July/August 1999

ExecutiveReport

Published by Mental Health Corporations of America, Inc.

Vancouver: August 10-13

Summer Meeting Approaches

MHCA is pleased to announce **Jim Beaubien, PhD** as keynoter for our Summer Meeting in Vancouver. Dr. Beaubien is CEO of HOPE Learning Systems, Ltd which he founded in 1973. A psychologist by training, Dr. Beaubien focuses on strategy development, fostering leadership and managing change. His topic for our General Session on Wednesday, August 11 will be "Executive Team Development."

Dr. Beaubien replaces Monica Oss of OPEN MINDS who was originally scheduled as keynoter. Ms. Oss will instead join MHCA as keynoter for our Fall Meeting in Scottsdale, Arizona.

Agenda Notes

The Mental Retardation/Developmentally Disabled Focus Group scheduled in two parts on Tuesday afternoon and Wednesday Morning offers the opportunity for members to explore potential for MHCA involvement with this important aspect of behavioral healthcare delivery.

Our Member Showcase on Thursday, August 12 will be presented by Danita Johnson-Hughes, CEO of Edgewater Systems in Gary, Indiana along with the center's Chief Financial Officer, Kevin Johns and Chief Clinical Officer, Asvin Sheth. Joining them will be Fred Kreider, Senior Consultant with Pragmatix. The panel will tell us "How the BEAST Helps Increase Revenues and Reduce Costs."

Among the presenters for Thursday's segment on Child Welfare Reform and Privatization will be representatives from Directions for Mental Health in Clearwater, Florida and from the Adult and Child Mental Health Center, Indianapolis, Indiana.

Jim McDermott, PhD and other panelists will make the Corrections and Mental Health presentation on Thursday morning.

"...that quintessence of Canada in its most amiable kind, the city of Vancouver whose reputation is nothing if not tolerant, whose appearance is always seemly, whose temper is famously kind, and whose stance between the mountains and the sea is a model of municipal etiquette."

Travel writer Jan Morris

Come to Vancouver!

We are excited to be returning to Canada for MHCA's second visit. Just to clarify our hotel preferred room rate: It will be approximately $245-255 Canadian (on your bill) but $167-172 American after the exchange rate is computed. Join us for this great meeting! ❖

Summary of the MHCA Board Meeting, May 21, 1999

Board Highlights

FINANCE COMMITTEE:

The Committee reviewed and approved the 1998 audit report. MHCA's financial position remains sound and there were no management or internal control issues noted.

MENTAL HEALTHCARE AMERICA:

The Board approved MHA's portion of the 1998 audit and reviewed terms of office, recommending the current slate of officers be elected to another term. The Board will confer with MHCA's Executive Committee on two Board vacancies. Directors reviewed a recommendation from the Outcomes Committee to engage a firm to do market research on pricing the Customer Satisfaction product. The Board also approved as an interim step an increase in the non-member licensing fee for the Customer Satisfaction Management System from $300 to $750 per year. The Board also received reports from the IS and EAP Committees.

EAP COMMITTEE:

Chuck Thayer reported that the Committee reviewed progress of the EAP web site being developed by the Providence Center. The Committee is pleased with the development of the site and sees future potential for it. A recommendation was made by Lloyd Sidwell because of the current heightened sensitivity to school issues to provide student assistance program information on our web site. Chuck Thayer also recommended a presentation on disaster preparedness. The Committee discussed the EAP Focus Group that met Wednesday morning. The two consultants, Linda Ahrens from Towers Perrin and David Hay from David Hay & Associates were well received and provided useful information. The Committee will continue to meet quarterly and hold an EAP focus group meeting every six months at the Spring and Fall meetings.

OUTCOMES COMMITTEE:

Bill Peel reported that the Outcomes Committee Task Force is working on wider distribution and marketing of the Customer Satisfaction Product. An RFP will be let for market analysis. The Committee also recommended consideration of other outcome measure instruments and will survey the membership. The Committee will then make recommendations about the acquisition or development of other measurement tools. Nancy Maudlin met with the group and reviewed the Customer Satisfaction Management System quarterly report. Usage of the System continues to increase. Nancy requested that those members that have notified JCAHO of their intent to use our Customer Satisfaction Management System notify MHCA as well. Bill reported that Nancy will join the MHCA staff effective July 1.

NEW TRENDS WORK GROUP:

New Trends was chaired by Grady Wilkinson. The Committee held the usual round table discussion of state by state Medicaid issues and welfare reform issues. Of particular concern was the difficulty in enrolling children in the State Childrens Health Improvement Program (SCHIP). SCHIP eligibility variations was a topic suggested for futher discussion. The Committee also discussed the planned Committee structure change to a two hour forum format and agreed to continue with the present roundtable discussion for the first part of the meeting and then focus on some specific issue based on data gathered between meetings.

INFORMATION SYSTEMS COMMITTEE:

Issues discussed were: (1) Results of the IS cost survey. A report on the final results will be sent to the membership. (2) Participation in an Internet based software product now owned by Jim Gaynor's center. Jim's partnership with Socratic Systems has dissolved and he has acquired all of their assets. He is currently seeking partners to complete the product. Denny Morrison, Don Hevey and Frank Collins will evaluate it on behalf of MHCA.

MHRRG:

Chairman Gil Aliber reported that balance sheets ending December 31 were better than originally predicted. Total assets have increased about 7.9% over 1997. Gil reminded members of the annual shareholders event to be held in Scottsdale, AZ in November and encouraged members to participate. He encouraged members as the market tightens to partner with MHRRG in retention of shareholders by making them aware of the value of MHRRG.

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MISSION STATEMENT: Mental Health Corporations of America, Inc., a national system of mental health organizations, was formed to strengthen the competitive position of its members within the health care industry and to enhance their financial viability.

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Board Highlights, *continued*

STANDARDS/ACCREDITATION COMMITTEE:

Stan Eichenauer reported 66% of MHCA members are now accredited by COA, CARF or JCAHO with 14 members dually accredited. He also reported that a formerly endorsed accreditation preparation booklet has been published by Preferred Behavioral Health. Updates were made on the accrediting entities, JCAHO, CARF and COA. Howard Bracco, MHCA's representative to PTAC reported several issues. (1) Accreditation with commendation status is now being widely conferred (20% of JCAHO accredited organizations) and is under review. (2) New standards are being drafted for pain management and foster care. (3) There is continuing concern about physical restraint of patients

CARF's methadone project is progressing well. Pilot surveys have been completed. CARF is now considering the development of standards for assisted living with encouragement from the trade association representing those facilities.

COA has appointed a new CEO.

Some employers are suggesting that ISO standards and certification be applied to healthcare providers. (ISO is an international certification program for industrial organizations.) Don Hevey will contact ABANA members that are ISO-9000 compliant for information.

Nelson Burns summarized for the Committee the National Council's publication on comparisons of the various accrediting bodies. The Committee encouraged all members to seek national accreditation and pledged its support to the members in their survey preparation.

FUTURES COMMITTEE:

Several issues were identified by the Committee: 1) Succession planning 2) Survivability of the organization's mission, 3) Outsourcing and 4) skill building. The Committee also suggested contacting a futurist specifically familiar with the healthcare area to present at a future meeting. Mary Jane England was recommended. At its next meeting the Committee will focus on healthcare models that might succeed HMOs or Managed Care. Chairman Tony Kopera will review issues raised by keynoters Nelson Otto and Warren Evans and extract essential issues for the Committee's discussion. MHCA's ListServer will be used to request recommendations on resources of interest to the Committee.

EXECUTIVE DEVELOPMENT COMMITTEE:

The Committee reviewed evaluations from the Annual meeting and discussed 1999 and 2000 meeting sites and dates. Due to lack of hotel availability, the May 2000 meeting location was changed from Las Vegas, NV to St. Louis, MO. Future meeting topics identified were: (1) telemedicine, 2) online prescriptions 3) job coaching 4) treatment of violent or dually diagnosed clients, and 4) the integration of mental health and substance abuse services.

Gene Boccialetti, who presented at our February meeting, has offered to develop a series of workshops for the membership on integration strategies etc. A survey showed members in Northeast and Midwest with highest interest. Cost for the proposed workshop could be $500- $1000 per participant.

The newly structured Executive Development Committee will be comprised of committee chairs and will be chaired by the Vice Chairman of MHCA's Board.

CORPORATE STRUCTURES COMMITTEE:

Keynoters Bill Knowlton and John Chesley met with the Committee in a forum format. Presentations on two of the four topics recommended for future meetings have been completed. Planned still are a presentation on environmental mapping and cost issues, valuation of partnerships etc.

EXECUTIVE COMMITTEE:

The Committee discussed proposed change in committee structure and meeting schedule. General response by the membership has been good. Arranging for meeting space to accommodate the new structure has mandated that we phase in the changes over several meetings. The new schedule will be fully implemented by the November meeting. Gary also reported that the employment contract for Don Hevey has been signed for another three years.

There are now two vacancies on the board. It was recommended that Chuck Thayer's position be filled by the regular nomination/ election process in August 1999. Due to the fact that John Barnette's term has 2.5 years remaining, a recommendation was made to fill that vacancy by appointment. Wayne Dreggors was recommended to fill the term. A motion was made, seconded and approved to appoint Dreggors.

Tom Riggs suggested that the Executive Development Committee meet during lunch to allow members to attend more of the forums that are planned for Wednesday. Don noted the logistical difficulties of doing so. Bill Peel suggested that due to the need for more meeting time and expense of travel we include Tuesday as another full meeting day.

MHCA ENTERPRISES BOARD:

The Board reviewed terms of office and board vacancies. Elected as officers were: Wes Davidson, Chairman, Erv Brinker, Vice Chairman, Tony Kopera, Treasurer and Kris Angell, Secretary. Bill Sette was recognized for his many years of service on the Board. ❖

MHCA's Spring Meeting

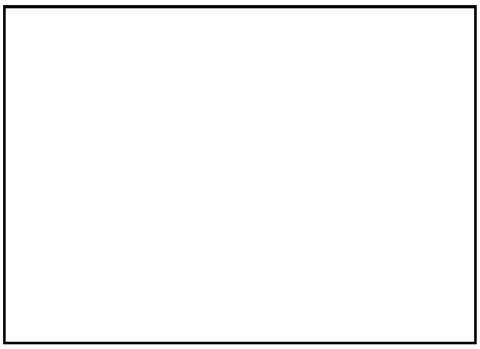
A small but focused group of MHCA members attended MHCA's 1999 Spring Meeting May 18-21 in the lovely Buckhead section of Atlanta, Georgia. Keynoters Bill Knowlton and John Chesley examined "The Legal Aspects of Corporate Reconfiguration", completing the second of a two part series on the cultural/legal considerations of mergers and affiliations.

Wednesday morning's EAP Focus Group was well attended and will be followed by another meeting of EAP administrators at MHCA's Fall Meeting in Phoenix *(see report, page 8)*.

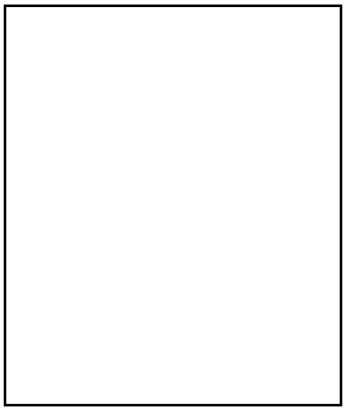
Thursday's agenda included updates on MHCA's PES project and Clinical Staffing Guidelines Project as well as a demonstration of the MHCA and EAP America Web Sites. Dr. Mark Glat of Group Interactions, Inc. presented with FEGS' Joe Miller and Amy Dorin on the topic of Group Therapy in Behavioral Managed Care.

And closing the Thursday session with a warmly received presentation was long-time MHCA friend and colleague, Craig Savage of McManis Associates. Craig discussed health care industry trends and their impact on behavioral healthcare providers. ❖

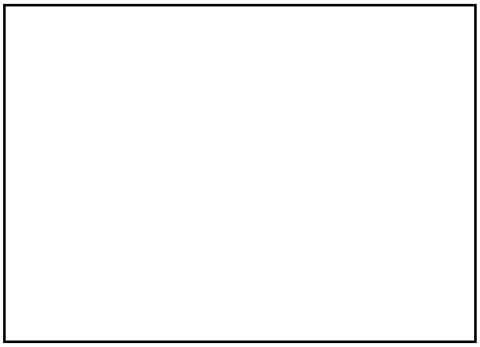
Atlanta Keynoters explored "Legal Aspects of Corporate Reconfiguration". Pictured are (left to right) MHCA Chair Gary Lamson, Mary Hiland, Co-Keynoter John Chesley, Tom Riggs and Co-Keynoter Bill Knowlton



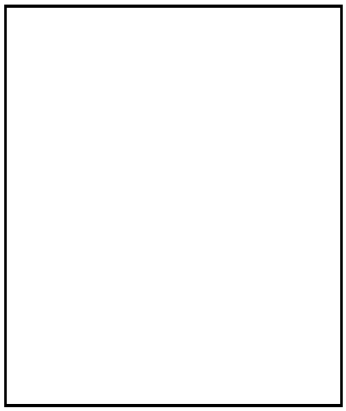
Joe Miller and Amy Dorin (left) of FEGS participated with Dr. Mark Glat of Group Interactions, Inc. in a presentation on "The Coming Age of Group Therapy in Behavioral Managed Care."



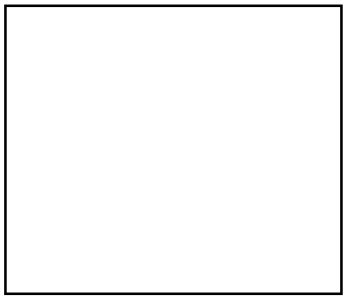
Bill Sette (right) was recognized as outgoing Chairman of MHCA Enterprises. Wes Davidson was elected to fill the position.



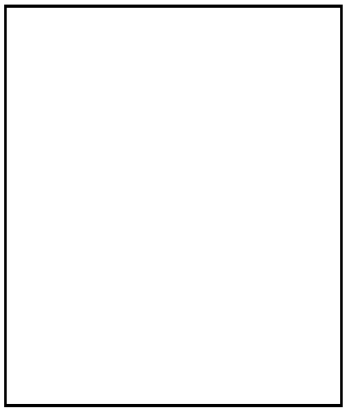
John Barnette and Kathleen Buescher described the PES pilot program and greeted new CEO Jeffrey Grimm (right) of North Carolina.



MHCA's Glenda Deal assisted Craig Savage, who shared information on Health Care Industry Trends.



Debra Falvo updated members on our Clinical Staffing Guidelines project.



Linda Valiante and Frank Collins educated us about the EAP and MHCA Web Sites.

Reducing Risk Through Quality Improvement - Part II

by The Providence Center

Winner: Chairman's Award - 1999 Negley Awards for Excellence in Risk Management

Nationally, medication errors place individuals at risk for injury or death and health care organizations at significant risk for malpractice suits and added health care costs:

- Adverse drug reactions were found to be the leading cause of iatrogenic injury (injuries that occur to the patient while in a health care setting)[1].
- The cost of an adverse drug event is estimated at $2,000, not including malpractice costs.[2]
- Drug injuries frequently result in malpractice claims, accounting for the highest total expenditure of any type of procedure related injury.[3]
- More than 10% of adverse drug events were due to transcription mistakes, according to a 1995 study[4].

Through a continuous quality improvement process, The Providence Center was able to reduce the incidence of medication errors due to staff transcription errors. This process focused on medication errors among our 24-hour residential group homes for adults with severe and persistent mental illness. This setting was chosen because it is the most restrictive setting of care we offer or exists in the community other than inpatient hospitalization. The risk exposure in this area was extremely significant because a majority of these medication errors involved Clozaril. Clozaril is a medication that treats schizophrenia effectively but has serious side effects, if administered incorrectly.

Nature of the Risk Exposure Due to Medication Errors

Medication errors - the administration of incorrect dosages - can have major health risks for mentally ill adults taking Clozaril for their schizophrenia. The health risks associated with overdosage, for example, include delirium and coma, tachycardia, respiratory depression and failure, and cardiac arrhythmia. Under dosing can have significant health effects as well, including those related to the medication itself and the return of psychiatric symptoms. In addition, agranulocytosis, a potentially fatal blood disorder, is a potential side effect for individuals taking this medication.

Computerized Medication Transcription Initiative

We used the FOCUS-PDCA quality improvement model *(Appendix 1)* to reduce risk exposure as a result of medication errors.

Find - We identified this opportunity through a review of the monthly Quality Improvement data we collect on risk management indicators. The data indicated that there had been a significant increase in the number of medication errors reported among group home clients. Group home clients receive 24-hour residential care due to the severity of their illness. Our group homes, which house 43 individuals, are our most restrictive treatment setting and the most intensive setting that exists in the community (the highest level of care is hospitalization).

As a result, the Medical Director and Quality Improvement Committee recommended that this matter be investigated. The Quality Improvement Director reviewed the medication errors and categorized them according to type of error *(Appendix 2)*. This review found that the predominant type of medication errors were transcription related, where staff were rewriting the doctor's order to the medication sheet. With respect to the type of medications that were transcribed incorrectly by staff, Clozaril was the most frequently found. Based on this information, the Quality Improvement Committee established an ad hoc quality improvement team whose mission was to reduce the incidence of medication transcription errors at our 24-hour group homes for chronically mentally ill adults.

Organize - The quality improvement team's membership consisted of staff who were most closely associated with the problem and who had direct, detailed, and personal knowledge of some part of the problem, as well as time for a series of

continued on page 6

Reducing Risk II, continued from page 5

meetings. Specifically, members included the group home managers, the psychiatric nurse assigned to the group homes, and support staff. The Quality Improvement Director was named team leader.

Clarify - Once the team was formed, they went right to work clarifying their current knowledge of the problem. The first step was to flow chart the entire process, starting with the physician's medication order being written through the time when the client self-administered his/her medication *(Appendix 3)*.

Clients in our group homes self-administer their medications. Self-administration involves the client removing the medication from the bottle, package or previously packaged medication minder and ingesting, applying or injecting the medication themselves. With the guidance of a psychiatric nurse, clients either pack their own medications or have them prepacked by the nurse. A list of prescribed medications, along with their dosages, is kept on a medication sheet, a form that clients sign to indicate that they have taken the prescribed amount and type of medication at the designated time of day. Staff observe the resident as they take their medications, comparing medications taken to those listed on the medication sheet. Once the resident has taken medication they initial the appropriate space on the medication sheet.

Simultaneously, research was conducted and presented to the team on practices at other mental health centers in the state to obtain information on best practices and benchmarks. When we found that these other mental health centers lacked good data or model processes, we expanded our research to pharmacies and hospitals, where computers are used to reduce transcription errors.

Uncover - Through the flow charting process, the team examined the time frames during which the transcription process occurred. They learned that most transcription errors occurred not when the medications were originally transcribed from the doctor's order to the medication sheet, but rather when staff rewrote the medication sheet, which is done every month and when prescriptions or dosages are changed. The process flow chart indicated that that there were no feedback loops to catch errors and that the transcription process did not account for the differences between the process for a new/revised order and a monthly re-write. It was also noted that prescription changes were frequent for Clozaril due to the fact that the clients were being titrated as a result of the blood work results, symptom management, andlor initial titration.

Start - Armed with this information and insight, the work group was authorized to initiate the Plan-Do-Check-Act process to reduce medication transcription errors. The initial hypothesis - computerization of the medication sheets would reduce transcription errors - was also endorsed

Plan - The work group's plan was to create a computerized medication sheet and process for its use from the time that the prescription is written to the time of self administration. *(Appendix 4 - Process Flow Diagram and Appendix 5 - Medication Sheet)*. Furthermore, it was determined that the project would focus on the five group homes serving adults with severe and persistent mental illness who participated in the initial planning process. The work group agreed that they would pilot test the tool and the process in the group home with the highest number of transcription areas first for a three-month period.

Do - Once the plan was finalized, the work group developed a template for the computerized medication sheet and trained support staff, the psychiatric nurse assigned to the group homes, and the group home staff in the new process and the medication sheet's use. The work group also explained the new process to our group home residents to make them aware of the changes, which for them were essentially cosmetic changes to the form, and answer any questions.

Check - The work group met monthly during the pilot to review the efforts to date and the problems experienced. At the end of the three month pilot test period, a review of the data showed a decrease in the transcription error

rate. In addition, the test created an unanticipated gain: staff were spending more time with clients and less time transcribing forms.

Act - As a result of these findings, the work group celebrated its success and expanded, one by one, the process to the remaining group homes. Each group home experienced a reduction in the incidence of medication errors due to transcription and the added benefit of more staff time spent with clients (see graph at right).

Medication errors involving Clozaril were also reduced *(Appendix 6)*. These successes had additional unanticipated positive effects, including increased sensitivity to and reporting of medication errors of all types throughout the organization. Staff time to process the medication errors was reduced from 43 hours/month to 4 hours/month.

Holding the Gains

This quality improvement effort has maintained the following results to date:

- Medication errors remain low in the transcription area.
- This process has been expanded to our long term care residential substance abuse treatment program for chronic substance abusers who receive medications for concomitant mental illness and our residential program for mentally ill adolescents.
- There have been no deaths or injuries resulting from medication errors or Clozaril.
- Program costs have remained minimal and savings in staff time has been retained. ❖

To obtain Appendixes referenced in this article, contact MHCA at 850-942-4900

About the Center

Founded in 1969, The Providence Center is the largest and most comprehensive of Rhode Island's mental health centers. The Providence Center currently provides a continuum of behavioral health care services for children, adolescents, adults, and families who need mental health and/or substance abuse treatment.

Their Community Support Program offers comprehensive services for Providence residents who have severe and persistent mental illnesses. Services include a range of supported housing, assertive community treatment, substance abuse-counseling, employment and rehabilitative services, 24-hour emergency services, and case management. The Child and Family Program offers intensive outpatient, specialized adolescent services, and general counseling to families, children and adolescents who experience moderate to serious behavioral and emotional disorders. Specialized programs include a therapeutic preschool program and a licensed school for students in need of special education. An Adult Behavioral Services program offers outpatient substance abuse and mental health treatment, as well as a continuum of more intensive substance abuse treatment programs, day treatment, short term residential, long term residential, and detoxification - for individuals suffering from addictions.

In 1996, The Providence Center received a three-year accreditation from the Joint Commission on Accreditation of Healthcare Organizations. In Fiscal Year 1998, the Center treated more than 7,500 clients. As Winner of the 1999 Negley Chairman's Award, the Center receives an unrestricted cash gift of $5,000.

Spotlight: *EAP Focus Group*

Employee Assistance Programs (EAP) were once again in the spotlight at MHCA's recent meeting in Atlanta. A group of more than 20 EAP directors, managers and sales professionals gathered on Wednesday morning to discuss a range of practical EAP matters, including marketing, internet/intranet EAP applications, work/life services and EAP cost/benefit issues.

Joining the discussion were two benefit design consultants, both responsible for developing EAP RFPs and managing EAP vendors for both small and large, national corporations. David Hay, of David Hay & Associates made the trip from New Paltz, New York to share his informed perspective, while Linda Ahrends stopped in from the Atlanta office of Towers Perrin.

Much of the discussion centered on an EAP provider's enduring challenge: How to convey to HR purchasers the cost-saving value of EAPs. While Hay and Ahrends admitted there is little marketing research data on the topic, both agreed that in many, if not most, cases cost-savings in outpatient behavioral health admissions can be demonstrated over a specified time period in the presence of a strong EAP – particularly in a gatekeeper model with up to 8 visits. Both visitors offered some valuable data-gathering tips.

And what business discussion would be complete without ample discussion about the internet? David Hay considers the internet/intranet to be the inevitable direction of many aspects of the EAP. Among the applications touched upon: on-line intakes, support "chat" groups, and on-line training."

Both invited industry guests and member EAP administrators had a lot to say about dealing with the competition, value-added EAP services, new service trends and utilization reporting. A summary of major points covered at the focus group can be found at **eap-america.com** by clicking on **"EAP Meeting News."**

Also noteworthy was the EAP Committee's decision to spotlight EAPs at two MHCA meetings each year. This was welcome news to the focus group's attendees, all of whom are eager to share knowledge among themselves and learn from industry professionals as they strive to develop effective EAP products and services.

The focus group planners and participants owe a great deal of thanks to Jeanne Wurmser and Kathleen Buescher for their efforts in including Mr. Hay and Ms. Ahrends. Watch for information about MHCA's November meeting, when EAPs will be a topic of discussion in Phoenix! ❖

Calendar

MHCA 1999 Summer Meeting
Date: August 10-13, 1999
Location: Waterfront Centre ☎ 604-691-1991
Vancouver, British Columbia, Canada
Rate: $245-255 Canadian or 165/$172 American, single or double, depending on room choice.
Registration Deadline: July 7, 1999

MHCA 1999 Fall Meeting
Date: November 2-5, 1999
Location: Doubletree Paradise Valley Resort ☎602-947-5400
Scottsdale, Arizona
Rate: $179/single or double
Registration Deadline: September 30, 1999

MHCA 2000 Annual Meeting
Date: February 22-25, 2000
Location: Don Cesar Beach Resort
☎ 800-282-1116
St. Pete Beach, Florida
Rate: $180 single or double
Registration Deadline: January 19, 2000

Executive Employment Ads Are Online!

Remember to visit MHCA's web site (www.mhca.com) for leads on executive employment. At this time there are listings for:

Chief Executive Officer
Executive Director
Director of Behavioral Health Reh Services
Director of Quality Improvement
Medical Director (2)I
Psychiatrist (2)
Director of Substance Abuse Services

These positions are offered in the following states: Arkansas, Georgia, Indiana, Maine, Massachusetts, Ohio, Vermont and Washington.

In addition, through MHCA's partnership with *Management Recruiters of Washington*, the following listings are offered:

Adult Psychiatrist
Chief Financial Officer (2)
Director of Professional Standards and Research
Executive Director (2)
Geriatric and Forensic Psychiatrists
Unit Director

MRW's positions are available in Connecticut, Maryland, Minnestoa, New York, Ohio, and Pennsylvania. Visit MRW directly at www.MRIwashington.com.❖