

SQIT Minutes

3/22/10

Region 1: Laura Richards, Suzy Davis, Mittie Helm, Judie Moorehouse, Brent Anderson

Region 2: Kathy Seacrest, Nancy Rippen, Teresa Ward

Region 3: Jolene Stalker, Ann Tvrdik,

Region 4: Amy Stachura, Lisa Sullivan, Renee Otto Berklund

Region 5: Margaret Van Dyke, Pat Kreifels-R5, Linda Wittmuss-R5, Lisa Christensen-Magellan, Christine-Centerpointe, David Furst-Consumer

Region 6: Lori Thomas, Cathy Cassel, Jean Hartwell, Dave Gaines

DBH: Sheri Dawson, Abigail Anderson, Christine Newell, Dr. Shaffer, Rachel West, Bob Bussard, Sarah Cox, Carol Coussons de Reyes, Eric Hunsberger, Jim Harvey, Vicki Maca,

Welcome and start-up:

Introductions

Minutes – No changes.

There were no additions to agenda.

Review of Performance Measure Methodology for 2010

Review Consumer/Family Survey question:

The question that has been identified to obtain consumer and family perception of care is, “The service you (your child) received at (agency) has improved your quality of life.”

Nine answer choices appear below the statement for consumers to answer ranging from ‘strongly disagree’ to ‘refuse.’ The goal/benchmark is 75% of consumers and/or their family strongly agreed or agreed that the services they received improved their quality of life.

The consensus of SQIT was to add this performance measure question to the annual Nebraska Division of Behavioral Health survey, since it is already an existing process. Due to sampling techniques which are in place, statistical results may be small for some providers and not considered reliable.

Review Communication: re: survey:

It is time for the annual DBH consumer survey. This year DBH has created an information sheet concerning the consumer survey. In the past, DBH has received feedback from consumers, providers, and Regions that the survey was a surprise, and when consumers called the providers and Regions there was not adequate information to address their questions. This sheet can be distributed to providers by the Regions so the basic information about the survey is known, providers know the survey is starting, can encourage participation, and answer questions. Regions can change the format of the sheet to make it more consumer-friendly as they deem necessary.

The survey is contracted to a vendor.

- The contractor sends out a cover memo that is basically a consent-to-participate letter.
- It explains what's going on, how consumers are selected, and supplies a toll-free phone number to call if the consumer decides not to participate, if there is a different phone number they would like to be used, if they would like a written survey instead of a telephone survey, or if they have any questions. Surveyors will begin to call consumers in April.
- If after numerous attempts, the consumer has not been reached by phone, a written survey will be mailed to the consumer.
- If the consumer receiving the services is a youth, the youth's parent or guardian is called, not the youth.
- The information sheet explains that the DBH annual consumer survey is focused on consumers who are receiving substance abuse or mental health services. At this time the Gambling Assistance Program is using a different consumer survey, and therefore is not included.
- Participation is voluntary. The method of obtaining the sample is explained also. It is a random sample of consumers that have been authorized, or registered in the Magellan database system. The list of names is provided confidentially to the vendor and is not used for other reasons or projects.
- 9,000 consumers are chosen by random sample to participate in the survey in the first part of April. In the past, about 2,000 consumers actually responded to the survey.

Actions:

1. A press release is sent out so that those consumers who are not in contact with their provider anymore will be aware of the survey. Jeanne Atkinson at DHHS will use the letter and turn it into a press release.
2. Bob Bussard will send an announcement of the survey on the Magellan BH Reform List Serve.

Quality Initiatives Update:

Co-Occurring Disorders Service Delivery Quality Initiative:

The first meeting is May 3rd, from 1:30-4:30 p.m. The meetings will occur on the first Monday of each month for approximately 15 months. Dr. Blaine Shaffer is the Chair of the workgroup. The members of the workgroup are Susan Adams, Dr. Susan Boust, Teresa Campbell, Dr. Chelsea Chesen, Sheri Dawson, Dr. Vijay Dewan, Paula Eureka, Dr. Kathleen Grant, Topher Hansen, Vicki Maca, Dr. Rick McNeese, Diana Meadors, Tara Muir, Jean Sassatelli, Ken Timmerman, Ann Tvrdik, Margaret Van Dyke, Cameron White, Rand Wiese Linda Wittmuss, Julie Scott, Donna Polk-Primm. One other representative from the Native American community will be chosen. Also, Carol Coussons de Reyes is working on finding two names to serve as Office of Consumer Affairs representatives on the workgroup. Mary O'Hare is the contracted facilitator of the workgroup.

Consumer-Family Survey Process Quality Initiative:

Sheri is meeting Thursday with Carol Coussons de Reyes, Dr. David Furst, and Ying Wang to finalize a process of aggregating all the existing consumer family surveys that the Regions and providers have sent into DBH. DBH will analyze what the surveys have in common, major themes and recommendations for consolidation. When that step is complete, invitations and a meeting date will be sent out to the members of the Consumer-Family Survey workgroup.

Trauma Informed Care and Outcomes:**Overview of TA:**

The National Technical Assistance Center (NTAC) arranged consultants for the TA that DBH requested on Trauma Informed Care. Raul Almazar of Almazar Consulting and Janice LeBel of Massachusetts, came to Lincoln the afternoon of March 8th and all day March 9th.

The consultants met with DBH Management from 1:30 to 4:30 on the afternoon of March 8th. They began working with DBH to identify priorities and assist strategically planning for trauma informed care infrastructure as this is the last year of the Trauma Informed Nebraska contract.

The NTAC consultants then met on March 9th with TIN. The NTAC Consultants took the information gathered in the management session and sought additional feedback from the stakeholders. The consultants also shared some national models and initiatives that DBH can consider for infrastructure.

After the stakeholder session on March 9th, there was a short debriefing meeting from 2:30 to 4:00 at DBH with some of the DBH management team from the March 8th meeting. The group discussed the recommendations from the consultants based on the stakeholder meeting.

DBH will meet with Director Adams to determine next steps.

Members Share how their Agency or Region Monitors and/or Measures Outcomes for Trauma Informed Care:

The group was asked to share if they have outcomes or specific areas they are monitoring in terms of trauma-informed care, at provider level, or a regional level.

Linda Wittmuss stated it is a work in progress for Region 5 Systems. Region 5 completed a full year of trauma agency self/peer assessments utilizing the Fallo/Harris modified tool. The tool examines how trauma informed an agency is. People who are hired need to be trained in trauma-informed care, which will gradually move them to a more trauma-informed system. Some wonderful things are being done in Region 5, and more people are being trained on basics of trauma informed care (Trauma 101).

Chris from Centerpointe said they are focusing on improving outcomes by implementing trauma specific interventions. They are reviewing training and have identified resources to move them along in the process.

Kathy Seacrest at Region 2 said they took a lot of recommendations and changed how information is gathered in the pre-treatment assessment process and also have an annual trauma training.

Region 6 is looking at assessments and treatment plans when conducting audit site visits with providers.

R3 commented that they have contracted with Roger Fallot, a national expert on trauma, and have brought him out to work with Region staff and providers.

R1-Region 1 audits for trauma-informed care while auditing intakes and looks for the link in the treatment plan. They do not have any outcome measures set up for trauma-informed care, but have set up some training events with Kim Carpenter.

R4-Region 4 looks at what providers are doing with trauma-informed care through the audit process. They may expand screening questions. Renee Otto Berklund conducted a trauma-informed care training, and has also had Kim Carpenter conduct trainings. R4 is assessing the providers concerning trauma-informed care. They do have a trauma screening they have been using but there are no outcomes yet.

R2- Region 2 monitors all restraint and seclusion, de-escalation, and monitoring policy. Kim Carpenter has been out to conduct training, but R2 hasn't turned it around to outcomes.

In summary, there is much variability in how SQIT members are including trauma-informed care, practices and theory throughout the 6 Regions of Nebraska. Regions are in various stages and places in terms of trauma informed care, and there is no structured way of defining outcomes.

Brainstorming Potential System Trauma Informed Care Outcomes:

In order to promote trauma-informed care to the leaders within an organization they must be shown quantitative and qualitative evidence that trauma-informed care makes a difference. Responses to surveys, and reduced number of injuries, restraints, and seclusions as a result of trauma-informed care are examples of outcomes.

Sheri encouraged members to think about the next steps Nebraska can take with trauma informed care. Originally, DBH had a three-year grant to promote trauma informed care. It was refreshing and energizing to see and hear the value people see in trauma informed care at the last Trauma Informed Nebraska meeting. People are utilizing different activities to try to make an impact. There are changes being made at all levels, including consumer participation. It was really a very positive message to hear as we are nearing the end of our fourth year with the TIN grant. We have to think about how we will keep these initiatives moving forward.

Nebraska received some technical assistance from the national consultants as was mentioned earlier. It was a pleasure to host Janice Labell, from Massachusetts, and Raul Almazar, from Illinois, who now does his own consulting. Both had very different experiences in how they kept trauma informed moving in their states. Janice started by having conversations at a state level, saying they wanted to move it forward, and looked at contracts, policy and regulation. This energized their initial discussions with people.

Raul on other hand, looked at it from a different angle as his background was in forensic at a state hospital. He concentrated on needed changes and asking how can they could make a difference. He promoted resilience, recovery, and healing. He explained to people that if they want to help folks with trauma, it should be seen as a universal precaution. You assume everyone has experienced trauma so everyone is screened, assessed and treated accordingly. He started by having simple conversations with staff in the state hospital system. Everyone was expected to be involved in this activity. Staff became acquainted with consumers at a more personal level. It was a creative grassroots movement.

The consultants were very complimentary of the work Kim Carpenter had done at a statewide level. Sheri encouraged the SQIT group to look at grassroots activities. DBH needs to be able to articulate how the Division's strategic plan incorporates trauma informed care.

We have individuals in veteran services, those that are in licensed facilities, those associated with CFS, with Magellan and with Medicaid. The question needs to be explored as to whether there is a way to broaden trauma informed care to these other agencies and facilities.

Linda Wittmuss stated that one of the things that was done early on in TIN was a trauma survey of all providers, administrators, down to technicians. TIN is repeating this survey along with trauma specific practices.

Linda Wittmuss added information should also be discussed at the Level of Care meetings.

FY2011-Community QI Goals, Measures:

Community QI Reports – Share plans for measures/QI activities in FY2011:

Last year Sheri did a statewide tour, held quality improvement forums and brainstorming. That is how we arrived at the perception of care measure. Providers have regional budget plans due, and this year the plans will be based on deliverables. There is a quality improvement deliverable, which asks everyone to start looking at their quality improvement process.

The group discussed whether members want to conduct quality improvement forums in order to determine a list of measures or if people would rather SQIT decide on the measures for 2011.

R1 – Region 1 would like the Region and the providers discuss what has taken place in FY10 and how to proceed in FY11. Region 1 would like to have Sheri come out and visit with providers. They do have some QI measures for quality improvement.

R2 – Region 2 met with providers a few weeks ago, and determined their quality improvement idea for the year. The idea still needs to be put into a format, with appropriate language, and they need Sheri's help to do that.

R3 – Region 3 does have outcomes for providers for different services. It was beneficial for the Region to collect satisfaction surveys for the survey initiatives.

There are three areas that Region 3 wants their providers collecting in a more consistent manner. It is going well so far. People are just getting the process down. What Region 3 wants is to aggregate information across all providers. The three areas are accessibility; satisfaction with services; and determining whether answers were able to provide input into their treatment.

R4 – Region 4 would love for Sheri to help. There is a little disconnect in what they are doing, but their providers send in quarterly reports. There needs to be one main goal, and Sheri can assist with a quality improvement forum that will help with consensus among providers.

R5 – Region 5 stated since there are so many initiatives in so many areas, they have just started a Regional quality improvement group to discuss how to bring that into the provider network, and the consumer-family network. Chris from Centerpointe stated that one of the big issues is access. There are more people than the capacity for 2011, and so they are making changes there. She would love to have national outcome measures for her organization, people don't need to think up new measures – they should use the NOMS.

Sheri stated that DBH has had meetings with Magellan on national outcome measures reporting. DBH wants the NOMS reports to be meaningful at the service level and they should be delivered late in 2010.

R6 – Region 6 stated the biggest challenge is measuring the desired outcome. Providers report process outcomes and have a quality improvement initiative. Region 6 just sent out a survey to the provider network and they want Sheri to come to a provider meeting. It's helpful to see the connection the Region and the Division.

Actions:

Sheri will work with Regions as requested. She will work with Kathy in Region 2 one on one. She will schedule a date/time with both Region 4 and Region 6.

What Data Is Needed from DBH Related to Your Community QI Activities:

Sheri asked if SQIT members needed anything further concerning the data integrity piece. Chris from Centerpointe stated that it would help to see the data, as they do not

have a sense of where Centerpointe is as an organization and they are anxious for the NOMS reports.

Sheri offered two statements to the group. The first was that the DBH data system is maintained with Magellan. DBH has done a lot of work with Magellan through MQIT, such as sending information out to address and clean-up the system. DBH wants data to be as accurate as possible and continues to urge everyone to use the MQIT process. DBH is trying to make sure that people have a better understanding of the monthly Magellan reports. Sheri is conferencing with the Regional Administrators regarding reports. If there are issues people want the Regional Administrators to address on that call, they are asked to please contact their Region.

The second statement Sheri had for the group was that she continues to be impressed as everyone has gone through this SQIT process. Many of the comments lead her to believe quality improvement is alive and well. The things that we need to be doing to lead continue to be clearer as we move forward.

Over the last few months Sheri has developed a better idea of the data needed for quality improvement activities. She encouraged people to get their data questions to the Regional Administrators so that we can start making sure we get people what they need.

Next Steps and Meeting Close:

Everyone liked the Telehealth system for this meeting. The Hastings group would prefer a Grand Island site instead of Hastings. Kathy from Region 2 stated that the phone connection was much better.

Next meeting: May 17th 2-4pm.

We will have the same sites except we will try to get a Grand Island site.

The meeting was adjourned at 3:34p.m.