QI Coordinators' Meeting, May 12, 2008
Work Group of OHP Contractors Committee

PRESENT:
Mari Jones (LaneCare) Chair; Kathy Savicki (BCN); Jim MacLeod (Wash.Co); Raetta Daws (JBH); Charmaine Kinney (Verity); Tracey Robichaud (AMH); Jay Harris (ABHA); DeAnn Carr (GOBHI); Brett Asmann (Acumentra); Julie Guenette; Debra Brooks

ITEMS/ISSUES	PRESENTATIONS/DISCUSSIONS	ACTION & ASSIGNMENTS (DUE DATE)
Next Meeting	Meeting Date: July 14, 2008 at DHS, Salem, OR.	
Minutes:	Distributed via e-mail and approved as revised	
Introductions	Were conducted	
General Updates	1. Gilliam County will move from Clackamas MHO to GOBHI. Douglas County will leave JBH and GOBHI will likely pick them up as of July 1. 2. Site Review changes: 6-9 months after Acumentra completes the review AMH will conduct audits and focus on findings and/or lower scores in report—(partially met or lower). They will also review areas the compliance review does not cover. 3. Web Page update: Will be putting together a process to keep contact list updated on a regular basis. 4. Provider Capacity Assurance Report: revisited questions and collapsed some. Two have been added for special healthcare needs and ICTS.	2. Tracey will send out criteria for AMH reviews 4. Tracey will send revised questions and give examples of reports.
QI Coordinator Charter	The Charter was reviewed by the MHO contractors who sent it back with minor revisions. Revisions will be made and the charter will become effective: June 1, 2008	
Performance Measures	The committee reviewed the draft of the performance measure and gave feedback with further revisions. Discussion highlights: • Hedis measures are useful if it fits what we want to track. Can modify measures to fit, IE: Kaiser has narrower measures for asthma • Penetration rates: change to 16-24, ICTS rule. At a later date use pharmacy	Need to finalize and approve measures, sub committee to meet before next meeting.

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	data for 65+. Too many variables need to refine to 2-3 indicators. • ICTS residential care: Do we want to look at readmission rates. Lateral data affects data. Kids utilization group is a resource. • Peer Delivered Services: Widely varies throughout state and does it rise to the level of a primary measure? Consumers want this and it may not move ahead unless we make it a measure. It is cutting edge mode of treatment options and a federal mandate. Having the measure sends a message that we value it. There are problems such as difficulty to get real benchmark data. This measure is in the development phase and needs to be a qualitative rather than quantitative. Pat Davis (AMH) working on peer delivered services. The group is close to formalizing criteria for peer staff. Three levels: peer support, peer mentor, and peer counselor at a QMHA level. Does this work for a measure with the feds? This is an access issue and increases care through these delivery systems. • Hospitalization data: Agreed to delete I&E and stick with % of clients who received services during the first 30 and 90 days post discharge. Explore I&E in the future. Follow up in 7 days is a HEDIS measure that would be useful.	Peer: Development includes definition of what a peer delivered program is, criteria for peer staff, and encounter codes to use. Ask Pat Davis to come and discuss work being done with peer delivered services at the state level. Have John Collins come to sub committee group meeting. Charmaine will send I&E pilot study and performance specs.
NPI	State needs License numbers, Taxomony, and end dates for all practitioners. FFS app has much of the info they need. If they decide MHO is responsible for the provider panel it will be added to the provider capacity report. Contractors will be discussing. Presently only need to report down to the facility level. However, EQR reviewers are questioning Licensed staff, MD's NP's and QMHP's which need to be reported individually. NPI system: some are being programmed in with present information.	
Restraint and Seclusion	Jeannie Beatrice: Restraint and Seclusion is being discussed in several committees'. Need uniform data. Advocacy center: SB 265 requires that agencies report to the state incidents of R&S. DHS will make the data public. ITS rule followed. Measure: Restraints per patient per day. R&S by LOC. Residential and Day tx will have to be broken out. Can not break out by MHO. Will be able to click on provider to see their data. The provider will be able to put in small statement to discuss data. Numbers can look high if the N is low. There will be a standardized definition of S&R posted on web. Seclusion data will be different between res and day tx. Acute facilities will also have criteria and post stats. Does not include DD. Would	Will send ITS rule and put on state website by provider.

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	like to facilitate public forum every six months. EQR will review residential sites and cover S&R. How does MHO document? Through P&P and that we monitor data/complaints, etc. Contractor group has delegated review of S&R to QM coordinators.	
Critical Incident Criteria	Not uniform across state at agency or MHO level. How can we match state data to us? Need uniform criteria that is distributed and monitored.	Kathy will send monitoring tools she has developed.
Tobacco Cessation	Bulk of MH/addiction clients still smoking in Oregon. Current interventions are not working for this population. Need more intensive interventions. Data suggests 10 cognitive sessions would reduce smoking levels in population. Assessment and offering counseling mandated by contract but there is not enough resources for cessation programs in this population. There are better overall outcomes for both recovery from addictions and reduced smoking if both are addressed at the same time. How do we build capacity to provide cognitive groups and where is the funding coming from? Need training for providers. Need to have quit smoking materials developed for MH/addictions population. Key problem is being able to be reimbursed for sessions. Can pull some money from physical health and/or do integrated projects for stop smoking campaigns. Do we contract with DMAP to provide services in MH settings? Smoke free campuses need to occur but not being taken seriously. IE; staff smoking outside building with clients. Smoking privileges used as an award system in treatment programs. Providers need to see data and link to recovery. There are some materials to use. Smoke alarm is a powerful video. Need to reframe: Right to appropriate healthcare smoking assessment in contract.	Who can prescribe tobacco cessation medication? Don't implement assessment and counseling until we have more to offer.