Summary Conference Set for Seattle

*A*n outstanding agenda is coming together for MHCA's 2006 Summer Conference, August 15-18 in Seattle, Washington. We will meet at the Westin Seattle, a beautiful waterfront property with views of Puget Sound, Lake Union and Seattle's urban skyline.

The conference will be preceded on Monday, August 14 by a workshop provided by OPEN MINDS (see sidebar). Separate registration materials are being provided by the sponsor. Take advantage of this opportunity to combine travel arrangements and benefit doubly from your trip.

Tuesday will be devoted primarily to MHCA's 2007-2009 Strategic Planning Meeting. For a description of that process, see Don Hevey's comments on page 2. In addition, the MHA Board of Directors will meet Tuesday afternoon.

Keynoter Richard Ruhe will open General Session on Wednesday following welcoming comments by MHCA Chairman Erv Brinker. Ruhe has inspired countless audiences on productivity improvement, change and customer loyalty. He is a senior consulting partner for The Ken Blanchard Companies and author of the training program,

Total Quality Leadership and the field book for change and leadership, *Getting Major Results.*

Complementing the keynote, on Wednesday and Thursday will be presentations by MHCA members and guest speakers. Topics include MHCA's Sabbatical Program, Leadership Academies, Clinic Pharmacies (by Genoa Healthcare and a panel of MHCA members), and others. A separate track will be provided for Executive Assistants (contact Gwen Watts, Centerstone, for details: 615-463-6630 or gwen.watts@centerstone.org).

Committee meetings and Forums will be held throughout the conference as well. Refer to registration materials for scheduling information on these as well as the MHCA Board of Directors meeting and MHRRG Board of Directors meeting.

Registration deadline is July 17. Contact the Westin at 206-728-1000. Printed registration materials will be mailed mid-June, and meeting information is continually updated at www.mhca.com. For area information, visit Seattle's Convention and Visitors Bureau online at www.seeseattle.org

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Pre-Conference Workshop Will Enhance Conference

A Futures Briefing: Planning For The Next Generation Of Behavioral Health and Social Services

Is your organization prepared to deliver services in the emerging behavioral health and social services market? The OPEN MINDS Next Generation Briefing explores trends and statistics that will shape what the "next generation" organization needs to look like. The Briefing features up-to-the-minute information, industry forecasts, and in-depth research analyses. The Q/A wrap-up session can cover any areas that you want to delve into - or to explore new areas of interest. The Briefing includes

◆Overview of the field from a service delivery/financial view, with a historical perspective
◆A statistical update on demand, rates, and service supply issues
◆Discussion of current trends in financing, policy, regulation, demographics, technology, and more in terms of how they affect service delivery, competition, and profitability
◆Outlook for care management and service delivery organizations, along with a forecast for rates, consumer demand, funding sources, competition, and profitability

Who should attend:
. Board Members
. Executives in leadership positions
. Strategic planning teams

To **register** or receive the complete agenda, call toll-free 877-350-6463 or visit http://www.openminds.com
Fees: $395/person. Early bird discounted fee applies through July 14 ($295). Group discounts available.

A Message from the President

Executive Committee's Tallahassee Visit Sets Ambitious Tone for Future

Don Hevey

$\mathscr{U}$nder newly elected MHCA Chairman Erv Brinker's direction, team leadership will be the *modus operandi* for your Executive Committee in the coming year. Committee members came to Tallahassee on April 7 to acquaint themselves with MHCA's corporate offices and collectively strategize for the remainder of 2006.

Together with MHCA staff, Brinker, Vice Chair Denny Morrison, Treasurer Tony Kopera, Secretary Susan Rushing and Immediate Past Chair Sue Buchwalter spent a full day setting an ambitious course. We missed Director-at-Large Dan Ranieri who was unable to attend. At the end of the day what emerged from our animated conversations was a preliminary set of observations that will serve as fuel for a more formal strategic planning process in August.

First and foremost the group agreed that it is time to reconfirm and emphasize MHCA as an industry leader. This can be accomplished through continuation of important existing partnerships and pursuit of strategic new ones within the fields of health, technology and public policy. Promotion of MHCA member services, products and expertise will be a key goal.

Second, we will find ways to address the evolution of MHCA as an organization and its members as service providers. By so doing we will enhance members' investment in the organization. Clearly we are all more than we were in 1985 when MHCA was first founded. The earlier notion of a continuum of care has been expanded in ways we might never have imagined - creative service options now include housing, transportation, international partnering and more.

Finally a renewed effort will be made to focus on the future of behavioral healthcare within the larger framework of general healthcare. This will require a global view. Key alliances and consideration of non traditional delivery systems will be explored.

So what's next? On Tuesday, August 15 a 2007-2009 Strategic Planning Session will be held just prior to MHCA's Summer Conference in Seattle, Washington. Joining the Executive Committee in these deliberations will be Board members of both MHCA and our for-profit subsidiary corporation, Mental Healthcare America (MHA), along with all MHCA Committee chairs. A cross-section of recently added members will be invited as well to ensure that new voices are heard as the plan is formulated.

The preliminary conversation in Tallahassee was a great start. I fully expect these issues to be expanded in creative and dynamic ways when we meet again in August. Results of the August 15 session will be shared with conference participants on Thursday, August 17 in a Member Forum and fully distributed to all members soon thereafter.

Thanks to the Executive Committee for their recent visit to Tallahassee and for their shared and exciting vision for MHCA's future. Each time we tackle the task of strategic planning I am reminded what a great group this is. Nothing is off the table; nothing is too hard. Just because "it hasn't been done that way before" doesn't mean it can't be considered. Entrepreneurial defines us. Excitement is the norm. Roll up your sleeves - we have a job to do! ❖

Membership is Growing as MHCA Adds Exemplary New Organizations

Since January we have added ten new MHCA members for a total of 143 as ER goes to print. Some have already been introduced, and we are very pleased now to welcome our four newest organizations.

Seminole Community
Mental Health Center, Inc.
237 Fernwood Boulevard
Fern Park, FL 32730-2116
James P. (Jim) Berko ACSW
Executive Director
TEL: (407) 831-2411
FAX: (407) 831-0105
mail: jberko@scmhc.com
WEB: www.scmhc.com

This central Florida provider was founded in 1969. Debbie Driskell, Associate Executive Director, and Scott Griffiths, CFO, have attended MHCA conferencesalong with CEO Jim Berko.

Mental Health Association
of Essex County, Inc.
33 S Fullerton Avenue
Montclair, NJ 07042
Robert N. (Bob) Davison
MA LPC
Executive Director
TEL: (973) 509-9777
FAX: (973) 509-9888
Email: rdavison@mhaessex.org
WEB: www.mhaessex.org

The addition of MHA of Essex Co. brings to ten the number of New Jersey members. This organization operates with a budget of $7 million and 120 FTE. Senior Director Trina Parks, MHA attended our Spring Conference along with CEO Bob Davison.

Washtenaw Community
Health Organization
555 Towner Street
Ypsilanti, MI 48197-0915
Kathleen M. (Kathy) Reynolds
MSW ACSW
Chief Executive Officer
TEL: (734) 544-3000
FAX: (734) 544-6732
Email: reynoldk@ewashtenaw.org
WEB: www.ewashtenaw.org

Michigan members enthusiastically welcomed their colleague, Kathy Reynolds at both our Annual and Spring Conferences. Jeremy Nelson, Chief Information Architect, and Brad Zimmerman, Change Management Leader, joined her in Savannah.

Southwest Solutions, Inc.
1700 Waterman Street
Detroit, MI 48209
John Van Camp
President/CEO
TEL: (313) 841-8900
FAX: (313) 841-4470
Email: jvancamp@swsol.org
WEB: www.swsol.org

It is especially satisfying to have John Van Camp rejoin MHCA. He was a charter member in 1984 and has now found his way "back home!" Southwest Solutions operates with a $17 million budget and serves Wayne County, Southeast Michigan and Detroit.

Satilla Selects Thomas

In November, Satilla Community Services of Waycross, Georgia selected from within by choosing former Director of Performance Improvement Glyn Thomas, PhD, as Executive Director. Thomas replaces Dr. Dennis Wool who accepted the leadership of Colonial Community Services in Williamsburg, VA

Dr. Thomas holds a BS in Psychology from the University of Wales and a PhD from the University of Nottingham. Working first at Stirling University in Scotland and then at Birmingham University in England, Dr. Thomas has published extensively on mental health, developmental disability, and developmental psychology. He is a Fellow of the British Psychological Society and Professor Emeritus at the University of Birmingham.

Now a naturalized American citizen, he has served as Chair of the Corporate Compliance Section of the Georgia Association of Community Service Boards and as a part-time teacher in Psychology at Georgia Coastal Community College. ❖

High Attendance, Great Participation Mark Spring Conference

*A*n enthusiastic 132 members and guests participated in MHCA's 2006 Spring Conference held May 9-12 in Savannah, Georgia where a theme of quality was threaded throughout presentations and forums. On Wednesday our keynoter, Dr. Russell Eckel of NOMMOS Consulting Group, aptly described the millennial employee and was convincing in his message of inclusion and adaptation.

Dr. Susan Buchwalter then reported the results of MHCA's 2005 Benchmarking Survey that aims to identify excellence within seven key service indicators. Forty of the 84 survey participants were present and received their individualized reports at the conference.

On Wednesday afternoon the New Trends Forum, Information and Technology Focus Group, Future Forum and International Planning Committee

Keynoter Russell Eckel, PhD (second from right) visited with MHCA's CEO Don Hevey, Tony Kopera of C4 and Rich Leclerc of Gateway Healthcare following his presentation on "Engaging the Millennial Employee".

Top: Presenter Allen Daniels, left, visits with Joe Masciandaro of Care Plus NJ. Bottom: Presenter Laura Adams chats with Tod Citron of Cobb & Douglas CSB

provided interactive opportunities to examine challenging issues confronting behavioral healthcare. In New Trends, Dr. Denny Morrison led a discussion on "Clinical Data Management and Outcomes". A tough subject, this one – as Morrison observed, "The future will be won or lost based on our ability to show to unconcerned third parties that what we do works. It will be challenging because, like the problems we experienced with electronic health records, every state is different."

Session One of the IT Focus Group excluded CEOs to give IT staff an opportunity to roll up their sleeves and delve into the specifics of electronic signatures, disaster and recovery planning. Phyllis Persinger of Volunteer Behavioral Health led that session. Future Forum Chairman Jim Gaynor skillfully introduced participants to author Jim Collins' recent monograph, "Good to Great and the Social Sectors". It seems the world of business can learn a lot from the leadership qualities found

within the not-for-profit arena. Communicating essentiality and demonstrating community "rootedness" remains a challenge and will be the topic of the Forum in August. The International Planning Committee focused on IIM-HL's international exchange that is to take place in June. Seventy-eight U.S. behavioral health leaders will travel to Scotland and England to attend the exchange and conference, 33 of whom are MHCA members.

On Thursday guest speakers Dr. Allen S. Daniels and Laura L. Adams did double duty in making general session presentations and following up as facilitators for smaller work sessions. Adams is President and CEO of the Rhode Island Quality Institute. MHCA members clearly appreciated her energy and passion for promoting improvement of health quality, safety and efficiency through effective use of information. She joined the second session of our IT Focus Group to provide discussion leadership on this topic. Daniels, who
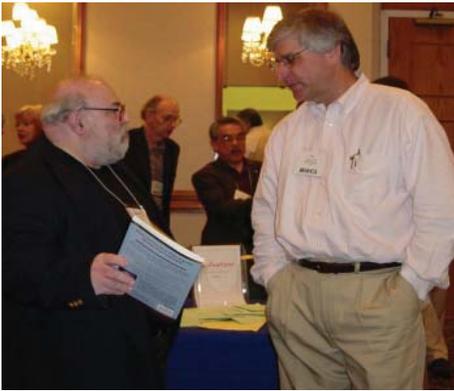
Above: Howard Bracco and Jim McDermott catch up.
Below: IIMHL Director Fran Silvestri visits with MHCA's Glenda Deal.

MHCA Joins Standards Developing Organization

*I*n an effort to promote successful implementation and use of electronic health record systems by our members, MHCA has joined Health Level Seven (HL7), one of several American National Standards Institute (ANSI) accredited Standards Developing Organizations (SDOs) operating in the healthcare arena. Our membership will be represented by MHCA's Information & Technology Committee.

HL7 is an international community of healthcare subject matter experts and information scientists collaborating to create standards for the exchange, management and integration of electronic healthcare information. HL7 promotes the use of such standards within and among healthcare organizations to increase the effectiveness and efficiency of healthcare delivery for the benefit of all. Whereas most SDOs produce standards (sometimes called specifications or protocols) for a particular healthcare domain such as pharmacy, medical devices, imaging or insurance transactions, HL7's domain is clinical and administrative data.

HL7 is a not-for-profit volunteer organization. Its members, which include providers, vendors, payers, consultants, government groups and others who have an interest in the development and advancement of clinical and administrative standards for healthcare, develop the standards. Like all

is with the University of Cincinnati's Department of Psychiatry, has done extensive work interpreting the Institute of Medicine's Blueprint for Change as it applies to mental health and substance use issues. His general session presentation and follow-up small group discussion explored systems transformation and the responsibilities of all stakeholders. He will be developing a proposal to fund further efforts that will include MHCA members and the results of our Benchmarking work.

Of the 132 conference attendees, 14 were new members, new CEOs or behavioral health provider guests. An orientation luncheon on Wednesday acquainted them with the mission and opportunities of MHCA. Our exhibitors included Genoa Healthcare, sponsor of Wednesday evening's reception, and MHRRG/Negley Associates, Continued Learning, and Essential Learning. ❖

Right: Co-CEOs Carol Smerz and Ginni Findlay of South Community Behavioral Healthcare in Dayton, Ohio, were in Savannah for their first MHCA conference.
Below: New member Kathy Reynolds with staff members Jeremy Nelson and Brad Zimmerman, represented Washtenaw Community Health Organization.

Implementation of an Electronic Quality Improvement Reporting System

By **Pikes Peak Mental Health**, Colorado Springs, Colorado
Winner: Chairman's Award, 2006 Negley Awards for Excellence in Risk Management

$\mathcal{P}$ikes Peak Mental Health, a JCAHO accredited Behavioral Healthcare Center serving 10,000+ clients annually from three counties in the Pikes Peak region of Colorado, has instituted an electronic interface for all staff to use for reporting critical incidents involving risk to Center clients or staff. Pikes Peak utilizes this system for both managing risk and identifying issues amenable to quality improvement and liability reduction activities.

Need and Organizational Goals for Enhancement of Risk Management

In 2004, the Joint Commission of Healthcare Organization (JCAHO) conducted a triennial survey of Pikes Peak Mental Health (PPMH). The survey results indicated a need for improvement in the collection, analysis, and reporting of center-wide data regarding client safety issues. In addition, JCAHO identified a need for a comprehensive risk management system to include Quality Improvement Reporting (QIR), infection control, fire drills, chart auditing, and monthly safety inspections. The recommendation was made for PPMH to improve risk management through the use of an electronic input interface that would be available for data entry by clinical and operational staff. The proposed system would allow concomitant reporting mechanisms for routine trend identification, subsequent risk management activity, and systemic quality control.

Five project goals for the development and deployment of this system were to: (1) collect, aggregate, and disaggregate incident data as a means to monitor safety; (2) utilize collected data to improve care and services rendered; (3) relate categorized environmental risks to staff and clients; (4) engage in monthly data analysis to reduce both potential risks and liability concerns; and (5) make incident reporting an expected and proactive job function.

Operationalization of Risk: The Definition of Quality Improvement Reporting and Adopted Procedural Policy

Pikes Peak Mental Health, cognizant of the need to operationalize critical incidents in terms of policy and procedure, identified the following risk categories as required reporting for all personnel:

Homicide; Homicide Attempt; Suicide Death; Suicide Attempt; Natural Death; Unauthorized Leave; Duty to Warn; Endangered Staff Assault/Fight; Unexpected Death; Alleged Physical Abuse; Alleged Psychological Abuse, Fire; Fire Setting/Property Damage; Client Unusual illness/Disease; Communicated Threat; Fall, Accident/Injury; Employee Injury/illness; Obscene Phone Call Message, Medication Error; Missed Medications; Adverse Drug Reactions; and Other.

All critical incidents are documented using the Quality Improvement Report (QIR) electronic interface (Appendix A). The information is stored in a relational database, and each event is automatically emailed (Appendix B) to the Director of Operations and Compliance, the Director of Quality Assurance, and the applicable Program Director responsible for the facility or area cited. The reporting staff member is required to classify the severity of the incident and to specify a staff member to "follow-up" (if deemed warranted). All incident "follow-ups" must be reported via the electronic interface within one month of the event. In addition, in order to manage adverse events with expediency, the following risk incidents must be reported immediately, via phone or in person and prior to completion of the electronic incident report, to appropriate supervisory personnel, with "follow-up" required within 24 hours:

• *All critical incidents involving property damage or injury that may precipitate itate a damage claim must be reported immediately to the Director of Operations.*
• *All critical incidents involving safety related issues must be reported immediately to each facility's Environment of Care Committee site designee and Program Director.*
• *All critical incidents involving an injury to an employee must be reported immediately to the Human Resources Department.*
• *All critical incidents involving infection control issues must be reported immediately to the designated Infection Control nurse.*
• *All critical incidents involving medication errors/adverse side effects must be reported immediately to the program physician or Medical Director.*

In addition to these regulations, all QIR incidents involving client or staff injury must be reviewed on a monthly basis by the organization's Environment of Care Committee. QIRs involving death, suicide, suicide attempts, medication errors, and clinical competence concerns must be reviewed on a monthly basis by the organization's Clinical Issues Committee. The reviewing committee documents its investigation and resolution, and reports the results to the appropriate Program Director and Senior Vice President.

Reporting Risk: Utilization of Aggregated and Disaggregated Reports

QIR data are key performance indicators, thus are vital for the determination of risk and the decision to implement targeted performance improvement initiatives. As a continuous improvement vehicle, PPMH issues differentiated reports once per month to management staff, program directors, the PPMH Governing Board, and several internal compliance committees (i.e., Environment of Care, Clinical Issues, and the Ethics and Compliance Committees). Examples of these data reports are presented in Appendix C, including (1) an executive summary provided to the PPMH management team, (2) program director reports, and (3) annual tracking summaries.

If an area is identified as a targeted priority based on QIR monthly trending, the program directors initiate a performance improvement *"Plan, Do, Study, Act"* process. This action plan was developed based on failure-mode analytical parameters. Details of this action plan are entered into the PPMH Quality Project Tracking System (Appendix D). Two current risk reduction activities focus on the development of a separate and more sophisticated infection control reporting system and a reduction in client decompensation due to problems with medication appointment scheduling.

Other current risk reduction initiatives include improving responsiveness to client complaints/grievances, developing clinical progress indicators for clients aged *0-5* years, and identifying solutions to supply shortages. The PPMH Quality Performance Improvement Committee reviews the progress of each performance improvement project monthly. Updates regarding progress to date, as well as recommendations from committee members, are structured for each performance improvement initiative (Appendix E).

Future Risk Reporting Enhancements: Refinement of Infection Control Reporting

The success of Pikes Peak Mental Health's QIR electronic interface, incorporating the concepts of risk management monitoring and targeted focus areas, has stimulated the application of this system to additional areas of concern. For example, this procedure is now being applied to the development of a unique, independent infection control interface. Surveillance, prevention, and control of infection within the treatment environment are the aims of this project. The goal is to promote a clean, safe environment for clients, staff, visitors, and the community through the application of best-practice monitoring. The overall design will be directed at reducing the rates or trends of epidemiologically significant infections by reducing infection risk. The critical importance of reporting staff and client infections by specific categories will be emphasized. The risk of infection will be minimized by expedient collection and analysis of reports regarding occurrence of infection and the subsequent analysis of situations through which risk of infection can be reduced. Several distinct population groups will be monitored, including geriatric, adult, and child and adolescent clients as well as employees. Deployment of this tool is anticipated in Spring, 2006.

Summarized Outcomes of the Implementation of an Electronic Quality Improvement Reporting System within Pikes Peak Mental Health's Service Delivery Environment

Pikes Peak Mental Health has a longstanding tradition of quality improvement, such as organizational project improvement initiatives, utilization management planning, and quality improvement reporting from the field. The implementation of a contemporary computer-based QIR system has increased the accurate identification of risk issues in need of attention. Since the implementation of the QIR system using an electronic interface, staff reporting of incidents involving risks to client and staff has increased 34% compared to baseline paper-based reporting. This increase has resulted in the ability to quantify systemic liabilities across the organization at any time point. Furthermore, reporting mechanisms and feedback loops associated with both data aggregation and dissemination have resulted in significant and timely performance improvement initiatives.

The new QIR electronic system has been showcased as a best practice, shared with governing bodies, and firmly incorporated into all high-stakes organizational accreditation reviews. Furthermore, this project has resulted in the identification and documentation of risk reduction practices and has matriculated into a database that allows for the monitoring of quality improvement activities. This interaction between incident reporting and targeted performance improvement has resulted in:

(1) The assurance that PPMH has the ability to continuously improve the quality of client services through the appropriate analyses of risk data and the prudent intercession of the organization's management/leadership;

(2) The activation of mechanisms by which all departments, teams, and staff can proactively evaluate their efforts to improve organizational outcomes and processes;

(3) The enhancement of the organization's internal preemptive risk management whereby unacceptable outcomes, procedures, and processes can be promptly detected and improvements swiftly implemented;

QIR System, continued from page 7

(4) The practical use of comparative and baseline data to measure quality of care and level of environmental safety afforded to both clients and staff

(5) The establishment of a tangible tool by which staff members at all levels of the organization are motivated and encouraged to contribute to improving organizational processes and outcomes; and,

(6) The documented infusion of risk reduction and quality services into the efficient and effective management of PPMH as a client-centered organization. ❖ *Contact Pikes Peak Mental Health for referenced appendices.*

ABOUT THE ORGANIZATION:

Pikes Peak Mental Health (PPMH) is a 501(c)(3) non-profit community-based mental health organization established in 1875 to care for the indigent. Its mission is to promote recovery through delivery of clinically sound behavioral healthcare solutions. The company delivers comprehensive mental health and chemical dependency treatment services to approximately 11,000 clients annually in El Paso, Teller, and Park Counties. It is the only comprehensive non-profit outpatient behavioral healthcare provider in the area. PPMH has maintained accreditation by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) for over 20 years, and is the only mental health center in Colorado with JCAHO accreditation.

PPMH services focus on three groups: 1) those with chronic mental illness, 2) children and families, and 3) individuals in need of crisis, detoxification, and substance abuse treatment services. Behavioral healthcare services target individuals and families of all ages, socioeconomic levels, and ethnic groups. PPMH provides mental health services on a contract basis throughout the region with many healthcare partners, and is a provider of services under Medicaid. The company employs approximately 300 staff with a FY2006 budget of approximately $20.5 million. (PH: 719-572-6100 CEO is Morris L. Roth)

HL7, continued from page 5

ANSI-accredited SDOs, HL7 adheres to a strict and well-defined set of operating procedures that ensures consensus, openness and balance of interest. The organization does not develop software but instead develops specifications, the most widely used being a messaging standard that enables disparate healthcare applications to exchange keys sets of clinical and administrative data.

There are several health care standards development efforts currently underway throughout the world. MHCA has chosen to join HL7 as it is singular in its focus on the interface requirements of the entire health care organization while most others focus on requirements of a particular department. Moreover, on an ongoing basis, HL7 develops a set of protocols on the fastest possible track that is both responsive and responsible to its members. The group addresses the unique requirements of already installed hospital and departmental systems, some of which use mature technologies.

While HL7 focuses on addressing immediate needs, the group continues to dedicate its efforts to ensuring concurrence with other United States and International standards development activities. Argentina, Australia, Canada, China, Czech Republic, Finland, Germany, India, Japan, Korea, Lithuania, The Netherlands, New Zealand, Southern Africa, Switzerland, Taiwan, Turkey and the United Kingdom are part of HL7 initiatives. ❖

For more information about MHCA's HL7 membership, contact Grady Wilkinson of Sacred Heart Rehabilitation Center, Inc. (gwilkinson@sacredheartcenter.com).

Calendar

IIMHL 2006 Leadership Exchange
Dates: June 5-9, 2006
Location: Working site visits in England and Scotland with Conference in Edinburgh, Scotland
Contact: Fran Silvestri, IIMHL Director fran@iimhl.com

Braveheart I and Braveheart II

aka - Erv Brinker   *aka - Wes Davidson*

MHCA 2006 Summer Conference
Dates: August 15-18, 2006
Location: Westin Seattle Seattle, Washington
Phone: 888-627-8513 or 206-728-1000
Rate: $199single/double with $25 early departure fee unless hotel is advised before or at check-in.
Deadline: July 17, 2006

MHCA 2006 Fall Conference
Dates: October 31 - November 4, 2006
Location: Westin Riverwalk San Antonio, Texas
Phone: 210-224-6500
Rate: $215 single/double
Deadline: September 28, 2006