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## Healthcare Quality and Your Board of Directors

**Mary Thornton, BSRN, MBA**  
*Mary Thornton and Associates Health Care Strategies*

*The Office of Inspector General and the American Health Lawyers Association recently issued a joint resource publications on compliance and the role of the board of directors in health care organizations. The publication reviewed in this article, Corporate Responsibility and Healthcare Quality: A Resource for Health Care Board Directors<sup>1</sup>, is specifically concerned with healthcare quality.*

Many behavioral healthcare providers have to reckon with vast changes in their business environment over the past decade or so. Payers and accrediting agencies are ratcheting up demands for quality improvement plans, evidence-based practice implementation, utilization and review programs or departmental corporate compliance programs, internal audit departments, peer reviews, risk management, client rights officers, new reimbursement configurations, and other tools. Providers must

react quickly (sometimes retroactively) to these complex quality-of-care issues across multiple areas of their community behavioral health organizations.

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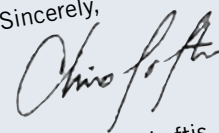
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Sincerely,



Christopher Loftis, PhD  
Managing Editor, Compliance Watch

## Achieving Documentation

**Bill Schmelter, PhD**  
*Senior Clinical Consultant, MTM Services Consultant, The National Council for Community Behavioral Health*

The current fiscal crisis will likely have behavioral health providers looking for more efficient and effective ways to meet compliance standards. History suggests that those efforts will focus primarily on documentation training; the development of more "compliant" and efficient form and documentation models, including electronic health records; and the development of more sophisticated compliance review and improvement systems.

All staff, supervisors, and managers must have a firm grasp of the critical relationships between the assessment, service planning, and service provision processes and the documentation of these processes. "Concept-based" documentation training allows staff to understand these concepts

### Service Mix

It makes intuitive sense that the services developed and offered by a community behavioral health organization are based on the distribution of the target population needs within the geographic area served. A corollary to this concept is that most community behavioral

## RESOURCES ON THE WEB

*Compliance Watch* subscribers can access valuable resources and tools online at [www.TheNationalCouncil.org/ComplianceWatch](http://www.TheNationalCouncil.org/ComplianceWatch).

In addition to source materials referenced in the newsletter, the website will soon have job descriptions, best practices, coding for evidence based practices, source documents, sample policy and procedures, forms, and templates, and much more.

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- Topics you'd like to see covered in future issues
- Your compliance questions to be answered by our executive editor, Mary Thornton
- Article submissions on best practices and case studies in corporate compliance
- Materials (sample forms, procedures, job descriptions, etc.) you want to share with other *Compliance Watch* readers.

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## Breach Notification Laws: Protecting Personal Information Used or Maintained by Your Organization

**Robin A. Johnson & Susan Rayne**

*Johnson & Aceto, LLP*

### Problem: Identity Theft

Federal agencies estimate that between 3.5 million and 9 million consumers are victims of identity theft each year (see, e.g., Federal Trade Commission, n.d.).<sup>1</sup> These victims are typically not singled out on an individual basis by the perpetrators; rather, a repository of their personally identifiable information is the target. Because databases hold personal information on hundreds (and, in some cases, thousands or millions) of people, their infiltration results in a huge information windfall for hackers, who can then sell it to the highest bidder or use it for their own gain. Almost daily does the news report unauthorized disclosures of personal information resulting from security breaches of electronic data. Organizations as diverse as retail giant TJX Corp and the Veterans' Administration are affected, exposing their constituents to potential identity theft. Costs to identity theft victims as well as the organizations whose data security is breached are considerable and include nonmonetary considerations, such as lost productivity and reputations jeopardized or lost as a result of the disclosures.

### Legislative Solution: Breach Notification Laws

It therefore comes as no surprise that states have been adopting security breach notification laws at a rapid clip. As of November 2008, 44 states, as well as Washington, DC, Puerto Rico, and the Virgin Islands, had enacted legislation requiring that consumers be notified of security breaches involving personal information.<sup>2</sup>

Breach notification laws establish a duty on the part of organizations, including businesses and healthcare providers and plans, to disclose security breaches involving unencrypted (and sometimes even encrypted) personal information to consumers. A security breach is defined as the unauthorized acquisition or use of computerized data that compromises the security, confidentiality, or integrity of personal information maintained by the organization. Breach notice

requirements provide consumers with a warning that their personal information may have been compromised and offer them an opportunity to protect themselves against the consequences of identity theft.

Below is a summary of certain key provisions of state breach notification laws and recommendations to organizations grappling with this new business challenge.

### Identifying Whether a Data Breach Has Occurred

#### *Unencrypted Personal Information*

In analyzing these laws, we first consider an important question: What data are protected by breach notification laws? State laws vary somewhat, but typically, protected information includes any personal information that has not been encrypted.<sup>3</sup> "Personal information" is generally defined to include first (or first initial) and last name in combination with one or more of the following: (a) Social Security number; (b) driver's license number or state-issued identification card number; or (c) financial account, credit card, or debit card number, with or without any required security code, access code PIN, or password.

#### *Reasonable Belief of Unauthorized Acquisition*

Often, state laws require notification only for those incidents in which personal information is "reasonably believed to have been acquired by unauthorized persons." Therefore, when faced with a security breach, organizations should consult legal counsel to determine whether a particular breach requires a notice process. Given the substantial cost of notification, organizations need to be able to disclose only those incidents that meet the statutory requirements.

#### *Unencrypted Medical and Health Insurance Information*

In certain states, unencrypted medical information and health insurance information, in combination with a person's name, are considered to be personal information. In others, the notification laws do not specifically reference medical or

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# Quality Improvement: Opportunities to Affect the Health Status of Consumers

**Barbara J. Mauer, MSW CMC,**  
*MCPP Healthcare Consulting*

Most of us in the behavioral healthcare field are now familiar with the recent evidence that the incidence of serious morbidity (illness) and mortality (death) in the population with serious mental illnesses has increased. A report released in 2006 by the National Association of State Mental Health Program Directors Medical Directors Council stated that people with serious mental illness are now dying 25 years earlier than the general population.<sup>1</sup> According to the report, the increased morbidity and mortality are largely due to treatable medical conditions, such as smoking, obesity, substance abuse, and psychotropic medication side effects, along with inadequate access to medical care—all of which are caused by modifiable risk factors.

In September 2007, the Center for Mental Health Services of the Substance Abuse and Mental Health Services Administration convened participants for a *Wellness Summit*. The action plan developed from this summit focused on “creating systematic capacity to measure baseline data and the future impact of our initiatives.”<sup>2</sup>

The NASMHPD Medical Directors Council followed up with a new report at the end of 2008, *Measurement of Health Status for People With Serious Mental Illnesses*.<sup>3</sup> This report outlines an approach to adopting and routinely collecting standardized health indicators in the mental health system. The recommendations in the report will be piloted in a number of states; the goal is that eventually, these health indicators will be “gathered and used to inform the clinical care of each person we serve, as well as aggregated to provide population health data.”

The Wellness Summit and the NASMHPD recommendations are closely aligned.

## Proposed Health Indicators

The NASMHPD group developed a set of 10 health indicators and two process indicators (see the box). The indicators are recommended for use with everyone age 18 or older who are entering or currently served in mental health systems.

The chief principle for determining key indicators was that “the SAMHSA Fundamental Components of Recovery and the Dimensions

### Health Indicators

1. Personal History of Diabetes, Hypertension, Cardiovascular Disease
2. Family History of Diabetes, Hypertension, Cardiovascular Disease
3. Weight/Height/Body Mass Index (BMI)
4. Blood Pressure
5. Blood Glucose or HbA1C
6. Lipid Profile
7. Tobacco Use/History
8. Substance Use/History
9. Medication History/Current Medication List, with Dosages
10. Social Supports

### Process Indicators

1. Screening and monitoring of health risk and conditions in mental health settings
2. Access to and utilization of primary care services (medical and dental)

of Wellness are foundational principles for all service models and interventions.” Another key principle was to “measure what is important for improving care at the person-level and aggregate that information for population-level data, quality improvement, and planning.”

## Early Efforts to Improve Consistent Practices

These efforts are not the first to systematically improve the care of individuals within the mental health system. The American Diabetes Association, American Psychiatric Association, American Association of Clinical Endocrinologists, and North American Association for the Study of Obesity held a Consensus Development Conference on Antipsychotic Drugs and Obesity and Diabetes in 2004 and issued guidelines for baseline screening and ongoing monitoring related to obesity and diabetes.<sup>4</sup> Despite having been available for 4 years, the ADA/APA guidelines are generally not followed, according to recent research efforts cited in the NASMHPD report.

## Opportunities for Quality Improvement

Within the National Council’s Primary Care–Mental Health Collaborative, participants have worked on Plan-Do-Study-Act (PDSA) improvement cycles to reliably assess some of these health indicators as a part of regular clinical practice. They have found several barriers, from lack of

consumer access to affordable lab services to staff turnover, that have resulted in lack of consistency of practice.

Some state and regional mental health authorities have worked with provider organizations on similar quality improvement initiatives. One innovative pilot project in King County, Washington asked several provider organizations to choose from a list of options for assessing and counseling clients about metabolic syndrome and related health concerns. The options included on-site phlebotomy or use of handheld equipment to perform the lab analyses. Results of this study are still being tabulated. However, Marc Avery, chief medical officer at Valley Cities Counseling and Consultation (one of the organizations involved in the study), noted that “these innovative strategies offer us some real hope in our efforts to improve our clients’ overall health and well-being.”

Many opportunities exist for running PDSA cycles to improve your organization’s monitoring of consumer health status and to prepare for future reporting of aggregate data. Consider the following possibilities:

- Ensure that the organization’s electronic medical record or paper record has a consistent location for noting and updating the health indicators.

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## Risk Management for Violence Behaviors

**Ron Zimmet**

*Mental Health Risk Retention Group*

People with mental illness who are or may become violent present a unique risk within the mental health setting. Often unpredictable and unexpected, such acts of aggression are sometimes quite brutal and can result in a media circus and a great deal of negative attention given to the various members of the current and recent treatment teams. Media attention is also likely to alter the character of judicial proceedings to the detriment of any professional sued for malpractice or liability.

Mental health professionals can be held liable for patient violence, despite research concluding that predicting specific acts of violence is not possible. Courts often use a prudent professional standard in evaluating the actions of a treatment team, even though there is great disagreement on what that standard means in a particular set of circumstances. Organizational risk management is critical to avoiding potential findings of liability.

In risk management, organizations generally use two primary tools: adequate liability insurance that is reviewed and updated annually, and a set of risk management policies and procedures that reflect the risk inherent in the population being served.

Consider the following two hypothetical claims.

1. A person who attempted to shoot a neighbor and was found not guilty by reason of insanity was held in a state forensic hospital for 2 years. He was discharged home and admitted to outpatient treatment at a community mental health center. Three weeks into treatment, he stopped taking his medication and was brought to crisis services after threatening another neighbor. After 2 weeks on the unit, he was again discharged, after an assessment by a psychiatrist during which the person denied homicidal or suicidal ideation or plans. He was to follow up at the CMHC within 1 month. Two days later, he shot and killed eight people, including the parents of a small child who was a witness and a local celebrity. The police interrupted him and found in his pocket a list of the people he intended to kill. Later, a nurse at the state forensic hospital admitted that she had been shown this list but didn't believe the person really intended to kill anyone.

2. The girlfriend of a man who was receiving care at a CMHC called his counselor and said that she had broken up with him, was leaving town, and was worried about him. He was increasingly agitated and threatening and said that people were trying to spy on him or get into his home. The counselor did a home evaluation (accompanied by another counselor for safety), during which she spotted a hunting rifle. The counselor did not question the presence of the gun because it was a rural area and hunting was common. The man denied having delusions and agreed to a medication management appointment in 3 days. The next day, he put up a road block near his home. When a mother driving her daughters to an appointment got out to move the barricade, he shot and killed her and one daughter and seriously wounded the other.

In both cases, the question asked by the public, by the insurer, and by the providers within the organization was: How this could have been avoided?

### Paying Attention to High-Risk Patients

Risk assessments are a key tool to avoiding liability. The standard of care in assessing risk has changed, especially during the past decade and a half. Updated tools, research, and the like support the implementation of risk assessments for certain client groups.

Psychiatrist Paul Appelbaum at Columbia University encourages what he calls the "structured risk assessment," believing that it is "becoming the standard of care. . . . It ensures that clinicians gather relevant data about the most important risk factors for violent behavior. . . . In the absence of a structured way to think about risk, clinicians tend to be highly inaccurate in their assessment" (Lamberg, 2007).<sup>1</sup>

Performing structured risk assessments for the typical CMHC requires balancing needs and resources. An adequate structured risk assessment involves gathering information beyond that included in the usual biopsychosocial assessment—spending sufficient time with the patient, seeking consultation with other clinicians, and using some of the actuarial tools developed by researchers over the past 15 years to complement

### ABOUT THE EXECUTIVE EDITOR

Mary Thornton is a National Council consultant specializing in change management, coding and billing, revenue development, corporate compliance, program development, and marketing. Mary combines her nursing and business experience to train behavioral healthcare professionals about the rehabilitation model, medical necessity, and corporate compliance.

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