumer’s care. Where once care providers operated in silos, each department working toward its own specific goal, we now operate within a system that has broken down the barriers and works toward the common goal of consumer recovery.

Utilizing the EHR provides the opportunity for the consumer to drive care. Sessions can be used to review a consumer’s progress towards goals, complete progress notes with the consumer, and establish new goals. During the session the consumer can evaluate progress within the treatment process and ensure that their viewpoint is included in the progress note.

Improving the quality of clinical supervision further enhances quality of care. The EHR supports an environ-
ment that allows for concurrent documentation, provides for the use of reports to assist staff in developing a successful work pattern and caseload management, and ensures that the supervisor has the ability to provide timely case direction. Furthermore, caseload management via reports allows management staff to identify diagnostic patterns of new admissions to assure the appropriate service mix is being offered to meet consumer needs.

The opportunities within the EHR for controlling the quality variable are derived from the system’s ability to generate reports, end duplicative work, and track sessions, all of which contribute to the care provider’s ability to focus on treatment, thus improving the quality of care.

Access
In October 2006, North Central eliminated its waiting list. Leadership concurred that the lack of service access was detrimental to our community and compromised our mission. North Central implemented changes in our operations, which allowed us to work down the waiting list and schedule new clients at the same time. In May 2007, North Central formed a process improvement workgroup that focused on redesigning the access process.

The Access to Services Workgroup identified 3 outcomes for the access redesign:

1. Initial call to clinical appointment should occur within 7 business days.
2. Reduce upfront dollar investment in access process.
3. Reduce the no show rate for initial appointments from 28% to 17%

To date, the first time appointments have doubled in availability. Total caseload has increased by 10%. Access to services occurs within 5 business days of the initial call and the no show rate for initial appointments has dropped from 28% to 18%.

As our team reviewed the organization’s Key Performance Indicators, we realized that the outcomes achieved support the conclusion that the three variables of cost, quality, and access have been impacted by North Central’s use of an EHR. Through management of these interrelated variables, North Central has achieved an ROI that supports the organization’s clinical quality/service improvement objectives, fiscal objectives, and mission enhancement objectives.

North Central Behavioral Health Systems, Inc. is a community behavioral health services provider offering a broad range of mental health and substance abuse services to a seven county area. Jodi Mahoney maintains responsibility for managing and directing all functions related to the clinical services, marketing, human resources, support services, and information services/technology. She has 10 years experience in the behavioral health field and has held positions as Front Office Supervisor, Manager Support Services, Director of Health Promotion and Educational Services, Assistant Vice-President/Operations as well as her current position of Vice-President/Chief Operating Officer.

Diane Farrell is the Director of Clinical Operations for North Central. Her responsibilities include supervision and directing a full continuum of services for outpatient mental health and substance abuse treatment in the seven counties. She has more than 20 years experience in the community setting. She has overseen the development and implementation of adult and children’s community based services, and worked towards implementing a service continuum that meets the consumer’s need in a fee for service system.
Technology

Connected Care in a Connected World

Kevin Scalia, Executive Vice President, Corporate Development, Netsmart Technologies

Over the last several years, behavioral healthcare providers have instituted a variety of programs and initiatives designed to improve access to and quality of care for clients. These have taken many forms, including “no wrong door,” “integrated client care” and others.

The reality is that care is becoming more complex, and many behavioral health providers believe they will never have the funding they feel is required to deliver the level of care they think is truly needed. Trained to maximize human potential, clinicians find themselves pushing paper instead of serving clients in need. Therefore, a breakthrough is required in the way care is delivered. Connected care is that breakthrough. For the past several years, much of the discussion has been around electronic health records. While EHRs are critical to ensuring clinical processes are automated, they may not be enough. The EHR is only the foundation to a larger goal – to provide connected care.

In its simplest terms, connected care is sharing clinical information within your organization, with other care providers, and with clients themselves – all in an effort to provide the highest quality care.

Besides improving the continuity of care and promoting quality care, connected care reduces medication errors, improves efficiency and, most importantly, enables consumers to be more involved in their care process.

Connected Care Impacts Internal and External Processes

The initial step toward a connected care environment is to link and automate internal clinical processes with scheduling, billing/finance and other internal processes and systems. Automating key clinical functions and sharing the data with other departments can provide exponential process improvements to a provider organization. For example, many agencies realize immediate revenue gains by capturing and billing for services that had previously gone unrecorded.

With the appropriate system, you can enhance service utilization and profitability by program and make fact-based decisions on how to optimize resources. Specifically on the clinical side, clinical directors can review case information and have more productive case reviews with clinicians.

From an external perspective, care is no longer provided just in the office or even just by a single agency. In the past, it was easy to locate and talk with one of your agency’s clinicians – you simply walked down the hall to find them at their desk or meeting with a client. Now, in many cases, clinicians spend the majority of their time out of the office meeting with consumers at locations and times most convenient
Sharing clinical data throughout the care process – both internally as well as externally between independent agencies and with the client will help to promote quality care, reduce medication errors, and improve efficiency.

to them. Clinicians and case managers can work disconnected in the field and then synchronize their case record upon returning to the office, thus eliminating the need for error-prone and time-wasting re-keying of data.

In this more fluid environment, it is vital to share clinical data throughout the care process – both internally as well as externally between independent agencies and with the client.

For example, if a consumer needs to be referred to an inpatient facility, how long does it take to create the referral? Are you able to send medication information and other important clinical data to that facility quickly and efficiently? And, when the client is discharged and referred back to an outpatient program, do they arrive before the discharge summary?

A true connected care environment also includes a health information infrastructure that treats the clients’ physical as well as mental health by supporting connections with other agencies involved in the care process, including public health and primary care facilities. This is achievable, but requires resources and buy-in from all parts of the equation.

**Connected Care and Medication Management**

60% of preventable medication errors occur at the prescribing and transcribing stages. The average prescriber’s office spends 1.25 hours per day handling calls about changing prescriptions, up to 40% of physicians’ prescriptions have to be rewritten due to errors, and 150 million calls are made from pharmacists to prescribers annually to clarify prescription information.

In a connected care environment, the incorporation of e-prescribing for outpatients and order entry and electronic medication administration record (eMAR) systems for inpatient facilities can help reduce polypharmacy, prevent medication errors, and effectively track a consumer’s medication history as they move through different areas of care. In fact, many agencies see rapid reduction in polypharmacy by being able to review all medication orders in the agency on one screen.

**Client Involvement in Connected Care**

Clients and their families are becoming much more proactively involved and engaged in their care. One newly developing aspect of connected care is a secure client web “portal.” Accessible via a browser from home or a public Internet access point, clients could use the portal to schedule appointments, review and comment on their treatment plans, view current medications and track usage, and communicate with their care providers. Through features like online journals, clients can record their feelings prior to a scheduled session, and if required, list psychiatric advanced directives.

Imagine if your clinicians could double or triple the amount of interaction they have with their consumers on a monthly basis without increasing your costs! A Web portal can serve as the basic tool to enable this additional contact.

Understandably, a client care portal cannot be used by all clients due to the lack of Internet accessibility for some clients and other factors; however, many consumers, and perhaps most importantly, their families are able to access the Internet from home, libraries, or other public access points. Clients and care providers will benefit greatly from this type of interaction.

**Making Connected Care a Reality**

How can you prepare for connected care? Take an introspective look at your current processes for collecting and managing information, both within your organization and with other care providers who interact with your consumers. As you do, think about ways clinical information can be shared more efficiently. And think about it not just from your perspective, but from the perspective of the clients you serve each day.

Also, be sure your technology platform is flexible and adaptable enough to support this growing trend, and consider connected care as you do your long-term strategic planning.

Let the transformation begin!

*Kevin Scalia has executive management responsibility for marketing, business development, strategic planning, and mergers and acquisitions for Netsmart Technologies, which provides clinical, financial, and management software solutions for more than 1,300 health and human services organizations. Scalia is a founding member of the Long Island Software and Technology Network and a member of the College of Engineering Advisory Board, State University of New York at Stony Brook. He also serves on the board of directors of the Software And Technology Vendors’ Association.*
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