NORTH SOUND
MENTAL HEALTH ADMINISTRATION

QUALITY MANAGEMENT OVERSIGHT COMMITTEE

COMMITTEE MEETING PACKET

May 24, 2006

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

Draft May 24, 2006
NORTH SOUND MENTAL HEALTH ADMINISTRATION
QUALITY MANAGEMENT OVERSIGHT COMMITTEE AGENDA

Date: May 24,, 2006
Time: 12:30-2:30 PM
Location: NSMHA Conference Room
For Information Contact Meeting Facilitator Wendy Klamp, NSMHA, 360-416-7013

Topic	Objective	ACTION NEEDED	Discussion Leader	Handout available pre-mtg	Handout available at mtg	Tab	Time
Introductions	Welcome guests, presenters and new members		Chair				5 min
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	Chair	Agenda			5 min
Review and Approval of Minutes of Previous Meeting	Ensure minutes are complete and accurate	Approve minutes	Chair	Minutes		1	5 min
Announcements	Inform QMOC of news, events and other important items		All				5 min
Comments from the Chair	Update the committee on recent developments that impact QMOC-	Suggestions to improve meeting -	Chair				5 min
Quality Management Department Report	Standing Agenda Item for Monthly Review	Review accomplishments, data and plans of department-	Wendy Klamp		QM Dept. Report	2	Hand out only
Policy Work group	Report from Work group and update on Board action regarding recommendations		Chair				15 min
Ombuds Report	Report from Ombuds	Review and advise	Chuck Davis				15 min

MHD report on NSMHA reported deaths and Critical Incident Program	Inform committee as to MHD report	Review and advise	Debra Jaccard	Summary of meeting and report		3	10 min
EQRO Report	Review report	Review and advise	Wendy Klamp				10 min
High Intensity Treatment Work Group Draft Policy and Recommendations	Recommend draft policy for approval	Approve to move forward	Debra Jaccard	Policy 1527.00		4	10 min
Hospital Inpatient Reduction Workgroup	Review recommendations and determine how to incorporate into QM plan	Approve to move forward	Debra Jaccard	Summary of Workgroup		5	10 min
QRT Work Plan	Explanation of plan	Review and advise QRT	Deborah Moskowitz				15 min
Date and Agenda for Next Meeting	Ensure meeting date, time and agenda are planned.		All				5 min
*Review of Meeting	Were objectives accomplished? How could this meeting be improved?		All				5 min

Next meeting June 28, 2006

Potential Agenda Items

Draft Integrated Report

NORTH SOUND MENTAL HEALTH ADMINISTRATION
April 26th 2006
Special QMOC Workgroup Meeting – Review of NSMHA Policies per APN's Request

Convene: The workgroup was convened at 9:04 a.m.

Attending: Gary Williams, QMOC Chair, Board of Directors, Human Services Supervisor, Whatcom County; **Karen Kipling,** Care Crisis Response Director, Volunteers of America; **Janet Lutz-Smith,** Whatcom County Advisory Board; **Chuck Davis,** Skagit County Mediation Services Ombuds; **Deborah Moskowitz,** Skagit County Mediation Services Ombuds; **Mary Good,** NSMHA Advisory Board; **Wendy Klamp,** NSMHA Quality Manager; **Mike Manley,** Administrator of Developmental Disabilities LTC/Aging, Mental Health, Snohomish County Human Services; **Dan Bilson,** NSMHA Advisory Board; **Russ Hardison,** Clinic Manager, Sea Mar; **Chuck Albertson,** NSMHA Advisory Board Chair; **Rochelle Clogston,** Chief Administrative Officer, APN; **Nancy Jones,** Community Mental Health Program Supervisor, Snohomish County Human Services; **Maile Acoba,** Skagit County Coordinator; **Susan Ramaglia,** NAMI Skagit; **Dr. June LaMarr,** Tulalip Tribes, **Shannon Solar,** NSMHA

Timekeeper: Janet Lutz-Smith.

Guests: Chuck Benjamin, NSMHA Executive Director; Stacey Alles, Compass Health Quality Manager; Mike Watson, Clinical Director, Lake Whatcom Center, Dr. Keith Brown, NSMHA Medical Director.

Introduction: Gary thanked all for taking the time out to work on this important issue and noted this session could be an important chance to get a refresher course in policies and procedures and better understand their impact on providers and consumers.

Gary added that the purpose of this workgroup is to address APN's concerns that many of NSMHA's policies are excessive beyond State and Federal requirements and have increased the burden and cost for providers. Today this group will review problematic policies identified by the APN to make recommendations to the NSMHA Board of Directors.

Gary noted policies we will be examining are those indicated as a top priority (1) in the policy tracking list which NSMHA staff have reviewed and disagreed with APN. The other policies, identified as (2) are off the table, as NSMHA staff agree there is room for negotiation and will be discussed and changed later. Policies identified as (3) are those which NSMHA staff have examined and agreed with the APN on.

Gary added that if there is specific WAC language that the policy must exist, we can not dispute it. Interpretations are what need to be discussed, and best practice standards that RSN have established in the past are up for discussion.

Rochelle stated the contract between NSMHA or providers states that "*NSMHA policies should not exceed Federal and State requirements, and shall be limited only to such requirement*s". Chuck Davis added the RFQ would be a State requirement. Chuck Benjamin asked to remember context of language in the contract, which states was if there was a federal or state statute, NSMHA policies would not exceed. However, NSMHA's contract with the State requires them to do *continuous quality management* of providers. Chuck Davis added NSMHA is required to flesh out WAC statutes. Gary suggested in order to prevent any delay in the process, guests from APN and the RSN will leave and return in the afternoon.

Karen clarified that there are other providers here than those part of APN. VOA's contract with NSMHA does not have the same language as APN's and VOA has always negotiated with the RSN in good faith. Rochelle noted she will abstain from including all providers in APN's opinions.

POLICY REVIEW

1002.00 Section A

Rochelle gave a brief statement of APN concern: Concern lies with tracking of complaints. Tracking every complaint, even for issues that can be resolved quickly, such as a waiting room being too cold, is an administrative burden which takes up clinician's time.

Wendy gave a brief statement of RSN response: Diana Striplin expert in this complex intersection of WAC, BBA, RFQ, state model contracts and current contracts, prepared this response. The State requires provider reporting of complaints to NSMHA for Exhibit N. The RSN strongly believes in tracking and reporting complaints as an important part of quality management.

Comments: Gary asked Wendy if this is an interpretation by NSMHA staff of the source or if it is a clear requirement from WAC. Wendy answered she believes this to be a clear requirement. Susan stated the consumer voice is the most important voice and she does not want that voice to be edited. Chuck stated he feels this policy and procedure is working exceedingly well, he knows in talking to other Ombuds this region has the best complaint process in the State, and this is important to clients. Deborah added that Ombuds are committed to resolving complaints at the lowest possible level. If we eliminate this policy/procedure, we will be editing consumer voice, which should be allowed to rise to the surface.
Rochelle stated that issues are resolved right away, agencies would not stop listening to consumers or resolving problems, the concern is with the administrative burden of tracking complaints. While the WAC is laid out very clearly for the grievance, not for complaints. Deborah added the issue is also of having consumer voice being heard broadly, needs to be recorded.
Rochelle noted this is a resource issue. Time is taken away from face to face visits and going to paperwork.
Janet asked if there a difference between levels of complaints, as providers shouldn't have to report miniscule things, while they should report complaints related to service. Process. Karen agreed that some level of judgment is needed on low level complaints, there should be some discretion allowed. Wendy noted the State expresses that any level of complaint be recorded. Chuck noted Ombuds takes the majority of complaints and they need the 30 day requirement to stay.
Russ agreed with Karen, stating that Sea Mar wouldn't track a miniscule issue as a complaint.
Dan added if the complaint was immediately resolved, common sense would be that there is no need to track. Rochelle responded the policy states that even if the complaint is minor it needs to be tracked.
Nancy agreed with Dan. Further clarification is needed on the definition of what defines complaints, we need to set a bar of what constitutes a request vs. complaint.

Action: Gary entertained a motion to support this policy, with the caveat that NSMHA and providers re-examine the definition of what defines a complaint and what does not, to possibly streamline the process. Motion carried, seconded, all in favor.

1002.00 Section B

Rochelle gave a brief statement of APN concern: The requirement to send the additional copy to NSMHA as well as the client when the problem is not resolved is the issue. Rochelle noted if the complaint process is amended, there will likely be less problem with this.

Wendy gave a brief statement of RSN response: RSN feels due to current contract/BBA, it is necessary to send letter to consumer.

Comments: Chuck Davis noted he likes the current process as it informs the client what is going on. Wendy noted this is part of contractual requirements with providers. Nancy asked for clarification on why it is a problem-Rochelle noted it is time consuming. Rochelle added if we get a better definition of what is a complaint, sending letters out will be less of a burden. Chuck noted very few complaints are unresolved, the majority are Ombuds complaints. Gary noted this issue may be mitigated by previous discussion, and made a recommendation to support the policy with a caveat will examine definition.

Action: Gary entertained a motion to support the policy with the caveat there is a potential to bundle with previous policy discussion. Motion made, seconded, all in favor.

1002.00 Section C
Rochelle gave a brief statement of APN concern: The requirement to report narrative for the Exhibit N report every six months is excessive.

Wendy gave a brief statement of RSN response: The RSN is required by the State to submit a report for Exhibit N. The RSN does not ask for a lot of information from providers. A specific template used by the State is used, and the information asked for is required.

Comments: Gary asked for clarification on what amount of information is asked for, Wendy noted it is brief, a summary of each category. Rochelle noted it is the issue of time taken to compile the data. Susan asked wouldn't providers want to do this anyhow? Rochelle noted it is a repetitive process. Karen asked if there is a report that APN QA staff are currently doing that could be sent., Rochelle noted there is, but it is data, not narrative. Deborah noted data without explanation is less useful. Russ added Sea Mar's Exhibit N report has always been brief, but acceptable to NSMHA. He also noted individually these requirements seem small, but they add up to a lot.

Action: Gary –entertained a motion to continue the support the policy with the possible caveat that some other activity similar that APN is doing that could replace this reporting, motion made, seconded. Discussion: Chuck stated that Ombuds makes the same summary, but feels good about collecting the information. Motion was made, seconded, all in favor.

1002.00 Section D
Wendy noted this was a technical requirement, a citation correction has been made.
Action: A motion was made to accept the policy, motion seconded, all in favor.

1007.00 Primary Source Verification
Rochelle gave a brief statement of APN concern: APN does complete a thorough review when new employees are brought into the agency to ensure licenses/degrees are valid. The policy (excessively) requires going back to the agency where the license was issued, instead of using common sense in examining given information.

Wendy gave a brief statement of RSN response: The State has requirement to establish uniform credentialing process, although specifics are not given. There have been high-profile cases where

doctors/counselors have given false credentials. The page that comes off WA DOH website would be acceptable source of verification.

Comments: Mike noted Snohomish County has run checks on degrees and come across places never heard of, so how far back do we need to check the diploma comes from a legitimate source? Gary asked if any work is done in the human resource area on this at APN, Rochelle was not sure. Wendy noted the RSN does not do HR review when agency does not, (Sea Mar only) otherwise MHD does. Rochelle suggested a compromise position if see standard WA state degree that looks valid that would be accepted, if degree comes from a questionable institution then validity of the degree must be ensured.
Rochelle added this is going way beyond WAC. Karen noted the VOA agency is moving towards accreditation, we will likely have to do this anyway, but acknowledged VOA has smaller staff than APN.
Nancy added providers sometimes have to pay fees to do verification. There needs to be a policy on the part of agency hiring, as the agency itself does not want unqualified people. Wendy noted we want to provide the most protective policy for consumers and is happy to revisit the policy.

Action: Gary proposed a motion that the policy be referred for discussion between NSMHA and APN. Janet noted all providers should be included. Chuck Davis stated he would like to vote whether or not to support the policy now rather than postpone the process. Gary suggested a new motion to accept the existing NSMHA policy. Motion made, seconded. A motion was made to amend the motion to add a recommendation there be further discussion that there be best practice. All were in favor of main and secondary motions.

1009.00 Critical Incidents
Rochelle gave a brief statement of APN concern: The issue is with the definition of Critical Incidents exceeding the WAC definition, leading to excessive reporting. CI (critical incident) reporting has to be done for any type of death, including natural causes. This is a big increase in administrative burden from what is MHD reportable to what must be reported to NSMHA.

Wendy gave a brief statement of RSN response: The RSN feels this is a foundational part of continuous QM and have exceeded State contract requirement in this regard for many years but have tried to limit the amount of areas which need to be reported.

Comments: Mike noted the State only describes CI's as those media-related, but as a health care provider the RSN would be interested in incidents that may lead to court, or where misconduct occurred. He feels this policy needs more work, more thought should be put into what constitutes a CI. Deborah noted as Ombuds, she feel strongly about this, and sits on the CI committee which looks at incidents through a prevention/QI filter. They often see thread between a CI and a gap in care. If they were only to look at incidents MHD is concerned with, those gathering media attention, a big part of consumer care would be lost. Janet stated we owe clients to know what has happened to them. Rochelle noted APN does not want to lessen quality of services, but time is taken away from serving clients doing reporting on things that are not critical incidents. This is above and beyond WAC requirements and adds another level of burden to APN.

Chuck asked what has resulted from the QM program on the whole. Wendy noted the area of seclusion and restraint at E&T's, a client died in restraints, leading to QI. There were also a cluster of issues with CH, some reportable, some not, QM identified serious problems with the organization and CH submitted a corrective action plan, did major restructuring and since have not seen level of problems. Wendy noted the RSN is concerned with natural deaths (or cases when cause of death is unclear) in people not elderly.

RSN feels this does not go beyond WAC as WAC calls for continuous QM. This has been approved by QMOC before, and in all levels of system.
Mike noted he is not recommending that we do away with this process, nor that we approve the policy and step away, clarity is needed in the kind of incidents reported to increase efficiency in the system. Russ stated Sea Mar is JCAHO accredited, and these list of things which should be reported is almost identical to what Sea Mar reports to JCAHO.

Susan asked what APN objecting to reporting to. Rochelle noted not all would raise to level of reportable CI – ex: illness, or natural death of elderly client.

Action: Gary entertained motion to re-confirm NSMHA policy of Critical Incidents with a caveat to review the operational definition of CI and define what is reportable/not reportable. Motion was made, seconded, all in favor.

Policy 1504.00 Assessment for Ongoing Services
Rochelle gave a brief statement of APN concern: Specific concern is with the policy prescribing how to do diagnostic justification: APN wants more flexibility in doing assessments. An ex: there are 5 pts needed for diagnostic justification. APN wants to give clinicians ability to do diagnosis with their own clinical judgment.

Wendy gave a brief statement of RSN response: The RSN previously amended the policy with provider input. NSMHA Medical Director Dr. Brown felt provider diagnostic justification did not meet professional standards, and he requests language from DSM to show how the clinician arrived at diagnoses, what other diagnoses were ruled out, etc.

Comments: Rochelle noted the way diagnoses are done now is very prescribed as clinicians have to check off every item, clinicians should have flexibility in justification. Nancy – does Sea Mar have a problem – Russ no. Karen asked why we would have a medical director and not follow his recommendations? Rochelle – CH has medical director and feels that is unnecessary. Chuck stated this is something we should be doing to treat clients as well as we can. Gary noted this issue seems it should be discussed between RSN/APN medical directors, and the BOD should determine whether they follow recommendations of Medical Director hired but the RSN. Nancy moved to defer this item until guest representatives are present.

Action: A motion was made to defer to this afternoon to discuss. Gary articulated questions that will then be asked: Are the RSN medical directors' requirements to support diagnosis excessive, and what is the basis of the RSN medical directors requirements? Wendy noted the basis is from the DSM, which is standard clinical practice. Susan, Wendy, Chuck and Deborah voted against deferring, the majority were in favor, and the policy was deferred until the afternoon when guests arrive.

B-1 & C-1 also deferred to afternoon.

1505.00 Authorization for Ongoing Outpatient Services
Rochelle gave a brief statement of APN concern: APN has problems with the amount of things that go into developing the initial assessment and the 30-day time limit. It is difficult to make the initial assessment to get treatment plan completed.

Wendy gave a brief statement of RSN response: There needs to be discussion with APN as there may have been a misunderstanding, this policy is taken verbatim from RFQ and is not meant to be the final treatment plan. The timeline discussion (A-2) will have impact on this (B-1). Wendy noted we can not change main components as this comes from RFQ.

Comments: Janet noted this should be discussed with the state/RFQ in next contracting period, this is impossible situation.

Action: A motion was made to approve policy with discussion for part A & B for further clarification on what definition is needed. Motion was made, seconded, all in favor.

1517.00 Coordination of care with primary care provider and other health care providers

Rochelle gave a brief statement of APN concern: Issue is with the way the policy dictates how to have coordination. APN wants more flexibility in how to work with different PCP's as they are all different and how to work with them differs.

Wendy gave a brief statement of RSN response: This policy was developed by regional medical directors. NSMHA believes we need a policy to ensure consistency among providers. NSMHA saw a cluster of complaints indicating problems in how this was done, therefore framework was instituted, especially in area of medication management, want smooth handoff. Wendy noted frustration that this policy previously went through QMOC, was approved, and is now back here again.

Comments: Rochelle noted this is adding additional requirements than WAC. Susan stated from a consumer viewpoint, there is not a lot going on with PCP's, many consumers do not even have a PCP. Consumers need to know certain dangers, need someone monitoring, they will be better served. Charles noted more and more clients are being served by PCP's than this system, and the transition needs to be smooth. Rochelle noted the concern is with adding extra layer in how this happens. APN wants more flexibility. Susan stated APN should care that the PCP is qualified to do med management. Deborah noted she does not think this "flexibility" is working, as shown by several active cases of hers, complaints with coordination between MH providers and PCP's. We need a better system, people ending up in hospitals is not acceptable. Chuck noted he spoke to a PCP in Mount Vernon who was very unsure about prescribing psychotropic meds, really unsure what he was prescribing to consumer. We should not loosen requirements.

Karen noted these policies have been developed by workgroups and have gone through QMC, QMOC, yet we are here trying to figure them out. This is a frustrating process. Nancy asked if objections were raised previously. Wendy noted they were not; consensus was reached at QMC and QMOC.

Rochelle stated the accumulation of so many excessive requirements adding on to clinicians is leading to APN losing sight of client care. Gary noted this policy was created in 2004.

Susan noted documentation is an important part of service so everyone knows what's going on, including the client.

Wendy noted that Rochelle is representing the viewpoint that there is a fundamental issue of policies exceeding contracts. In previous contract period, there was discussion with APN on who agreed with the concept of a policy driven health plan system. At the time of signing contract, APN Boards raised concerns. Mike noted during contracting period, it was acknowledged that these policies could have a fiscal impact, and if there was a noticeable fiscal impact, it would be discussed. We need to discuss cost on providers.

Action: Gary entertained a motion to support the policy as written. Motion was made, seconded, one against (Rochelle), all else approved

Policy 1518.00 Mental Health Advance Directives
Rochelle gave a brief statement of APN concern: It is difficult to track down someone to sign MH advance directive.

Wendy gave a brief statement of RSN response: MH Advance Directives came into place in 2004. The witness to signature can not be the clinician, but can be receptionist or other clinician. As there are very few MH advance directives completed, the RSN did not feel it would be much of a burden.

Comments: Rochelle noted it was APN's understanding that it was a conflict of interest if other staff signs, Wendy noted it is not a conflict of law. Deborah added witnessing someone signing a document is not a conflict of interest. Wendy noted it is recommended that all clients have an advance directive, but most do not. Deborah suggested having an education for clients on advance directives, have them made and signed at that point. Possibly NAMI or a Church could sponsor this.

Action: Gary entertained a motion to support the current policy, with the sidebar that there may be special events where consumers could be given special opportunity to educate consumers about medical directors. Motion made, seconded, Rochelle against, all else approved.

Policy 1520.00 Second Opinions
Rochelle gave a brief statement of APN concern: This has a financial impact on providers as second opinions often go out of network. The level of second opinions becomes cost prohibitive when they are for higher levels of service.

Wendy gave a brief statement of RSN response: Wendy noted the language on second opinions comes out of BBA and RFQ. NSMHA has never charged providers for second opinions, they have always absorbed costs. The number of second opinions has increased. Clients have a right to request and receive a second opinion. Wendy noted there are two networks – the APN network and the NSMHA network – RSN tries to stay within the NSMHA network. Greg Long tries to get a second opinion from a provider other than where the issue was raised.

Comments: Chuck noted only two or three people in four years went outside of network, as special services were needed. As far as Ombuds this happens very infrequently. Maile asked if the issue is the provider being required to pay. Wendy noted that is in the policy, but has never been exercised. Maile asked if providers will be charged. Wendy noted the RSN has not charged in past as there have not been many, but the number has of late been increasing. Wendy noted that this is something that should be studied and reported back to QMOC on how many occur, how much they cost.

Action: Gary moved to support the existing NSMHA policy, with the addition that second opinions out of the network's financial impact to APN be reviewed at a later date. Motion – made, seconded, Rochelle opposed, all others in favor.
Discussion: Janet noted there is a large gap in what second opinions are on. Dan noted the consumer has the right to get a second opinion from whoever, but the contract will not allow the consumer to go out of network? This is a violation of the consumers civil rights.

1527.00 (in development)
Action: A motion was made to approve the policy, motion made, seconded, all in favor.

1540.00 Criteria for Closing an Episode of Care
Wendy gave a brief statement of RSN response: This specifically has to do with an LR. The State says we can not close someone on an LR.

Rochelle gave a brief statement of APN concern: APN feels they should be able to close an LR when someone dies or moves away.

Comments: Wendy noted agreement with the concept, is willing to make these minor edits. Gary asked how we know if someone has moved from service area? Rochelle stated the client sometimes informs, or get a records request from an agency outside the area.

Action: Gary entertained a motion to continue the existing policy with an added subtitle that the requirement definition of what to do with transferred or deceased clients needs to be clarified. Motion made, seconded, all in favor.

1541.00 Rationale of Use of Seclusion and Restraints and E&T's
Rochelle gave a brief statement of APN concern: APN feels there should be an allowance when doing monitoring that in some instances video monitoring is allowed.

Wendy gave a brief statement of RSN response: This policy came out of a cluster of CI's including a death of a consumer in restraints at an E&T. A collaborative workgroup was formed in reworking policies including this one, attended by CH Medical Director Dr. Stallings, who then agreed with this policy.

Comments: Mike stated video-monitoring at the E&T's could be improved inexpensively to include recording. More creative work needs to be done in this policy, we do not want to tie up a staff person at the E&T. Chuck noted he has been to the E&T's while clients are in restraint, and knows that the TV is not being watched, staff are too busy. Rochelle added E&T's run at high capacity, other clients suffer when staff is occupied servicing one person. Gary stated anyone in restraints needs to be under immediate line of sight of staff.

Susan noted as a NAMI member, NAMI opinion is that anyone in restraint needs face-to-face supervision. Deborah seconded Chuck's concern that video monitoring is ineffective for monitoring people in restraint. Janet asked how many people get put in restraints? Wendy noted the amount has lessened.
Karen stated if Dr. Stallings researched and approved this, it seems inappropriate for this group to contest. Rochelle noted that Dr. Stallings agreed with it but felt that it was potentially excessive.

Action: Motion was made to support the policy as written, motion as seconded, all in favor.

1550.00 EPSDT (early periodic screening, diagnosis, and treatment)
Rochelle gave a brief statement of APN concern: A better summary is needed.

Wendy gave a brief statement of RSN response: APN did not see the requirements in the RFQ or model contract, as they are the areas that are disputed. We must abide the MHD contract. This is word for word.

Comments: Rochelle noted we are getting ahead of ourselves as this is from the RFQ. Having a child MH specialist just to do assessments will be a heavy staffing burden. Wendy noted we agreed in QMC that we would not operationalize until September when the final contract is received.

Chuck noted the RFQ is a formal document, entailing formal federal requirements. We can not dance around them.
Gary noted this policy was developed for the RFQ process. The region does not intend to operationalize it until next contract is received and will change the policy if allowable.

Action: Motion made, seconded. All were in favor.
Discussion: Dan asked if there was discussion on whether there was Child MH specialist available as they can be scarce. Wendy noted there is one at every child-serving agency. Rochelle noted she wants to be clear in NSMHA auditing processes this is not audited on. Wendy agreed it has not been and will not be.

1538.00 – 30-day Letter
Rochelle gave a brief statement of APN concern: This process creates a huge administrative burden. Letters are sent out to every client that wants to terminate service, it does not always make sense to do so.

Wendy gave a brief statement of RSN response: This policy did not receive consensus at QMC, it was taken to RMC, RMC made compromise, revised, policy taken back to QMC, then the RSN had to do the RFQ. The policy has not yet been implemented, waiting to finalize. Concern is that clients were not always notified of termination of treatment in a consistent manner.

Comments: Deborah noted the letter triggers to clients that they have a choice to change case managers or providers, consumers may not understand that without the letter and may disrupt continuity of care. Rochelle noted some clients are insulted by the letter. It is also not CH process to close people's service "in the heat of the moment". Russ noted this issue has not presented a problem at Sea Mar's level. Rochelle stated this requirement is adding another administrative layer that doesn't need to be there.
Gary noted it is typical to get a letter from healthcare plan that coverage ends and sees the procedure as an opportunity to tell client if they need urgent care to call VOA crisis line, or if they need services again to go through access.
Wendy noted the State now requires a letter be sent in 15-days.
Susan asked why in a consumer driven system, other people decide when treatment ends.

Action: A motion was made to support policy as written, motion made, seconded, Rochelle objected, all else in favor.

At this point Dr. Keith Brown, via conference phone, Chuck Benjamin, Stacey Alles, and Mike Watson all joined the discussion.

Revisit of 1504.00
Stacey Alles voiced APN's concerns with the detailed 5-items NSMHA is asking for in diagnostic justification. There is no known source document for those levels of diagnosis and they exceeds a known source requirement. Dr. Brown clarified that in talking about a DSM IV diagnosis, is not the justification DSM IV itself? What else are we asking that is different from DSM IV? Stacey answered requirements to give other multiple diagnosis to show which have been ruled out, as well as to describe justification of GAF score. Dr. Brown stated that interrater liability is needed. Consumer's right to receive services is based on GAF score, so we would want to have integrity in GAF score given. There can be no question of bias, want more rigid, organized type of diagnosis. Stacey noted concern in being held to a rigid standard that may not always be the case. Dr. Brown acknowledged when you feel the diagnosis is clear, it is overkill to go through other diagnoses. How much detail you give in ruling out alternatives depends on situation. In every situation there needs to be a minimum standard.

Mike Watson noted the need for feedback in following the diagnostic tree in DSM IV. A lot of clients come with a lot of history, documentation, then why do need to dispute and give diagnosis again?
Dr. Brown noted it is sufficient to give examples of behavior, then present historical information.
Mike Watson noted clinicians have to spend time writing diagnostic justification whether have historical documentation or not.

Stacey noted this is an example of a policy that exceeds requirements. Dr. Brown stated if clinicians are already doing these assessments, then why are we disputing them? Wendy noted this policy came out of discussions Dr. Brown had with Quality Specialists. Dr. Brown noted that most diagnoses made using DSM IV are made looking at historical behavior.

Stacey noted they are not disagreeing with criteria, they are disagreeing with the way it is enforced.

Dr. Brown noted it is up to the provider how much detail is given. Providers already have discretion whether to rule out one diagnosis or three or writing one sentence or a paragraph, Dr. Brown asked wouldn't providers want more documentation if money was unlimited, there were no RSN requirements? Can providers give a practical example of how this creates more administrative work for providers?
Stacey noted Utilization Reviewers give feedback that they need more narrative than a sentence.
Gary noted there is an application issue when reviewers look at a chart. Dr. Brown stated he wants to enforce this policy in a way that is collaborative for providers, not difficult. Dr. Brown added in terms of auditing records, we need to look at best practice standards. It is unfair to examine the way providers treat clients and not the way they diagnose. Need interrater liability documented to some degree.

Action: Gary entertained a motion to approve staying with the existing policy, motion made, seconded, with the caveat there needs to be discussion on what is required for clarity. This will be operationalized at QMC. All were in favor.

Part C:
Stacey noted that concern is being locked into specific assessments. APN wants flexibility at agency level to have internal processes Rochelle added APN feels this exceeds and is an administrative burden and again stated NSMHA policies should not exceed Federal and State requirements in their contract with APN. Chuck Benjamin handed out portions of the contract that states the WAC requires continuous quality improvement. Dr. Brown noted that the WAC can be extremely vague, perhaps the State/MHD should clarify.
Stacey noted she disagrees with Wendy statement that items have been added over time part of continuous QI. APN developed the policy then RSN added to it, but putting down requirements takes away flexibility. Mike Watson noted this was developed from older WAC's.
Wendy stated the issue is not elements of the policy, but that APN wants to be able to define parts of the intake rather than be told by the RSN what constitutes components of an intake, we don't want to have a policy, even though this used to be APN's policy.
Susan noted recently a consumer into CH, was diagnosed with schizo-affective disorder, person at CH incorrectly diagnosed her in 20 min with depression, leading to crisis. If the clinician had followed the rules laid out in the policy, would that have happened?
Mike Watson noted diagnosis components don't correspond with how long assessment takes.
Wendy asked Dr. Brown is it ok to leave this flexible for providers discretion? Providers do their own training, QI, the RSN merely do auditing on that.

Deborah asked if the providers submitted criteria for assessment, and if using a best practice perspective would providers want to cross anything off the list? Rochelle gave an example of GAF score (not on list). Deborah asked outside of requirements, is there any piece of information that providers would not want to know? Wendy noted the issue APN is bringing up is should each provider have their own flexibility to develop an intake that best meets the needs of their clients. Janet voiced concern that enough time be given at intake. A misdiagnosis is a serious problem.

Action: Gary asked if there was consensus to move Part C to a priority 2 status to discuss further.
Motion was made, moved, seconded, all in favor.

1553.00 Evidence-Based Practices
Rochelle gave a brief statement of APN concern: There is no requirement to follow this policy right now, APN will go ahead with viewing EBP's as upcoming.

Wendy gave a brief statement of RSN response: This was required by the RFQ.

Comments: Susan noted this is part of caring for the client. Rochelle added it is an administrative burden on APN. Gary stated that there is emphasis on EBP's being pushed, there are some risk in EBP's in applying to our system, providers need to give feedback. EBP's need intensive retraining when there is no funding for it.
Action: A motion was made to continue to support the policy as written, motion seconded, all in favor.

1704.00 Crisis Services General Policy (required documentation on ES)
Rochelle gave a brief statement of APN concern: APN believes there is no source document and it adds administrative burden to the provider in having additional requirements beyond the WAC.

Wendy gave a brief statement of RSN response: This came up when RSN was put into corrective action on Crisis Services and MHD did not have a tool so the RSN created their own. When requirements are not written down, there are bad outcomes.

Comments: Karen noted as a Crisis Provider, she has concern that, if there are changes to the data collection process at APN, the Raintree intake screens may have to be changed , and there will be fiscal implications for VOA. ~~Changing this process would result in costs to change processes.~~ Deborah noted when there is no documentation it is difficult to get consumer background. Rochelle noted the broader concern is that corrective action plans will live on forever. Karen acknowledged this concern. Wendy noted the RSN is supposed to review policies annually. Because of RFQ and EQRO, the RSN went from 5 to 200 policies. Gary noted he would rather do a thoughtful review of policy than to modify. This is something we promised the State we would do.

Action: Gary entertained a motion to continue this policy but to keep on the radar screen to review and reflect the work that has been done. Motion made, seconded, Rochelle abstained, all else in favor.

4505.00 – Enrollee Rights A
Action: Motion was made to amend policy as written, motion seconded, all in favor.

4505.00 – Enrollee Rights B
Rochelle noted the policy should read to submit amendments or corrections instead of make amendments or corrections.

Wendy noted the need to cite the HIPAA requirements. HIPAA language states ASK FOR amendments or corrections not MAKE. Need to make in accordance to that in policy, MAKE to ASK FOR.
Action: Motion made to change wording in policy to reflect HIPAA language, seconded, all in favor.

5501.00 Concurrent UR of Outpatient Services
Rochelle gave a brief statement of APN concern: Currently UR's are excessive (5%), there are other opportunities for NSMHA to look at charts.

Wendy gave a brief statement of RSN response: BBA requires UM program that ensures that we do not over or under-utilize services. There is no sample size, it is up to discretion of health plan. RSN feels the amount of UR's done are minimal and probably need to do more. This is the most effective way to bring treatment into clinical guidelines. Don't see how RSN can get away from this as it is required.

Comments: Janet noted the UM subcommittee refers to some inconsistencies in how information is reported back to them. It is important to have a system to do this well. Wendy acknowledged a difficult situation where the RSN is policing providers but also needs to have a collaborative relationship with them. The RSN will commit to having a collaborative ongoing discussion at UM subcommittee. We don't want to change the policy, we want to discuss operationalization.

Action: Gary entertained a motion to continue this policy with the suggestion that identified needs be worked on. Motion made, seconded. All in favor.
Regional Training Plan (B Section)
Rochelle gave a brief statement of APN concern: APN wants to have the flexibility to determine what training is required, they do not want that to be mandated for them.

Wendy gave a brief statement of RSN response: There is a Regional Training Committee that meets every 1-2 months, which agreed to continue the Regional Training Plan. NSMHA also has an internal, extensive training plan.

Comments: Deborah noted she sits on RTC and there was consensus that the regional training plan be continued. Providers have requested more trainings, but there is little funding.
Gary noted concern from providers that there were different training requirements but little funding. Therefore a region wide dialogue was created, leading to the Regional Training Plan.
Deborah noted the big issue is looking at staff in each agency and determining which staff needs to take each training. Rochelle noted there is no source document for this, it requires all providers to do certain training. Deborah noted that APN is represented on the RTC and was given opportunity to do away with the RTP and they approved continuing its usage.
Dan noted that prior to coming to the RSN, he spent several months meeting with APN with reps from all organizations and case managers and consumers and they came up with a Training Plan. This went to APN BOD who did not approve the plan.

Deborah noted that if providers want to be heard, attend the Regional Training Committee and vote.

Karen noted that there is a system of committees and groups that are extremely effective, and her staff spend a lot of time at these meetings. Karen asked if there are necessary people from APN attending all of these committees and groups? Rochelle stated that APN is looking at the whole amount of requirements

being asked of them. Janet acknowledged there must be some feeling of oppression that builds up with a large organization such as NSMHA and its requirements for providers.

Action: Gary entertained a motion to keep the Regional Training Plan as a (2) priority.
Motion made, seconded. All in favor.

1547.00 Customer Service
Rochelle gave a brief statement of APN concern: Although customer service is good, her concern is with the process. Based on the RFQ there were new implementations without opportunity for APN to have discussion.

Wendy gave a brief statement of RSN response: Wendy noted this came out of the RFQ, which has very specific requirements. Customer service needs to be provided according to these requirements. Part of these requirements was that Ombuds could no longer stay at RSN. Now RSN has developed their own Customer Service standards.

Comments: Janet asked how many customer service calls does the RSN get? Wendy noted the RSN is working on a system to track this, it is now about 20 calls a day. Deborah gets feedback that consumers hate having to make extra phone calls. Delegating customer service to another agency from RSN would likely increase that frustration. Susan noted she also gets calls from people on customer service, she refers them to Wendy. Chuck noted the more we move into managed care, the more is required of providers, and the more complaints are received. Gary noted that as this is embodied in the RFQ, in the implementation phase, and will likely be in the new contract, there is not much we can do.

Action: Gary entertained a motion to accept this policy with the caveat that we will examine how this stated in the new contract, as it is required by the RFQ. Motion made, seconded, Rochelle objected, all others approved.

Conclusion
Gary noted that several times today the need for clarity in operationalizing policies was brought up. He added that APN's concern with NSMHA policies & procedures affecting clinician time is an important consideration. Also, all provider agencies need to attend committees and give feedback at every level because considerable time and energy goes into developing these policies and procedures. The region's quality improvement process has always been to look at Federal and State standards, and these will be expanded on, taking into consideration the fiscal impact. In the contract process there needs to be an opportunity for contractors to present substantial negative fiscal impact on their agencies.

Wendy stated she will finalize the policy tracking list and will e-mail out the committee. If there are errors, let her know. From there, the committee's comments will go to the Board of Directors. Gary stated he will be unable to attend so Dr. June LaMarr will present comments in his stead.

Janet asked Rochelle if she felt it was worth all this time to go through all the policies, Rochelle stated she felt it was. Wendy thanked Rochelle for being such a gracious messenger. Deborah thanked Gary for running an efficient meeting and thanked Rochelle and Wendy for succinctly expressing their opinions.

Adjourn: The special meeting was concluded at 3:35 p.m. The regular QMOC meeting originally scheduled for today was cancelled.

2/22/2006

Summary of Meeting and Report from MHD Regarding North Sound Death Rates

- MHD noticed that NSMHA reports significantly more reportable deaths than other RSN's (see MHD's table for total reported deaths from RSN's)

- This generated questions regarding our reporting and critical incident program

- NSMHA demonstrated quarterly data showing an actual decrease in reported deaths from past years (See bar chart of Reported Critical Incident Death Sub-types)

- MHD acknowledged that an appearance of an increase in deaths is likely due to NSMHA reporting more events as a result of changes in contract language

- MHD also acknowledged that reporting systems from RSN to RSN vary with little consistency as to definitions of types of incidents being reported

- MHD made recommendation that due to inconsistencies in reporting negative media events, that State Mental Health and PIHP contracts contain draft language that changes the requirement from "potential media event" to "sentinel event"

- Replacing "potential for negative media coverage with "sentinel events" would clarify the types of events that would need to be reported, and broaden the definition beyond only those events that have been or are likely to be reported in the media

- MHD is also recommending that future contract language require reporting via data rather than through telephone and/or fax narrative reports.

- Until reporting requirements are clear and consistent it is impossible to determine where the current death rate in NSMHA lies in comparison to other RSN's

POLICY #1527.00

SUBJECT: MATCH (MATCHED APPLICATION OF TREATMENT FOR CLIENTS WITH HIGH NEED)

PURPOSE
To define MATCH Treatment, Requirements of Service, Standards for Admission and Discharge as the NSMHA High Intensity Treatment modality

MATCH is unique to standard individualized treatment in that it aims to serve the client primarily in the community or home, frequency of client contact is emphasized to enhance stability, and the long-term aim is to provide maximal community integration for the client.

Goals of MATCH treatment include client reinforcement of safety, promotion of stability and independence of the individual in the community and restoration and stabilization to a higher level of functioning. Client services may be accessed 24 hours a day, seven days a week to meet their individualized treatment needs by members of their treatment team. Match treatment services are ongoing services and not Emergency Services, but will work in coordination with both Emergency Services and DMHP's/DCR's as situations arise.

POLICY
MATCH is a home and community based mental health high intensity treatment modality that provides a multi-disciplinary treatment team approach to those individuals who have been assessed to be in greatest need of these services. Team members work together to provide intensive coordinated and integrated treatment as described in an individual service plan. Services provided are designed to rehabilitate individuals who are experiencing severe mental illness symptoms in the community; thereby, a main goal is to avoid more restrictive levels of service such as psychiatric inpatient hospitalization or residential placement and facilitate discontinuation of services when medical necessity is no longer met.

WASHINGTON STATE HIGH INTENSITY TREATMENT STANDARDS
Basic elements of MATCH are consistent with the core requirements of the WA State Mental Health Division's modality definitions for High Intensity Treatment and must include but are not limited to:

1. Treatment is available upon demand based on the individual's need. Treatment intensity varies among individuals and for each individual across time.
2. Access to services is available twenty-four hours per day, seven days a week.
3. The staff to consumer ratio for this service is no more than 1 staff member to 15 consumers.

4. Treatment team composed of the individual, Mental Health Care providers under the supervision of a MHP, and other relevant persons as determined by the individual (e.g. family, guardian, friends, neighbor, etc), and or other community members including pastors, physician, probation or parole officers, CD counselors, etc.
5. Services delivered by the high intensity team are billed at a per diem rate and are not to be billed separately. Auxiliary services are those provided by staff that is not part of the team. Concurrent services in the following modalities will be allowed as auxiliary:

a. Medication Management
b. Day Support
c. Psychological Assessment
d. Special Population Evaluation
e. Therapeutic Psychoeducation
f. Crisis Services

PROCEDURES

Recommended Admission Standards for MATCH:
The purposes of MATCH admission standards are to:

1. Ensure that clients with the most severe and persistent mental illnesses have top priority for services
2. Prevent clients with severe mental illness from being inappropriately discharged, dropped or not adequately served due to complexity involved in engaging and finding effective interventions to achieve recovery
3. Prevent inappropriate use of modality by:

    a. Excluding those individuals who require 24 hour supervision for health and safety reasons and
    b. Excluding those individuals who would require a more restrictive environment such as a hospital, nursing home, or supervised residential placement

ADMISSIONS CRITERIA
MATCH admission criteria are aimed at clients with severe and persistent mental illness as listed in the diagnostic nomenclature (DSM-IV TR) which seriously impairs their functioning in community living. Priority is given to clients whose persistent mental illness, as defined by the Clinical and Eligibility Standards, would benefit from intense wrap around service.

CRITERION FOR DISCONTINUATION OF MATCH SERVICES
Discontinuation of the service modality occurs when clients no longer meet the definition of medical necessity. The following serve as examples for discontinuation of service but are not limited to:

1. Has successfully reached individually established goals for a change in modality/transfer, and no longer meets MATCH criteria described. A higher level of community integration and baseline functioning demonstrated over time would demonstrate this.

2. Successfully demonstrated an ability to function in some role areas (i.e., work, social, self-care) without ongoing assistance from the program, without significant relapse when services are withdrawn.
3. When the client requests discharge, and the program staff mutually agree to the termination of services
4. Moves outside the service area, declines or refuse services and requests discharge /transfer, despite the team's best efforts to engage the consumer.
5. Client demonstrates that he/she is not expected to benefit from this modality.

Transition from MATCH services shall occur in a smooth and reasonable manner in coordination with the client and consistent with conditions and timelines outlined in Criteria for Closing An Episode of Care/Planned Discharge from Treatment (NSMHA Policy #1540).

MATCH SERVICE INTENSITY AND CAPACITY

1. **Staff-to-Client Ratio** – The staff to consumer ratio for this service is no more than 1 staff member to 15 consumers.
2. **Availability of Services –** Services shall be available 24 hours a day, seven days a week and be in the format of a team model. There must be availability for 24 hour a day face-to-face or telephone contact by a member of the individual's team as client need arises. This availability must include the ability to reach a specialty member of the client's treatment team. Auxiliary services, including medication management, will be provided as needed in accordance with the Clinical Eligibility and Care Standards for Emergent, Urgent and Routine Service response timelines.
3. **Frequency of Client Contact**

    a. The treatment team shall have the capacity to provide multiple contacts a week with clients experiencing severe symptoms, trying a new medication, experiencing a health problem or serious life event, trying to go back to school or starting a new job, making changes in living situation or employment, or having significant ongoing problems of daily living. These multiple contacts may be multiple times a day, seven days per week and depend on client need and a mutually agreed upon plan between clients and program staff. Many, if not all, staff shall share responsibility for addressing the needs of all clients requiring frequent contact.
    b. The team shall have the capacity to rapidly increase service intensity to a client when his or her status requires it or a client requests it.
    c. The team shall have the capacity to match the individuals need for medication monitoring, to include multiple contacts per day as ordered by the prescriber.

4. **Service Components of MATCH**;
   Services must minimally, based on the individual's service needs include the following **core components**:

    a. Assessment
    b. Treatment Planning
    c. Case Management
    d. Counseling/Psychotherapy
    e. Service Coordination
    f. Ability to assess for the need for crisis intervention
    g. Symptom Assessment and Management

h. Assessment of Need for Medication and Monitoring
i. Dual-Diagnosis assessment/referral
j. Support Employment
k. Social/Interpersonal Relationship and Leisure-Time Skill Training
l. Group Treatment

Concurrent services in the following modalities will be allowed as **auxiliary components:**

a. Med management
b. Day support
c. Psychological Assessment
d. Special population evaluation
e. Therapeutic psycho-education
f. Crisis

5. **Location of Services** – Client services are primarily provided in the setting natural to the client including home, work, and residential or other community locations. The majority of client contacts shall not be made in the outpatient clinic or day support setting.

CLIENT ASSESSMENT AND INDIVIDUAL TREATMENT PLANNING

Matched Application of Treatment of Clients with High Needs assessment and treatment planning should include the following elements:

1. **Referral Information**

   a. Referrals/transfers from other agencies will include comprehensive background information relevant to the client's functioning, assessment for risk, medication needs, and health and safety issues.
   b. Referrals/transfers from the same agency will include updated information relevant to the client's current functioning, assessment for risk, medication needs, and health and safety issues.

2. **Initial Assessment** – For new clients entering service, an intake assessment and preliminary treatment plan shall be done with in one month after the client's admission to assess for client needs and include an assessment for risk, medication monitoring, functioning, and health and safety.
3. **Individualized Treatment Planning**

   a. Treatment plan shall be developed in collaboration with the client and the family or guardian and shall identify individual issues/problems in collaboration with therapeutic standards, set specific measurable long and short term goals for each issue problem, and establish specific approaches and interventions necessary for the client to meet his or her goals
   b. Team members work together to provide intensive coordinated and integrated treatment as described in the individual service plan. The team's intensity varies among individuals and for each individual across time. The assessment of symptoms and functioning will be continuously addressed by the team based on the needs of the individual, allowing for the prompt assessment for needed modifications to the individual and to other team members.

The treatment plan and modality shall be re-adjusted as there are changes in client condition, and reflect documentation of frequency and location of client contact. The written treatment plan will be reviewed and revised on an ongoing basis as needed at a minimum, every 6 months.

c. The treatment plan process will include global alert that will be completed and entered in the IS system, identifying the client as a MATCH client and listing the team contact(s) to improve coordination of services between the case managers, Crisis Line, and Emergency Services.

Final Recap/Summary

Hospital Inpatient Utilization Workgroup

December 2005-February 2006

- **A diverse group of stakeholders including outpatient providers, inpatient staff & program managers, social workers, WSH liaison, Emergency Services, VOA and NMSHA staff, met four times (December 12, 2005, January 5, 2006, January 27, 2006 and February 3, 2006) as a focused workgroup to examine issues contributing to hospital inpatient utilization. Member participation did not constitute agreement with or endorsement of recommendations made.**

- **The group looked at data reports generated by NSMHA staff including reports regarding**:
  - Average length of stays by year, patients per hospital & rates of rehospitalization
  - Percentages of Medicaid and State Only Funded Clients Not Receiving Outpatient Services Pre & Post Discharge

- **Discussions were supplemented by issues and challenges offered up by stakeholders and a list of Barriers and Strategies was reformulated each week with new suggestions added**

- **4 Areas Were Identified Using Strategies For Potential Recommendations for Implementation**

I. Communication

a. **Contact point (VOA) be resource bank for eligibility, discharge resource management and limited records management**
b. **Utilize current ICRS automated email notification of inpatient admission for those clients already receiving outpatient services. Develop notification process for those clients not touching ICRS/Inpatient Certification.**
c. **Work with individual hospitals regarding specific inpatient issues/beliefs/inconsistencies in system**
d. **Add outpatient representation to quarterly Hospital Inpatient Meeting schedule with overlapping and individual time for both service areas**
e. **Initiate regional psychiatrist meeting (utilize current Medical Directors Meeting)**
f. **Utilize WBHIA Inpatient Association list serve to get regional information out**

II. Care Coordination

a. **Provider contact/point person(s) to ensure deferral/appointments/follow-up DC plan**
b. **Regional Adult and Child Care Advocates – oversee coordination of client care for clients with highest need**
c. **Appropriate inpatient denial policy for inpt. Certification re: medical necessity**
d. **Medicaid eligible clients that need assistance for enrollment**

III. Outreach to Underserved Populations/Non-enrolled Medicaid Eligibles

a. **Engaging Non-POE pre and post discharge/assist with enrollment**
b. **Kids**
c. **Older Adults**

IV. Basic Resources Needed

a. **Housing**
b. **Medications, especially at discharge**

c. **Non-Medicaid funding**
d. **Availability of Prescriber time/More access to triage outside of ES**

Barriers Identified

1. **Getting inpatient records in timely manner to outpatient providers to facilitate a) making clinic and medication appointments, get prescribers with vital hospital records, including those from WSH and E&T's**
2. **Providers have little to no contact with client and or social worker/discharge planner**
3. **Difficulty of hospitals in obtaining timely clinical and medication follow-up appointments**
4. **Lack of communication/respect between inpatient and outpatient providers**
5. **No central resource management bank exchange for housing/DC options and/or the perceived barrier of no housing so hospital stays are lengthened due to placement delays and problems**
6. **Difficulty determining client eligibility while hospitalized and getting Medicaid paperwork done prior to DC**
7. **A majority of patients are not getting hooked up with outpatient services post DC**
8. **No clear and consistent way to notify provider of client being hospitalized**
9. **Resources/availability for meds prescribed in inpatient/walking out with prescriptions vs. actual medication**
10. **Lack of availability of CD treatment post DC or other programming to maintain stability (day treatment)**
11. **Difficulty transferring to WSH or CLIP, lengthening stays**
12. **Patient choice to not receive follow-up outpatient services – Won't accept outpatient services**
13. **Large number of hospitals used in our region – causes problems in consistency**
14. **Eighteen-month delay in reimbursement and rate changes makes it difficult to create incentive & fund transitional services**

Strategies Identified

1. **Contact point (VOA) to be resource bank/info point for eligibility, DC resource management and some records management**
2. **ICRS automated E-mail notification of admission to providers. Develop system for non-ICRS contact & impatient certification**
3. **Provider point person(s) identified to ensure deferral/appointments/follow-up DC plan**
4. **NSMHA Regional Adult and Child Care Advocates-oversee coordination of care of clients with high need**
5. **Add outpatient representation to quarterly Hospital Inpatient Meeting schedule with overlapping and**
   individual time for both service areas
6. **Functional interpretation of medical necessity (P&P) as support structure for inpatient cert denials**
7. **Work with individual hospitals regarding specific inpatient issues/beliefs/inconsistencies in system**
8. **Housing options and alternatives to facilitate discharge/to potentially use crisis beds for post-DC, not just to prevent hospitalizations**
9. **Use non-Medicaid dollars to engage consumers who will not accept outpatient treatment or to reach underserved populations (kids and older adults)**
10. **Urgent Care Psychiatric Triage Center in Snohomish County**

11. **When utilizing the need for Home and Community Services call early in stay to set up assessment appointment with the caveat that the appointment might be canceled if necessary**
12. **MD meetings regionally quarterly for (psychiatrists)**
13. **Need to obtain data on kids, possibly a survey to identify if in service at time of hospitalization**
14. **WA Behavioral Health Inpatient Association list serve good way to communicate with inpatient stakeholders**
15. **Discuss with CSO's for expedited discharge/jails**