NORTH SOUND
MENTAL HEALTH ADMINISTRATION

QUALITY MANAGEMENT OVERSIGHT COMMITTEE

COMMITTEE MEETING PACKET

AUGUST 20, 2003

QMOC GUIDING PRINCIPLES

The QMOC charge is to guide the quality assurance and quality improvement activities of mental health services within the NSRSN region. In assessing the necessary data and making appropriate recommendations, the QMOC members agree to the following:

- **Help create an atmosphere that is SAFE.**
- **Maintain an atmosphere that is OPEN.**
- **Demonstrate RESPECT and speak with RESPECT toward each other at all times.**
- **Practice CANDOR and PATIENCE.**
- **Accept a minimum level of TRUST so we can build on that as we progress.**
- **Be SENSITIVE to each other's role and perspectives.**
- **Promote the TEAM approach toward quality assurance.**
- **Maintain an OPEN DECISION-MAKING PROCESS.**
- **Actively PARTICIPATE at meetings.**
- **Be ACCOUNTABLE for your words and actions.**
- **Keep all stakeholders INFORMED.**

Adopted: 10-27-99
Revised: 01-17-01

North Sound Mental Health Administration
Quality Management Oversight Committee
NSMHA Conference Room
August 20, 2003
12:30 – 2:30

AGENDA

			Page #
1.	**Open the meeting & comments from the Chair**		
2.	**Approval of June 2003 Minutes** Action Item	**Chair Byrne**	**3**
3.	**Reports**		
	A. Quality Management Department Report FYI and Discussion	**Ms. Klamp**	**6**
	B. Review of Administrative Audits FYI and Discussion	**Ms. Klamp**	**7**
	C. WCPC Audit and Corrective Action Action Item	**Mr. Benjamin**	**25**
	D. Integrated Report Action Item	**Mr. McDonough**	**26**
	E. QMOC Restructure Action Item	**Chair Byrne**	**44**
	F. Episode of Care and E&T Reviews FYI and Discussion	**Mr. Williams**	**45**
4.	**Other Business**		
	A. Meeting Evaluation	**Chair Byrne**	
5.	**Adjourn**		

North Sound Mental Health Administration
Quality Management Oversight Committee
NSMHA Conference Room
June 18, 2003
12:30 – 2:30

MINUTES

Present:
Andy Byrne, QMOC Chair, Board of Directors rep
Melissa DeCino, QRT
Sharri Dempsey, Tribal Liaison/OCA Manager
Mary Good, Advisory Board Member
Wendy Klamp, Lead Quality Specialist
Terry McDonough, Quality Specialist
Karen Townsend, Quality Specialist
Michael S. White, IS Specialist
Gary Williams, County Coordinator

Not Present:
Claudia D'Allegri, Sea Mar
Chuck Davis, Ombuds
Joan Dudley, APN rep.
Marcia Gunning, Contracts
Joe Johnson, NSMHA Board
Karen Kipling, VOA
Bob LeBeau, APN rep.
Joan Lubbe, Advisory Board
Vacant-Advisory Board Member
Vacant-Advisory Board Member

Others Present:
Annette Calder
Heather Fennell
Greg Long

1. Open the meeting & comments from the Chair

Chair Byrne opened the meeting and welcomed those present. He distributed a letter from Rosemary Lea informing us of her position being eliminated at APN. She thanked everyone for the opportunity to work with them, see Attachment A for further information. Chuck Benjamin suggested that a resolution be passed by QMOC sending a letter to Rose thanking her for all of her contributions and expertise to QMOC. It was moved and seconded that Wendy will write a letter on behalf of QMOC, motion carried. Bob LeBeau will take Rosemary's place on QMOC.

2. Approval of May 2003 Minutes

The minutes of May 21, 2003 were approved as written.

3. Reports

A. Quality Management Department Report

Wendy distributed the Quality Management Department Report and went over it with the group. See Attachment B for more information. Wendy was thanked for her report.

B. NSMHA's Quality Management Process

Chuck Benjamin made a PowerPoint presentation updating the committee regarding the Quality Management reorganization and distributed handouts; see Attachment C for further details. Chuck asked Chair Byrne to consider the formation of a small workgroup to determine the function and membership of QMOC, much discussion followed. It was decided to form a workgroup to form a recommendation as to the function and membership of this committee; members will be: Andy Byrne, Sharri Dempsey, Mary Good, Wendy Klamp and Gary Williams. Chuck was thanked for his report.

C. Compass Skagit Supervised Living Re-Audit

Terry McDonough addressed the committee regarding the re-audit of Compass Skagit Supervised Living. It is a follow up to the Supervised Living review of the system wide review of supervised living programs and services to people in those programs. Ovenell's did not meet the standards of the program. The re-audit was completed during the end of May. Terry said Compass staff was open to suggestions and willing to do whatever needed to be done to meet the standard. The overall review scoring average for Compass North was 98%. NSMHA doesn't feel the need to do any re-reviews until 2004 and wishes to thank Ovenell's and Compass North staff for all their hard work. Chair Byrne feels this went very well and this is exactly what we want to have happen; identify problems and ways to correct them then re-audit and see that problems have been corrected. Terry was thanked for his report.

D. Results of Compass Chart Review

Terry McDonough informed the committee of the results of the Compass Chart Review. Terry stated Compass received 93% on the licensing audit. Terry said the NSMHA would continue to work with Compass on quality improvement issues. Chair Byrne thanked Terry for his report.

E. Crisis Review and Corrective Action

Greg Long updated the committee on the Crisis Review and Corrective Action that he reported on last month. Greg distributed an outline of the scope and focus of Crisis Services Focused Review; see Attachment D for more information. Greg went over the NSMHA Crisis Response Contact Sheet Check List with the committee, discussion followed, Greg and Michael will work together on the language on the check list. Greg was thanked for his report.

F. Inpatient Episodes of Care

Gary Williams presented the Inpatient Episodes of Care Review to the committee and distributed the report; see Attachment E for more information. Gary said there was significant improvement in having crisis plans in the charts 97% of the time. Gary said NSMHA is planning on working with APN to help plan for more effective interventions, titration of services, flagging risk factors, etc. and this is an opportunity to lessen inpatient admissions and decrease recidivism, committee discussion followed. Gary was thanked for his report.

G. E & T Reviews
Gary Williams distributed the Evaluation and Treatment Centers Reviews Report for committee review asking folks to review it and bring any questions or comments to the next meeting, see Attachment F for further information. This item will move to the July agenda.

4. Other Business
None.

6. Adjourn
Chair Byrne adjourned the meeting at 2:35 p.m.

Respectfully submitted,

Annette Calder

Please Note:
The attachments referenced herein are part of the official record and attached to the file copy. Please contact the NSMHA at 1-800-684-3555 extension 243 if you have any questions, comments or concerns.

NSMHA COMMITTEE DISCUSSION FORM

AGENDA ITEM: Quality Management Department Report

PRESENTER: Wendy Klamp, NSMHA Lead Quality Specialist

COMMITTEE ACTION: Action Item ( ) FYI & Discussion (x) FYI only ( )

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:

- ✓ Summary of June/July activities of the Quality Management Department and Quality Specialist staff

CONCLUSIONS/RECOMMENDATIONS:

- ✓ A summary of Quality Management Department activities will be given to the QMOC on a monthly basis

TIMELINES:

- ✓ Ongoing

HANDOUTS:

- ✓ The report will be distributed at the meeting.

NSMHA COMMITTEE DISCUSSION FORM

AGENDA ITEM: Administrative Audit Status Report

PRESENTER: Wendy Klamp

COMMITTEE ACTION: Action Item ( ) FYI & Discussion (x) FYI only ( )

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:

The NSMHA Audit Team has conducted ten administrative audits thus far in our cycle. This status report will inform QMOC as to the overall results and trends observed, pending corrective action plans and related issues, including feedback from providers as to how to improve the audit process.

CONCLUSIONS/RECOMMENDATIONS:
NSMHA will review our Administrative audit policy and incorporate identified areas for improvement as noted by the audit team and by providers.

TIMELINES:
N/A

ATTACHMENTS: Audit Schedule 2002-2003 Biennium
Audit Chart

NSMHA 2001-2003 BIENNIUM
ON-SITE ADMINISTRATIVE AUDIT
TENTATIVE SCHEDULE
8-1-2003

SERVICE PROVIDER	ENTRANCE DATE	EXIT DATE
Community Mental Health Services	5/16/02	5/20/02
Tulalip Tribes	5/30/02	5/30/02
Snohomish County	8/27/02	8/29/02
Associated Provider Network	9/11/02	9/13/02
Compass	10/29/02	11/01/02
Lake Whatcom Residential and Treatment Center	12/12/02	12/13/02
Seamar	1/29/03	1/31/03
Whatcom Counseling & Psychiatric Clinic	3/5/03	3/7/03
Bridgeways	4/29/03	4/30/03
Catholic Community Services	5/14/03	5/16/03
Volunteers of America	9/4/03	9/5/03
Whatcom County	10/1/03	10/1/03
Consumer Oriented Projects Monitoring will be accomplished through monthly desk audits. An on-site will be conducted as monthly desk audits warrant.		

Administrative Audit Status Report August 6 , 2003

Department	Agency Contact	Monitor(s)	Outcome	Date of Activity	Findings/ Recommendations/Other Area of Concern	Corrective Action	Date due	Date received	Staff Reviewer	Action Needed or Quality Improvement	Review Timeline	Date Completed	Further Action
Contracts	APN	Administrative Audit	Corrective Action Plan		Administration: ***1.*** *Administrative Structure* ***2.*** *Contract Deliverables* • Number known consumers or parents of consumers employed • Service agreements with Community Hospitals • *APN Operating Agreement & provider Agreements* *3. Contracted/Leased Employees* • One contracted staff does not fall into APN's Salary Schedule. • Training Plans • Clarify roles and responsibilities and update relevant Contracted/Leased Employee Agreements, *4. Policies and Procedures* • Anti-Harassment policy. • Peer Review Policy G-1. • Guiding regional principles, procedures, expectations and outcomes to be applied consistently by all APN's members and affiliates. • Use of qualified professionals, at critical treatment junctures • Implementing minimum of two APN provider initiated face-to-face meetings during each school year. • School District meetings not documented as being met in Skagit, San Juan or Island counties. Fiscal • Financial reports not submitted by deadline.			11/27/02	Marcia Gunning & Audit Team	NSRSN responded to Corrective Action Plan via integrated letter on 1/8/03 providing legal/contract citing for 8 findings and 1 recommendation APN did not provide corrective action plan for and requested complete corrective action plan. 4-22-03 CA action still pending: **"APN does not have Policy and Procedures that describe how ITA services provided will comply with "all applicable laws and standards". APN must develop a Policy and procedure to address this issue."**	11/18/02	Pending	

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					A. Quality Management 1. *Peer Review Process* *Initial Authorization and* 2. *Access and Assessment System* 3. *Care Management* • Access, engagement and utilization of mental health services • How appropriate services are provided to "older adults with mental illness" • Code of Federal Regulation Utilization Control Requirements. • Facilitated referrals 4. *Quality Management policies and procedures* • Critical Incident policy • *Quality Improvement Work Plan and biennial quarter reports.* Community Psychiatric Inpatient Services Management 1. Policies and procedures B. Quality Review Team Section 1. Marketing Plan								
Contracts	Snohomish County	Administrative Audit			ADMINISTRATIVE 1. *Personnel Files* • Clinical supervision • Staff Training Plans • Job descriptions. 2. *Policies and Procedures* • ITA contact sheets • Complaints, grievances and critical incidents *C. 3. Quality Management* • Policies and procedures. • No quality management	Corrective Action Plan submitted and found to be acceptable.	11/10/02	11/10/03	Marcia Gunning and Audit Team	Reviewed and notified Snohomish County of acceptance	12/10/02	12/6/02	None

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Contracts	Catholic Community Services	Administrative Review	Completed	5-16-03	**Administrative Section FINDINGS** **Personnel:** Although overall personnel files were pristine in their documentation of required elements, there is one major and serious issue. Catholic Community Services Northwest employs a job category called "Community Support Specialist." There are 23 staff with this job title, approximately 25% of total staff. These individuals provide direct care of clients. Per contract all staff who provide direct care must be licensed, certified or registered, as required for the position. No credentials were found in any of these files, although the job description required that they be eligible for registered counselor status. No annual performance evaluations were performed and there were no annual training plans present, both are required by WAC and contract. No supervision was recorded, also a requirement. **Quality Management Section FINDINGS** A review of Catholic Community Services Northwest's Quality Management Plan, policies, and procedures and overall implementation revealed the following finding. This is a repeat finding from the 2001 audit. Planned corrective actions that were accepted by the NSMHA were not adequately completed. Documentation of an agency-wide quality management process to	*CAP*	6-30-03	7-03-03	W. Klamp, Audit team	CCSNW to resubmit CAP re: counselor registration for Community Support Staff. QRT-CCSNW did not respond to QRT recommendation	Letter sent 8-4-03 detailing our response and needed actions. CCSNW to answer by 9-5-03		

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					design, measure, assess and improve system performance throughout CCSNW needs to be implemented. This process should include a measure that identifies how CCSNW's quality improvement goals and objectives fit with the goals and objectives of the NSMHA Quality Management Plan. The current CCSNW Quality Improvement Plan does include a checklist of the goals and objectives in the NSMHA Quality Management Plan. However, beyond listing what the NSMHA measurements are, there is no specific documentation regarding how CCSNW has measured or assessed their agencies performance / attainment of these goals and objectives. A more complete paper trail, not simply listing the NSMHA measurements, but describing how these measurements have been assessed and built into the quality improvement process throughout CCSNW needs to be documented. Also, upon reviewing the CCSNW Quality Improvement Compliance Committee meeting minutes, no documentation could be found to indicate how information discussed and / or decisions engendered by this Committee are communicated throughout CCSNW. Such information is apparently shared with staff at weekly meetings and with CCSNW Trustees annually, but a documentary paper trail to quantify this process needs to be established and formalized. Without such documentation, there is no way to verify the necessary agency-wide implementation of quality								

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					improvement initiatives and activity throughout CCSNW. Information about Quality Management activities needs to be embedded at all levels of the organization from the individual staff level up to the Board. Quality Improvement staff needs to be a part of the Administrative Team meetings so that regular and ongoing reporting can occur of Quality Management activities and the Quality Management Plan can be monitored so that areas of concern can be corrected and innovations or opportunities for Best Practice can be incorporated into ongoing operations in timely and meaningful ways. Consumers, parents and advocates need to be included in the oversight of quality management activities. Quality Review Team Section **FINDINGS** The NSMHA Contract states that CCS will provide a locally responsive delivery system by ensuring that consumers, advocates and family representatives are included in your on-going process of decision-making and policy setting regarding planning, implementation, operation and evaluation. It also states that CCS will create an on-going workgroup that focuses on the involvement of consumers, advocates and family members and evaluates their current involvement. This was a Finding at the 2001 On-site Review. Although CCS created a policy in your "E" series, items #2-6 are not procedures								

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					that will fulfill this requirement. Local responsiveness and communication refers to consumer empowerment and voice in the arena of quality assurance and improvement specific to CCS programs operations. A luncheon does not fulfill the requirement of an on-going decision-making quality improvement process of CCS programs and operations. Therefore, this is a Repeat Finding. **RECOMMENDATIONS** The NSMHA Contract also requires CCS to conduct a minimum of 2 face-to-face meetings with schools per counties during each school year. CCS has written a wonderful policy to provide for this requirement. Unfortunately, you got a late start and were not able to complete the connections. Quality Review Team recommends that you start this process earlier and maintain it on a quarterly basis.								
Contracts	Community Mental Health	Administrative Review			Administrative Section ***1. Personnel Files*** • Documentation of Mental Health Specialist • Clinical supervision • Staff evaluations not current • Annual staff training plans and training documentation **3. *Subcontracts*** • Ovenell Long Term Care Inc. contract sunset in 1999. ***3. Policies and Procedures*** Major rewrite, distribution and training process are needed	***Partially acceptable.*** ***Partially acceptable. Partially acceptable.*** ***Partially acceptable.*** ***Acceptable.*** ***Acceptable.***	12/20/02		Marcia Gunning & Audit Team	Follow-up on corrective action plans not acceptable and partially acceptable. 5-7-03 Discussed with Tom Sebastian. He believes in the transition to Compass the final corrective actions have been missed. Letter to Tom requesting response. 6-2-2003-Response received-several areas remain partially or not accepted. Letter to Tom	6-1-03 6-2-2003-Response received 8-1-03 Response received. 8-6-03 Letter to Compass North. Still open QRT items requiring further CAP.	Concurrent review re-audit as part of Compass-**score 93%**	

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					throughout the agency. **Quality Review Team *On-site Review – Facility Postings*** 28.6% of the CMHS facilities visited did not have evacuation routes posted. ***1. Policies and Procedures*** Complaint grievance 2. Complete formalized process for consumer/advocate input. 3. Employee comment cards. 4. Develop more ways to involve consumer/advocates. **5.** Residential services Policies, Procedures and Rental Agreemer	***Acceptable.*** ***Not acceptable.*** ***Not acceptable.*** ***Not acceptable.*** ***Not acceptable*** ***Not acceptable***				–response needed by June 30, 2003 8-1-03-Following meeting with tom Sebastian and Stacey Alles Compass Skagit has submitted additional corrective action plans which are now under review/	Immediate response requested		
Contracts	Compass Health	Administrative Audit			**1. Clinical** - overall cluster average for 109 clinical records = 83%. 2. Personnel Files - Review ed 126 files (Outpatient Services = 75 MHP/ 38 Clinical. E & T = 13 clinical E & T • Unable document clinical supervision occurred in 16% of files 54% E & T staff files , 11.5% Outpatient Staff files. • Staff evaluations not current 12.7% of files: 46% E & T staff files 8.8%% Outpatient staff files. • 41% of files reviewed did not contain current Staff Training Plans/documentatio n. 69% E& T Staff f8% Outpatient staff • Annual Oath of Confidentiality is missing in 18% of t	**1. Clinical** - overall cluster average for 109 clinical records = 83%. 6. Personnel Files - Review ed 1 files (Outpatient Services = 75 MH and 38 Clinical. E & T = 13 clinica staff) • Unable document clinical supervision occurred in 16% of files 54% E & T staff files , 11.5% Outpatient Staff files. • Staff evaluations not current 12.7% of files: 46% E & T staff files 8.8%% Outpatient staff files. • 41% of files reviewed did not contain current Staff Training Plans/documentat ion. 69% E& T		2-24-03	W. Klamp	Some responses not accepted-returned to APN and Provider – awaiting response 5-1-03 2nd response from Compass received. Accepted Personnel doc. Plan and QRT-requested Housing Support policy. Notified Terry Clark that we need a response to items “Partially Acceptable” such as Peer Review. This is still open. 5-7-03 response received, all corrective actions in place	06/2003 revisit for clinical record review	6-2003 Clinical re-audit score 93%	none

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					files. 54% of the E & T . 14% of the Outpatient staff files. **3. Policies and Procedures -** Employee Performance Review and Developmental Training Plan Protocol cites WAC 275-57. 4. Quality Management - "Peer Review protocol does not meet the Corrective Action requested in the September 2000 NSRSN Admin Audit of APN. ***5.*** QRT ***– Facility Postings*** ▪ LRA Consumer Rights were not available or posted. ▪ WAC 275-57 Non-English Outpatient Consumer Rights were posted	Staff f8% Outpatient staff • Annual Oath of Confidentiality is missing in 18% of the files. 54% of the E & T . 14% of the Outpatient staff files. **7. Policies and Procedures -** Employee Performance Review and Developmental Training Plan Protocol cites WAC 275-57. 8. Quality Management - "Peer Review protocol does not meet the Corrective Action requested in the September 2000 NSRSN Admin Audit of APN. ***9.*** QRT ***– Facility Postings*** ▪ LRA Consumer Rights were not available or posted. ▪ WAC 275-57 Non-English Outpatient Consumer Rights were posted							
Contracts	LWTC	Administrative Audit			1. Clinical - overall cluster average for 25 clinical records reviewed was 90%. No findings 2. Clinical recommendation - Review areas where cluster scores are below 90% and develop and implement a plan to bring to 90% or more. Clinical Records 84% Intake Evaluation 86% Crisis Planning 69% Community Support 86% 3. Fiscal - Must file a schedule of federal expenditures as part of their financial statements.	Corrective action plan due 3/3/03 for fiscal finding- **4-23-03 New guidance received from state, finding will be withdrawn, no plan required.**	none	N/A	N/A	N/A	N/A	N/A	N/A

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Contracts	WCPC	Administrative Audit	Completed	March 2003	**FINDINGS** **4. Personnel Files** • A review of 80 personnel files revealed sustained improvement in the maintenance of personnel files. However, 20 files or 25% were missing an application. • No supervision records were found for ICRS staff. **5. Policies and Procedures** WCPC lacks policies and procedures regarding provision of resource management of community hospital care for consumers in order to: Coordinate the provision of appropriate and timely community mental health supports and services to service recipients upon discharge from inpatient services, including face-to-face treatment planning prior to hospital discharge by the PCP. Coordinate and actively participate with hospitals and residential care s in discharge planning designed to maximize use of least restrictive care alternatives. Utilize flex funds to ensure transition of individuals discharged from WSH and/or community hospitals. Participate with hospitals in the development and implementation of an inpatient plan of care in accordance with applicable standards and written agreements with the inpatient facility. Ensure that each service recipient's community plan of care is integrated	Pending	5-12-03 5-12-2003 report not received due to WCPC staff family emergency. Deadline extended to June 1, 2003	5-28-03	W. Klamp	CAP accepted and completed		5-30-03	

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					with the inpatient plan of care jointly developed with the inpatient facility. Ensure that an appropriate and timely discharge plan is jointly developed and implemented Actively work with NSRSN and Service Area's CLIP Committee, to ensure the provision of medically necessary mental health services to individuals discharged from CLIP programs on a no decline policy, regardless of recipient's Medicaid eligibility. Provide clinician contact the inpatient staff within two (2) business days of a child's admission to an inpatient facility. For any hospitalization exceeding five (5) days, ensure that child's primary care clinician be present for at least one face-to-face meeting with the child and their treatment team before the child's discharge for any inpatient facility. Coordinate and actively participate with hospitals and residential care in discharge planning designed to maximize use of least restrictive care alternatives. Whatcom Counseling and Psychiatric Clinic should file a schedule of federal expenditures as part of their annual financial statements. This report is required per the OBM circular A-133. This report gives the total federal block grant spent, the funding source and the CFDA number. **QRT RECOMMENDATIONS** **RESIDENTIAL & HOUSING PROGRAM-** WCPC has many different wonderful programs to								

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					assist in the housing needs for their clients. There is a need for the lease agreement to be updated to include the name and location of the bank that holds the security deposit from the tenant. Clause #15. "Landlord's Right to Access must be filled in with the legal appropriate notice required."								
Contracts	Sea Mar	Administrative Audit	Review complete. Auditing report due to Sea Mar by March 18, 2003 Report sent April 25, 2003 due to Marcia's illness	1-31-03	Administrative: Contract Deliverables Finding Reports of the number of known consumers or parents of consumers employed by the Contractor and/or provider for 7/1/02, 1/1/03 have not been submitted as of the audit date. Report of Contractor/Provider oppor for volunteer work for youth, adults and older adults who are consumers due 1/1/03 has not been submitted as of the audit date. A plan developed with allied community providers (deliverable #19) has not been submitted for approval by July 1, 2002 as required. **<u>Outpatient/Community Support S</u>** ***Finding***	Received Sea Mar's Corrective Action Plan 7-03-03. Met with Claudia and Julia on 7-24-03 to explain why we were not accepting most of their corrective actions as they were not responsive to the identified deficiencies and lacked specificity.	May 25, 2003 To re-submit by 8-31-03	July 3, 2003	Audit Team	Following meeting with Julia Ortiz and Claudia D'Allegri they will resubmit their response for the areas not accepted.	August 31, 2003		

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					Sea Mar lacks the necessary policy and procedure to ensure compliance with and State Fraud and Abuse implemen reporting requirements. Initial/Continued Authorization ***Finding*** No policy was located that addresses how Sea Mar will ensure that the NSMHA Standards of Care manual is consistently implemented. **Complaint and Grievance** **Finding** Sea Mar had two separate policies for complaint and grievance. Neither was consistent with the NSMHA Complaint and Grievance policy current at the time of the audit. These policies need to be updated. Fiscal: **FINDING**: Sea Mar should report on their schedule of federal expenditures the federal block grants passed through to them from the North Sound Mental Health Administration. The program is CMHS block grants and the CFDA number is 93.958. This is a reporting required per the OBM circular A-133. **Quality Review Team Surveys:** **RECOMMENDATIONS:** Develop a formal policy and								

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					procedure that speaks to the integration of referring the Quality Review Team Satisfaction Report Findings and Recommendations to Sea Mar Quality Improvement committees for action. Develop a formal policy and procedure which ensures Sea Mar will attend NSMHA Boards for an effective representation of Sea Mar voice. Develop complaint and grievance log that tracks any complaints or grievances, written or verbal, how resolved, which is reported to NSMHA Lead Quality Specialist.								
Contracts	bridgeways	Administrative Audit	Completed review 4-30-03	4-30-03	Onsite Scheduled for 4/29-30/03	**FINDINGS** Consumer Voice- In 2001 it was recommended in the Administrative Audit report that service recipients need to have a voice on the structured bridgeways committees. A policy to accomplish this was written and put in place, however there was no evidence that it had been operationalized. In a mental health system that is committed to the values of the Recovery Model, consumer voice and involvement is of paramount importance for setting policy and decision making. Consumers, family members and advocates need to be included in your strategic and marketing planning, as well as Quality Management, in a meaningful ongoing manner. **RECOMMENDATIONS**	June 30, 2003	June 20, 2003	Audit Team	CAP accepted	August 1, 2003	6-17-03	none

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						Currently bridgeways staff provide an annual report to their Board of Directors on Quality Management activities. Given the importance of this information to your strategic planning and other operational decisions, NSMHA suggests that you increase the frequency of reporting to your Board and also review other ways to elevate quality management issues to their attention, such as Board representation on your Quality committee.							
Contracts	Volunteers of America	Administrative Audit			Onsite originally scheduled for 8/7-8/03 has been postponed to Sept. 4 and 5, 2003								
Contracts	Whatcom County	Administrative Audit			Onsite scheduled for 10/1/03								

NSMHA COMMITTEE DISCUSSION FORM

AGENDA ITEM: Whatcom County Crisis Response Program

PRESENTER: Charles R. Benjamin, Executive Director, NSMHA

COMMITTEE ACTION: Action Item ( ) FYI & Discussion (x) FYI only ( )

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:
Whatcom Counseling & Psychiatric Clinic's Crisis Response System is under close monitoring as follows:

1. Mental Health Division (MHD) has placed this program on probation for one year.
2. NSMHA has:
    a. Requested a Corrective Action Plan to ensure 24/7 Emergency Services.
        i. Part of plan requires WCPC and NSMHA to conduct daily reviews of crisis system "event sheets."
    b. Issued a $20,000 sanction to APN/WCPC.
    c. Sanction funds to be used to contract with an independent consultant to assess the management and functioning of the Emergency Services Program.

CONCLUSIONS/RECOMMENDATIONS:

- NSMHA needs to expedite the hiring of an independent consultant.
- NSMHA will report back to QMOC once we receive a report.
- These efforts need to be integrated with the NSMHA's review/survey of the Crisis System throughout the North Sound.

TIMELINES:
As outlined above

ATTACHMENTS:
N/A

NSMHA COMMITTEE DISCUSSION FORM

AGENDA ITEM: 3rd Biennial Quarter 2002-2003 Integrated Report (January 1 – June 30, 2003)

PRESENTER: Terry McDonough

COMMITTEE ACTION: Action Item (X) FYI & Discussion ( ) FYI only ( )

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:

The Integrated Report addresses the following points:

- A follow up to issues identified in the 2nd Biennial Quarter 2002-2003 Integrated Report
- Strengths identified during the 3rd Biennial Quarter
- Issues identified during the 3rd Biennial Quarter
- Follow up actins taken in response to identified issues
- Accomplishments of note during the 3rd Biennial Quarter

CONCLUSIONS/RECOMMENDATIONS:

The Integrated Report is being presented to QMOC for review and feedback and potential revision. Once reviewed and approved by QMOC, either as is or with revisions, the Integrated Report will be submitted to the NSMHA Board of Directors.

TIMELINES:

The Integrated Report will be presented at the August 20, 2003 QMOC meeting.

ATTACHMENTS:

3rd Biennial Quarter 2002-2003 Integrated Report

North Sound Mental Health Administration

Quality Management Department

Integrated Report

For

3rd Biennial Quarter 2002-2003

(January 1– June 30, 2003)

NSMHA Quality Management Plan 2002-2003
Integrated Report for 3rd Biennial Quarter, January 1 – June 30, 2003

Executive Summary

The Integrated Report provides an overall summary of Quality Management activities performed in accordance with the 2002-2003 Work Plan. The 3rd Biennial Quarter 2002-2003 Integrated Report addresses NSMHA Quality Management activities performed between January 1 and June 30, 2003.

Follow up to issues identified during the 2nd Biennial Quarter Integrated Report

The 2nd Biennial Quarter (BQ) Integrated Report identified three (3) significant issues that required follow up actions during the 3rd BQ; clinical record documentation, consumer dissatisfaction with crisis plans, and concerns regarding providers Quality Management (QM) and/or Utilization Management (UM) Plans. During the 3rd BQ, providers attained passing scores on clinical record re-review and this issue has been successfully resolved. Also, appropriate Corrective Action plans from providers to address consumer dissatisfaction with their crisis plans were received and accepted. Corrective Action Plans requested from the Associated Provider Network (APN) and other providers regarding QM and/or UM concerns have been received and are under review by NSMHA staff.

Strengths identified in the 3rd BQ Integrated Report

- Whatcom Counseling and Psychiatric Clinic passed their clinical record re-review (96%)
- Compass Health passed their clinical record re-review (93%)
- Compass Health passed their Supervised Living re-review (98%)
- Providers submitted acceptable Corrective Action Plans that address consumer dissatisfaction with their crisis plans (An area of concern identified by Quality Review Team staff during the 2nd Biennial Quarter)

Issues Identified during the 3rd Biennial Quarter Integrated Report

- The requirement for a comprehensive review of the North Sound public mental health system, regarding clarification of roles, responsibilities and possible duplication of services, based on a Mental Health Division (MHD) audit of the NSMHA
- The requirement by MHD to address issues related to the delivery of crisis services throughout the North Sound region

Follow up actions taken in response to issues identified during 3rd Biennial Quarter

To address public mental health system review concerns, NSMHA staff have;

- Presented a System Review and Restructuring proposal to the NSMHA Board of Directors
- Participated in a planning group that included NSMHA and provider staff and resulted in the NSMHA Integrated Quality Management Process
- Participated in and led the ongoing NSMHA Quality Management Committee component of the
- NSMHA Integrated QM process

To address issues related to the delivery of crisis services throughout the region, NSMHA staff have;

- Prepared a NSMHA Crisis System Corrective Action Plan that will be implemented region wide during the upcoming Biennial Quarter

- Combined the scheduled 4th Biennial Quarter Focused Review of the NSMHA Crisis System Review with the Crisis System Corrective Action Plan

Accomplishments of note during the 3rd Biennial Quarter

- Renewal of Coordinated Quality Improvement Program (CQIP) status for NSMHA
- A comprehensive review of the North Sound public mental health system
- Crisis Plan redesign
- Crisis System Review/Corrective Action
- Clinical record documentation
- Representation changes on the NSMHA Quality Management Oversight Committee
- Internal review/redesign of NSMHA Quality Management Dept

3rd Biennial Quarter 2002-2003 Integrated Report

January 1 – June 30, 2003

Introduction

The 3rd Biennial Quarter 2002-2003 Integrated Report is intended to present information related to the quality management activities of the North Sound Mental Health Administration (NSMHA) during the first six months of 2003. Also, the 3rd Biennial Quarter Integrated Report describes the current status of Corrective Action activities identified as necessary by the 2nd Biennial Quarter 2002-2003 Integrated Report. Further, the 3rd Biennial Quarter Integrated Report summarizes the information learned from trends identified and information learned during the 1st, 2nd and 3rd Biennial Quarter 2002-2003 Reports. The summarization will include recommendations and suggestions from the NSMHA Quality Department regarding how to address the implementation and measurement of quality improvement activities through the NSMHA, based upon what has been learned and observed during previous Integrated Reports.

3rd Biennial Quarter 2002-2003 NSMHA Quality Management Department

Activities/Reports

During the first six months of 2003, NSMHA Quality Management Department staff performed multiple quality management activities and reviewed several quality management report documents.

Quality Management activities performed included;

- Administrative Audits at
  - Sea Mar Community Health Center (January 2003)
  - Whatcom Counseling and Psychiatric Clinic (March 2003)
  - *bridgeways* (April 2003), and
  - Catholic Community Services Northwest (May 2003)

- Inpatient Episode of Care Review Report and
- Residential Inpatient Evaluation and Treatment Facilities Clinical Review Report
  - Note: These Reviews were performed during the 2nd Biennial Quarter and are being reported during the current Biennial Quarter

- Clinical Record Reviews in response to Corrective Action requests at;
    - Whatcom Counseling and Psychiatric Clinic (March 2003), and
    - Compass Health (June 2003)

- Supervised Living Review in response to Corrective Action request at;
    - Compass-North (Mt. Vernon)

Quality Management Reports reviewed included;

- Reports from the NSMHA Ombuds Department
- Reports from the NSMHA Quality Review Team
- NSMHA Complaint, Grievance and Fair Hearing Document
- NSMHA Critical Incident Reports
- Children's Hospitalization Alternative Program (CHAP) report

Administrative Audits- 3rd Biennial Quarter

Significant strengths were noted during Administrative Audits conducted at each provider agency. Also, areas of needed quality assurance/quality improvement were identified. NSMHA provided each agency reviewed with a written Administrative Audit Report that recognized agency strengths and requested a Corrective Action Plan (CAP) to address areas requiring quality assurance/improvement. The current status of Corrective Action Plan requests from agencies receiving Administrative Audits during the 3rd Biennial Quarter 2002-2003 is as follows;

- Sea Mar Community Health Center-
    - NSMHA received a CAP from Sea Mar and is in the process of reviewing it.
- Whatcom Counseling and Psychiatric Clinic (WCPC)-
    - NSMHA has received, reviewed and accepted a CAP. All required corrective actions proposed have been implemented. The Administrative Audit at WCPC is now considered completed and closed.
- *bridgeways*-
    - NSMHA received a CAP from *bridgeways* and is in the process of reviewing it.
- Catholic Community Services Northwest (CCSNW)-
    - NSMHA received a CAP from CCSNW and is in the process of reviewing it.

Quality assurance issues identified in the Administrative Audits conducted during the 3rd Biennial Quarter 2002-2003 that pertain to Focus Areas included in the NSMHA Quality Management Plan 2002-2003 Work Plan are addressed in Attachment A (page 12) of this report.

Administrative Audits performed to date

1st Biennial Quarter Jan-June 2002	2nd Biennial Quarter July-December 2002	3rd Biennial Quarter Jan-June 2003
Community Mental Health Services (CMHS)*	The Associated Provider Network (APN)	Whatcom Counseling and Psychiatric Clinic (WCPC)
The Tulalip Tribes	Snohomish County	Sea-Mar Behavioral Health
*Note: An acceptable		

Corrective Action Plan from CMHS (now Compass North) has not yet been received by the NSMHA	Compass Health-Snohomish	Catholic Community Services- Northwest (CCSNW)
	Lake Whatcom Center	*bridgeways*

The Administrative Audit cycle of the NSMHA Quality Management Plan 2002-2003 is now nearly complete. Two Administrative Audits remain to be done during the 4th Biennial Quarter; audits of the Volunteers of America and of Whatcom County. An overview of the Administrative Audits performed to date indicate several overarching themes, both areas of concern and areas of strength that are presented below.

Areas of Strength

- An overall, region-wide improvement in provider personnel files. Such areas as staff background checks, professional certification, salary schedules and job descriptions were found to be much more complete in agency personnel files than during previous Administrative Audits.
- Fiscal practices, policies and procedures were sound throughout the provider network.
- Disaster Preparedness and Emergency Response plans at provider agencies were responsive to the needs of the local community, and coordinated with such agencies as the American Red Cross and local hospitals.
- Throughout Associated Provider Network (APN) agencies, standardization of clinical and consumer right documentation was evident. Consistent usage of APN wide forms and documents is a goal that APN providers identified previously and appear to have achieved.
- Agencies throughout the region have begun implementation of the regional Training Plan.

Areas of Concern

- Clinical record documentation at several provider agencies did not meet the NSMHA or the State Mental Health Division (MHD) standard of 90%. Agencies that did not meet this standard were asked to implement Corrective Action Plans to correct this deficiency and were subsequently re-reviewed by NSMHA and MHD staff. To date, all providers who had their clinical records re-reviewed have implemented effective Corrective Action Plans and have successfully met or exceeded the 90% clinical record documentation standard.
- Under-representation of consumer voice, as indicated by lack of consumer inclusion in agency planning processes and committees was noted at several provider sites. Corrective Action Plans to address this issue have been requested from agencies needing to improve internal consumer voice.
- Insufficient documentation on consumer crisis plans to address health and safety issues and to specify progressive and preventative measures that consumers could employ to avert or minimize a crisis. A region-wide work group of provider and NSMHA staff met to investigate this issue. The group revised the consumer crisis plan format to include an increased focus on health and safety issues, as well as developing specific self-help reference checklists that consumers can use to identify individualized preventative steps that help them avert or minimize crisis situations.

Inpatient Episode of Care Review
and
Residential Inpatient Evaluation and Treatment Facilities Clinical Review

The Inpatient Episode of Care Review was conducted at Whatcom Counseling and Psychiatric Clinic, Compass-Skagit and Compass-Snohomish. A total of 36 clinical records of consumers from these agencies who had received inpatient services between August and September 2002 were reviewed. The review was designed to evaluate the quality of consumers outpatient care before, during and after an inpatient episode.

Review strengths were; the presence of crisis plans for consumers in 97% of the cases reviewed, extensive pre-hospitalization diversion activities in some cases and documentation of involvement of consumer support sources, in some cases.

Areas of concern raised by the review were; the rate of re-hospitalization for consumers (13 of 36 consumers), the infrequent revision of the consumer's treatment plan following an inpatient episode and the lack of consumer case manager involvement in hospital discharge planning for the consumer.

These results have been reported to providers and to the NSMHA Quality Management Oversight Committee. Recommendations regarding how to address areas of concern are included in the Inpatient Episode of Care Review. NSMHA Quality Specialists will be conducting a re-review at a future date.

The Residential Inpatient Evaluation and Treatment Facilities Clinical Review was conducted at the North Sound Evaluation and Treatment Facilities (E&T's) in Sedro Woolley and Mukilteo. This was the first time NSMHA staff have reviewed either of the regional E&T's. 15 clinical records were reviewed at each E&T. The review was intended to address clinical concerns as well as to assess compliance with current Washington Administrative Codes (WAC's) and Revised Codes of Washington (RCW's).

Review results established that both North Sound E&T's are operated in compliance with current Washington State regulatory requirements (WAC's and RCW's). NSMHA reviewers shared quality improvement suggestions with E&T staff regarding:

- Consumer inpatient initial treatment plan documentation
- Involvement of the consumer's outpatient case manager in discharge planning from the E&T
- Documentation of inpatient staff efforts to inform consumers of their involuntary rights, and
- Documentation of inpatient physician's efforts to inform consumers of their consent rights regarding psychotropic medications

A response from both E&T's has been received by NSMHA Quality Management staff and is under review.

Clinical Record Reviews

Whatcom Counseling and Psychiatric Clinic (WCPC)-

- 108 clinical records at WCPC were reviewed in March 2003. This was a follow up to a NSMHA Clinical Record review and State Mental Health Division Licensing and Certification review at WCPC conducted during the 2nd Biennial Quarter 2002-2003 in which WCPC failed to achieve a passing score of 90% (WCPC received a score of 83%). The overall score for the 108 records reviewed at WCPC during the follow up review in March 2003 was 96%. Therefore, WCPC has now successfully passed the clinical record review. However, the Crisis Plans reviewed at WCPC scored a 76% compliance rating, with 90% expected for passing. To address this deficiency, a region wide group of provider and NSMHA staff met and reviewed the current crisis plan format. The group implemented several significant improvements to the documentation in consumer crisis plans. Some of these improvements are:
    - Listing examples of crisis early warning signs the consumer might experience on the crisis plan
    - Detailing action steps selected by consumers on the crisis plan in a sequentially progressive and preventative manner, focusing on the consumer's health and safety
    - Providing lists describing "Early Warning Signs", How Others Can Help" and "Actions I Can Take" to consumers, allowing them to specify their individual voice and choice regarding their preferred crisis intervention procedures.

Provider staff have already begun using the revised and improved crisis plan format throughout the region.

Compass Health-

- 100 clinical records at Compass Health were reviewed in June 2003. This was a follow up to a Clinical Record review and State Mental Health Division Licensing and Certification review at Compass Health conducted during the 2nd Biennial Quarter 2002-2003 in which Compass Health failed to achieve a passing score of 90% (Compass Health received a score of 84%). The overall score for the 100 records reviewed at Compass Health during the follow up review in June 2003 was 93%. Therefore, Compass Health has now successfully passed the clinical record review. However, the Crisis Plans reviewed at Compass Health scored a 61% compliance rating, with 90% expected for passing. Compass Health staff are now implementing the revised crisis plan documentation.

Supervised Living Review

The Supervised Living Review of services provided to residents at Ovenell's Boarding Home in Burlington by staff at Compass Health- North determined that documentation in Ovenell's resident's clinical records by Compass staff did not meet NSMHA expected scoring standards. The Supervised Living Review also found that Compass-North staff had not implemented Corrective Action regarding the provision of services to Ovenell's residents previously requested by NSMHA. NSMHA Quality Specialists conducted a re-review of Compass-North services and documentation in May 2003. The review inspected the clinical records of all Ovenell's residents currently receiving mental health services from Compass-North. Results of the Supervised Living Review indicated that clinical records reviewed were 98% in compliance with NSMHA expected scoring standards. Also, NSMHA Quality Specialists met with Ovenell's and Compass-North clinical staff to review policies/procedures that Compass-North has now implemented at Ovenell's. These policies/procedures are designed to facilitate coordination and continuity of care for Ovenell's residents receiving mental health services from Compass-North. They specify what roles and responsibilities are expected of Compass-North staff. Ovenell's staff tell NSMHA that the policies/procedures now in place are working well and meeting the Ovenell's staff and residents needs satisfactorily.

Complaint, Grievance and Fair Hearing Report
Ombuds Department Reports
Quality Review Team Reports

Information from these two (2) report sources for the 3rd Biennial Quarter Biennial Report is presented to describe the tracking of system issues over time and to point to system trends that are identifiable. During the past reporting period, the majority of complaints raised by consumer/advocate and/or family members were in the following areas;

- Emergency Services (including both crisis and in-patient services),
- Continuity of Care/Intensity of Services, and
- Quality/Appropriateness of Services

Issues related to Emergency Services throughout the NSRSN comprised the highest number of complaints received in the most recent Complaints, Grievances and Fair Hearing Report. Also, consumers and family members have expressed concerns to NSRSN Ombuds staff about how they often feel either under-utilized or excluded in the civil commitment process involving consumers being evaluated for involuntary detention to a mental health facility. From interviews and surveys with consumers, NSRSN Quality Review Team (QRT) staff have heard that consumers are either dissatisfied with the content of their individual crisis plans, or do not know what their individual crisis plans are. Deficiencies in consumer crisis plans have also been noted in previous clinical record reviews by NSRSN Quality Specialists. Recent results from the State of Washington's Mental Health Division's (MHD) review of crisis plans for consumers verify this concern. Results indicate that these plans do not adequately represent consumer voice, are not sufficiently strength based, do not contain sequential progressive and preventative steps to address consumer health and safety issues, and do not appropriately utilize identified family and natural supports for the consumer.

MHD has requested that the NSMHA conduct a review of its Crisis System. The NSMHA Crisis System Review requested by the MHD will address issues raised by consumers. The Crisis System Review specifies the responsibilities of the NSMHA and crisis system providers regarding several areas, to include;

- Working with hospital staff, Care Crisis Line staff, crisis outreach staff and County Designated Mental Health Professionals (CDMHP's) to increase the amount of crisis services provided in the community, rather than in hospital Emergency Rooms
- Training crisis staff and CDMHP's as to the importance of including family members/natural supports when providing crisis services to consumers
- Documentation by crisis staff and CDMHP's of the inclusion of family members/natural supports in crisis planning, or, documentation as to why such inclusion was not appropriate, and
- Documentation that crisis staff and CDMHP's receive regular, on-going supervision to assist them in the provision of community based and family member/natural support inclusive crisis services.

As part of the Crisis System Review, a survey will be conducted at hospital Emergency Rooms throughout the region, when a consumer is seen for crisis services at the Emergency Room. The survey is designed to query who referred the consumer to the Emergency Room, what factors precluded the consumer from being seen in the community and whether the Emergency Room was the appropriate setting to have referred the consumer. Also a Utilization Management study regarding

where crisis services are conducted will be performed during the 4th Biennial Quarter 2002-2003 by NSRSN Quality management staff.

Coordination of Care/Intensity of Services concerns were expressed by consumers during the 3rd Biennial Quarter. Consumers reported that they were not always able to see either their case manager or their medication prescriber as often or as quickly as they felt they needed. They also expressed concern that their outpatient mental health services, case management and/or medication services, were being terminated or transferred before they, the consumers, felt they were ready for such a transfer/termination. Some consumers felt their cases were being "closed" by providers without the consumer's agreement or approval.

The Complaint, Grievance and Fair Hearing Report and the Ombuds Department Report received a number of complaints is the category "Quality and Appropriateness of Services". The previous Biennial Report identified that consumers in the region were concerned about the availability of services that addressed trauma and trauma related disorders. A workgroup of NSMHA, APN and provider staff was developed to address this issue. The group met on a regular basis during the 3rd Biennial Quarter. Its goal is to increase awareness and education about trauma and trauma related disorders.

Other activities/accomplishments of the trauma related disorders work group during the 3rd Biennial Quarter include:

- A review of the trauma services models currently being used in Maine and Oregon, with review of other state's models planned,
- The decision to use the Multinomah Quality of Life Scale (from Oregon), as a starting point for establishing benchmarks to evaluate trauma disorders
- A request to the Eli-Lilly Foundation for financial support to enhance trauma disorder services throughout the region,
- The receipt of $20, 000, in response to a pilot project grant request written by the Associated Provider Network (APN). A trauma specialist from Harborview Hospital in Seattle has been consulted and several trauma trainings have been attended by members of the NSMHA trauma disorder workgroup, and
- The evaluation of the Skagit Battered Women's House as a potential site for respite services for those with trauma based disorders.

NSMHA Quality Review Team Reports

During the 3rd Biennial Quarter, NSMHA QRT staff mailed out consumer satisfaction surveys to multiple sites throughout the region, including; Haven House, O'Leary House, Green House, Sun House and the Skagit Respite House. Surveys were also sent to primary care centers at the Everett Mall Way, the Smokey Point, Adult and Children, the Lynnwood and the Coupeville sites. Surveys have been returned to QRT and QRT staff are in the process of responding to the various sites. QRT staff will present a report on their projects and activities from the 3rd Biennial Quarter at an upcoming Quality Management Oversight Committee (QMOC) meeting.

Follow up to Quality Assurance issues identified in the 2nd Biennial Quarter 2002-2003 Integrated Report

Several areas were identified in the NSMHA 2nd Biennial Quarter 2002-2003 Integrated Report that needed follow up corrective action. This status report identifies what corrective actions have taken place to address the noted quality assurance deficiencies. The areas needing follow up corrective action were:

NSMHA Administrative Audit of The Associated Provider Network (APN)-

- NSMHA Quality Assurance follow up- NSMHA requested a Corrective Action Plan from APN that identifies how APN will develop and implement Policies and Procedures regarding the use of qualified professionals during critical treatment junctures. APN submitted their response and NSMHA staff are in the process of reviewing it.

NSMHA Administrative Audit of APN-

- NSMHA Quality Assurance follow up- NSMHA requested a Corrective Action Plan from APN that identifies how APN will develop and implement Policies and Procedures that describe how appropriate mental health services are provided to older adults with mental illness. APN submitted their response and NSMHA staff are in the process of reviewing it.

NSMHA Administrative Audit of APN- determined that APN does not currently have procedural mechanisms in place that allow the APN to adequately measure system capacity.

- NSMHA Corrective Action Plan strategy- During the 3rd Biennial Quarter, the NSMHA instituted a major revision of the Quality Management system throughout the North Sound region. The purpose of this system revision was to establish a region wide integrated quality management process. This revision established a NSMHA Regional Management Council, comprised of the NSMHA Executive Director, members of the APN Management Council and Chief Executive Officers of other direct service providers who contract with NSMHA, and a NSMHA Quality Management Committee, comprised of clinical, quality management, fiscal and information system staff from NSMHA and provider staff. The task of system capacity measurement will now become the responsibility of these two groups and will now longer be a task requested of the APN.

NSMHA Concurrent Review at Compass Health-

- NSMHA Quality Assurance follow up- The NSMHA Concurrent Review conducted during the 2nd Biennial Quarter 2002-2003 found that Compass Health did not meet the NSMHA expected 90% standard. The overall score for records reviewed was 83%. NSMHA and State of Washington Mental Health Division (MHD) staff conducted a re-review of clinical records at Compass Health in June 2003. The overall score for records reviewed was 93%. No further Quality Assurance follow up action by NSMHA is necessary at this time.

NSMHA Supervised Living Review-

- NSMHA Quality Assurance follow up- The NSMHA Supervised Living Review conducted during the 2nd Biennial Quarter 2002-2003 determined that documentation in the clinical records of consumers served by Compass-Skagit who resided at Ovenell's Group Home in Burlington was deficient and did not meet NSMHA documentation standards. NSMHA Quality Specialists conducted a re-review of the records of all Ovenell's residents receiving mental health services from Compass-Skagit during the 3rd Biennial Quarter 2002-2003. The score for this review was a 98%. No further Quality Assurance follow up action by NSMHA is necessary at this time.

NSMHA Quality Review Team (QRT)-

- NSMHA QRT staff conducted Consumer Satisfaction Surveys regarding Compass Health, Compass-Skagit, Whatcom Counseling and Psychiatric Clinic (WCPC) and the APN during the 2nd Biennial Quarter. Results of these surveys indicated significant consumer dissatisfaction in two (2) particular areas, eg.,
    1. Consumers report they do not understand their Crisis Plans and do not feel they are sufficiently involved in the formulation of these plans, and
    2. Consumers report they do not feel free to complain about being dissatisfied with services they receive from providers without fear of retaliation from providers.

- NSMHA Quality Assurance follow up- QRT staff requested Corrective Action Plans from Compass Health, Compass-Skagit, WCPC and the APN to address identified areas of consumer dissatisfaction. Also, QRT staff met with provider agency staff to strategize methods by which consumer's fear of retaliation may be reconciled and resolved. QRT staff reviewed the Corrective Action Plans and found them to be acceptable. No further Quality Assurance follow up action by NSMHA is necessary at this time. QRT staff will continue to monitor areas of consumer-expressed dissatisfaction.

ATTACHMENT A

D. Quality Assurance Grid- 3rd Biennial Quarter Integrated Report

Report Source	**Focus Area 1.1** Crisis system standards	**Focus Area 2.1** Access standards	**Focus Area 3.1** Critical treatment junctures	**Focus Area 4.1** Continuity of care	**Focus Area 5.1** Consumer, advocate, family voice	**Focus Area 6.1** Service capacity, utilization
Admin Audit Sea Mar				YES	YES	
Admin Audit WCPC				YES		
Admin Audit bridgeways					YES	
Admin Audit CCSNW					YES	YES
Clinical Review-CH				YES		
Clinical Review-WCPC				YES		
QRT Reports *****						
Ombuds Reports *****						
Complaint, Grievance and Fair Hearings *****						
Inpatient Episode of Care Review*****						
Residential Inpatient Clinical Review *****						

How To Interpret The Grid

A "**YES**" in a Focus Area column indicates that a Quality Assurance issue was noted for the Report Source being referenced in the particular Focus Area where the "**YES**" notation appears.

If a Report Source has no "**YES**" entries in any of the Focus Areas listed in the grid, this means that there were no Quality Assurance issues related to that Report Source during the 3rd BQ.

NOTE: A Quality Assurance issue is one for which there is a measurable and objective requirement identified in the NSRSN contract with regional mental health providers.

* No Quality Assurance issues with this Report Source were identified during the 3rd BQ.

3rd Biennial Quarter Integrated Report Quality Assurance Grid Addendum
Details to substantiate the "YES" answers in the QA grid

Administrative Audit- Sea Mar Community Health Center

- **YES** in Focus Area 4.1- Continuity of Care
  - Sea Mar has no Policy/Procedure regarding Initial/Continued Authorization of Services that addresses how Sea mar will ensure that the NSMHA Standards of care and Clinical Eligibility guidelines are implemented
- **YES** in Focus Area 5.1- Consumer, Advocate and Family Voice
  - Sea Mar has two separate policies for complaints and grievances. Neither of these are consistent with the NSMHA Complaint and Grievance Policy and need to be updated

Administrative Audit- Whatcom Counseling and Psychiatric Clinic (WCPC)

- **YES** in Focus Area 4.1- Continuity of Care
  - WCPC lacks policies and procedures regarding provision of resource management of community hospital care for consumers

Administrative Audit- *bridgeways*

- **YES** in Focus Area 5.1- Consumer, Advocate and Family Voice
  - *bridgeways* needs to incorporate consumer voice into structured *bridgeways* committees. Consumers, advocates and family members need to be included in *bridgeways* strategic and marketing planning, as well as in *bridgeways* quality management process

Administrative Audit- Catholic Community Services Northwest (CCSNW**)**

- **YES** in Focus Area 5.1- Consumer, Advocate and Family Voice
  - CCSNW needs to develop and implement a locally responsive delivery system by ensuring that consumers, advocates and family members are included in CCSNW's ongoing process of decision making and policy setting regarding service planning, implementation, operation and evaluation.

- **YES** in Focus Area 6.1- Service Capacity, Utilization
  - CCSNW needs to provide more complete documentation of its agency-wide quality management process to design, measure, assess and improve system performance throughout CCSNW.

Clinical Record Reviews

Whatcom Counseling and Psychiatric Clinic (WCPC)-

- **YES** in Focus Area 4.1- Continuity of Care
    - WCPC passed their clinical record review overall, but their Crisis Plans did not meet the NSMHA expected standard of 90% (76%)

Compass Health-

- **YES** in Focus Area 4.1- Continuity of Care
    - Compass Health passed their clinical record review overall, but their Crisis Plans did not meet the NSMHA expected standard of 90% (61%)

Trends identified and issues addressed during the 3rd Biennial Quarter 2002-2003

During the 3rd Biennial Quarter, two (2) significant issues related quality management throughout the North Sound region have been identified and addressed by NSMHA staff. These issues are;

1. The need for to conduct a comprehensive review of the North Sound public mental health system to clarify roles, responsibilities and possible duplication of services between NSMHA and APN, and
2. The need to address issues of concern and deficiency related to crisis services throughout the North Sound region

To follow up on issue #1, regarding mental health system roles and responsibilities, NSMHA has instituted the following actions and undertaken the following steps;

NSMHA Public Mental Health System Review- Numerous audits/surveys conducted in the past have identified consumer and stakeholder confusion as to the respective roles/responsibilities of NSMHA and APN. The most recent State of Washington's Mental Health Division's (MHD) Administrative and Medical Audit of NSMHA raised the concern of potential duplication/overlap of administrative and quality management functions between NSMHA and APN. To address these concerns, NSMHA initiated a System Review during the 3rd Biennial Quarter. The NSMHA Executive Director established a NSMHA Transition Committee, tasked with meeting the following objectives;

- Improve the quality management capabilities throughout the region by establishing a single, integrated model at the NSMHA, and
- Hold administrative costs to a minimum and maximize resources to direct consumer services

The NSMHA Transition Committee met several times and proposed an "NSMHA Integrated Quality Management Process". The process includes the establishment of two (2) groups charged with the implementation of region wide quality management. These two groups are;

- The NSMHA Regional Management Council, comprised of the NSMHA Executive Director, the APN Management Council and Chief Executive Officers (CEO's) of other North Sound direct service providers. This groups tasks include;
    - Formulating a concise legislative agenda for the NSMHA to pursue
    - Reviewing aggregate quality management system reports
    - Establishing representation on statewide and community work groups

- o System wide problem solving and dialogue, and
- o Dispute resolution

- The NSMHA Quality Management Committee, comprised of clinical, quality management, fiscal and information system staff from NSMHA and provider staff. This group is charged with the following tasks;

  - o To establish a joint, region wide quality management process
  - o To review aggregate system data
  - o To report recommendations based on system data to the NSMHA Quality Management Oversight Committee
  - o To develop regional Policies and Procedures regarding quality management activities
  - o To develop regional standards of care
  - o To identify regional program development and quality improvement activities
  - o To develop and oversee annual quality improvement performance indicators based on the State of Washington Mental Health Division (MHD) and the Center for Medicaid Services (CMS) guidelines
  - o To charter both standing committees as well as time limited quality management work groups, and
  - o To review and act on the reports/recommendations from these standing committees or work groups.

The proposed NSMHA Integrated Quality Management Process, as described above, was presented by the NSMHA Executive Director to the NSMHA Board of Directors, and approved by the Board, during the 3rd Biennial Quarter. An initial organizational and planning meeting between the Regional Management Council group and the Quality Management Committee group took place on May 30, 2003. The Quality Management Committee has begun twice monthly meetings to begin accomplishing their numerous tasks.

To follow up on issue #2, regarding concerns related to crisis system services throughout the North Sound region, NSMHA has instituted the following actions and undertaken the following steps;

NSMHA Crisis System Corrective Action Plan- This plan has been developed by NSMHA staff, in collaboration with Care Crisis Line staff, crisis outreach staff, County Designated Mental Health Professionals (CDMHP), and their supervisors. The plan is intended to address issues concerning place of emergency service provision and the involvement of consumer's family members and natural supports in the provision of these services. These issues have been raised by consumer complaints received at the NSMHA and the State of Washington's Mental Health Division. They have also been noted during NSMHA Administrative Audits

In response to the concerns related to Crisis System Services, NSMHA have implemented the Corrective Action Plan, which focuses on assuring the following:

- Crisis outreach services to consumer's homes, residential living facilities and community locations,

- Inclusion of family members, significant others and treatment providers to support people in crisis,
- The use of mobile stabilization services to provide in-home or in-community crisis stabilization services to consumers in their natural environment, and
- Provision of supervision and oversight to crisis stabilization staff

As part of the Crisis System Review, a survey will be conducted at hospital Emergency Rooms throughout the region that investigates how and why the consumer was referred to the Emergency Room for crisis services and to determine if the referral was appropriate, or if crisis services could/should have been provided in another setting.

NSMHA Quality Specialist (QS) staff will also be conducting a Focused Review of the region-wide crisis response system during the 4th Biennial Quarter 2002-2003. This review will focus on the four (4) key issues referenced above, and will also include data collection and analysis, as well as monthly chart reviews at crisis service provider sites. Ongoing review and quality improvement suggestions related to the provision of crisis system services throughout the region will be addressed in future NSMHA Integrated Reports.

Accomplishments of Note during the 3rd Biennial Quarter

Renewal of Coordinated Quality Improvement Program (CQIP) status for NSMHA-

- Application for renewal of the NSMHA's CQIP committee status was submitted to the State Department of Health during the 3rd Biennial Quarter. The Department of Health reviewed and accepted the NSMHA application.

A comprehensive review of the North Sound public mental health system -

- The System Review was conducted in response the State Mental Health Division's (MHD) Administrative and Medical Audit of the NSMHA. The System Review produced a NSMHA Integrated Quality Management Process, which includes a Regional Management Council and a Regional Quality Management Committee. Both groups have met and are in the process of implementing desired quality management process improvements.

Crisis Plan redesign-

- A group of providers and NSMHA staff met to redesign the consumer Crisis Plan document. The Crisis Plan is now much more specific and descriptive regarding early warning signs of crisis. It also details sequential steps the consumer can take to avoid and/or minimize the impact of a crisis.

Crisis System Review/Corrective Action-

- NSMHA staff have designed and implemented a Corrective Action Plan pertaining to crisis system services throughout the region. The Corrective Action Plan is in response to findings related to the State Mental Health Division's (MHD) review of crisis services. The plan focuses on providing crisis services in the consumer's home, residential living facility or other community location, rather than in hospital Emergency Rooms. Also, the plan promotes the inclusion/involvement of family members, significant others and/or treatment providers in crisis planning/stabilization for the consumer.

Clinical record documentation-

- All provider agencies that had previously not met the 90% standard for documentation in the consumer's clinical record have met or exceeded the 90% standard upon re-review. All providers throughout the region are now meeting clinical record documentation standards.

Representation changes on the NSMHA Quality Management Oversight Committee (QMOC)-

- Some current members of the NSMHA QMOC are also now serving on the Regional Quality Management Committee. Because the Regional QM Committee will be forwarding recommendations to QMOC that QMOC will need to vote on, members serving on both committees simultaneously would constitute a conflict of interest. Therefore, current NSMHA staff that are voting members on the regional QM committee will no longer serve on QMOC. Also, QMOC membership will be expanded to include more consumers and more County coordinators.

Internal review/redesign of NSMHA Quality Management Dept

- NSMHA Quality Specialist (QS) staff participated in a three month Time Study of current QS duties and responsibilities. The review focused on the expectations of QS staff in the new region-wide quality management process. Resultant changes in QS duties will include less direct service and resource management activities, and an increased focus on system measurement and utilization management activities on behalf of the NSMHA.

Please refer any questions regarding this Integrated Report to:

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NSMHA COMMITTEE DISCUSSION FORM

AGENDA ITEM: QMOC sub-committee Review of QMOC charter and structure

PRESENTER: Andy Byrne

COMMITTEE ACTION: Action Item (x) FYI & Discussion ( ) FYI only ( )

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:
By request of QMOC a sub-committee consisting of Andy Byrne, Mary Good, Chuck Benjamin, Sharri Dempsey and Wendy Klamp has met to review the current charter and membership, in light of the recent NSMHA system redesign.

CONCLUSIONS/RECOMMENDATIONS:
This QMOC sub-committee recommends that QMOC approve the committee's recommendations and accept the charter as revised, including changes to membership to reflect increased involvement and representation for consumers and advocates.

TIMELINES:
Changes to be effective 1-1-04 as part of the 2004-2005 Quality Management Plan

ATTACHMENTS: QMOC Charter
Sub-committee recommendations

NSMHA COMMITTEE DISCUSSION FORM

AGENDA ITEM: Inpatient Episodes of Care

PRESENTER: Gary Williams

COMMITTEE ACTION: Action Item ( ) FYI & Discussion ( ) FYI only (x)

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:

- ✓ This is the second NSMHA review of inpatient episodes of care
- ✓ The review was conducted consistent with the model used in the first review that took place two years ago
- ✓ NSMHA Staff reviewed outpatient records 30 days prior to, during and 30 days following an inpatient episode
- ✓ The tool utilized by NSMHA Reviewers was modified during the second review to be referenced to specific WACs and contractual requirements

CONCLUSIONS/RECOMMENDATIONS:

- ✓ Data generated from these reviews was consistent between the two review periods
- ✓ Review identifies numerous areas for quality improvement
- ✓ As a result of both NSMHA and the providers concerns regarding inpatient utilization it is our hope that this data will be used to evaluate opportunities for hospital diversion, better risk management, and more positive consumer outcomes.

TIMELINES:

- ✓ Ongoing process with APN and the providers that connects with the current NSMHA corrective actions regarding emergency services and the implementation of Raintree.

ATTACHMENTS:

- ✓ Episodes of Care Review

Executive Summary
Inpatient Episode of Care Review Report
Second Biennial Quarter 2002

Introduction

This was the second NSMHA review of outpatient records of consumers admitted to an episode of inpatient care. Charts for this review were drawn in a random selection from the period August 1, 2002 to September 30, 2002. The Inpatient Episode Reviews were conducted at three APN provider agencies (Whatcom Counseling and Psychiatric Clinic, Compass Health, and Community Mental Health) between December 9, 2002 and December 19, 2002. The review was conducted in accordance with the schedule detailed in the NSMHA Quality Management Plan 2002-2003, Work Plan section.

NSMHA Quality Specialists, Terry McDonough and Gary Williams, conducted this review of 36 clinical records.

Purpose

The Inpatient Episode of Care review is intended to be a means to evaluate the quality of consumer's outpatient care before, during, and after an inpatient episode. Reviewers were looking at the use of Crisis Plans, efforts of outpatient staff to identify and act in a proactive manner to reduce or eliminate the need for inpatient care, titration of services and supports, risk assessment, care management, and continuity of care.

Strengths

Crisis Plans were present in 97% of charts reviewed. Records showed increased inclusion of consumer voice; and Crisis Plans being proactive and preventative improved from 62% in the last review to 77% in the 2002 review.

Areas of Concern

Overall review scores showed little change between the 2000 and the 2002 review.

Of note is the high rate of re-hospitalization in 13 out of 36 cases reviewed. There were few cases reviewed where intensive case management was used to augment regular case management services or where services were increased to daily or several times a week contacts.

Recommendations

This review was intended as a first step in understanding how our outpatient mental health services and inpatient mental health services interrelate. Because of the high cost of inpatient treatment we are interested in exploring what aspects of outpatient intervention may assist in preventing or reducing hospital stays. We also wish to determine whether crisis plans are effective tools to reduce hospitalization. Also of interest are the impact of the involvement of outpatient treatment providers in discharge planning and subsequent continuity of care in reducing or eliminating re-admission. We now have two similar reviews which raise troubling concerns. We will include some aspects of this review in our Crisis Review scheduled for the 4th Biennial Quarter, and will also involve all providers in the development of plans for an expanded review of this area.

Introduction

This was the second NSMHA focused review of outpatient records of consumers admitted to an episode of inpatient care. The review was conducted in accordance with the schedule detailed in the NSMHA Quality Management Plan 2002-2003, Work Plan section.

The Inpatient Episode of Care review is intended to serve as a means to evaluate the quality of consumers' outpatient care before, during and after an inpatient episode to evaluate use of crisis plans, efforts by outpatient staff to identify the potential need for inpatient care and provide services in such a manner as to reduce or avoid hospitalization, titration of services and supports, risk assessment and management, and continuity of care.

The NSMHA Inpatient Episode of Care Review is intended to assess three areas of clinical services provided:

- Thirty days prior to the inpatient admission
- During the inpatient stay
- Thirty days following the inpatient period

Methodology

Gary Williams, Quality Specialist designed the tool and led the review which was conducted by himself and Terry McDonough in December 2002. 36 adult records of NSMHA enrolled consumers were selected at random from Compass Health, Community Mental Health Services (now Compass-Skagit) and Whatcom Counseling and Psychiatric Clinic. These providers were chosen because of their volume of outpatient adult treatment services. Records selected were from a period from August 1, 2002 to September 30, 2002. All records selected had at least one episode of inpatient treatment during this period of time.

The format and tool are similar to those used in the previous review, which was conducted in August 2000. All questions represent NSMHA contract, Standard of Care or WAC requirements. The operational definition for re-hospitalization was admission within thirty days or less from the date of inpatient discharge. Scoring was either on a YES/NO/NA basis or a 1-5 scale with zero representing no required documentation present and 5 representing best practice. (See attached tool.)

Results from each of three phases of the review are presented. All results represent a combined score from the three providers surveyed.

Section 1 Outpatient Pre Hospital Period

This is a review of the outpatient records for the period of 30 days prior to the inpatient episode including the intake assessment, most recent crisis plan and individualized treatment plan and progress notes in the chart.

Pre-Hospital Period		2000	2002
1.	Crisis Plan present in the chart	Yes 71%	Yes 97%
2.	Crisis Plan Proactive & Preventative	Yes 62% No 48%	Yes 77% No 23%
3.	Risk Management concerns identified	NC	2.3
4.	Past crisis history identified in the Crisis Plan	Yes 41% No 69%	Yes 67% No 22% N/A 11%
5.	Past hospitalizations and locations on Crisis Plans	Yes 12% No 88%	Yes 50% No 39%
6.	Crisis Plan clear and specific	NC	2.1
7.	Documentation of known risk factors	Yes 71% No 29%	Yes 72% No 28%
8.	Appropriate response to known risk factors	Yes 59% No 41%	Yes 63% No 33% N/A 4%
9.	Intensity of medication monitoring reflects individual need.	NC	2.38
10.	Documentation of titration of services and supports	NC	2.27
11.	Documentation that services provided in an appropriate location and frequency	Yes 56% No 26%	Yes 56% No 42%

(NC) Questions <u>not comparable</u> between reviews

Case Plans:
Crisis Plans are now found in almost all of the cases (97%) being reviewed. Reviewers have concerns as to the use of Crisis Plans to identify risk factors and opportunities for the consumer to use identified strengths and personal coping strategies.

The reviewer's assessment of 77% the Crisis Plans found they increasingly included some proactive and preventative language.

The more detailed review of this question regarding the quality of documentation regarding risk management (2.3) and being clear and specific (2.1) regarding who, what, and when were below minimum standard to be considered useful.

We are hopeful that efforts by the Associated Provider Network providers and Volunteers of America to improve the Crisis Plan form will address many of the shortcomings noted in the Crisis Plans. Also, improvements in use have been reportedly addressed in through the Raintree IS system.

Outpatient Treatment Notes:
A lack of response to identified risk factors was found in 33% of the cases reviewed and the intensity of medication monitoring (2.38) and titration of support (2.27) in all cases.

In many cases where the consumers were known to have a history of numerous hospitalizations, contact with the consumer decreased in the 30 days prior to the hospital admission. Chart notes indicate no shows, cancellations, and appointments being rescheduled weeks later in response to consumers missing appointments. In some cases, there were calls from the community expressing concern about the consumers, which were documented in the outpatient record without a corresponding clinical response. In almost all of these cases consumers were given facility-based appointments; there were no additional services offered, and rarely was an outreach offered or attempted.

Section 2 Inpatient Hospital Period

Inpatient Period		2000	2002
1.	**Documentation of contact with inpatient facility staff**	**Yes 61% No 49%**	**Yes 81% No 19%**
2.	**Documentation of outpatient staff having contact with the patient**	**Yes 62% No 48%**	**Yes 56% No 28% N/A 17%**
3.	**Documentation in the outpatient record of coordination with the inpatient staff for treatment and discharge planning**	**NC**	**Yes 78% No 22%**

(NC) Questions not comparable between reviews

Documented contact between outpatient and inpatient staff has greatly improved between 2000 and 2002. In 81% of the cases reviewed, there was some documentation of contact between the outpatient staff and the inpatient facility staff. There was a slight decrease in outpatient staff having contact with their consumer once hospitalized. The outpatient progress notes did not always document consumer's inpatient admission.

There was no documentation of contact between the case manager and inpatient staff after 3 days, then weekly in 38% of the records reviewed.

The review of the outpatient records did not document pre discharge coordination in 22% of the cases reviewed.

Outpatient records frequently documented discharge with only a post discharge appointment being scheduled.

Coordination between inpatient staff and outpatient staff for enrolled consumers is almost totally limited to phone calls. There is little documentation of collaborative discharge planning other than appointments being set for community follow up.

Section 3 Outpatient Post Hospital Period

This is a review of the outpatient records for the period of 30 days after the inpatient episode including the intake assessment, most recent crisis plan and individualized treatment plan and progress notes in the chart.

Post-Hospital Period		2000	2002
1.	Individual Treatment Plan and or Crisis Plan modified after discharge	Yes 32%	Yes 36%
2.	Documentation that services and or supports were reviewed and/or modified	Yes 62% No 21%	Yes 56% No 23%
3.	Consumer seen with in seven days	65%(5d)	72%(7d)
4.	Re-hospitalized within 30days of discharge	Yes 12% No 68% N/A 7%	Yes 36% No 22% N/A 11%
5.	Post hospital medication appointment	N/C	N/C
6.	Copy of Inpatient records in Outpatient file	Yes 76%	Yes 72%
7.	Hospitalization may have been preventable	Yes 29%	Yes 30%
8.	Prevention cause code	N/C	N/C

(NC) Questions not comparable between reviews

Slightly over a third of the cases reviewed showed the Crisis Plans and Individual Treatment plans being modified and or evidence that there was a review of the documents. Documentation of titration of services and/or supports decreased.

Of some concern to the reviewers was that in the event of no shows for the first post hospital appointment, consumers were either rescheduled (sometimes a week or more later) or a chart note simply documented the no show without further comment or review. In some cases this extended the

first face to face for several weeks. Only 64% of consumers on medications were seen for their first follow-up outpatient medication appointment within 14 days. While consumers sometimes initiated cancellations, rescheduling tended to be non-urgent and appointments given a week or more later.

There was a high re-hospitalization rate (37%) for the cases reviewed. The previous review was within 12 to 18%.

Summary:

In light of increasing inpatient utilization and capacity concerns, the issues raised in this review are troubling. This review found clinical concerns similar to those reported in the 2000 NSMHA Inpatient Episode Review. There were several positive changes, such as Crisis Plans in almost all charts reviewed (97%) increased inclusion of consumer voice; and Crisis Plans being proactive and preventative improved from 62% to 77% in the 2002 review. Unfortunately, the overall review scores showed little change.

There were cases reviewed, which documented exemplary care titration and use of diversionary resources. These cases also documented increase use of consultation with crisis and medical staff. While these consumers ultimately required inpatient care, it was clear that extensive preventative efforts occurred.

Also of note is the high rate of re-hospitalization. There were few cases reviewed where there was intensive case management that occurred daily or even several times a week. While almost all Crisis Plans reviewed included the statement "call case manager" there was not a single case where the CM was the first person contacted by the consumer. The reviewers wondered if this was a documentation issue or a result of increased use of provider voice mails, consumer choice, or some other factor not identified.

Outpatient ITP's reviewed tended to be static documents, which once created, were not modified to reflect additional information and assessments available from inpatient practitioners and other records. Some Individual Treatment Plans reviewed were up to five years old without any or significant modification. Some of these consumers with the aforementioned ITP's had been hospitalized numerous times during this period. This finding has been corroborated in recent Outpatient Record Reviews.

There were several records, which included excellent current evaluations and recommendations by inpatient, outpatient, and medical and/or crisis staff, which were not reflected in the outpatient treatment or Crisis Plan modifications

The post hospital period chart review documented an overall lack of emphasis on using the inpatient episode as an opportunity to review and revise the consumer's treatment plan. There was little or no documentation of direct dialogues between consumers and clinicians regarding the inpatient episode. It was the impression of the reviewers that up to one third of the hospitalizations might have been prevented.

There was limited documentation of case managers seeking assistance and consultation from medical staff, supervisors, and/or from the Intensive Crisis Response Staff. Crisis Alert were used in a limited number of cases reviewed.

NSRSN Inpatient Episode of care review Tool

Key Review Questions to be Addressed:

- What array of services was provided to the (enrolled) consumer both 30 days prior to the hospital episode of care, as well as 30 days following discharge from the hospital?
- Was the appropriate and necessary documentation evident in the consumer's outpatient chart, which describes events leading up to, including and after the hospitalization? (Evidence of coordinated discharge process including availability of hospital records in the outpatient record.)
- Was the appropriate and necessary documentation evident in the consumer's chart, which describes the plan for assisting the consumer after their discharge from the hospital?
- Was clinically appropriate continuity of care maintained throughout this episode of care by the primary care providers?

SECTION I
Outpatient -Pre Hospitalization Period (30 days prior to admission)

Standard	Compliance	Justification
There is a Crisis Plan in the Chart	Yes No	North Sound APN/Sea Mar Contract 02-03 P14 3 h/ SOC P6
The Crisis Plan is pro-active and preventive	Yes No	North Sound APN/Sea Mar Contract 02-03 SOC P6
Risk management issues identified in the clinical record (e.g. intake, IP, CP, progress notes, medical notes) are addressed in the crisis plan.	O through *5*	North Sound APN/Sea Mar Contract 02-03 SOC P6 P8
Past suicide attempts. incidents of self harm, parasuicidal behavior, and suicidal Ideation/preoccupation / Past incidents of violence and br threats to others and or property are listed in the crisis plan	Yes No	North Sound APN/Sea Mar Contract 02-03 SOC P6 P8
Past hospitalization dates and locations are identified on the crisis plan	Yes No	North Sound APN/Sea Mar Contract 02-03 SOC P6 P8
The crisis plan is clear and specific re: who will do what when a crisis	O through *5*	North Sound APN/Sea Mar Contract 02-03 SOC P6
Does the clinical record document awareness of known risk factors, which are occurring prior to the hospitalization?	Yes No	North Sound APN/Sea Mar Contract 02-03 SOC P6
Is there an appropriate and effective response to address the risk factors identified?	Yes No	North Sound APN/Sea Mar Contract 02-03 SOC P6 P13

Intensity of medication monitoring reflects individual need.	O through *5*	North Sound APN/Sea Mar Contract 02-03 SOC P6 P13
. Titration of mental health services and supports occur to meet the individual's level of need, and to encourage the outcomes identified on the IP/CP and CP reviews Summaries.	O through *5*	North Sound APN/Sea Mar Contract 02-03 SOC P6 P13
Are Mental Health services scheduled with appropriate frequency and at a location appropriate to support monitoring of known risk factors	Yes No	North Sound APN/Sea Mar Contract 02-03 SOC P6 P13

SECTION II
Hospitalization Period

Standard	Compliance	Justification
Documentation in the Outpatient record of agency staff contact with the E&T within three working days of admission.	Yes No	North Sound APN/Sea Mar Contract 02-03 P19 J
Documentation in the Outpatient record of agency staff contact with the consumer while hospitalized for inpatient stays exceeding five (5) days.	Yes No	North Sound APN/Sea Mar Contract 02-03 P19 J
Documentation in the Outpatient record of coordination of care between the outpatient staff and appropriate inpatient staff to develop coordinated discharge plan	Yes No	North Sound APN/Sea Mar Contract 02-03 P19 J SOC 13

Section III
Post Hospitalization Period (30 days post discharge)

Standard	Compliance	Justification
Were the consumer's treatment plan, crisis plan and discharge plan appropriately modified to address issues identified by/during the hospitalization episode of care?	Yes No	North Sound APN/Sea Mar Contract 02-03 P19 J /SOC P6 P13
Documentation that service array and intensity were actually increased and or modified, based on medical necessity	Yes No	North Sound APN/Sea Mar Contract 02-03 P19 J SOC 13
Were the consumer's treatment plan, crisis plan and discharge plan appropriately modified to address issues identified by/during the hospitalization episode of care?	Yes No	North Sound APN/Sea Mar Contract 02-03 P19 J SOC13

Was the consumer seen face to face (other than crisis services) within seven days of their release from the hospital (or E&T facility)	Yes No	North Sound APN/Sea Mar Contract 02-03 P15 d-4
Was the consumer re-hospitalized within 30 days of their discharge from inpatient care.	Yes No	North Sound APN/Sea Mar Contract 02-03 Quality Improvement
Was the consumer seen for an outpatient medication evaluation within two weeks of their discharge from the hospital. (if medications were prescribed)	Yes No	North Sound APN/Sea Mar Contract 02-03 P19 J
Are there copies of appropriate hospital records in the clinical file to document coordination of care (history & physical, discharge summaries)	Yes No	North Sound APN/Sea Mar Contract 02-03 P19 J
Could the hospitalization have been prevented?	Yes No	North Sound APN/Sea Mar Contract 02-03 Quality Improvement
If you answered question #20 yes, please select (a) better outpatient care, amount and type (b) better use of hospital diversion services (c) lack of staff expertise in managing a acute care issues (d) involvement by other formal systems (Sub/Abuse ,DDD et.) (e) other	N/A a. b. c. d. e.	North Sound APN/Sea Mar Contract 02-03 Quality Improvement

0 No documentation
1 Mentioned in documentation without clinical value
2 Mentioned in documentation with minimal clinical value
3 Minimum Standard
4 Above Standard
5 Best Practice

NSRSN Clinical Review Rating Standards

The clinical review is based on the written documentation in the clinical record. If documentation for the standard being reviewed cannot be located in the chart, the assumption is that the standard was not met.

Explanation of rating criteria: This rating criteria is designed to give a common basis for judging clinical practices in the concurrent review process, and to be a guide for clinicians and supervisors for the best practice expectations of the NSRSN. Questions are rated either yes/ no/NA or on a 0-5 scale. Rating levels 4 and 5 assume that the standards of level 3 are met. A level 5 rating is the NSRSN's current description of the best practice. Clinical examples are in italics to illustrate examples. Below is a general explanation of the Yes/No/NA categories and the 0-5 scale:

Yes Means that the information can be located in the appropriate location in the clinical record and the documentation is in substantial agreement with the issue being evaluated.

No Means that the information is missing or incomplete; or can not be located in the appropriate location in the clinical record; or there is a deficiency in the documentation of the issue being evaluated; or there is an actual clinical deficiency in the handling of the issue being substantial enough that it can not be marked "Yes".

NA The question is not applicable because the issue or circumstance has not arisen in the case. (i.e. An individual is a level I consumer so the treatment requirements of a level II or level III consumer are not applicable. A person is not being medicated so there is no coordination of medical services. An individual is an adult so the specific issues evaluated for children are not applicable.

0. Missing/blank/cannot be located.

1. Inadequate; little awareness of consumer needs; little awareness of issues; little understanding of intended goals (i.e., little awareness of State and NSRSN standards for quality service).

2. Some awareness of consumer needs and/or issues; some understanding of intended goals (i.e., some awareness of State and NSRSN standards for quality service); vague; narrow; rigid; categorical thinking, planning, and action; programmatic conception of services (i.e., needs are identified in terms of program availability); minimal flexibility.

3. Adequate; individualized care planning; some flexibility of services; awareness of intended goals (i.e., plan reflects basic understanding of State and NSRSN standards for quality service); meets minimum standards of care (NSRSN Level of Care, WAC).

4. Reflects good understanding of individual's/child's/family's needs/issues, and good effort has been made to put that understanding to work; creative; good efforts to integrate services; individualized care that is timely and responsive to changing needs of the consumer, and reflects their preferences; reflects "big picture" thinking, and goes beyond State and NSRSN standards of care.

5. Best practice; comprehensive; reflects depth of understanding; fully integrated; team functions as a team, not in name only; sharp, focused planning; maximum flexibility; original; unique; exceptional; dynamic care planning that allows for immediate, flexible response to changing needs of the consumer; has the flavor of "WOW".

NSMHA COMMITTEE DISCUSSION FORM

AGENDA ITEM: E&T Reviews

PRESENTER: Gary Williams

COMMITTEE ACTION: Action Item ( ) FYI & Discussion (x) FYI only ( )

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:

- ✓ This is the first site review of our two E&Ts
- ✓ The review was done based on current WAC and Contract Requirements

CONCLUSIONS/RECOMMENDATIONS:

- ✓ There will be a follow up on a couple areas of concern; discharge follow up and informed consent on medications and objective suicide assessment process
- ✓ Overall, the review team found both E&Ts to be compliant with current rules and regulations

TIMELINES:

- ✓ Within 45 days the facilities will be revisited

ATTACHMENTS:

- ✓ The report was handed out at the June meeting and will be available at the August meeting.

QUALITY MANAGEMENT OVERSIGHT COMMITTEE
MEETING EVALUATION FORM

Please complete this form and turn it in at the end of the meeting to the secretary.

1. Receipt of Information:
   A. Was information received in a timely manner?

1	2	3	4	5
Does not meet expectation		Meets expectation		Exceeds expectation

   B. Overall, did you receive enough information to make informed decisions?

1	2	3	4	5
Does not meet expectation		Meets expectation		Exceeds expectation

   C. Was information sent to the appropriate place?

1	2	3	4	5
Does not meet expectation		Meets expectation		Exceeds expectation

   D. Did we use the appropriate method? (Fax, mail, etc.)

1	2	3	4	5
Does not meet expectation		Meets expectation		Exceeds expectation

2. Meeting Logistics:
   A. Are meeting times convenient for you? ___Yes ___No
   B. In order of priority (1, 2, 3) would you rather meet
      ____morning or _____afternoon or _____evening?

   C. Are meeting places convenient for you?

1	2	3	4	5
Does not meet expectation		Meets expectation		Exceeds expectation

3. Are meeting agendas complete and understandable?

1	2	3	4	5
Does not meet expectation		Meets expectation		Exceeds expectation

4. Are meetings conducted in such a way to allow you to speak and participate with a sense of safety and comfort?

1	2	3	4	5
Does not meet expectation		Meets expectation		Exceeds expectation

5. Are there any special accommodations you need that would be helpful to you? If so, what are they?

- ❑ Yes
- ❑ No

Please provide any additional comments you may have.

Total Score_____

Meeting Date: 08/20/03 Name (optional)_____