ExecutiveReport

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MHCA in NOLA

Behavioral health leaders will focus on the future when they assemble for MHCA's 2004 Fall Quarterly Meeting in New Orleans, LA in November. Meeting dates are November 2-5 (get that absentee ballot!). Keynoting on Wednesday is David Zach (see sidebar). His message together with MHCA's Futures Forum discussion will expand the known universe! Don't miss these exciting opportunities to think beyond current trends and envision the effect of today's advancements on tomorrow's reality.

Visiting with MHCA also will be Linda Rosenberg, newly appointed President/CEO of the National Council for Community Behavioral Healthcare. On Wednesday morning Ms. Rosenberg will describe her vision for behavioral healthcare services and reconfirm the essential partnership enjoyed by MHCA and NCCBH.

Thursday's general session features presentations by representatives of several MHCA based peer consultation groups, a report on our 2004 Benchmarking Project, a visit from MHRRG's Edward T. Negley and a "fishbowl discussion" on information technology purchasing and implementation. Wrapping up Thursday's agenda will be a member showcase (TBA).

Committees and Boards will meet according to their regular schedules. All are invited to attend MHCA general sessions; members and invited guests are invited to attend committee and board meetings unless specifically noted in the meeting program.

Come to "NOLA" for a great MHCA program. You might even make time for some pretty good food and jazz while there! Again, remember to do your civic duty, order that absentee ballot and vote before you arrive. ❖

David Zach, Futurist

trends detected
implications identified
changes evaluated
ideas connected
assumptions challenged

Comment: MHCA Futures Forum Chairman, Jim Gaynor

At MHCA's Futures Forum held in San Francisco August 3, we determined to focus on continued separation between topics appropriate for consideration in our New Trends Forum and the Futures Forum. It is our hope and intent to successfully evolve toward this direction by keying our discussions on the long term (multiple years out) implications of current trends and the short term implications of those trends for strategic planned change initiatives. The Futures Forum then will function as a "think tank" where members are comfortable with their task of pushing the envelope.

We have also determined to limit our dialogue to three primary future domain categories.

One category is **technology** (What are the implications of machines approaching or surpassing human cognitive capacities?)

Another category will be **biological**. This includes pharmacology (What is the difference between chemically induced emotional experience versus other means. What are the implications?), as well as advances in medicine in general (What may be some of the unintended negative consequences associated with certain "cures" of major disease states?).

Finally, the remaining category will be **socio-political demographics.** How might we successfully deploy workforce development of ESL (English as Second Language) minority populations as they become the majority?

We look forward to November's keynote address by futurist David Zach and expect that his observations will give us a wealth of information as fodder for our next Futures Forums.

President's Column by Donald J. Hevey

Integrating Behavioral and Physical Care Services

New AMHC Project to Improve Health Care in Northern Maine

I am pleased to yield "my space" this quarter to the following article provided by AMHC. It describes an excellent effort to accomplish one of MHCA's long-held, strategic goals - integrating behavioral and physical healthcare. We know many of you are doing good work in this area. Thanks to AMHC for sharing their story.

Wes Davidson, Executive Director of Aroostook Mental Health Services, Inc. (AMHC) has announced that AMHC has received major funding of $132,884 from the Maine Health Access Foundation (MeHAF). The two-year award supports a project that integrates behavioral health with physical healthcare services. The end result is better access to high quality, efficient, and cost-effective health care in rural Northern Maine communities.

According to Wes, "AMHC will work collaboratively with two primary care partners, Pines Health Services in Caribou, Maine, and Katahdin Valley Health Center in Patten, Maine, a Federally Qualified Health Center. The primary intent is to improve and expand customer access to integrated healthcare services through any door – whether it be AMHC, Pines or Katahdin Valley. MeHAF's financial support will help to expand and sustain this program over the next two years."

Jamie D. Owens, AMHC Director of Marketing and Development, states, "The project's goal is to blend the skill sets of primary care physicians and behavioral health clinicians to better serve our customers. In particular, we want to help patients with chronic disease, such as diabetes, arthritis, depression, and heart disease, to better manage their lifestyle, by adopting and implementing the Stanford University Chronic Disease Self-Management Program. As the project develops, we plan to share our experience and outcomes with local, state, and national healthcare and public policy officials. Increasingly, projects that involve integrated behavioral and physical healthcare services are seen as meeting the needs of health care consumers."

AMHC Integration Project Director, Joan Wright, LCSW, LADC, explains of the project: "We envision having regular treatment team meetings to address patient and team collaboration matters. We will share charts and scheduling, participate in face-to-face interactions and coordinate treatment planning. Ultimately, our collaborative treatment team will ensure that there is a shared allegiance to a biopsychosocial approach that advances each patient's best interests."

The project service area covers almost 2,000 square miles and 28,000 residents in northern Maine's Aroostook County. Up to 17% of the population is over the age of 65; 11% of the residents are unemployed; and up to 53% of individuals live below the poverty level, especially in the Patten region. Project outcomes include:

- increased access to care, ("no wrong door");
- improved customer and provider satisfaction;
- improved patient behavioral and physical health status; and
- improved cost management and health care cost savings.

Outcomes will be measured through use of satisfaction surveys, tracking improvement in patient health status, and evaluating health care costs before and after project activities. National behavioral and physical health integration consultant, Bob Dyer of Criterion Health, has been retained by AMHC to assist with project implementation, provide training in the Stanford Chronic Disease Self-Management Program, and measure, assess, and evaluate outcomes.

The Maine Health Access Foundation (MeHAF), created in 2000, is the state's largest health care foundation. Their mission is to promote affordable and timely access to comprehensive, quality health care and to improve the health of every Maine resident. In particular, MeHAF targets strategies that serve the uninsured and medically underserved.
AMHC offers a continuum of emergency, outpatient, and residential mental health and substance abuse services for children and adults in 19 sites across a 6,400 square mile service area. For more information about AMHC's Behavioral and Physical Health Integration Project, please contact Jamie Owens at 207-498-6431 or jowens@amhc.org ❖

MISSION STATEMENT: MHCA is an alliance of select behavioral health organizations. It is designed to strengthen members' competitive position, enhance their leadership capabilities and facilitate their strategic networking opportunities.

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Welcome Wyandot and Compass Health

Peter Zevenbergen

The Wyandot Center of Kansas City, Kansas joined MHCA in July..."doubling" the membership of that state! CEO is Peter W. Zevenbergen, Jr. Founded in 1953, the Center has a staff of 250 and operates in four service locations. To learn more, visit Wyandot's website: www.wyandotcenter.org

After visiting with MHCA at our recent Summer Meeting in San Francisco, Dr. Jess Jamieson made the decision...his company, Compass Health, joined MHCA on August 30. Compass Health is located in Everett, Washington and serves the communities of Island, San Juan, Skagit and Snohomish Counties with an overall budget of $38 million and 659 staff members. This full continuum behavioral health organization was established in 1997. Visit them at www.compassh.org ❖

Jess Jamieson, PhD

A True Leadership Transition

Craig Lysinger

Having actualized an effective leadership succession effort, Craig Lysinger will step down September 30 as CEO at Wabash Valley Hospital in West Lafayette, Indiana. It's a job he's held for 20-something years and a behavioral healthcare community he has served for nearly 30 years.

Taking his place will be Rick Crawley who before coming to Wabash served on the staff of the Hamilton Center in Terre Haute for 19 years. Crawley was hired by Lysinger in November 2003 and has been gradually assuming leadership over the past year. When Rick assumes the reins on October 1 both he and WBH will be comfortable with the transition.

An informal farewell is planned for Craig on September 30, and one thing is certain…he can enjoy his retirement knowing he has prepared well for the continued success of his organization. Congratulations to Craig, to Rick and to WBH on a job well done. ❖

MHA Elects Officers

Mental Healthcare America, Inc. (MHA) has elected new officers for 2005. They are Dennis P. Morrison, PhD, Chairman; Dale Shreve, Vice Chairman, and Morris Roth, Secretary-Treasurer. MHA is a wholly-owned, for-profit subsidiary of MHCA thst recently absorbed the projects and responsibilities of MHCA Enterprises, Inc., formerly MHCA's second for-profit subsidiary. The mission of MHA is to provide tools, technical assistance and other resources which enhance corporate opportunities for MHCA members. Specific among those are oversight of MHCA's Customer Satisfaction Management System, Peer Consultation Model, and the annual Negley Awards for Excellence in Risk Management. The MHA Board meets quarterly during MHCA's conferences. Many thanks to outgoing MHA Chairman Hal Loewen and Vice Chairman Bob Williams; both continue to serve on the Board. ❖

2005 Negley Awards
for Excellence in Risk Management
Applications due November 12

Calendar

MHCA 2004 Fall Meeting
Dates: November 2-5, 2004
Location: JW Marriott
New Orleans, Louisiana
☎ 1-800-771-9067
Rate: $209/single or double
Registration Deadline: September 30, 2004

MHCA 2005 Annual Meeting
Dates: February 8-11, 2005
Location: Omni Orlando Resort
at ChampionsGate
Orlando, Florida
☎ 1- 321-677-6664
Rate: $189 + $10/day resort fee
Registration Deadline: January 11, 2005

IIMHL 2005 Leadership Exchange & Conference
Dates: February 28 - March 4, 2005
Location: Wellington, New Zealand

For more information contact Fran Silvestri at fran@iimhl.com or visit: www.iimhl.com

NCCBH 2005 Training Conference
Dates: March 12-15, 2005
Location: San Francisco Marriott
San Francisco, California

For more information contact José Escalante at sanfrancisco@nccbh.org or call (301) 984-6200

MHCA Summer Meeting Informs, Energizes

San Francisco Scene

Clockwise from top left: ***(1) MHCA's Frank Collins assists Keynoter Lynn Upshaw; (2) Panelists address jail diversion issues: Sonja Gaines and Jim McDermott of MHMR Tarrant County, Tony Zipple and John Fallon of Thresholds, and Declan Wynne of Seattle Mental Health; (3) New member Linda DePiano welcomes guests Jan Eustis and Gail Lapidus; (4) Presenter Dennis Wool of Satilla Community Services works out part of the FISH philosophy with Susan Rushing; (4) Panelists Grady Wilkinson of Sacred Heart Rehabilitation Center, John Paton of SATVA, Chris Wyre of Volunteer Behavioral Health Care System, Bill Connors of SATVA and Rick Doucet of Community Reach Center explore The Selection and Implementation of Workable IS Systems.***

An outstanding faculty provided abundant learning opportunities for behavioral health providers at MHCA's 2004 Summer Meeting in San Francisco, August 3-6. Keynoting on Wednesday was Lynn Upshaw whose general session presentation on *Successful Brand Management : Building a Health Services Brand* also provided valuable discussion material for the afternoon's Marketing Focus Group. (Members can view his presentation materials in the Document Archives Section of our website). Thursday's two panel presentations (*Jail Diversion* and *Selecting and Implementing Workable IS Systems)* were equally compelling as was Dennis Wool's delivery on the *FISH Philosophy*. It was good to hear updates on MHCA's Benchmarking Survey from Susan Buchwalter and IIMHL's 2004 and 2005 Leadership Exchanges from Fran Silvestri.

Our New Trends Forum initiated two discussion groups on Wednesday afternoon. The first addressed "Operational Metrics", exploring the meaning, application and existing misinformation about performance instruments including balanced scorecards, dashboards and benchmarking. A second discussion addressed "Consumer Transportation." Participants shared their "war stories" and agreed that with few options available, transportation is a challenge that must be met in the face of woefully inadequate funding. On the positive side, some reported successes in their transportation programs and emphasized the importance of staff/driver training and adequate insurance. Many must provide transportation over considerably large geographic areas.

New Trends Chairman Diana Knaebe intends to repeat the discussion group format at our Fall Meeting in November and is looking to the membership for topic recommendations.

Summer Meeting participants numbered 130, equally representing CEOs and staff, many of whom attended primarily to take part in the Marketing Focus Group. That Group was led by Marketing Committee Chairman David Guth and included discussion leaders Nelson Burns, David Paine and Linda Valienti. Behavioral health guests who participated in an orientation luncheon included Larry Burch (IN), Jan Eustis (FL), Jess Jamieson (WA), Gail Lapidus (OK), Gary Larcenaire and Davin Magno (TX) and Amanda Murphy (MO). ❖

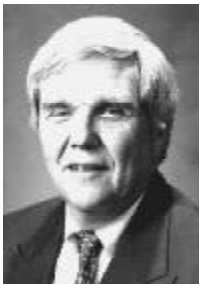
Richey Leads Georgia's DeKalb

Gary Richey

Derril Gay

Elevated to the top leadership position at DeKalb Community Service Board in Georgia is Gary Richey, Chief Financial Officer there since 1994. Prior to coming to the DeKalb CSB, Richey worked as a CPA for 14 years, was vice president of finance for Atlanta's Morris Brown College for four years and served two years as CFO of community development corporation, ANDP, Inc. Richey succeeds Derril Gay who served as DeKalb's CEO for forty years and retired June 30. ❖

Search Is on at Valley MH



David Dangerfield

MHCA and The Meyers Group have begun their first joint Executive Search. Together we are recruiting for a new President/Executive Director for Valley Mental Health in Salt Lake City, Utah. VMH is a private, not-for-profit $82 m diversified system of care committed to serving its clients within the framework of the Recovery Model. David E. Dangerfield, DSW is retiring from that position at the beginning of 2005 after a long career there. He will be staying on in a part time capacity as CEO during the transitional stage working on Board related and strategic issues. For those of you interested in learning more, contact Stuart Meyers (301-625-5600 x 102), Don Hevey (850-942-4900) or David Dangerfield (801-263-7100). ❖

Goering Will Retire

Melvin Goering

Prairie View of Newton, Kansas has announced the October 2004 retirement of its 12-year CEO, Mel Goering. This well respected leader notes that Phase I of the Center's Share the Hope capital campaign will end at that time, offering an "opportune time for change at Prairie View." Founded by the Mennonite churches in 1954, Prairie View is the state's largest private behavioral and mental health services provider. It includes a 38-bed psychiatric hospital and outpatient location in Newton as well as outpatient locations in Hutchinson, Marion, McPherson and Wichita.❖

CenterPoint Seeking CEO

Ron Morton

Ron Morton, who became an MHCA member as CEO of North Carolina's CenterPoint, has provided terrific leadership to "spin off" a new Community Mental Health Center called HopeRidge as the provider of comprehensive CMHC services in the Winston-Salem area. What remains is CenterPoint, the Local Management Entity with a $49m budget that now contracts with HopeRidge and a multitude of providers in the region. Ron will be leaving this role this Fall, and The Meyers Group is conducting a search for a new CEO for CenterPoint. Stuart Meyers has provided a job description via email to MHCA members; contact Meyers at 301-625-5600 x 102. ❖

Changing of the Guard at Volunteer

Bob Freeman

Chris Wyre

Bob L. Freeman, PhD retired as CEO of Volunteer Behavioral Health Care System in Murfreesboro, Tennessee on June 18. Replacing him is Chris Wyre, formerly Volunteer's Executive Vice President. Freeman earlier served as CEO of Plateau Mental Health Systems in Cookeville while Wyre was CEO at The Guidance Center in Murfreesboro. The centers merged along with Johnson MHC of Chattanooga in the mid-1990's. Chris is a familiar face around MHCA, and we salute both Bob and Chris on this official "changing of the guard." ❖

Riverside Community Care Risk Management Program

By ***Riverside Community Care***

Winner, Board of Directors Award, 2004 Negley Awards for Excellence in Risk Management

Riverside Community Care, a comprehensive behavioral healthcare organization with a service area of one million people in Eastern and Central Massachusetts, developed and implemented a multi-faceted risk management program to enhance the safety and well being of staff and consumers and to minimize financial and business loss for the organization.

Identification of Increasing Safety Risks

Beginning about three years ago, Riverside Community Care began seeing increased referrals of consumers with serious forensic or unadjudicated violent and aggressive histories. This coincided with renewed efforts by the State of Massachusetts to close inpatient units at State institutions and move more people into community programs. At the same time, managed care penetration had grown in the State and community hospital inpatient units were routinely discharging patients who had not been fully stabilized and were making referrals to outpatient clinics with shorter notice and less information. Some program managers and staff began raising questions about the safety of their programs, clients, and themselves. Conversely, senior managers identified instances where concerns that should have been raised were not. Our residential, emergency, day treatment, and outreach programs, and outpatient clinics all were serving high risk consumers in greater numbers and often with much greater potential for dangerousness than had been the norm.

Within this climate of change, executive management determined that developing comprehensive risk management policies and procedures was an organizational priority. In addition to the goals of reducing risk of violent incidents and property loss, we hoped provide support to our staff and train them in necessary skills in order to minimize resignations or any negative impact on staff morale. The quality of care would suffer and the organization's finances would be stressed by the expenses of recruiting and training replacement staff and by paying overtime to cover shifts. Revenue would be lost if clinical staff were not available to provide billable units of service or if consumers felt unsafe and dropped out of care. The potential for legal actions by staff or consumers was an additional consideration. Finally, we wanted to minimize the downtime of programs in the aftermath of any serious incidents, and thereby reduce the financial costs and diminished accessibility for consumers who rely on the services. Although we had not seen a spike in critical incidents, we understood that the potential was increasingly there.

Our challenge was to enhance our risk management practices by utilizing existing agency resources as much as possible. The shift of responsibility for the care of forensic and other high-risk consumers to community behavioral healthcare providers was taking place without increased contract rates that might have allowed Riverside to retool for the more challenging referrals. In fact, the increased risks and costs of these referrals were occurring after more than a decade without cost of living increases to state provider contracts. In this climate, we were highly motivated to improve our risk management practices to protect existing resources and to keep the costs of doing so down.

Riverside's Multi-Modal Approach to Risk Management

Our risk management program includes the following components: (A) Risk Management Team; (B) Policies and Procedures; (C) Management Retreat; (D) Program Safety Plans; (E) Staff Training; (F) Critical Incident Team; and (G) Unified Service Planning. Deciding on these seven components was the result of both thoughtful planning and the inevitable "learning while doing?. Addressing each involved a formal or informal needs assessment to determine points where the organization was vulnerable and/or intervention could have a significant impact; identification of existing resources within the organization that could be utilized to respond to the needs; and finding outside resources that could be accessed to meet need areas where internal resources were inadequate.

The job of planning Riverside's risk management program was made both more complicated and more manageable by the fact that the organization is geographically and programmatically diverse. Riverside operates over sixty different programs, serving consumers from infants to elders who have mental illness, emotional disturbance, mental retardation, traumatic brain injury, substance abuse, and other disabilities or need areas. Programs range from office based services such as outpatient clinics, milieu programs including day treatment and clubhouses, group homes, and supported housing to outreach based services such as mobile crisis teams, family support, and adolescent wrap-around programs.

(A) Risk Management Team: One of the first and most important aspects of our program was the creation of a team of seasoned clinicians and managers from across our organization that reviews referrals of individuals with serious forensic or other high-risk issues prior to their admission. This team functions as the voice and authority of the organization, so that no single program manager is left alone to convince a referring payer that specific conditions or additional resources must be met or provided prior to admission or, on rare occasion, that the referral is not manageable in that program. An outside consultant psychologist with extensive forensic experience was brought in to help educate the team, develop review protocols, and

mentor team members through the first several months of case review.

Our *Clinical Risk Management Review Policy* established mandatory review by the team for referrals of consumers to residential services who meet the criteria of history of, or current involvement in: fire setting; assault, violence toward others, or history of significant threats; sexual perpetration; stalking or harassment; involvement in the criminal justice system; or behavioral problems that may place self or others in *serious* harm. Managers of non-residential programs may also refer cases for review. The team consults with the receiving program to establish a client specific risk management plan prior to acceptance of the referral. The accompanying *Risk Management Protocol* describes the framework for program presentation to the team and the components of the team's consultation.

(B) Policies & Procedures: Riverside already had disaster/emergency plans at programs and administrative offices, but additional policies were needed to focus directly on preventing and managing breaches of program safety. Three new policies were developed for this purpose. The *Clinical Risk Management Review Policy* was discussed in (A) above. Another, *Program Safety Plans Policy*, established guidelines for mandatory site review and plans to reduce and manage incidents of violence and other threats to consumer, staff, or facility physical safety for each program and site throughout Riverside. This will be explained in (D) below.

An additional policy was developed to specifically meet the risk management needs of programs that provide services off site. Entitled *Maintaining Safety When Services Are Provided Outside the Office*, the policy addresses the unique risks and circumstances of outreach services and provides general safety guidelines and protocols for staff to follow prior to, during, and after the visit. It prescribes pre-planning and consultation with supervisors and others within and outside the organization whenever safety is a concern. The policy also encourages staff to voice their fears and makes explicit that the organization supports taking all appropriate steps in the event of a safety related incident, up to and including filing criminal charges. We found that while some staff may be overly anxious, many staff members were reluctant to admit concerns and unsure whether people with disabilities should ever be held accountable for their actions. The agency's explicit support in this policy has made a big difference in staffs comfort level and morale.

Although elements of risk management are included in various other policies throughout the organization, including division and program specific policies, these are incidental to the organization-wide program and will not be included in this discussion.

(C) Management Retreat: Risk management was the focus of our annual organization-wide Management Retreat in November 2001. The title was *Managing Forensic And Other Safety Related Issues In Programs.* This six-hour meeting was attended by approximately ninety managers and had four goals: 1. To communicate executive management's position on accepting and managing risk - that Riverside would accept referrals of challenging consumers only after a reasonable evaluation is completed and safety/treatment plan is in place; 2. To build managers?' awareness and skills in risk management; 3. To introduce the Risk Management Team and related policies; and 4. To allow managers to share experiences, concerns, successes and strategies to improve safety, reduce risk and support staff. Breakout groups of similar modalities (Home/Community based services; Clinical and Office based Services; Mental Health Residential; Clubs and Respite Services; and Other Residential Services) provided opportunity for shared ideas. Groups reported back to the whole assembly. Action steps were developed to build on recommendations, with senior management responsible for follow-up.

(D) Program Safety Plans: A key recommendation from the Management Retreat was to create site-specific safety plans. A committee of senior managers and selected staff convened to develop requirements and a plan template for program to follow. The template is very prescriptive, requiring sites to address detailed issues such as limiting unauthorized access to premises, rooms in which high risk interviews could and could not be conducted, etc. The major headings for Program Safety Plans include: Physical Site Considerations (including an environmental assessment), Communication Protocols (for communicating anticipated risk or an actual occurrence), Identification of Safety Concerns (including procedures for assessing new referrals for risk factors), Risk Reduction/Prevention Procedures (including clinical and administrative practices), Coordination with Other Services, and Incident Follow-up Procedures.

(E) Staff Training: In addition to ongoing training about risk management policies and procedures, Riverside programs are now required to provide de-escalation training to all staff. The Mental Health Residential Division took the lead in developing a curriculum and shared it with the other service divisions. A "train the trainer" model was employed to allow each division to have sufficient trainers to reach our nearly one thousand staff workforce.

(F) Critical Incident Team: Even with best efforts at prevention, a serious safety related incident may still happen and Riverside seeks to limit the damage to staff, consumers, and the organization if it does. Borrowing from our organization's expertise in disaster counseling and response, a Critical Incident Support Team with prescribed protocols was developed. The team is led by three seasoned clinical managers with disaster response experience and includes

See Risk Management, page 8

Risk Management, continued from page 7

staff from throughout the agency. The team's charge is to provide debriefings and/or support meetings for program staff in the wake a disturbing or traumatic incident. We found that developing the boundaries within which the team operates to be crucial to preserving the organization's business interests and responsibilities while still ensuring the effectiveness of this staff support vehicle. The team explicitly does not provide therapy (is not an EAP) and explains the limits of confidentiality to staff prior to meeting with them. In this way, critical information that could lead management to take corrective actions in the aftermath of an incident can be communicated to appropriate directors. Establishing criteria for mandatory contact with the team allows programs to have this support regardless of the skill level of their particular manager.

(G) Unified Service Planning: Service integration is an organization-wide initiative on a parallel course with our risk management program. The goal is to shape our range of services into a truly seamless system of care. The more information is known and treatment is consistent, the better able all programs are in managing high-risk consumers. A pilot project begun in December 2002 to launch cross-program treatment planning will soon be expanded to include all Riverside's geographies for consumers in multiple programs, prioritizing those who present with high-risk issues.

Measuring Effect of the Risk Management Program

Riverside's Department of Quality Management oversees the organization-wide assessment of consumer and family satisfaction and quality of care. Major components of this oversight are annual satisfaction surveys, tracking of all incident reports in an extensive database, and quarterly trend analysis. Interestingly, despite the increase in high-risk consumers in programs, consumer and family satisfaction rates remain extremely high and have not declined. Analysis of types of incidents at programs has indicated a small increase in overall incidents, but there have been no events to date that resulted in serious physical harm to staff or consumers or damage to facilities. At this point, we are hopeful that our risk management efforts will help to keep the trends positive, but this will need to be followed over the next few years.

Payer and regulatory bodies continue to rate Riverside highly for quality of services and operations during their regular formal and informal reviews. All programs are licensed by the relevant State agencies, all our clubhouses are certified by the International Center for Clubhouse Development, our organization and employment service are certified by CARF, and our organization has won State wide and national awards for services. Maintaining the quality of care, our reputation, and of course, the satisfaction and morale of staff and consumers is high motivation for our risk management initiatives in the face of increasingly high-risk referrals.

Replicating Our Program at Other Community Mental Health Centers

Developing and implementing the components of Riverside's risk management program mainly utilized internal agency resources, primarily staff. Many of our best and brightest contributed to the planning and implementation of all phases of the program. Doing so yielded real benefits. Costs were kept to a minimum and the inclusion of a broad spectrum of managers and staff throughout the organization led to increased ownership and "buy-in" of the policies and procedures that were developed. Outside resources used included hiring a consulting psychologist to train the Risk Management Team and purchasing de-escalation training and materials for a few key staff who then created Riverside's curriculum and employed a train the trainer model.

Riverside's risk management program meets the needs of our large organization, diverse services, and wide spread geography. A smaller or single service provider may be able to reduce the number or complexity of policies and procedures. Most agencies would probably find that utilizing their own staff in developing a comprehensive planning process and implementing an integrated approach, as we did, allows them to build on their agency's strengths and establish risk management practices that are effective for their unique configuration of programming while keeping costs to a minimum. Copies of our key policies and procedures can be shared upon request. ❖

About Riverside Community Care: Riverside, a non-profit behavioral health care organization, was originally created through the merger of several predecessor organizations, some with roots in the 1960's Community Mental Health Centers. Today it provide a comprehensive system of community based mental health care, developmental disability services, services to individuals with traumatic head injuries, substance abuse treatment, community crisis response, and other health and human services to people of all ages. Riverside operates over 60 programs in more than 50 Eastern and Central Massachusetts cities and towns with a population base exceeding 1 million people. Despite its size and complexity, Riverside is an integral and accessible part of the neighborhoods it serves. This year alone more than 11,000 people have come to Riverside seeking help and hope.

Riverside's CEO is Scott M. Bock. For more information about this program, contact Marsha Medalie, Vice President/COO at 781-329-0909.