NORTH SOUND
MENTAL HEALTH ADMINISTRATION

QUALITY MANAGEMENT OVERSIGHT COMMITTEE

COMMITTEE MEETING PACKET

November 22, 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

NORTH SOUND MENTAL HEALTH ADMINISTRATION
QUALITY MANAGEMENT OVERSIGHT COMMITTEE AGENDA

Date: November 22, 2006
Time: 12:30-2:30 PM
Location: NSMHA Conference Room
For Information Contact Meeting Facilitator Greg Long/Debra Jaccard, NSMHA, 360-416-7013

Topic	Objective	ACTION NEEDED	Discussion Leader	Handout available pre-mtg	Handout available at mtg	Pg.	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		3	5 min
Review and Approval of Minutes of Previous Meeting	Ensure minutes are complete and accurate	Approve minutes	Chair	Minutes		5	5 min
Announcements	Inform QMOC of news, events: • Children E & T • EQRO • Clinical Redesign Update • Authorization Check-in • PACT RFP	Inform/discuss	DEBRA/ALL				10 min
Comments from the Chair	Update the committee on recent developments that impact QMOC- • Board action	Inform	Chair				5 min
QRT Report	Inform QMOC of QRT activities	Discuss and Approve	DEBORAH M.	Packet		9	15 min

Policy Sub-Committee Report	Inform QMOC of work of sub-committee	Inform	GARY WILLIAMS		Grid and Policy Handout at Meeting		10 min
Semi-Annual CIRC Report	Inform QMOC of January-June 2006 CI activity in region	Discuss & Review	KURT/ DEBRA	Packet		16	10
Regional Training Committee Charter & PSTD Training Module	QMOC to Review & Discuss	Review and approve	CHARRISA/ DEBRA		Available at meeting		10
Clinical Guidelines	Inform QMOC of proposed clinical guidelines to submit to MHD by 11/30/06	Discuss and preliminary approval – to be revisited in early 2007	DEBRA J.	Packet		28	10
Quality in Action: EPSDT	Inform QMOC of program for children and new contract and monitoring requirements	Informational	ANGELA, QS DEBRA	Packet		31	10
PIPS	Discuss which to bring to close, which to continue and pursue	Inform & discuss	DEBRA/DIANA/ CHARISSA		Available at meeting		15
Date and Agenda for Next Meeting	Ensure meeting date, time and agenda are planned.		All				5
*Review of Meeting	Were objectives accomplished? How could this meeting be improved?		All				5

Next meeting December 27, 2006, 12:30-2:00 (Decide to have meeting or cancel for December)

Potential Agenda Items: PIPS
EQRO
Policy Sub-Committee Update
Integrated Report

North Sound Mental Health Administration
Quality Management Oversight Committee
NSMHA Conference Room
October 25, 2006
12:30 – 2:30
DRAFT MINUTES

Present:
Gary Williams, QMOC Chair, Board of Directors, Human Services Supervisor, Whatcom County
Mike Manley, Snohomish County Human Services
Joan Lubbe, NSMHA Advisory Board
Mary Good, NSMHA Advisory Board
Russ Hardison, Sea Mar
Dan Bilson, NSMHA Advisory Board
Chuck Davis, North Sound Ombuds
Susan Ramaglia, NAMI Skagit
Karen Kipling, Volunteers of America
Debra Jaccard, NSMHA
Deborah Moskowitz, North Sound Ombuds
Janet Lutz-Smith, NSMHA Advisory Board

Not Present:
Maile Acoba, Skagit County Coordinator
Charles Albertson, NSMHA Advisory Board
Janelle Sgrignoli, Snohomish County Human Services

Excused:
Donna Konicki, *bridgeways*
Nancy Jones, Snohomish County Human Services
June Lamarr, the Tulalip Tribes

Guests:
Kurt Aemmer, NSMHA
Charissa Fuller, NSMHA
Margaret Rojas, NSMHA
Betty Scott, NAMI

1. Open the Meeting & Comments from the Chair

The meeting was convened at 12:38 p.m. and introductions were made.

2. Agenda

The agenda was reviewed. Dan noted he would like to hear discussion on the clinical redesign process.

3. Approval of September Minutes

The minutes from the previous meeting were reviewed and corrections were requested, Susan noted courts had been found to be non-compliant, not MHD. Rochelle should be added present, Tom Sebastian should be noted as a guest. The minutes were approved with those changes.

4. Announcements

- EQRO (external quality review organization)– will be doing a desk audit, RSN will receive questions, RSN will submit answers, EQRO visit is one month later. Debra noted PIP's and

encounter validation will be focused on as the RSN scored low on those areas previously. Greg noted the federal government has required all Medicaid-providing programs to have external audits.

- Greg noted work is still being done to find a site for the Children's E&T. Bailey's Center in Everett will not be used. It is possible Aurora House will be used and other housing will be created for people living in Aurora. Greg noted there will be a meeting between RSN/Compass Health/King County. This program is behind schedule. Mike asked about the implications around the state funding received to be used for this. Greg noted Chuck Benjamin has discussed this with MHD director Richard Kellogg, no penalties have been discussed. However since the program is late, we can't use federal block grant funds on start-up costs. Dan asked if the E&T was to end sending children out of state, Greg noted it is more to end sending children out of region and to alleviate general lack of inpatient resources.
- Laptop Update – Rochelle noted the call center has been closed as concerns from consumers have trickled down. A media advisory was put in all newspapers across the state. Rochelle addressed the financial impact of this incident, stating she was assured that funds that were directed to clients was not used by Compass Health to deal with the laptop theft. Rochelle stated financial projections were that administrative/managerial hours were taken up and the call center costs were a little over $28,000. Greg noted there was no indication PHI was used in any illegal way. Joan noted she found there were patients scared by what happened. Gary noted this has caused preventive steps.
- Contracting Funding Workgroup – Greg updated on the process NSMHA is going through in looking at changing the contracting/funding design. This group met four times in Sept. with Barbara Mauer from MCPP to develop a model of the services we would like in the region, a second workgroup on financial design has been created and will meet with the clinical group to come up with presentation for the Board of Directors. Greg noted there will be a public meeting tentatively set for Nov. 9th to present to the Board of Directors and community at large. A formal announcement will be sent out later. Mike noted Dale commented on how the change will impact the staff at the RSN who perform QM doing UR, they will switch to monitoring over-commitment of resources/misallocation of resources. Greg noted expenditures will be monitored monthly and yearly projections will be done. We will have a list of strategies to use if it looks we are over or under-spending. This will change incentives and the need for productivity from providers. Gary noted in the future, this committee will be making important determinations on continuing funding certain items in the system. Dan asked if the committee has considered breaking up the monopoly of having one entity (APN). Greg noted this is being discussed by the Board of Directors, advocates have expressed need for more choice. The capitated fee-for-service system will change this. Dan noted as an advocate he supports the change. Greg invited all to the Nov. 9th mtg, Mike noted increased providers is an underlying reason for the change
- Authorization process – Debra noted consumers have been getting letters, there has been some confusion, it is being adapted to be clearer for the consumer. About 600 are done a month. Providers are called on a case-by-case basis. The policy still being worked on. The authorization workgroup continues to meet to refine the process, there are complications in transmitting data. Susan asked if letters were going to be sent to people that haven't been authorized. Debra noted none have been issued yet, Greg noted it is unlikely there will be many denials at the re-auth point.

6. Comments from the Chair
Gary noted at the October Board of Directors meeting, the BOD acknowledged that motions coming from QMOC with unanimous approval re: policies will go directly to their consent agenda without need of their review. If there is disagreement within QMOC on policy, Board of Directors will discuss and review issue with input from those assenting and those dissenting. This adds responsibility to QMOC to do their work at policy subcommittee.

7. Treatment Planning Workgroup Summary
Charissa noted this workgroup was formed based recommendations from QMC/UM Subcommittee. The focus was making the Treatment Plan meaningful to the consumer. Optimal numbers of goals as well as definitions were reviewed. Charissa noted MHD gave approval of definitions. Susan asked if there was any consumer input, Charissa noted there was no consumer on the committee but the workgroup tried to incorporate recovery into all components of the treatment plan. Susan noted adding the word recovery to documents is not covering the whole spectrum of recovery, recovery means self-directed treatment. Charissa noted the group broadened definitions so the consumer defines outcomes. Deborah noted the group struggled with the medical model and recovery model as well as federal requirements. Gary noted the medical model is counting widgets, whereas consumers have physical outcomes such as going to school. Debra noted the workgroup came about when providers expressed frustration on low scoring in reviews. Janet noted the date of 6-mths is not very long, Deborah noted a case review is done at that point and can be continued. Gary noted this will be evolved into a policy, this group can look at the policy in draft form and give input.

8. Policy Subcommittee Report
Gary noted the QMOC subcommittee for policy review has joined the QMC committee to more efficiently address efforts. Debra passed out a policy review grid which need to be prioritized. Recommendations made by the subcommittee will be presented to QMOC. Two policies, 1703 (Duration of Crisis Services) & 1701 (Crisis Respite Standards for Adults) were brought to QMOC for review.
1703 – the group noted "or physical harm" should be deleted from A. Since this was not a subsitive change, the policy will not go back to the policy subcommittee. A motion was made to approve 1703 as amended, motion seconded, carried.
1701 – The group noted "or designee" should be added to be able to carry out authorizations in addition to the program director. A motion to accept 1701 with amendment, motion, seconded, carried.

9. Ombuds Report
Chuck Davis went through the Fall 2006 Ombuds Report. Chuck noted he has asked NSMHA IT to come up with exact percentages of ethnicities in the region. Chuck noted providers have been doing a very good job with appeals. Deborah noted the drop in provider-level grievances, she feels good about this.

10. Semi-Annual CIRC report
Deferred to next meeting.

11. QRT Report
Deferred to next meeting.

12. Quality in Action WRAP presentation
Betty Scott noted the WRAP (Wellness Recovery Action Plan) training was held in Seattle, sponsored by DSHS. There were 3 and 5-day trainings. Betty passed out some resources on the program. Betty noted the dichotomy between the term "consumer" with "provider", she wants to stop using the term

consumers. Joan asked what term was replacing this, Betty noted "people with chronic illness" Betty noted we want to stop labeling ourselves, be it "bipolar", "consumer", etc. Betty went through the WRAP elements. Betty noted we hope there will be funding to hold these presentations. A preliminary budget has been drawn up and given to NSMHA. James Mead has stated there will be more trainings for consumers to be trained in this program. Gary asked about the daily maintenance plan usage, Betty noted this tool can not be part of the treatment plan, it is for people in recovery who choose it. Medication is not part of the plan. Betty noted the book is available online, or if training is attended, the book is given. Debra noted there is potential for Advisory Board funds to be used for WRAP trainings. The group thanked Betty for presenting.

13. Documentation Flow Chart

Debra drew attention to the document forms flowsheet. Providers and NSMHA have been looking at who requires what forms and why there is so much paperwork. Debra noted yellow items are state required. Chuck is taking feedback to Richard Kellogg at MHD who requested feedback on why there is so much paperwork and why it takes so long for clinicians to fill out paperwork. Gary asked if an electronic record helps at all the paperwork load. Greg noted it is likely it will as it puts everything in one place.

14. Adjourn

The meeting was adjourned at 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 REVIEW TEAM (QRT)

Six-Month Report for April-September 2006
Prepared by: Deborah Moskowitz - October 2006

The Quality Review Team began a variety of new activities in May 2006 and continued with ongoing outreach activities that were previously begun. Three consumers from the NSMHA Advisory Board joined the Quality Review Team and have conducted site reviews of provider agencies. Quality Review Team staff have conducted the cross-system interviews. This report summarizes the activities and findings of the Quality Review Team for this period.

OUTREACH

Deborah Moskowitz conducted the following outreach activities for this period:

- Elder Service Providers meeting in Bellingham – assisted in the presentation of Ombuds/QRT services as part of "Unraveling the Mysteries of the Mental Health System;" distributed Ombuds brochures and business cards (April)
- Mailings of Ombuds brochures (Stevens Hospital, Northwest Regional Council) (May)
- Volunteers of America, Community Information Line (211) – submitted Ombuds/QRT information to be included in statewide database (May)
- ARIS (At Risk Intervention Specialists) meeting – presentation about Ombuds/QRT services; distribution of program brochures and business cards (June)
- SPARC (specialized preschool program) – presentation of Ombuds/QRT services to program director; distribution of brochures and business cards (July)
- DSHS-Division of Developmental Disabilities (DDD), Bellingham field office – presentation of Ombuds/QRT services to social workers and field office manager; distribution of brochures and business cards (July)
- NAMI Skagit – presentation of Ombuds/QRT services, discussion of needs in Skagit County, consumer concerns, funding issues (August)
- Dorothy Place, Bellingham (housing program for victims of domestic violence) – presentation of Ombuds/QRT services to program staff; distribution of brochures and business cards (August)
- Whatcom County Probation Services – presentation of Ombuds/QRT services to all adult probation officers and supervisor; troubleshooting/problem-solving session; distribution of clinical eligibility guidelines, brochures and business cards (September)

SITE VISITS

Three volunteer QRT members conducted 8 site visits between May and August. The following sites/programs were visited, and the score for each site follows:

- Compass Health-Skagit (5/25/06) – **84%**
  - Adult/Older Adult Services
  - Crisis Services
- Whatcom Counseling and Psychiatric Clinic (6/1/06) – **84%**
- SeaMar (Mount Vernon) (6/8/06) – **85%**
- Lake Whatcom Residential Treatment Center (6/29/06) – **67%***

- SeaMar (Bellingham) (7/6/06)
- Compass Health Coupeville (8/8/06) – **91%**
- Compass Health-Everett (8/18/06) – reviewed by 2 site reviewers – **80%**
    - Crisis Services – **80%**
    - Drop-in Center – **78%**
    - Adult Extended Care – **82%**
    - Adult Crisis Respite – **78%**
- North Sound Evaluation and Treatment Center (9/14/06) – **82%**

***** Results for Lake Whatcom Residential Treatment Center reflect the survey tool evaluating the accessibility of the facility. LWC-RTC is not licensed to serve people who are non-ambulatory; therefore the facility is not required to be accessible.

Results of the site visits are presented in Attachment 1.

SURVEYS – CROSS-SYSTEM LINKAGES

Targeted surveys have been conducted through telephone and face-to-face interviews by Deborah Moskowitz and Roger Ridgway, support staff from the Skagit County Mediation Services Department. The decision was made to focus on varying aspects of the correctional system during this 6-month period. Six interviews were conducted, including the following types of individuals:

- ✓ Chief of Corrections
- ✓ District Court and Probation Services Administrator
- ✓ Skagit County Jail Program Office (Sergeant from the Sheriff's Department)
- ✓ Probation Officers
- ✓ Skagit County Jail Transition Case Manager
- ✓ Skagit County Criminal Justice Intervention Coordinator

Survey results are included in Attachment 2.

CURRENT ISSUES OF CONCERN:

Two major issues of concern have been dealt with through an increase of calls and complaints from consumers over the past six-twelve months: medications and physicians; and dignity and respect. Ombuds has dealt extensively with these issues, and they are pervasive throughout the region and across a number of providers. QRT is a member of all of the quality committees at NSMHA and has brought these issues forward in an attempt to address them at a system level.

Ombuds/QRT submitted "cluster" reports about both of these issues. These reports are presented in Attachment 3. Following is a brief discussion of each of these areas:

MEDICATIONS and PHYSICIANS:

Over the past year, and particularly since the beginning of 2006, Ombuds has seen an increase in the number of consumer calls and complaints in this area. Consumers report the following types of complaints:

- Upon intake for mental health services, consumers are told that they are not "eligible" for a medication evaluation and/or medication management services, even though they are eligible;
- Consumers are waiting abnormally long periods of time to see a provider after their intake visit (sometimes up to 8 weeks) and on an ongoing basis;
- Due to the high turnover of psychiatrists and lack of prescribers in the region (at times during this reporting period), consumers are often unable to get in to see a prescriber on a regular basis;
- Consumers complain of a tremendous lack of continuity of services for medication management, due to the high turnover of prescribers. Consumers often see a new/different prescriber at each visit; they are concerned that the new prescribers are not familiar with them or their history; and they are uncomfortable with the prescribers making immediate changes to their medication regime;
- Consumers are often not given adequate time during an appointment with a prescriber to discuss their medication issues. This has sometimes resulted in the consumer having adverse reactions to the medications and making trips to the emergency room at the hospital.

More specific details about this issue are presented in Attachment 3.

DIGNITY AND RESPECT

As with the complaints regarding medications and physicians, dignity and respect complaints have been on the rise in the past year, across the entire region. During the period of time last winter and spring funding was being reduced, while client caseloads were increasing and there were greater documentation requirements. Clinicians were overwhelmed, there was increased stress, and morale among provider agencies reached a low point. Ombuds received numerous complaints that seemed to be symptomatic of this climate. The following types of complaints were received:

- Receptionists made rude, disrespectful remarks to clients;
- Consumers often felt pressured to sign paperwork given to them at the end of a session, without adequate time for their clinician to explain the paperwork. This often caused conflict if the consumer questioned the paperwork or was reluctant to sign it.
- Clinicians made inappropriate remarks to clients (such as complaining about lack of funding, telling consumers that they did not have time to talk to them);
- Prescribers accused consumers of abusing their medications (when the accusation was unfounded and untrue);
- Consumers were being ignored by staff and needs went unmet (especially at the E&Ts).

More specific information about the dignity and respect complaints is presented in Attachment 4.

OBSERVATIONS AND CONCLUSIONS

SITE VISITS

Observations:

- Reviewers found all the facilities to be clean and well kept.
- Consumers seem to gather around the clinic entrances of 2 clinics, and often they are smoking near the entrance (WCPC, CH-Everett).
- Consumer rights were posted only in English at 2 providers (LWC, WCPC) and only English and Spanish at SeaMar Bellingham.

Conclusions:

- According to the QRT site reviewers, all the facilities visited were maintained and had a welcoming atmosphere. As noted, consumers were gathered and "hanging out" and smoking at the entrance of 2 clinics. This sometimes creates a barrier for people who are approaching the building. Consumers are often intimidated and uncomfortable by these groups at the entrance and feel that they do not want to attend treatment at that location. This is born out by complaints that Ombuds has consistently received from consumers. They often feel afraid and vulnerable and are reluctant to approach a building when there are people hanging around near the entrance.

  On a visit to CH-Everett on October 11, I observed that there were a number of chairs lining the front walkway, under the canopy, with a large bucket next to the chairs that contained cigarette butts and ashes. There was one person sitting there smoking as I walked into the building, and there were other people hanging around the doorway. The bucket of cigarette butts was not particularly welcoming, and the smokers were just barely at the legally allowed distance from the entrance.

- Informing consumers of their rights and having them posted and accessible to consumers continues to be an important issue. Ensuring that rights in a printed format are posted in an easy-to-read place, without obstruction is most useful. Having consumer rights posted in all the languages recommended is a proactive approach to informing consumers.

Recommendations:

- ✓ Ensure that entrances to all clinics and facilities are attractive and welcoming to consumers and visitors and that they are free of people gathering there. Provide a smoking area that is well away from any entrances, so that smokers have a place to gather, and that entrances are safe and inviting for people approaching the building.
- ✓ Post a current copy of consumer rights that are consistent with those listed in the Medicaid booklet. Post, or have available in the vicinity of the posted rights, copies of consumer rights in all the required languages, so that they are self service for those who want them.

CROSS-SYSTEM LINKAGES

Observations:

- Everyone surveyed has had contact with the public mental health (MH) system.

- ❖ At best, only 50% of those surveyed received help that was satisfactory; the remainder were either referred elsewhere or an attempt was made to assist them.
- ❖ When they referred people to someone in the pubic MH system, 67% of those surveyed did not have much hope for help for their client.
- ❖ 83% of those surveyed have contacts in the MH system who they could call on for help or information.
- ❖ 83% of those surveyed feel that the MH system has only occasionally helped people they have referred.
- ❖ All people surveyed know of NSMHA, and 50% have had at least a little contact.
- ❖ Respondents felt that the MH system is comprehensive, offering services in many different areas and seems to do fairly well with people in crisis.
- ❖ Respondents felt that medication management, access to services for a wider range of individuals, and better quality services with higher quality clinicians are pressing issues.
- ❖ Respondents also noted a desire for more cross-system collaboration and information sharing.
- ❖ Respondents expressed great frustration with the difficulty of getting their clients into services and that there are services adequate to meet their needs.

Conclusions:

- ❖ Professionals working with offenders very frequently have great difficulty connecting with the MH system and helping their clients get needed services.
- ❖ These professionals often feel isolated and excluded from the MH system and less effective at helping their clients integrate back into the community.
- ❖ There is a great deal of frustration at the increasing number of individuals who have a mental illness and end up in jail. These inmates often lack the necessary MH services when they are released and continue to reoffend.

Recommendations:

- ✓ Explore strategies for collaborative relationships between MH providers, chemical dependency providers and professionals in the correctional/legal system and look at ways to exchange information that will help the client, without confidentiality becoming a barrier to services and supports.
- ✓ Address the “larger picture” regarding the high proportion of offenders who have a mental illness, and propose services and supports that would decrease this number and deter people from reoffending. This might be helpful and timely information for the Transformation Grant.
- ✓ Appeal to the state for increased jail transition funding that would serve a wider range of offenders with mental illness than are currently served.

<u>PHYSICIANS AND MEDICATIONS</u>

Observations:

- ❖ Ombuds has received a significant number of complaints regarding access to medication management and conflict over being transferred to primary care physicians (PCPs) for management of the psychiatric medications (14 complaints during the most recent 6-month period).

- ❖ This has been an ongoing area of concern for the past year.
- ❖ Ombuds/QRT has brought this concern forward to NSMHA, initially in the form of a cluster report and then as a "template" issue for the purpose of studying the issue and taking action.

Conclusions:

- ❖ Medications and access to qualified prescribers continues to be a critical issue for consumers who rely on these chemicals to help them achieve and maintain stability.
- ❖ When consumers do not receive the medication that helps them feel confident, there is a decrease in their stability and well-being. Often this is accompanied by an increase in anxiety and other symptoms of their illness when then leads to more frequent hospitalizations.
- ❖ There is an increase in the amount of resistance from PCPs who are not qualified to prescribe and monitory psychiatric medications and are uncomfortable in doing so. Sometimes there have been disastrous results when an unqualified prescriber has managed these medications for a consumer, resulting in abrupt termination of medications, extreme adverse side effects and negative drug interactions.
- ❖ This issue appears to be reaching crisis proportions for our consumers, as there is a concerted move by the MH system toward shifting responsibility for psychiatric medications to PCPs.

Recommendations:

- ✓ Recruit more qualified prescribers for the MH system, so that service is available to consumers.
- ✓ Screen all consumers upon intake for medication management needs and provide timely appointments with prescribers.
- ✓ When a transfer of medication management to a PCP is being considered for a consumer, follow the NSMHA/agency policies requiring communication and collaboration the MH prescriber and the PCP and provide ongoing consultation.
- ✓ Listen to and respect consumer voice and input regarding the medications prescribed, side effects experienced, long-term effects of the medications, and choice of prescriber for management of the medications.

<u>DIGNITY AND RESPECT</u>

Observations:

- ❖ This is an ongoing area of concern in our region, as Ombuds continues to receive a high number of complaints from consumers and family members.
- ❖ There are consistent complaints about consumers being treated rudely.
- ❖ There are consistent complaints from consumers accusing them of being med-seeking and abusing certain medications (such as benzodiazapenes and pain medication).

Conclusions:

- ❖ Complaints from consumers in this area appear to be an indicator, and sometimes a symptom, of the health of the system. For example, when MH providers/staff are under increased stress, there is an increase in complaints in this category.

- ❖ There appears to be a lack of emphasis on providing excellent customer service, along with MH treatment, to consumers.
- ❖ It appears that consumer voice often goes unheard; and sometimes when it is heard, it is devalued, ignored or there are negative consequences.

Recommendations:

- ✓ Since stress and funding issues are a given in the public MH system, develop strategies for processing staff distress, frustration and negativity so that it does not invade the treatment environment and affect consumers.
- ✓ Emphasize the delivery of excellent customer service, at all levels of the system. If consumers are not treated with dignity and respect and services delivered with care and compassion, then it matters little if “evidence-based practices” or state-of-the-art techniques are used.

NSMA Semi-Annual Critical Incident Report
JANUARY THRU JUNE, 2006

PURPOSE: To inform NSMHA Executive Board and Executive Director, county coordinators, CIRC, QMC, QMOC, and other stakeholders in the region interested in critical incident data and activities on a semi-annual basis.

HIGHLIGHT OF CI DATA FROM JANUARY THROUGH JUNE, 2006

Total Number of Critical Incidents, System-wide by Quarter 7/03 thru 6/06 (chart 1)

- Although the number of total reported incidents in the 1st quarter (86) was relatively high compared to the previous 10 quarters. 2nd quarter showed a significant decrease to 55

Total Number of Critical Incidents by County (chart 2)

- Snohomish County reported 30 critical incidents in the 2nd quarter, down from 38 in the 1st quarter
- Whatcom County reported 10 critical incidents in the 2nd quarter, down from 23 in the 1st quarter
- Skagit, Island, and San Juan Counties each reported 11 or less critical incidents in both 1st and 2nd quarters

Deaths (chart 3)

- Snohomish reported 9 deaths in the 2nd quarter, up from 7 in the 1st quarter
- All other counties reported a range of 0-3 in the 2nd quarter, with a reduction of at least 1 death per county from the 1st quarter to the 2nd

POSSIBLE TRENDS FROM JULY 2003 THROUGH JUNE 2006; A RETROSPECTIVE VIEW

In the 1st quarter of 2006 NSMHA expanded the "Other Critical Incidents" category (chart 7) into three specific categories for more focused monitoring. Those new categories include: Disruption of Services (chart 8), Property Damage (chart 9), and Other Negative Media (chart 10). Whether by coincidence or possibly as a result of a Hawthorn Effect, the number of reported critical incidents previously monitored in the "Other" category decreased from an mean average of 9.9 per quarter to only 4 per quarter in the combined 1st and 2nd quarters of this year.

Total Number of Critical Incidents by Quarter, 7/03 thru 6/06 (chart 1): The greatest quarter-to-quarter decrease in the total number of incidents occurred in the 1st to 2nd quarters in 2005 and 2006.

Total Number of Critical Incidents by County (chart 2): The total number of reported critical incidents has remained relatively consistent over the last 12 quarters in all counties except Whatcom. The smaller counties (San Juan and Island) range from 0-5 incidents in a given quarter. Skagit has shown a range of 5-15, and Snohomish, a range of 25-46. These numbers would seem to reflect the varied consumer populations in those counties. From the 4th quarter of 2003 to the 3rd quarter of 2005, Whatcom County showed a constant downward trend from 34 (4th quarter 2003) to 5 (3rd quarter of 2005), and has averaged 13 incidents per quarter over the past 3 quarters.

Deaths (chart 3): The numbers of deaths were 4 or less in all counties in 1st quarter 2006, falling to 3 or less in all counties except Snohomish and Whatcom. Snohomish seems to be in an upward trend since 4th quarter of 2005, which saw 4, then 7 in 1st quarter 06, and 9 in 2nd quarter 06. In the same period Whatcom County reported deaths have been steadily dropping. Only 2 deaths were reported by Whatcom in the 2nd quarter of 2006.

CRITICAL INCIDENT REVIEW PROCESS UPDATES AND INITIATIVES

In the 2nd quarter a specific type of incident occurred for the first time in the region. A Laptop was stolen from the car of an employee of a data processing partner resulting in the loss of PHI on 8,000 consumers from an NSMHA subcontracted provider.

- Following the incident the provider and subcontracted data processing partner followed the standard critical incident reporting protocol, notifying NSMHA and MHD
- A contract was entered into with a company who specializes in implementing corrective action in this type of occurrence
- Letters were sent to all involved consumers notifying them of the of the lost of their PHI
- An ad was placed in newspapers across the state to notify those consumers who could not be contacted by mail
- A state-wide call center was set up to field questions and complaints about the incident
- NSMHA and MHD have been monitoring the situation and are receiving bi-weekly corrective action status reports from the data processing company
- To our knowledge no PHI has not been used inappropriately

ONGOING CRITICAL INCIDENT QUALITY MANAGEMENT RECOMMENDATIONS AND REVIEW ACTIVITIES

- The CIRC reviewed all 141 reported incidents and all provider incident reviews
- The CIRC continues to further investigate incidents and the circumstances surrounding their occurrence to ensure compliance with policies and processes affecting the quality of consumer care, health and safety
- The CIRC highlights and pursues specific incidents that provide examples of region-wide need or challenges in consumer care that may be impacted by provider directed system changes or policy development
- The CIRC and critical incident review process continue to work in tandem and cooperation with other NSMHA quality assurance and improvement activities including denial review requests, utilization review, formal audits and selected projects aimed at improved consumer outcomes and decreased risk to consumers
- The CIRC continues to be active in spearheading new ways to utilize Critical Incident Data to best facilitate quality improvement activities for the benefit of consumers in the NSMHA region
- The CIRC continues to follow specific incidents of concern that affect consumers

DRAFT 11/16/06

Youth – Anxiety Disorders	
Diagnostic Features	**Consistent with DSM IV –TR criteria. In cases where the client is not benefiting from treatment the diagnosis will be reassessed.**
Assessment Components and Considerations	**Anxiety Disorders disrupt the normal psychosocial development of youth, affecting their ability to interpret ordinary situations, which are often determined by the child to be negative rather than ambiguous.** **1. Parental anxiety disorder has been linked to an increased risk in youth.** **2. Screen for other conditions that may be co-morbid or may be confused with Anxiety Disorder (e.g. other mood disorders, organic / medical conditions, substance abuse, other psychotic disorders and disorders of childhood, infancy & adolescence)** **3. Assess for both suicide & homicide risk at intake and when signs, symptoms or circumstances change such that the client is at increased risk.** **4. Family / caregivers should be involved in the assessment process whenever possible. Family systems should be assessed to determine needs that can be met that may be contributing to the Anxiety Disorder.** **5. Age of the youth may be a factor and should be considered when assessing the presentation of behaviors, signs and symptoms.**
Treatment Guidelines	**1. Initial and periodic psychiatric screening to determine need for consultation, evaluation and/or medications, for symptom management.** **2. Treatment plan includes interventions consistent with the level of risk for self harm or harm to others. Interventions may need to involve others beyond the youth and family (e.g. school personnel).** **3. Case management services may be helpful for coordination, family support and advocacy.** **4. Psychoeducation about anxiety, incidence and treatment options are important and should be included. Family members and significant others may engage in the treatment process wherever appropriate and possible.** **5. Co-occurring disorder treatment as indicated.** **6. Individual, family and/or group psychotherapy can be provided.** **7. Crisis planning focusing on early signs of decompensation, safety and management strategies.** **8. Inpatient services for acute stabilization as needed / appropriate.**
Optimal Outcome of Treatment	**The client will attain symptom relief, learn skills to prevent or manage future episodes and improve functioning in daily life.**
References	**DSM IV-TR** **Wyoming Public Mental Health Guidelines** **American Academy of Child and Adolescent Psychiatry** **NAMI**

Adult-Attention Deficit Hyperactivity Disorder 'ADHD' (DSM IV-TR codes 314.00, 314.01, 314.9)	
Diagnostic Features	**Consistent with DSM IV –TR criteria. There are three subtypes: Inattentive, Hyperactive/Impulsive and Combined type. Impairment must occur in at least two of three major life settings, such as work, home and social settings, and be consistently present for a 6-month period. Symptoms of ADHD must have been present by the age of 7 years, and be consistent throughout the life span, not episodically. Symptoms must be caused by ADHD, not another mental disorder. Symptoms often look different in adults than in children: Hyperactivity may present as restlessness, edginess, difficulty relaxing; Deficits in sustained attention and concentration may present as missing appointments, etc. Impulsivity, difficulty with organization and prioritizing, as well as disinhibition are common.** **In cases where the client is not benefiting from treatment the diagnosis will be reassessed.**
Assessment Components and Considerations	**1. Structured interview with client including a detailed history, self-report of symptoms, past school records and a therapeutic history.** **2. Symptoms of ADHD must have been present by the age of 7 years. A review of school records in addition to talking to family members who knew the client as a child are helpful for making this determination.** **3. Interview with spouse/significant other is useful.** **4. Higher prevalence of the disorder for people who have first degree biological relatives with ADHD.** **5. Psychometric assessment with a tool, such as: the clinician-rated Connor's Adult ADHD Rating Scale; and consumer-rated Wender-Utah rating scale; Adults Investigator Symptom Report Scale (AISRS); Pilot Adult Self-Report Scale (ASRS); Copeland Symptom Checklist for Adult ADHD; Brown ADHD Rating Scale. Other similar scales exist as well.** **6. Screen for other conditions that are co-morbid or may be confused with ADHD, co-morbidity is more likely the rule than the exception. The most common psychiatric conditions that may have overlapping symptoms with Adult ADHD include mood disorders, anxiety disorders, substance use disorders, antisocial and borderline personality disorders, developmental disabilities, mental retardation and certain medical conditions.** **7. For a clear description of differential diagnosis, please see reference for the journal, *Psychiatry.***
Treatment Guidelines	**1. Treatment plan includes interventions consistent with severity of symptoms** **2. Psychiatric screening to determine need for consultation, evaluation and/or medication management. Some medications have been found to effectively manage ADHD symptoms.** **3. Cognitive Behavioral Therapy in conjunction with psychiatric intervention has shown to be the most successful treatment for Adult ADHD.** **4. Individual and/or group psychotherapy focusing on self-worth, social skills and compensatory strategies.** **5. Adults with ADHD benefit considerably from education about the disorder. They can be taught self-management strategies such as using computers for planning, scheduling and organization. They can find ways to decrease distraction in their homes and workplaces.** **6. Adults with ADHD should be educated about their elevated risks for drug/alcohol abuse and co-occurring mood disorders** **7. Varied employment strategies including prevocational and supported employment to assist clients ready to pursue employment.** **8. Treatment of this disorder occurs in conjunction with treatment for other currently relevant mental health issues.**
Optimal Outcome of Treatment	**The client will attain symptom relief, and/or develop skills to cope effectively with the symptoms of this disorder in daily life.**
References	• **American Psychiatric Association (2000) *Diagnostic and Statistical Manual of Mental Disorders*. Fourth Edition, Text Revision. Arlington, VA.** • **Canadian ADHD Resource Alliance (2006) *Canadian ADHD Practice Guidelines* [Electronic Version]61-95** • **Levin, F.R., Evans, S.M., Kebler, H.D. (1999) Alcohol & Drug Abuse: Practical Guidelines for the Treatment of Substance Abusers With Adult ADHD [Electronic**

	Version] ***Psychiatric Services,*** **50: 1001-1003** • **Adler, LA (2004) Clinical Presentations of Adults with ADHD [Electronic Version]** ***Journal of Clinical Psychiatry*** **2004; 65 (Suppl. 3)** • **Primary Psychiatry (2006) 13:5 (Suppl 3) and 13:10 (Suppl 5), Multiple Authors and Articles on Adult ADHD** • **Gentile, JP, Rafay, A, Gillig, PM (2006) Adult ADHD: Diagnosis, Differential Diagnosis, and Medication Management.** ***Psychiatry*** **Vol. 3 #8 pp. 25-30** • **Gentile, JP; Rafay, A; Gillig, PM (2006) Psychotherapy for the Patient with Adult ADHD. Psychiatry Vol 3 #8 pp. 31-35**

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

- **What is EPSDT?**

  - ✓ Early and Periodic Screening, Diagnosis and Treatment (EPSDT) is a health program for children with Medicaid that provides regular "Well Child Check-ups" by a Primary Care Provider (PCP).

  - ✓ Child here is defined as someone from age 0 to 21 years.

- **What is EPSDT designed to do?**

  - ✓ These check-ups or "screenings" are designed to aide Medicaid agencies to manage a comprehensive health program for children. This includes Mental Health.

  - ✓ EPSDT focuses on prevention & treatment, helping families access & use health resources, asses the child's overall health needs through examinations and evaluations and help to ensure health problems are diagnosed and treated early.

- **EPSDT Screening Services must Include:**

  - ✓ Comprehensive health and developmental history (includes mental health development), comprehensive physical exam, immunizations, laboratory tests, lead toxicity screening, health education, vision services, dental services, hearing services and other necessary health care to correct or ameliorate defects and physical and mental illnesses / conditions discovered by the screening services.

- **What is an EPSDT Mental Health referral?**

  - ✓ EPSDT referral is a referral given by a PCP regarding a mental health concern based on the PCP's initial impression the child and/or family may be struggling with a mental health problem.

  - ✓ A child will then have further evaluation and a mental health status exam by a mental health agency within 10 working days from the date of referral.

  - ✓ This comprehensive assessment of the child must include at a minimum a developmental, psycho-social and medical history, current conditions, academic / learning problems, family needs and chemical dependency assessment if appropriate.

.

- **What are the benefits to having this referral?**

  - ✓ Allows the Mental Health Professional (MHP) to be aware of a physical condition / illness that may impact mental health problems / concerns.

- ✓ Treatment planning and types of services offered can be more comprehensive and better designed to fit the needs of the child / family.

- ✓ Providers (in addition to PCP's and other treatment team members) can help to monitor periodic EPSDT appointments; encouraging the child / family to attend for a better continuum of care.