NORTH SOUND
MENTAL HEALTH ADMINISTRATION

QUALITY MANAGEMENT OVERSIGHT COMMITTEE

COMMITTEE MEETING PACKET

October 26, 2005

QMOC GUIDING PRINCIPLES

The QMOC charge is to guide the quality assurance and quality improvement activities of mental health services within the NSMHA 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

October 26th, 2005
NORTH SOUND MENTAL HEALTH ADMINISTRATION
QUALITY MANAGEMENT OVERSIGHT COMMITTEE AGENDA

Date: October 26, 2005
Time: 12:30 PM-2:30 PM
Location: NSMHA Conference Room
For Information Contact Meeting Facilitator Wendy Klamp, NSMHA, 360-416-7013

Topic	Objective	ACTION NEEDED	Discussion Leader/ Speakers to Issue	Handout available pre-mtg	Handout available at mtg	Page # in packet	Time Allotted
Introductions	Welcome guests, presenters and new members						5 minutes
Review and Approval of Agenda	Ensure agenda is complete and accurate, determine if any adjustments to time estimates are needed. Meeting will start and end on time.	Approve agenda		Agenda		1	5 minutes
Review and Approval of Minutes of Previous Meeting	Ensure minutes are complete and accurate	Approve minutes		Minutes		3	5 minutes
Announcements	Inform QMOC of news, events and other important items		All				5 minutes
Utilization Management Dashboard	Standing Agenda Item for monthly review	Review trends, NSMHA priorities	TERRY MCDONOUGH		Dashboard		10 minutes
Quality Management Department Report	Standing Agenda Item for Monthly Review	Review accomplishments, data and plans of department	WENDY KLAMP	QM Dept. Report		6	5 minutes
Training-MHD Request for Qualifications	Educate QMOC as to RFQ process, implications for Quality Management		WENDY KLAMP				15 minutes

Topic	Objective	ACTION NEEDED	Discussion Leader/ Speakers to Issue	Handout available pre-mtg	Handout available at mtg	Page # in packet	Time Allotted
Ombuds report	Six month Ombuds complaint and grievance data	Review report and determine whether any quality improvement action is needed	Chuck Davis	Ombuds Report		10	10 minutes
Performance Improvement Project - Restraint and Seclusion at the Freestanding E & T's	Review PIP	Approve adding this as PIP #4	Wendy Klamp	Performance Improvement Project - Restraint and Seclusion at the Freestanding E & T's		19	10 minutes
QM Plan work group update	Inform committee of status of plan development	Review	Terry McDonough		QM plan to date		10 minutes
Complaint, Grievance, Appeal, Fair Hearing policies	Revision of policies is needed due to contract and RFQ	Approve policies	Diana Striplin		Policy drafts		20 minutes
Trauma Work group	Review work group's recommendations and QMC feedback and plan as how to proceed	Approve plan	Terry	Trauma Work Group recommendations		24	10 minutes
Date and Agenda for Next Meeting	Ensure meeting date, time and agenda are planned.		ALL				5 minutes
*Review of Meeting	Were objectives accomplished? How could this meeting be improved?		ALL				5 minutes

Next meeting November 23, 2005

North Sound Mental Health Administration
Quality Management Oversight Committee
NSMHA Conference Room
September 28, 2005
12:30 – 2:30
DRAFT MINUTES

Present:
Gary Williams, QMOC Chair, Board of Directors, Human Services Supervisor, Whatcom County
Mary Good, NSMHA Advisory Board
Wendy Klamp, NSMHA Quality Manager
Terry Clark, Compass Health
Russ Hardison, Sea Mar
Dan Bilson, NSMHA Advisory Board
Joan Dudley, Lake Whatcom Center
Terry McDonough, Snohomish County Mental Health ITA

Not Present:
Maile Acoba, Skagit County Coordinator
Nancy Jones, Snohomish County
Janet Lutz-Smith, Whatcom County Advisory Board
Linda Carlson, Volunteers of America
Janelle Sgrignoli, Snohomish County Human Services
Karen Kipling, Volunteers of America
Patricia Little, NSMHA Advisory Board
Preston Hess, Snohomish County

Excused:
Joan Lubbe, NSMHA Advisory Board
June LaMarr, The Tulalip Tribes
Deborah Moskowitz, Skagit County Human Services

Others Present:
Greg Long
Margaret Rojas
Diana Striplin
Shannon Solar

1. Open the meeting & comments from the Chair

Gary Williams opened the meeting at 12:35 pm and introductions were made.

Margaret announced that posters were in and encouraged all to take posters with them after the meeting.

Gary noted that the QMOC charter statement was changed to reflect that participants who are not able to attend must let NSMHA staff know prior to the meeting, otherwise they will be listed as un-excused. This is due to the fact that increased policy and procedures will be coming through QMOC and regular attendance is required.

2. Approval of July 2005 Minutes

(*August meeting was cancelled*). The committee reviewed the July meeting minutes. Diana asked that the fourth recommendation under the Exhibit P section of the minutes be added, stating that this committee will be a source of quality improvement processes. A motion was made to approve the minutes as amended, seconded, motion carried.

3. Reports

A. Quality Management Department Report

Wendy announced that NSMHA has hired a new Quality Specialist – Julie De Losada, who previously worked on Inpatient Certification at Compass Health. She will be starting on October 5th.

Wendy stated that the RSN has sent EQRO required materials from a desk audit and now another desk audit of performance improvement projects has been received, noting that it takes a lot of time to respond to those requests for information.

A Disaster Behavioral Health training was held at the RSN on September 22nd. Diana Striplin is the NSMHA disaster representative to the State.

Wendy noted that RSN staff have been looking at contracts, trying to revise complaint, grievance, appeal, fair hearing, and critical incident policies to accord with state requirements.

Greg has completed NSMHA 2006-2009 Strategic Plan draft to go to the BOD.

Greg stated that the RFQ from the State regarding if the RSN wants to be an RSN anymore will be out by the end of the week. Gary noted the importance of the RFQ- as it will influence whether public mental health stays the same or if for-profit PHP replace RSN's. Mary Good asked if the state wanted to get rid of the RSN, and why. Gary noted that some legislators believe that the RSN's are expensive and ineffective and would be better replaced by organizations such as Molina.

Training – Quality Management Requirements in the new MHD contract

Wendy reviewed the quality management requirements for the PIHP contract. (see attachment). The RSN is continuing both PIP projects on consumer satisfaction and participation in treatment planning and improvement of data submitted to MHD. A third PIP to begin is on the mortality review and there will possibly be a fourth on Compass E&T looking at reducing injuries and incidents. EQRO wants the process to be very formalized with strict protocol and record-keeping. Dan asked if the provision of providing contacts to MHD is relative to timely notification from the client. Some committee discussion followed. Diana noted that this committee as a region's process of walking through access to services is an area to be examined.

B. Utilization Management Dashboard

Terry distributed the dashboard with numbered columns as per committee request. Greg noted that WSH is at 104, community hospitals are currently full, and there is a current risk of liquidated damages. Gary suggested adding RSN cap after the WSH (column 9). Terry will make the request to Michael. Terry noted that VOA statistics were skewed and he has spoken to Michael and this should be corrected next month. Gary asked if Access staff feels automated process reflect proper number of calls, and Terry noted that calls from people who are already in service calls are being pulled out and routed out to other offices, so not many referrals are coming back. Gary thanked Terry for adding the average column. Gary asked about correct procedure for calls from out of state (does the current VOA and Access 800 number work from out of state?). Terry will check whether the 1-888 Access line works out of state, and Wendy will check regarding the VOA number.

C. Update on Quality Management Plan Development

Terry noted that the RSN is in the process of developing the 2006-2007 QM plan. Three meetings are scheduled, the first was held in August, second today form 3-5 upstairs at Rehabco and the third meeting will be held Monday October 31st. Gary asked that when a final draft is ready, it be e-mailed to the QMOC committee. Gary would like the QM plan to be on the agenda to keep the correlation between QMOC and QM activities.

D. Utilization Review Recent Issues

Wendy passed out a handout on Utilization Reviews. Three types of reviews are done – initial reviews, concurrent reviews, high-utilization reviews. Some committee discussion followed. UR information is shared with providers at the UM subcommittee, and is also shared individually. Wendy noted she has asked Dennis to add a column to the table that would automatically calculate percentages, then shade those under a certain number. Greg asked if Wendy would send to MHD. Gary noted that this information is important because it establishes the UR process.

E. Update on Access

Terry Clark presented on what people calling the access line should bring to their initial assessment. There are three categories:

1- Children in foster care – Access clinicians need records sent ahead, or the person with most knowledge of the child should come in with the child.
2- Transfers between APN agencies – in these cases more information is available from other sources.
3- Anyone accessing care for the first time or after a lengthy break in care - APN access staff need to gather enough info about whether it is truly a request for mental health services and then where the assessment needs to take place.

Many agencies don't have assessment schedulers. Gary suggested sending something in the mail stating what the person scheduled for an assessment what is needed for them to bring as well as written directions. Terry noted want to cut down the amount of time spent on the call. Terry will take the suggestion back with her. Wendy suggested taking the suggestion to QMC to discuss with the providers. Joan noted that all want to make the procedure as fast as possible. Greg noted that we want to make a system improvement process in this committee.

F. QRT Plan

Greg reviewed Deborah's QRT plan as she was at training. Joan noted that she called Deborah and complimented her on the plan because it feels more collaborative and keyed toward improvements, not looking for negative aspects. Greg noted that Deborah is hoping to engender volunteers from advisory board/consumers to do some site reviews. Gary asked that Greg put the QRT on the next county coordinators agenda.

G. Six Month Critical Incident Report

Wendy stood in for Debra and reviewed the semi-annual critical incident report from January-June 2005. Noted that there are two categories of MHD-reportable incidents, those media-related, and non media-related. Wendy noted that a death occurred at the Compass E&T of an individual in restraints. Some discussion followed. Gary asked if the report could be handed back at the end of the meeting as it contains information not released outside of this meeting.

4. Other Business

None at this time.

A. Meeting Evaluations

Gary reviewed the evaluation results from the July meeting.

5. Adjourn

Chair adjourned the meeting at 2:40 pm. The next QMOC meeting is scheduled for October 26th, 2005, 12:30-2:30 pm.

Respectfully submitted,

Shannon Solar

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 if you have any questions, comments, or concerns.

Quality Management

Department Report September 2005

Achievements of Note: EQRO PIP Response
Completion of Strategic Plan
Transition of Inpatient Certification to VOA
Hire of new FTE

NMSHA Meetings

Facilitated	Attended
Quality Management Plan meeting-Terry	UM internal meetings-**Diana, Terry, Debra and Sandy**
CIRC - Debra	ICRS-**Diana, Sandy**
UM Sub Committee - Terry	QMOC- **Diana**
Inpatient Certification Transition Mtg. - Debra	QS internal meeting-**Diana, Terry, Debra, Sandy**
E&T Policy Review Process- Debra	Staff Meeting and Training-**Diana**
Regional Training Committee	VOA Inpatient Certification Transition Meeting-**Diana**
Quality Management Committee	Meeting with Medical Director-**Diana**
QMOC	Quality Management Plan Meeting-**Diana, Debra**
	QMC- Terry, Debra, and Sandy

Cross-System Collaboration and Community Committees

Facilitated	Attended
Regional CLIP meeting, Everett Sandy	**Meeting on Pearl St. CLIP child at Catholic Family, Sandy**
	DCFS meeting, Everett, Sandy
	Implementation and Design Group-MHD
	Provider Contract Negotiations

Tasks and Functions

- Quality Assurance-# of Clinical Records reviewed _0_
  # of Encounter Validation audits __0__

- Quality Improvement:

Mortality Review at Compass Health- Completed 6 reviews in September-Diana
Began work on the Quality Management Plan Integrated Report-4th Biennial Quarter 2005-Diana
Continued work on NSMHA QM Plan 2006-2007- Terry

- EQRO Preparation:

  Assisted with Mortality Review PIP for EQRO-Diana

- Policies and Procedure Development

  Revised the NSMHA Complaint, Grievance, Appeal, and Fair Hearing Policies and Procedures based on review of the new Complaint, Grievance, Appeal, and Fair Hearing templates from the Mental Health Division (Exhibit N)-Diana

  Continued review of draft BBA WAC and BBA to determine implications for Complaint, Grievance, Appeal, and Fair Hearing Policies-Diana

  Developed a second series of questions for the Mental Health Division regarding the new MHD Complaint, Grievance, Appeal, and Fair Hearing templates.-Diana

  Continued review of ICRS accessing services draft- Sandy

  Revised P&P regarding UR response timelines, per QMC request- Terry

- Disaster Planning
  Review of MHD Contract regarding Disaster Behavioral Health Services-, correspondence with MHD regarding Hurricane Katrina and additional resources, review of crisis counseling protocols for Disaster Behavioral Health Services, Attended ICRS meeting with providers to review contract - Diana

- Quality Improvement Case Reviews- 2 Sandy
- Utilization Management-
- Utilization Review-# of charts reviewed -74 # of denial requests reviewed- 22

- Risk Management-# of Critical Incidents reviewed= 30
- # of Complaints Reviewed-_0

- # of Grievances filed-0

- # of Appeals filed in September-**0**
- # of Appeals filed in previous months completed in September-**2-Diana**
- # of second opinions assisted-2

Planning:

- Resource Management (CLIP)

  Cases screened- 1

  - Resource Management (Medicaid Personal Care)-New authorizations- 3 Renewals-7

- Resource Management (WSH)

Monthly ADC 103.38 Cap- 105 Bed Days over Cap: 0

Other: Interviews with Quality Specialist Candidates: Wendy, Debra, Terry

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Training Provided: _

- **Facilitated NSMHA Web-based training on Disaster Behavioral Health-Diana**

Training Planned:

- **Training for the revised Exhibit N reporting for Denials, Complaints, Grievances, Appeals, Fair Hearings-Diana**

Training Attended:

- **Web-based training on Disaster Behavioral Health-Diana**

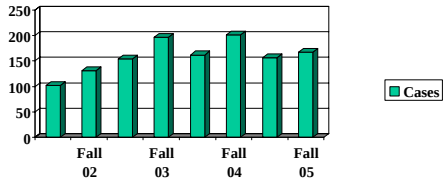
Activities Planned/Deliverables due in October:

- **Ongoing Appeals and Grievances-Diana**
- **Create new Complaint, Grievance, Appeal, Denial, and Fair Hearing Reporting Templates and Excel Database and create new Complaint, Grievance, Appeal, Denial, and Fair Hearing Reporting Instructions to comply with new MHD reporting requirements-Diana**
- **Continued revision of Draft NSMHA Complaint, Grievance, Appeal, and Fair Hearing Policies-Diana**
- **Continue Mortality Chart Reviews-Diana**
- **Continued training and consultation on the NSMHA Complaint, Grievance, Appeal, and Fair Hearing Policies and Procedures-Diana**
- **Participate in Statewide Disaster Preparedness Workgroup and facilitate disaster planning for Hurricane Katrina evacuees as needed. Develop list for provider disaster contacts-Diana**
- **Work on the Quality Management Plan Integrated Report-4th Biennial Quarter 2005-Diana**
- **Regional Meeting for CHAP/DCFS, Sandy and Linda**
- **Island Chap focus meeting, Sandy and Linda**
- **Work on ICRS CDMHP protocols for UR tool, Sandy**
- **MATCH Policy Draft – Debra**
- **CI Policy Revision – Debra**

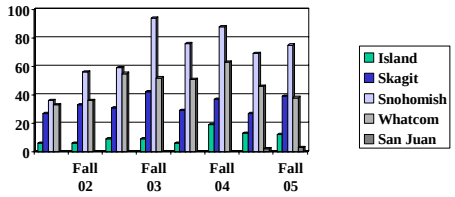
- **CI Report to QMOC – Debra**
- **E&T Policy and Review Process (Ongoing) Debra**
- **CI Form Revision (Ongoing) Debra**

New Quality Specialist staff Julie De Losada to start October 5, 2005!

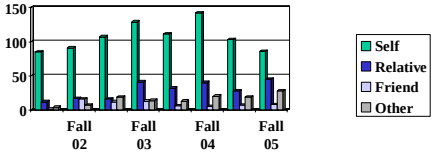
Semi-Annual Cases



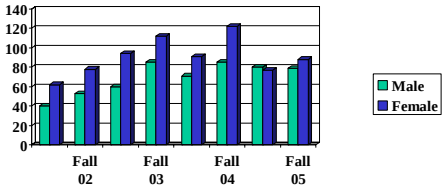
Cases by County



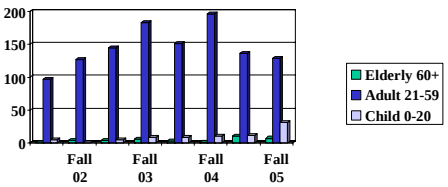
Source of Cases



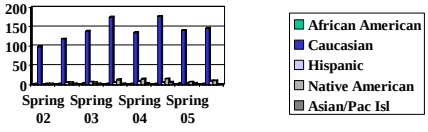
Gender of Client



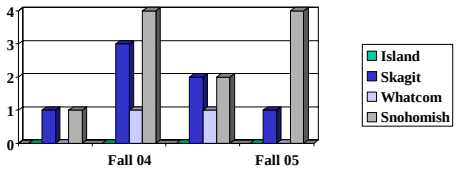
Age of Client



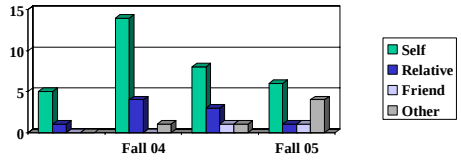
Ethnicity of Client



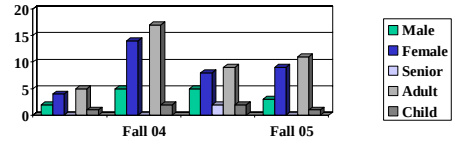
GLBT Clients



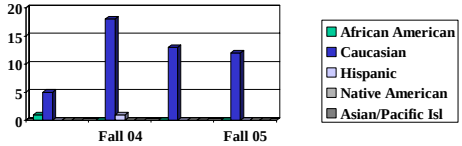
Island County Demographics: Referral Source



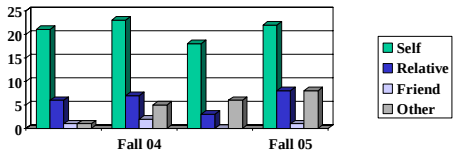
Island County Demographics: Gender and Age



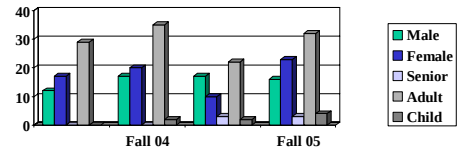
Island County Demographics: Ethnicity



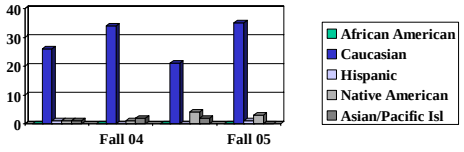
Skagit County Demographics: Referral Source



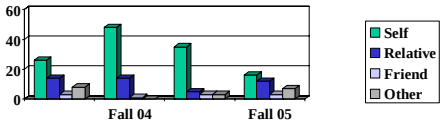
Skagit County Demographics: Gender and Age



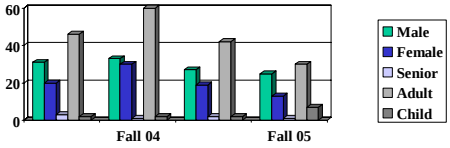
Skagit County Demographics: Ethnicity



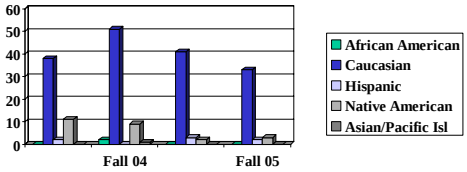
Whatcom County Demographics: Referral Source



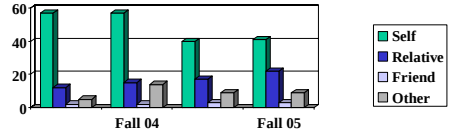
Whatcom County Demographics: Gender and Age



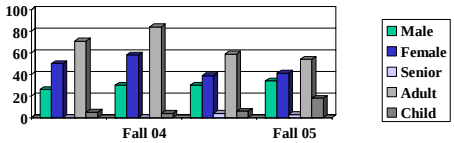
Whatcom County Demographics: Ethnicity



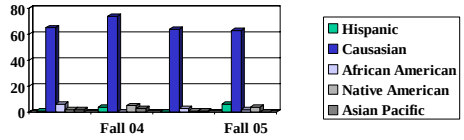
Snohomish County Demographics: Referral Source



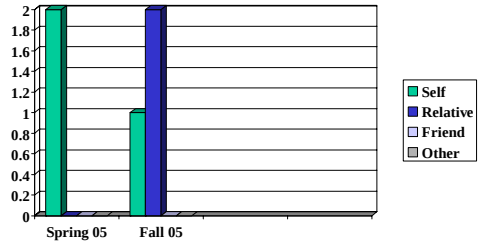
Snohomish County Demographics: Gender and Age



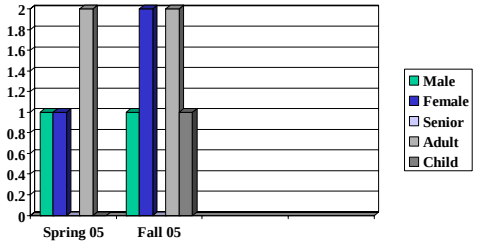
Snohomish County Demographics: Ethnicity



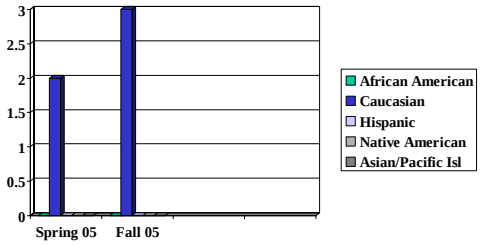
San Juan County Demographics Referral Source



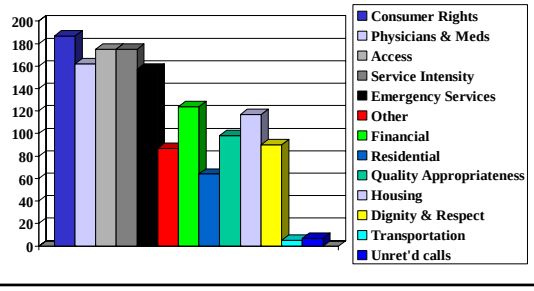
San Juan County Demographics Gender and Age



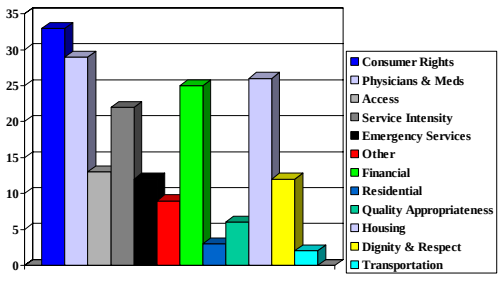
San Juan County Demographics Ethnicity



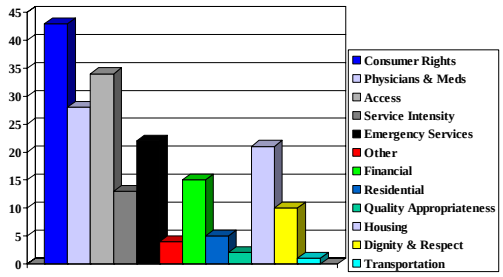
Overall Ombuds Complaints, Spring 2002 to Spring 2005



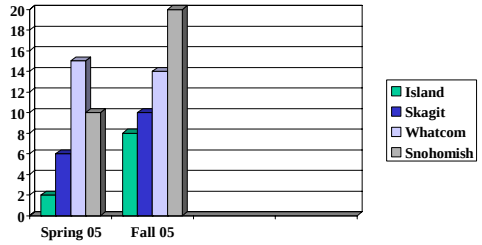
Ombuds Complaints, Spring 05



Ombuds Complaints, Fall 05



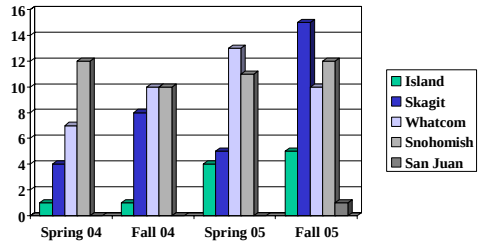
Complaints Not Involving Public Mental Health Provider Agencies



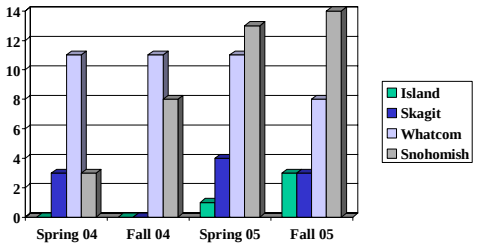
Complaints Not Involving Public Mental Health Providers, Fall 05

- **Island:** 1 Hosp, 4 Children's svs, 1 Senior svs, 1 DSHS, 1 SSA
- **Skagit:** 4 Hosp, 4 DSHS, 1 VOA, 1 DASA
- **Whatcom:** 1 DSHS, 1 WHA, 7 Hosp, 1 DDD, 1 Criminal Justice, 2 Medicaid Trans, 1 PCP
- **Snohomish:** 1 Children's svs, 2 VOA, 2 DSHS, 6 Hosp, 4 PCP, 3 CDMHP, 2 Criminal Justice

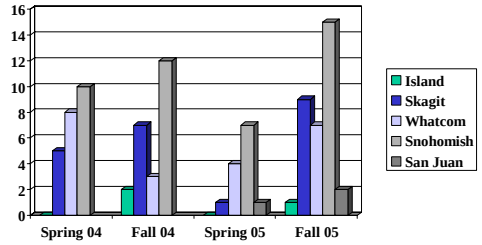
Consumer Rights Complaints by County



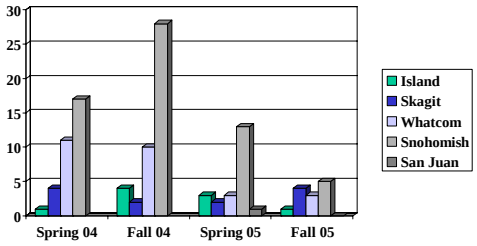
Physicians & Meds Complaints by County



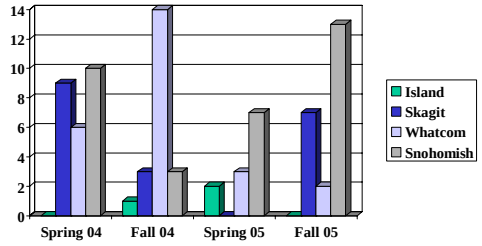
Access Complaints by County



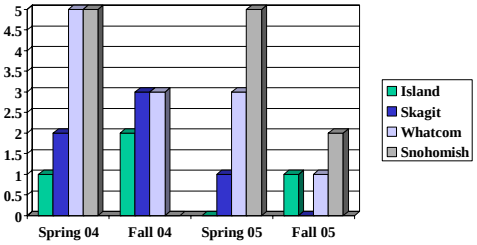
Service Intensity Complaints by County



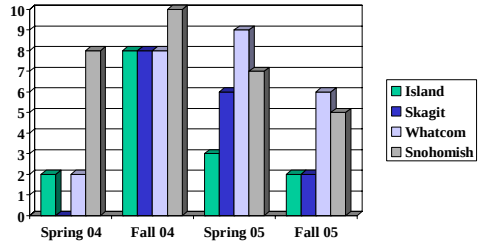
Emergency Services Complaints by County



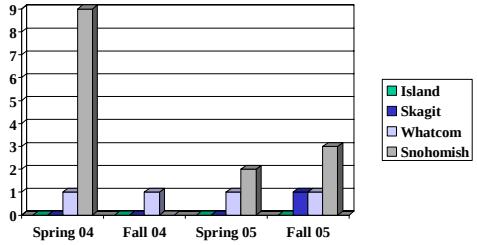
"Other" Complaints by County



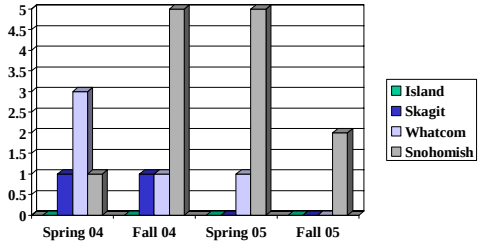
Financial Complaints by County



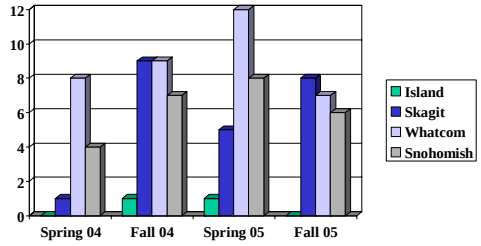
Residential Complaints by County



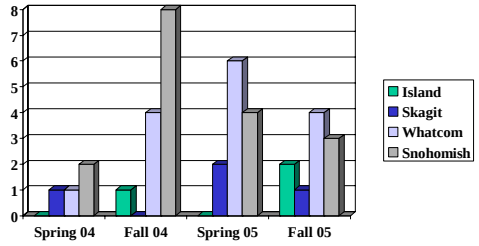
Quality Appropriateness Complaints by County



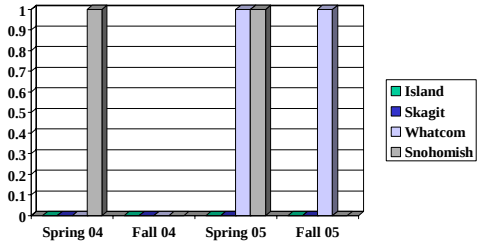
Housing Complaints by County



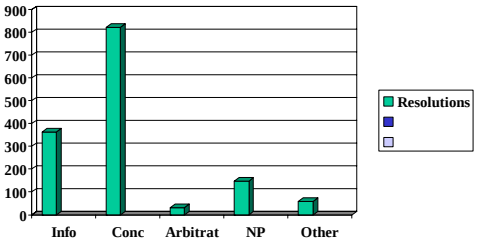
Dignity & Respect Complaints by County



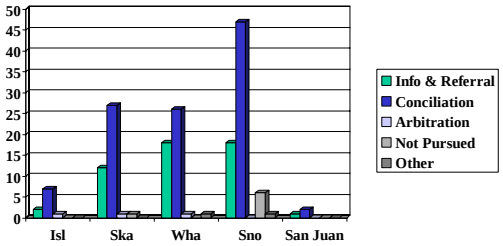
Transportation Complaints by County



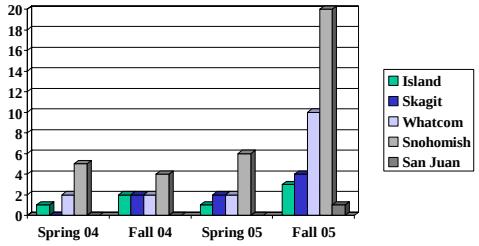
Overall Types of Resolutions Since Spring 2002



Resolution Types by County, Spring 2005



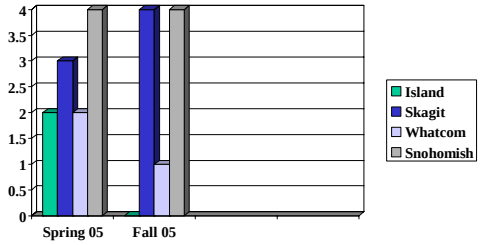
Complaints Involving Children



Complaints Involving Children Fall 2005

- **Island**: 3 Consumer Rts
- **San Juan:** 1 Access
- **Skagit:** 1 Access, 1 Consumer Rts, 2 Svs Intensity
- **Whatcom:** 4 Access, 2 Consumer Rts 3 Physicians & Meds, 1 Other
- **Snohomish:** 7 Access, 1 Svs Intensity, 2 Phys & Meds, 1 Quality Appropriateness, 3 Consumer Rts, 3 Residential, 2 Emergency Svs, 1 Other

Complaints Involving Seniors



Complaints Involving Seniors

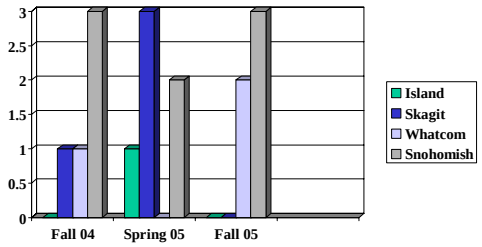
Island: Financial: 1, Emergency Services: 1

Skagit: Financial: 2, Housing: 1

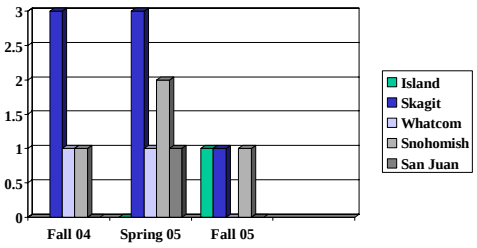
Whatcom: Financial: 1, Housing: 1

Snohomish: Housing: 2, Consumer Rights: 1, Physicians & Meds: 1

APPEALS to denial of Access



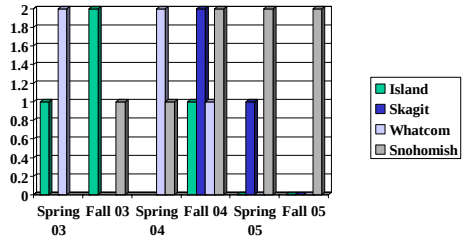
Provider Grievances



Provider Grievances, Since Fall 2004

- **Island:** 1 Financial svs
- **Skagit:** 2 Access, 2 Financial svs, 2 Consumer Rights, 1 Housing
- **Whatcom:** 1 Dignity/Respect, 1 Housing
- **Snohomish:** 1 Access, 1 Dignity/Respect, 1 Physicians & Meds, 1 Consumer Rights
- **San Juan:** Services Intensity: 1

RSN Grievances



Overall RSN Grievances

- **Fall 02:** 1 Type Unknown
- **Spring 03:** 1 Quality Appropriateness, 1 Consumer Rights, 1 Physicians & Meds
- **Fall 03:** 1 Dignity & Respect, 1 Other, 1 Housing
- **Spring 04:** 1 Financial, 1 Emergcy svs, 1 Residential
- **Fall 04:** 1 Emergcy Svs, 3 Svs Intensity, 2 Qual App
- **Spring 05:** 1 Svs Intensity, 1 Emergcy svs, 1 Access
- **Fall 05:** 1 Physicians & Meds, 1 Consumer Rights

Fair Hearings

- **Fall 2004:** 1, Type: Emergency Services, County: Snohomish, Status: Judge refused to hear.
- **Spring and Fall 2005:** None

Organizations Worked With Since Spring 2004

- Children's svs CPS/Foster Care: 22 cases
- Chemical Dependency Services: 27 cases
- DSHS Community Service Office: 34 cases
- Criminal Justice: 24 cases
- Developmental Disabilities: 23 cases
- Doctors & Hospitals: 63 cases
- Medicaid Transportation: 4

Organizations Worked With Since Spring 2004 (cont'd)

- Senior Services: 10 cases
- Social Security Administration: 17 cases
- Housing Authority: 19 cases
- Adult Family Homes: 4 cases
- Lawyers and Courts: 6 cases

Organizations Worked With Since Spring 2005 (cont'd)

- Hospice: 1
- Rehab Centers: 2
- Private Protective Payees: 4
- MAA: 5
- Missions: 5
- Schools: 1

NSMHA Performance Improvement Project #4 Restraint and Seclusion at the Freestanding E & T's

The Background of the Selected Study Topic

How was the study topic selected?

Interest in reviewing these processes was generated by several incidents including a recent client death, which over time have highlighted the need for higher level of standards regarding client health and safety while in restraint and/or seclusion at the freestanding E & T facilities operated in our region by Compass Health. Freestanding Evaluation and Treatment facilities are designated to serve mentally ill clients who have been involuntarily detained for treatment. By their design, they serve clients who are dangerous to self, others or gravely disabled and thus have a high acuity and complex needs, are frequently admitted in an agitated or severely anxious state and who have multiple co-morbid conditions. Restraint and/or seclusion are sometimes used when less restrictive alternatives have not been effective.

In addition, NSMHA is aware of national and state efforts to eliminate the use of restraint and seclusion. The unique nature of free-standing E & T's (Evaluation and Treatment) in the state of Washington has created a somewhat odd situation in that these facilities are licensed as residential programs but actually provide a type of service that is comparable to treatment in an inpatient psychiatric unit. There are only five freestanding E & T's in the state and NSMHA funds two of them, comprising a total of 31 beds.

The state Residential Treatment Facility WAC's are less stringent than either the Center for Medicaid and Medicare Services standards or the Joint Commission for Accreditation of Healthcare Organization's rules, which govern inpatient psychiatric units and freestanding psychiatric hospitals in the state and across the country.

- Description of the identified problem – which should include some key dimension(s) of quality care, such as appropriateness, competency, continuity, effectiveness, efficacy, efficiency, respect and caring, safety, and/or timeliness.

Through the NSMHA Critical Incident Reporting system, we became aware of some specific areas of concern, and one incident of client death while in five point restraint and seclusion. Also, in -------2005 the state of Washington implemented changes to the Residential Treatment Facility WAC which covers the E & T's, which included changes to restraint and seclusion standards. Restraint and Seclusion are high-risk, problem-prone procedures and in light of the incidents and WAC changes it was felt that a thorough collaborative improvement project was needed. Meetings were called between NSMHA quality staff, Compass Health's Medical Director, Compass Quality staff and the Director of the Evaluation and Treatment Centers for the purpose of planning the project.

- Description of the collected and analyzed data used to understand the problem that impacts the Medicaid enrollees' or consumers' care, needs, and/or services. How did you use the data to understand the problem? Use charts, graphs, or tables to display the data. **See Attached data and reports. We noted that over the last 2 1/2 years that the use of restraint has declined especially in 2005 after we began addressing the problem. The**

number of admissions has remained relatively constant as these facilities operate at or near capacity.

- How is this topic important to the PIHP? **Client safety is a core priority.** Did the identified problem fall under one of the key dimensions of quality care? **YES**

Study Question

1. **How can safety of clients admitted to the E & T's be improved while in restraint and/or seclusion?**
2. **How can the use of restraint and/or seclusion be minimized?**

Indicators

Identify the indicators:

- *An outcome indicator measures what happens* or does not happen as the result of a process or processes

- *A process indicator measures a discrete activity* that is carried out to provide care or service

Each indicator should specify:

- Denominator – the event being assessed or the Medicaid enrollees or consumers who are eligible for the service or care. Indicate whether all events or individuals are included, or whether the denominator is a sample.

1. **Number of clients restrained and/or secluded.**
2. **Number of clients admitted to the E &T's**

- Numerator – the criteria being assessed for the service or care. For example, the number in a population with a disorder/condition, or those who were involved in a particular event

1. **Number of incidents of client injury or death**
2. **Number of events of restraint and/or seclusion.**

- Baseline for the indicator-**2004**

- Goal for desired improvement - must be a numerical quantifier (e.g., % points or raw number) rather than simply "improve," "increase," or "decrease"

1. **Zero incidents of client injury or death**
2. **10% decrease in five point restraint, 10% decrease in seclusion only events.**

Why were these indicators selected? Again, client safety is our number one priority so there is no tolerance level for injury or death. In the area of reduction of usage, we wanted to establish an achievable goal in order to build on demonstrated success. Research reviewed indicates that this is a process that involves a major shift in organizational culture, staff must believe that it is possible to have a safe mileau

without the use of restraint/and or seclusion and the behavioral and attitudinal changes take time.

We feel that the ultimate goal to ensure client safety is to eliminate the use of these dangerous treatment interventions completely in line with national and state efforts and philosophies. This is a very long-term goal that will require substantial investment of resources and training to be successful. In the interim we will strive for ongoing reductions incrementally.

How do these indicators measure changes in mental health status, functional status, enrollee or consumer satisfaction, or process of care with strong associations for improved outcomes?

These indicators will measure changes in the process of care and have been demonstrated by numerous national initiatives to result in improved outcomes. The sentinel event of one client death shows the need for improvement in many process areas to decrease the likelihood of a recurrence.

Study Population

Describe the population to be included in the PIP, including the number of enrollees or consumers. **All clients admitted to one of our two freestanding E & T's. Average number is 800 per year.**

Describe how the population is being identified for the collection of data. **100% of events and 100% of admissions**

Data Collection Procedures

Describe the data to be collected. **All incidents of restraint/and or seclusion are reported and entered into a database. All incidents of injury and/or death are reported and entered into a database.**

Describe method of the data collection and the sources of the data to be collected. **Providers complete critical incident reports for every injury or death and fax to NSMHA.** Did you use existing data from your Information System? **No** If not, why? **Total number of admissions and length of stay are available through our IS. Restraint and/or seclusion, and critical incidents are not IS data elements and thus will be collected separately.**

Describe the plan for data analysis. **NSMHA maintains a standing committee, the Critical Incident Review Committee, which meets monthly and reviews the data.**

Identify the staff that will be collecting data as well as their qualifications, including contractual, temporary, or consultative personnel. **Debra Jaccard, BSN, NSMHA Quality Manager**

Improvement Strategies

Describe interventions employed to address the causes/barriers identified through data analysis and QI processes.

1. **Admission Criteria/Medical Clearance requirements-NSMHA and Compass Health are reviewing current admission criteria and medical clearance requirements. In reviewing cases where injury, illness and death had occurred, a common theme was the discovery following admission of significant unknown or under-assessed medical conditions, symptoms or injuries. In the case of the patient death, the client had been displayed out of control behavior in the community and had been repeatedly tasered in the community by police in order to subdue him. The client's evaluation in the referring Emergency Room did not include a thorough medical assessment or an EKG, and did not rule out other causation for his behavior such as delirium. Our review indicated that the E & T did not have specific admission or exclusionary criteria or medical clearance protocols that were adequate. Our objective is to update the criteria in order to better define the physical conditions that can be managed safely at the E & T, and to develop a systematic set of medical information parameters for a protocol to screen referrals to ensure that they are medically stable before admission to the E & T in order to eliminate the admission of clients who are not appropriate for this level of care.**

2. **Physical Assessment by nursing staff on admission and during client's stay at E&T's-In reviewing the cases where injury, illness and death occurred, the review group found that the frequency and comprehensiveness of physical assessment and systems to assist nursing staff in complying with established E & T policies needed to be addressed. We are developing revised policies, forms, flow sheets and documentation requirements to improve the quality and documentation of the initial physical assessment by nursing staff in the crucial early hours of admission so that adequate interventions to protect the client's safety and address health care needs can be initiated by nursing staff if restraint and/or seclusion interventions are required, and so that more thorough documentation of ongoing assessment and health care needs occurs according to established policies.**

3. **Seclusion and Restraint policies-The review team has decided to establish policies that are more consistent with national standards such as CMS and JCAHO in the area of restraint and seclusion and to go beyond what is allowable under the state Residential Treatment Facility WAC. As an example, E & T policy will require face to face monitoring of any client in restraint and seclusion simultaneously, where the state would allow video and audio monitoring. We believe that closer monitoring will decrease the likelihood of injury or death while in restraint and seclusion.**

The review team continues to meet to finalize these strategies with the goal of implementation of all components in the next quarter. Following full implementation we will enter the next stages described below.

Data Analysis and Interpretation of Study Results

Describe the data analysis process. **Ongoing** Did it occur as planned? **Yes**

Present objective data results for each indicator – including relevant tables or graphs. **Since the inception of this project there have been no injuries or deaths in either E & T. WE have not completed all planned activities but we are encouraged thus far that our efforts are bearing fruit.**

Issues associated with data analysis:

- Data cycles clearly identify when measurements occur.
- Statistical significance
- Are there any factors that influence comparability of the initial and repeat measures?
- Are there any factors that threaten the internal or the external validity?

To what extent was the PIP successful? Describe any follow-up activities and their success.

Determining if the Improvement is "Real"-To Be determined at the conclusion of the project

Describe how the methodology used at baseline measurement was the same methodology used when the measurement was repeated.

Does data analysis demonstrate an improvement in processes or consumer outcomes?

Describe the "face validity" – how the improvement appears to be the result of the PIP intervention(s).

Describe statistical evidence that supports that the improvement is true improvement.

Determining if the Improvement is Sustained -To Be determined at the conclusion of the project

Was the improvement sustained over repeated measurements over comparable time periods?

NSMHA Trauma Committee Recommendations

to the NSMHA Quality Management Council

Summary-DRAFT

The NSMHA Trauma Committee was formed in March 2004 as a time-limited group and met through October 2004. The group was comprised of NSMHA and provider staff. Tasks the group agreed to pursue included;

- Development of a Trauma Committee charter
- Development of a Work Plan
- Development/adoption of a Trauma assessment screening tool to be used during Intakes
- Development/implementation of Trauma Work Groups in Whatcom, Skagit and Snohomish counties
- Development/adoption of Trauma (PTSD) Clinical Guidelines
- Development of a Trauma (PTSD) Training Module for the NSMHA Regional Training Plan

The Trauma Committee has completed five (5) of the six (6) tasks it agreed to undertake. The final task yet to be accomplished is the development of a Trauma (PTSD) training module for the NSMHA Regional Training Plan. NSMHA staff are working on completing this training module and will have it completed soon.

Recommendations

Based upon the review of the Trauma Committee's charter, work group, trauma pilot projects, screening tool reviews and clinical guideline review, the Committee brings forward the following recommendations to the NSMHA Quality Management Committee;

1. Clinicians who suspect or observe trauma-cluster syndromes with their clients or who have clients indicate their desire to discuss/process feelings related to trauma experienced are encouraged to use the Trauma Screening document adopted by the Trauma Committee and implemented during the Whatcom Counseling and Psychiatric Clinic's (WCPC) Trauma Pilot Project. WCPC staff who used the tool felt it was useful in eliciting specifics related to the individual in a clinically safe and non-threatening measure. It provides the clinician with identifiable and individualized information related to the consumer's trigger events, level of symptom severity and experiential background. This tool could be used during ongoing counseling sessions to address issues not identified and/or revealed by the consumer during their initial Assessment interview. See attached.

2. Adoption of the proposed Clinical Guidelines for PTSD. See attached

3. Completion of the NSMHA Regional Training Plan module regarding PTSD. Under development; and,

4. Invitations to the three (3) Trauma Pilot Project teams to present their results to the NSMHA Quality Management Oversight Committee (QMOC) as part of QMOC's "Quality in Action" agenda.