NORTH SOUND
MENTAL HEALTH ADMINISTRATION

QUALITY MANAGEMENT OVERSIGHT COMMITTEE

COMMITTEE MEETING PACKET

January 24, 2007

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: January 24, 2007
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: • PACT RFP • RFP • GAIN-SS • EQRO Check-In	Inform/discuss	DEBRA/ALL				10 min
Comments from the Chair	Update the committee on recent developments that impact QMOC- • Board actions	Inform	Chair				5 min
Policy Sub-Committee Report	Review and discuss policies reviewed by QMC	Review and approve	GARY WILLIAMS	1006.00 1504.00 1527.00 High Intensity Treatmen t	Attach	10	15 min
Exhibit N	Inform QMOC of April-September 06 Exhibit N Report	Discuss & Review	DIANA STRIPLIN	Packet	Attach	19	15

Quality in Action: EPSDT	Inform QMOC of program for children and new contract and monitoring requirements	Informational	ANGELA, QS DEBRA	Previous packet	Attach	34	10
Crisis Services Policies	QMOC to Review	Review and approve	SANDY WHITCUTT		Attach	36	15
PIPS	PIP #4 Seclusion and Restraint Summary	Inform & discuss	DEBRA/CHARISSA	Attach		38	15
Clinical Redesign Implications for Provider Training Needs	Inform QMC of LOCUS Model and need for training	Inform and discuss	DEBRA		Available at meeting		10
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 February 28, 2007, 12:30-2:00

Potential Agenda Items: PIPS –Extended Summaries of PIP #3
Policy Sub-Committee Update
Integrated Report
CI Report
QM Plan

North Sound Mental Health Administration
Quality Management Oversight Committee
NSMHA Conference Room
November 22, 2006
12:30 – 2:30
DRAFT MINUTES

Present:
Gary Williams, QMOC Chair, Board of Directors, Human Services Supervisor, Whatcom County
Debra Jaccard, NSMHA Quality Manager
Mary Good, NSMHA Advisory Board
Russ Hardison, Sea Mar
Nancy Jones, Snohomish County Human Services
Mike Manley, Snohomish County Human Services
Janet Lutz-Smith, Whatcom County Advisory Board
Dan Bilson, NSMHA Advisory Board
Deborah Moskowitz, Ombuds
Chuck Davis, Skagit County Mediation Services
Susan Ramaglia, NAMI Skagit
Rochelle Clogston, Compass Health

Excused:
June LaMarr, Karen Kipling.

Not Present:
Maile Acoba, Skagit County Coordinator
Janelle Sgrignoli, Snohomish Co. Human Services
Terry Clark, Compass Health
Joan Lubbe, NSMHA Advisory Board

Others Present:
Barbara Jacobson
Charissa Fuller
Greg Long
Angela Fraser-Holtz

1. **Introductions**

The meeting was convened at 12:33 pm and introductions were made.

2. **Review and Approval of Agenda**

The agenda was reviewed. Debra would like to add a discussion on the meeting in December whether to cancel or change the date. Mike would like to speak about WSH later in meeting. The agenda is then approved.

3. **Review and Approval of October Minutes**

The minutes from the previous meeting were reviewed. Susan wants her comment corrected in the minutes from the last meeting. It is not our mental health division that was found non-compliant it was the Mass. Mental health division. The courts have found that the State of Mass. was non-compliant not MHD. It was noted that the packets that went out in the mail were very light and hard to read. Rochelle would like it noted that she was present at the October meeting. The minutes were then approved.

4. **Announcements**

Kids E&T--Greg noted we had a meeting with King Co and Snohomish Co. staff. Talked about site options and toured the Denny youth center that has an available pod which was looked at as a possibility. Chuck got a call from King Co though and they are not comfortable with this as it is a detention center. There is an estimate that it would take a half million dollars to remodel Aurora house and also the issue of placing the current residents elsewhere. Chuck is looking at our options and maybe going to MHD. A third option would be at the old Martin center. Gary says it

is off the table with sale pending. We've received $275,000 to remodel a facility and we set aside $130,000 of FBG funds for start up but still no facility. Mike noted we need to think of short term solutions as he doesn't want this to die; we need to broaden our search and see what our other options are. The money that is available is for the facility. Gary noted that if lack of site stops us maybe we should look at community based non-institutional settings to help kids and get something going. Nancy noted a program in Snohomish Co. but it has to be a specialized facility with several guidelines. Deborah noted a building in King County that may be a short term solution it was an RTF for long term care. Dan would like to know who is working on it from here and letting King Co. know of this facility. Greg stated that we are working collaboratively with King County and we will let them know of this facility also.

Gary says this Wednesday the 29th at 1:00pm Whatcom Co. is opening their behavioral health triage clinic and would like everyone to come.

Debra noted that for the EQRO our questions will be here to us on December 4th and we must turn them in by January 4th and the site visit hasn't been determined yet. We are continuing to prepare as best we can.

Debra noted that on the Clinical redesign there were two meetings on November 17th and 21st and a preliminary set of recommendations for what the design may look like is going to the planning sub-committee and then to the Board of Directors on December 14th for their approval. Dan would like to know if QMOC is looking at it, but it is more about funding and fees so for this committee it is mostly informational. It will produce a number of questions in the future of this committee however.

Debra states we have started our routine authorization of all requests for services and authorization letters are going out and that process seems to be going smoothly. On the PACT RFP Greg noted that the RFP has been released and 5 organizations have filed letters of intent: even one from out of state. We have sent out our responses to the questions and proposals are due on December 8th. More information will come as it is available. There will be an evaluation committee set up with representatives from DASA, corrections, DVR, two NSMHA staff, two county coordinators, consumers and advocates.

5. Comments from the Chair

There are no comments from the Chair.

6. QRT Report

Deborah distributed her handouts for her reports. They cover the time period of April through September 2006. Details of outreach activities are in the report. The next item is the site visits conducted by Andrew Davis, Marie Jubie and Russ Sapienza. There was a survey tool sent out ahead of time and they made appointments and then did an objective visit. It is a snapshot of the facility with no standards that must be met. They visited the facility and talked with clients and got a sense of the facility. The report has a list of the agencies visited this time and overall it was felt that things looked pretty good. LWC got a low score only because of accessibility, being a two story building and there was a concern over people congregating in doorways being intimidating to consumers. Also an issue with consumer rights being properly posted. Dan brought up his concern about consumers in residential housing having a forum to discuss issues so their voices are heard.

The surveys for cross-system linkages are attached and they focused on the correctional system. They were conducted by phone and face to face. Overall it looks like they knew of the mental health services but did not have much hope of clients getting help in the system. Gary would like to see the interviews done again next year to see what impact the recent addition of staff will have on things. Deborah says they are still doing the interviews and will include community hospitals in the region also.
Issues of concern that QRT has brought forward are medication management and the issue of dignity and respect. Still many complaints and issues about these and they have been brought forward to the RSN in many committees to address them. Both of these issues have been on the rise over the past year.

7. Policy Sub-committee Report

There is one policy to review 1006.00-first policy to go through the policy subcommittee and QMC. The red is the proposed changes; it is about how to write and review policy; our processes. The main change is the Executive Director is allowed to sign after a policy has gone through QMC and QMOC subcommittees and been passed by QMC and QMOC; it does not have to go to Board of Directors first. This relates to clinical and administrative policies. We need to go back to board on the 14th and ask about fiscal policy being included in that. Gary remembers QMC and QMOC would not see the internal ones relating to personnel just the quality policies. Make a motion to accept policy 1006.00 as presented with the request for clarification of the inclusion of NSMHA internal policy and procedures with the Board of Directors. The Motion is approved. Gary will present this at the next Board meeting and he will report back here at the next meeting what is decided.

8. Semi-Annual CIRC Report

Kurt is out today. Debra will go over the CIRC report handouts for this meeting. This report is done every 6 months. The period covered in this is January through June 2006. The report is reviewed. Gary wants to know if there is a pattern to these such as suicides and deaths and if there is anything from a quality improvement standpoint that could be looked at. Could something be done internally for clinicians to identify clients needing help before the quarter begins and what other things can be done to change the trends. Chuck says that CIRC has not looked at this before but he will bring this up to the committee. Deaths by county are looked at next. Greg notes that Diana looks at the number of deaths and one fact that stands out is that many consumers are not that old when they die. There is an estimate that life spans seem to be shorter by 25 years now and in the mid 1980s it was estimated to be 10-15 years shorter. There are probably several issues that cause this such as poor overall health care, disease management and life style. Diana is doing a mortality review and we will be looking at these things. It is a small sample of consumers that died before 50 not from suicide or other obvious causes that we are looking at more closely in this review. The other category was changed in January 2006 to include suicide, homicide, disruption of service and negative media so that tracking of trends in these areas can be done. Incidents seem to be on a downward trend overall. Janet wants to know if we can use these numbers to look at treatment and services to see if changes to those can affect these numbers. Deborah is on the CIRC committee and she states that we do look at trends and try to understand what has happened and we are asking for more follow up information now and trying to see what trends we may be able to affect. It may help us to give suggestions for services to best serve clients. Dan would like to see the reports broken down by population in Counties; numbers per 100,000. Gary was told that there is a suicide spike in Whatcom County in youth and is hoping that we are tracking these things.

9. **Regional Training Committee & PSTD Training Module**
   Will be postponed until next month.

10. **Clinical Guidelines**
    We submit two clinical guidelines each year and these two need to be to MHD by November 30th. QMC has approved both of these and they are coming to QMOC now for discussion and approval. They are Adult ADHD and Youth Anxiety Disorders. Chuck noted how important it is to work on adult ADHD because of all the complaints he receives of clients not being able to get treatment because they are adults. It is difficult to diagnose.

    Youth anxiety disorder is the other guideline needed at this time. There were small changes made in QMC, and Gary notes that guidelines make the documentation much clearer. There is a discussion of the definition of the age of a youth in the system. There is a motion to approve Youth Anxiety Disorders and it is approved. There is a motion to approve Adult ADHD and it is also approved. Greg wants this committee to look at how the current guidelines affect care; if we don't EQRO will do it for us. We have done 8-10 guidelines and have not looked at the effect of these yet.

11. **Quality in Action—EPSDT**
    Will be postponed until next month.

12. **PIPS**
    There are currently four PIPS. Charissa has a handout on them. PIP #1 was selected by MHD and began 1-1-2004 to increase consumer satisfaction on treatment planning. We want to discontinue this as a PIP and pursue in other avenues. Nancy asks what other avenues; it is going to the treatment planning workgroup to develop a policy and then to QMC. There is a motion to retire this PIP and it is approved.

    PIP #2 was started to improve data quality transmission and since data systems have been in place since April 2004 it is near 100%. There is a motion to retire PIP 2 and it is approved.

    PIP #3 is about mortality review from the CIRC committee. The data is being compiled and will be presented to QMOC in December or January.

    PIP #4 was begun to reduce seclusion and restraint in the E&Ts to prevent consumer injury or death. It began in June of 2005 to bring number down by 10 percent which has been met and exceeded. Three policies were implemented to address this also. We want to continue gathering this data and compare the numbers of the two E&Ts also. We don't get seclusion/restraint information from hospitals as they would be reluctant to disclose. This committee will bring it to the next inpatient meeting that we would like to have this data to compare to where we are.

    Nancy wants to know what our two new PIPS will be. Charissa is working on this and it will be brought to QMOC in December or January.

13. **Western State Hospital**
    Mike would like this as a topic at an upcoming meeting. He notes that the census continues to rise, this rise has occurred in the past year and there are several theories as to why. The region needs to look into the reasons why this is happening, is there some things that can be done to get the number down. This

rise is creating quality of care issue as client numbers rise the workload there increases. Debra states that this should go the hospital inpatient committee that meets in January as they send people to Western. Gary says that in looking at the numbers from Whatcom County, are there less restrictive avenues that could be pursued instead of sending them to Western. Things to look at such as getting more housing and more intensive case management to get the clients out of Western.

14. Other Business

Getting back to the discussion on formation of residential councils, the group discusses this being a guideline or part of the contract. To require the residential facilities to form these councils or strongly recommend that they do so. More discussion needs to take place on this issue, have them at every facility or only long term ones and also look at resource issues. Do it through a pilot or best practices model. There is a motion that residential facility providers must give written notification to residents that they have the right to form resident councils. As meeting has run over time there is a motion to table this for further discussion at the next meeting. The motion is approved.

15. Date and Agenda for Next Meeting

There is a motion to cancel the December 27th meeting due to proximity to holiday and several members not being available. The motion is approved so the next meeting is January 24, 2007. The meeting was adjourned at 2:40 pm.

Respectfully submitted,

Barbara Jacobson

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.

Effective Date: 7-28-04
Revised Date: Rev. B - 12/4/06
Review Date:

North Sound Mental Health Administration

Section 1000 – Administrative: Policy Development and Review

Authorizing Source: WAC 388-865
Cancels:
See Also: Approved by: Executive Director Date: 12/27/06
Responsible Staff: Contracts Manager Signature:

POLICY#1006.00

SUBJECT: POLICY DEVELOPMENT AND REVIEW

POLICY

NSMHA staff will review, revise, and develop, as necessary, policies relevant to federal, state, and contractual agreements. The review will be ongoing with a minimum yearly review of each policy and as necessary.

PROCEDURE

1. NSMHA staff will review the Policies and Procedures on an on-going basis, which may be directed to be reviewed by the QMC/QMOC Policy Sub-Committee.
2. QMC/QMOC Policy Sub-Committee will review all policies going to QMC/QMOC that affect clinical care or will necessitate changes in clinical policies, procedures or practices at the provider level. This committee will not review policies internal to NSMHA or policies which do not require provider level implementation or impact delivery of service.
3. After Policies have passed the review and approval of the Policy Sub-Committee they will then move on to be approved by QMC, QMOC and the Executive Director as defined in the Charter.
4. All Policies and Procedures which has been brought forward with consensus from QMC and QMOC will be reviewed and approved with a signature by the NSMHA Executive Director. Those policies and procedures without consensus will be referred to the Board of Directors. Reference: Motion 06-088, 09/14/06.
5. Changes to the Policies and Procedures will be issued to the Providers with a sixty-day notice of compliance.

ATTACHMENTS / REFERENCES

Policy Sub-Committee Charter, 10/8/2006
Reference: Motion 06-088, 09/14/06

POLICY #1504.00

SUBJECT: ASSESSMENTS FOR ONGOING SERVICES

PURPOSE

To assure that persons who may be eligible for NSMHA services are provided with a face-to-face assessment by a Mental Health Professional (MHP) as defined by the state of Washington to determine eligibility.

POLICY

All persons calling the NSMHA Access Line, a function delegated to VOA Access Line, who are financially eligible as defined in the Clinical Eligibility and Care Standards and not in crisis are referred to a NSMHA provider agency of their choice for a face-to-face assessment by a MHP to determine clinical eligibility.

All callers, regardless of funding, who are in crisis, are referred by Access to the crisis response system.

Callers who do not meet financial criteria for a face-to-face assessment who are not in crisis are referred to other agencies, programs and/or other community resources as available.

PROCEDURE

All callers who meet financial criteria requesting ongoing services are offered a face-to-face assessment appointment with a clinician who is a MHP within 10 working days (not to exceed 14 calendar days) to determine service eligibility and the appropriate level of care. For cases in which a provider indicates, or NSMHA or its designee determines that following the standard timeframe could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, NSMHA must make an expedited authorization decision and provide notice as expeditiously as the enrollee's health condition requires no later than three (3) working days after receipt of the request for service. An example of such an instance may be but is not limited to a consumer discharging from a hospital or jail may obtain an expedited assessment appointment through Access. The agency scheduler advises the consumer that they are encouraged to bring a friend or family member to the assessment appointment, if desired, and about any special accommodations that might be needed at the time of the assessment appointment. Also, the consumer will be asked to bring all available and relevant medical records with them to the appointments.

Assessment documents are completed within thirteen (13) calendar days from the Access call or twenty seven (27) calendar days for an extension request approved by NMSHA. If seeking assessment information presents a barrier to service, the requested item is left blank and the reason documented in the clinical chart. If a consumer requests an assessment for services and during or at the completion of the assessment the consumer indicates they no longer wish to receive services, the consumer will sign a document to that effect, and documentation of their withdrawal of request will be kept in their record.

The attempt to obtain the consent and Authorization for Release(s) of information will be documented in the consumer's clinical record. Services may be initiated prior to completion of the intake assessment.

The MHP doing the face-to-face assessment will determine if the person being referred meets medical necessity for service per the NSMHA Clinical Eligibility and Care Standards Manual and Washington State Access to Care Standards. (See Policy 1505-Authorization for Ongoing Services).

Assessment documents will include a diagnostic formulation summary that specifies:

1. A full 5-axial DSM IV-TR diagnosis including co-occurring disorders that contains diagnostic justification and a diagnostic rationale per DSM IV-TR criteria for all diagnoses cited, including Rule Out diagnoses, if any.
2. All diagnoses cited must document the historical factors and longitudinal course of the consumer's disorder. The diagnostic justification should reflect a picture of the current illness over time, using the patient interview and all available collateral information as substantiation of the diagnosis/diagnoses assigned.
3. A brief written description of the psychosocial stressors noted on Axis IV and the numeric descriptor rated on Axis V, known as GAF or CGAS, giving a brief rationale for the rating level.
4. A brief description of all differential diagnoses considered and the rationale for why these diagnoses do not apply,

If the individual is currently receiving mental health treatment or psychiatric medications, the assessor must explain the basis for any differences in assessments, especially if recommending the person not receives publicly funded mental health services at this time.

Other Required Elements to be completed by the MHP as part of the Intake Assessment:

1. Completion of Core Data Elements
2. A consent for treatment or copy of detention or involuntary treatment order; (**WAC 388-865-0420**)
3. Source of referral
4. Functioning in Daily Life Domains identifying Consumer strengths, needs and desired outcomes in their own words. At the consumer's request also include the input of people who provide active support to the consumer; (**WAC 388-865-0420**)
5. Mental Status Examination
6. Risk Assessment to include current and historical danger to self and others (ideation, plan, attempts), current risk factors to be addressed in initial treatment plan, history of violence, domestic violence, other dangerous behavior, access to lethality, ability to use available supports, co-morbid conditions that may interfere with impulse control, behavior that is elevated from client's baseline, compromised ability to care for self
7. Medical/Health/Disability History including current/historical medications, Current Medical/dental care provider(s), Need for assistance or referrals made to access health care and/or coordination with current care providers, allergies, and if child/youth, whether "Healthy Kids screen is needed, and whether immunizations are current and any other relevant information
8. Substance Use/Abuse History and substantiation of all co-occurring disorders diagnosed (**WAC 388-865-0420)**

9. Documentation that consumers receiving court ordered treatment or treatment ordered by the department of corrections (DOC) have been asked if they are under supervision by the department of corrections. The consumer is required to disclose this information. (**WAC 388-865-0420**)
10. Age (**WAC 388-865-0420**)
11. Developmental History of children/youth (**WAC 388-865-0420**)
12. EPSDT referral request for children (**WAC 388-865-0420**)
13. Psychosocial history and Cultural context (beyond ethnicity) (**WAC 388-865-0420**)
14. Employment/Education history
15. Special Population status
16. Medical and mental health services history (**WAC 388-865-0420)**. This may include what consumers and/or significant others identified as helpful or harmful in the past; i.e., a harmful or beneficial treatment modality, or a medication with adverse reactions.
17. Identification of involved professionals, family and natural supports and documentation of efforts to include input and any records or other formal documents reviewed in the course of the assessment
18. Desired treatment outcomes of the consumer and consumer's significant others (**WAC 388-865-0420**)
19. Initial Treatment Plan and recommendations, signature of Mental Health Professional completing the assessment (**WAC 388-865-0425**)

REFERENCES

Washington Administrative Code (WAC) 388-865-0420 Intake Evaluation –Revised 8/06
Washington Administrative Code (WAC) 388-865-0425 Individual Service Plan

North Sound Mental Health Administration

Section 1500 – CLINICAL: High Intensity Treatment

Authorizing Source:
Cancels:
See Also:
Responsible Staff: Quality Manager

Approved by: Executive Director Date:
Signature:

POLICY #1527.00

SUBJECT: HIGH INTENSITY TREATMENT

PURPOSE

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

HIGH INTENSITY TREATMENT 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 HIGH INTENSITY 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. High Intensity 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

HIGH INTENSITY TREATMENT 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 HIGH INTENSITY TREATMENT 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 HIGH INTENSITY TREATMENT:
The purposes of HIGH INTENSITY TREATMENT 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
HIGH INTENSITY TREATMENT 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 HIGH INTENSITY TREATMENT 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 HIGH INTENSITY TREATMENT 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 HIGH INTENSITY TREATMENT 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 #1540.00).

HIGH INTENSITY TREATMENT SERVICE 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 HIGH INTENSITY TREATMENT**;
   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. **<u>Location of Services</u>** – 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

High Intensity 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 HIGH INTENSITY TREATMENT client and listing the team contact(s) to improve coordination of services between the case managers, Crisis Line, and Emergency Services.

Policy Status to be removed once ready for final approval

The policy subcommittee group reached consensus that this policy could move forward for final approval with recommended changes – see minutes from 1/8/07 meeting.

NORTH SOUND MENTAL HEALTH ADMINISTRATION
COMPLAINT, GRIEVANCE, APPEAL, DENIAL, AND FAIR HEARING REPORT SUMMARY
April 1, 2006 through September 30, 2006

INTRODUCTION and PURPOSE

- The NSMHA continues to report grievance, fair hearing, appeal, and denial data in accordance with the Mental Health Division reporting templates and requirements. The Mental Health Division now requires reporting in variable increments rather than 6 month periods. For this reporting period the MHD also required reporting for the standard 6 month period. The Mental Health Division no longer requires the reporting of complaint data
- The NSMHA continues to provide information about complaint data in a separate format as complaints account for the majority of complaint, grievance, and fair hearing information used for quality management activities. The NSMHA also continues to collect this data by 6 month periods as we have done since 1999.
- Therefore in this report we will include the required Mental Health Division reporting formats as well as the expanded reporting used for additional quality management purposes by the NSMHA.
- Information about complaints, grievances, appeals, denials, and fair hearings remains central to the NSMHA's quality management processes. Complaint data has also become increasingly more central to individual providers' internal quality management processes.
- The NSMHA continues to promote a "no-blame" atmosphere in which to view complaint data--that information about complaints creates opportunities for improvement and that consumers' voicing concerns or ideas for improvement is one form of consumer voice in a recovery based system.
- Single complaints or grievances with system implications, patterns or clusters of complaints or grievances, and/or overall complaint and grievance data are used to identify areas for further study and review or quality improvement

COMPLAINT, GRIEVANCE, DENIAL, APPEAL, and FAIR HEARING DATA

- The overall number of complaint, grievance and fair hearing occurrences reported decreased from 368 to 275 since the last reporting period, and the number of cases (people) reported decreased from 238 to 176 since the last reporting period.
- Several reporting changes may account for some of this reduction in reporting. NSMHA Ombuds services have refined their reporting to reflect only complaints about publicly funded Mental Health Services. The NSMHA and Ombuds services will work to refine this aspect of reporting for future reports. In addition, the NSMHA has operationalized the term "case" to reflect the number of unduplicated people during a reporting period.
- The categories that accounted for the most reported complaints during the current reporting period are: ***Physicians and medications*** 44 (16%), ***Dignity and Respect*** 38 (14%), ***Access*** 34 (12%), ***Emergency Services*** 26 (9%), and ***Consumer Rights*** 22 (8 %),

- A review of the data shows that ***Physicians and medications*** 98 (15%) ***Consumer Rights*** 97 (15%), ***Dignity and Respect*** 75 (12%) ***Access*** 71 (11%), and ***Financial and Administrative Services*** 56 (9%) accounted for the most complaints over the past year.

- When combined, ***Dignity and Respect*** and ***Consumer Rights*** accounted for 60 (22%) occurrences as compared to 112 (30%) during the previous reporting period (***Dignity and Respect*** is one of the consumer rights).

- The NSMHA continues to break out the overall complaint, grievance, and fair hearing data by Medicaid and state-funded consumers. The majority of reported complaints, grievances, and fair hearings filed continue to be for Medicaid consumers. Of the 176 reported cases, 163 were for Medicaid consumers and 13 were for state-funded consumers. Of the 275 occurrences reported, 260 were for Medicaid consumers and 15 were for state-funded consumers.

- There was an decrease in grievance and fair hearing cases (people) and occurrences (types and levels of concerns) reported since the last reporting period (There were seven (7) grievance or fair hearing cases and seven (7) grievance or fair hearing occurrences (as compared to twelve (12) cases and twenty (20) occurrences in the last reporting period). The NSMHA and Ombuds services will also meet to review grievance reporting to assure that the multiple occurrences (types) are reported consistently at the grievance and fair hearing level.

- The overall number of denials for Medicaid consumers has increased since the last several reporting periods. There were 181 denials for Medicaid consumers in the current reporting period, as compared to 122, 129, and 128 in the previous three (3) reporting periods. Denials for children remain higher than for adults. There were 99 denials for children and 82 for adults. Fifty seven (57) percent of the denials over the past year were for children. Four (4) of the 181 reported denials were for inpatient services.

- There were four (4) appeals reported for the current period. Two (2) appeals involved services for children and two (2) for adults. For all appeals the original denial decision was overturned during the appeals process. The NSMHA has developed a table to track the number of denials and appeals over time.

BROAD and CONSISTENT REPORTING

- The NSMHA continues to work towards broad and consistent reporting of complaints across multiple reporting sources. Increased reporting of complaints remains a goal of the NSMHA. Part of this goal includes capturing concerns that occur at the provider level when consumers are not involved in Ombuds services.

- The NSMHA continues to track the number and percentages of complaints and cases reported by Ombuds services and providers. The percentage of cases and occurrences reported by Ombuds services is the lowest since 1993 when we began keeping this data. One factor may be the changes in Ombuds reporting outlined above.

- As outlined in previous reports increased reliability in the reporting process is an area identified for continuous quality improvement. Ombuds services completed initial training to the Regional Quality Management Committee (RQMC) on their use of the complaint type categories. The NSMHA also provided region wide training to Ombuds and providers. The NSMHA anticipates continued training in this area and will continue to identify next steps in the RQMC.

QUALITY MANAGEMENT PROCESSES

- The NSMHA Internal Quality Management Committee (IQMC) will review the current complaint and grievance data and report, make recommendations for further study and review or quality improvement, and present these recommendations to the Regional Quality Management Committee (RQMC) and Quality Management and Oversight Committee (QMOC).

- NSMHA providers continue to use complaint and grievance information in their internal quality management processes.

- The NSMHA Ombuds services provide a semi-annual summary of their data and recommendations for quality improvement.

- Quality Management Recommendations approved during the last reporting cycle include:

  ✓ **Inpatient Capacity** Recommendation for further study and review of inpatient capacity (Ombuds services raised concerns regarding inpatient capacity). After review in RQMC, the recommendation was made to refer inpatient capacity to Management Council and/or the NSMHA Planning Committee. RQMC consensus was that we cannot compartmentalize approaches to this issue and that we need to create capacity and review the systems that are in place regarding inpatient services.

  ✓ **Dignity and Respect and Consumer Rights** Recommendation to Monitor dignity and respect and consumer rights issues over the next 6 months and in future reporting cycles

  ✓ **Trauma** Recommendation to discuss and evaluate the status of the trauma project (There continue to be some complaints concerning the availability of trauma services).

  ✓ **Flex funds** Recommendation to increase flex funds (Ombuds services report that at times flex funds were unavailable when needed to assist consumers)

  ✓ **System Tensions and Frustrations** Ombuds services recommendation that the NSMHA and providers work jointly on issues that are causing systems frustration for example funding, documentation, time availability, case load sizes, and medication management capacity concerns to decrease system tensions from impacting consumers. The recommendation is to refer this to management council so that there is a discussion regarding ways to prevent future system tensions from impacting consumers (per ombuds report).

- Several NSMHA grievances with system implications were discussed in the NSMHA Internal Quality Management Committee and Regional Quality Management Committees:

  ✓ **Adult Attention Deficit Hyperactivity Disorder** The NSMHA received several grievances related to the treatment for Adult Attention Deficit Hyperactivity (ADHD) Disorder over the last several reporting periods. The NSMHA IQMC recommended to RQMC that Clinical Practice Guidelines for Adult Attention Deficit Hyperactivity Disorder be prioritized for development. This recommendation and the guidelines were approved and adopted by RQMC.

- ✓ **Eating Disorders** The NSMHA also received several grievances related to the treatment for eating disorders over the last several reporting periods. The NSMHA IQMC has discussed the need to clarify the continuum of care for eating disorders on a region wide basis. Initially, IQMC recommended to RQMC that Clinical Practice Guidelines for eating disorders be prioritized for development. At the time, this area was not prioritized for development. The NSMHA will revisit this issue in future IQMC and RQMC meetings.

- Updates on PREVIOUS Quality Management Recommendations:

✓ **Medication Management Services** Further study and review to include access and triage to medication management services, medication management capacity, and discharge from medication management services. (Ombuds services identified concerns about access to prescribers and medication services and the number of complaints in this category has shown an increase over time).

Update: *A review of the data shows that complaints regarding physicians and medications accounted for the most complaints in the current reporting period and the most complaints over the past year. The NSMHA Internal Quality Management Committee (IQMC) completed a plan to study medication management services and clarify any issues. The plan was reviewed by the NSMHA Medical Directors Committee and RQMC. . In addition to this study process, the NSMHA and providers, for the next contracting period, has adopted a modified fee for service model that will purchase an increase in medication management services.*

✓ **Region Wide Access Process** Further study and review of the processes used to gather information and records during the access process from the initial call to access through the assessment process (This recommendation was made in light of the need to establish consumer eligibility for services within a short time frame with the goal of maximizing the potential for complete information when establishing consumer eligibility for services).

Update: *As discussed in the last report the region wide Access system is undergoing a process of transition from Compass Health to the Volunteers of America. The NSMHA is also restructuring the process for Authorization of Outpatient Services. When these transition processes are complete the NSMHA will review this recommendation to determine how to proceed.*

✓ **Reliability in the Complaint and Grievance Reporting Process** Increased reliability in the reporting process.

Update: *As outlined in previous reports Ombuds services completed initial training to the Regional Quality Management (RQMC) on their use of the complaint type categories. Since that time the NSMHA provided region wide training to Ombuds and providers. The NSMHA anticipates continued training in this area and will continue to identify next steps in the RQMC. In addition the NSMHA and Ombuds services plan to meet to work on continued standardization of the reporting format.*

- Complaint, grievance and appeal data has been one factor in quality improvement efforts towards:

✓ Providing **trauma based services**
✓ Assuring staff is trained on **Dignity and Respect** and **Consumer Rights**
✓ Clarifying policies and procedures regarding the **outpatient discharge process**

- ✓ The development of a **medication management transfer policy** to ensure seamless transition to primary care physicians
- ✓The development of region wide **diagnostic practice standards**

NORTH SOUND MENTAL HEALTH ADMINISTRATION
COMPLAINT, GRIEVANCE, APPEAL, DENIAL, AND FAIR HEARING REPORT

April 1, 2006 through September 30, 2006

I. INTRODUCTION

The NSMHA continues to report grievance, fair hearing, appeal, and denial data in accordance with the Mental Health Division's reporting templates and requirements. The Mental Health Division now requires reporting in variable increments rather than 6 month periods. For this reporting period the MHD also required reporting for the standard 6 month period. The Mental Health Division no longer requires the reporting of complaint data.

The NSMHA continues to provide information about complaint data in a separate format as complaints account for the majority of complaint, grievance, and fair hearing information used for quality management activities.
The NSMHA continues to report and unduplicate this information through multiple reporting sources (Ombuds services, providers, designees, networks, and the NSMHA).

The NSMHA will also continue to collect this data by 6 month periods as we have done since 1999, in addition to the variable timelines. Therefore in this report we will include the required Mental Health Division reporting formats as well as the expanded reporting used for additional quality management purposes by the NSMHA.

The NSMHA continues to promote a "no-blame" atmosphere in which to view complaint data – that information about complaints creates opportunities for improvement and that consumers' voicing concerns or ideas for improvement is one form of consumer voice in a recovery based system.

In this report we will:

- Provide an overview of complaint, grievance, denial, appeal and fair hearing data
- Provide a summary of quality management recommendations from the previous reporting period and subsequent quality management cycle
- Provide follow-up from previous complaint, grievance, appeal, denial and fair hearing quality management activities or recommendations
- Provide an overview of internal provider quality improvement activities and Ombuds services recommendations
- Outline future plans

II. COMPLAINT, GRIEVANCE, APPEAL, DENIAL, AND FAIR HEARING DATA APRIL 2006 THROUGH SEPTEMBER 2006

The NSMHA reported grievance, appeal, fair hearing and denial data to the Mental Health Division for both April through September 2006 and for the month of September 2006 as required in contracts with the Mental Health Division. The NSMHA also collected data for complaints for April through September 2006.

A. Grievance and Fair Hearing Data

There was a decrease in grievance and fair hearing cases (people) and occurrences (types and levels of concerns) reported for April through September 2006 as compared to the last reporting period. There were seven (7) grievance or fair hearing cases and seven (7) grievance or fair hearing occurrences reported for April through September 2006 as compared to twelve (12) cases and twenty (20) occurrences for October 2005 through March 2006. Five (5) of the grievance cases and occurrences were reported at the NSMHA level and two (2) at the provider level. All cases and occurrences were for adults who had Medicaid funding.

A review of the grievance files and data for the most recent period suggests that multiple occurrences were not reported at the grievance level. The NSMHA and Ombuds services will meet to review grievance reporting to assure that multiple occurrences (types) are reported consistently at the grievance and fair hearing level.

The NSMHA also was required to report the number of grievances and fair hearings for September of 2006. There were no reported grievances or fair hearings for September. *(See Attachments A – PIHP Grievances and Denials 6 months, PIHP Grievances and Denials September, SMHC Grievances 6 months, and SMHC Grievances September).*

B. Complaint, Grievance, and Fair Hearing Data

There was a decrease in overall complaint, grievance and fair hearing cases (people) and occurrences (types and levels of concerns) reported for April through September 2006 as compared to the last reporting period. There were 176 cases (people) and 275 occurrences reported for April through September 2006 as compared to 238 cases (people) and 368 occurrences for October 2005 through March 2006.

Several reporting changes may account for some of this reduction in reporting. NSMHA Ombuds services have refined their reporting to reflect only complaints about publicly funded Mental Health Services. The NSMHA and Ombuds services will work to refine this aspect of reporting for future reports. In addition, the NSMHA has operationalzed the term "case" to reflect the number of unduplicated people during a reporting period.

The categories that accounted for the most reported complaints during the current reporting period are: Physicians and medications 44 (16%), Dignity and Respect 38 (14%), Access 34 (12%), Emergency Services 26 (9%), and Consumer Rights 22 (8 %).

A review of the data shows that Physicians and medications 98 (15%) Consumer Rights 97 (15%), Dignity and Respect 75 (12%) Access 71 (11%), and Financial and Administrative Services 56 (9%) accounted for the most complaints over the past year.

When combined, Dignity and Respect and Consumer Rights accounted for 60 (22%) occurrences as compared to 112 (30%) during the previous reporting period (Dignity and Respect is one of the consumer rights).

The NSMHA continues to break out the overall complaint, grievance, and fair hearing data by Medicaid and state-funded consumers. The majority of reported complaints, grievances, and fair hearings filed continue to be for Medicaid consumers. Of the 176 reported cases, 163 were for Medicaid consumers and 13 were for state-funded consumers. Of the 275 occurrences reported, 260 were for Medicaid consumers and 15 were for state-funded consumers.

The NSMHA has developed several tables to assist in identifying trends and provide information about complaints over time *(See Attachments C – Table 1, Table 2, and Charts).* The data in these tables includes complaints, grievances, and fair hearings for both Medicaid and state-funded consumers. In addition, the category of Access now includes access to inpatient and outpatient.

The NSMHA continues to collapse the new categories of violation of confidentiality and participation in treatment into the category of other. We will separate out these two (2) new categories in future tables so we can track them over time. (For this reporting period there were six (6) complaints reported for violation of confidentiality and four (4) complaints reported for participation in treatment (Medicaid consumers).

C. <u>Denial and Appeal Data</u>

1. Denials

The overall number of denials for Medicaid consumers has increased since the last several reporting periods. There were 181 denials for Medicaid consumers for April through September 2006, as compared to 122, 129, and 128 in the previous three (3) reporting periods. Four (4) of the 181 reported denials were for inpatient services.

The NSMHA realized that they did not report denials for September only in the original reporting materials sent to the Mental Health Division and have included them in this report (*See Attachment A – PIHP Grievances and Denials September).*

Denials for children remain higher than for adults. There were 99 denials for children and 82 for adults. Fifty seven (57) percent of the denials over the past year were for children. As outlined in the previous report the NSMHA has expressed concerns related to the Access to Care criteria for children to the MHD, as we are concerned that the criteria may be too restrictive. The NSMHA understands that the MHD is currently reviewing the Access to Standards for Children.

2. Appeals

There were four (4) appeals reported for April through September 2006 and none reported for September only. *(See Attachments B-- Appeals PIHP 6 months and Appeals PIHP September).* Two (2) appeals involved services for children and two (2) for adults. For all appeals the original denial decision was overturned during the appeals process.

All appeals were handled through the standard appeals process and decided within 45 days. There were no requests for expedited appeals. The NSMHA has developed a table to track the number of denials and appeals over time *(See Attachment D--Appeals and Denials Over Time).*

III. QUALITY MANAGEMENT RECOMMENDATIONS and ACTIVITIES from PREVIOUS REPORTING PERIOD AND QUALITY MANAGEMENT CYCLE

As outlined in previous reports, information about complaints, grievances, appeals, denials, and fair hearings remains central to the NSMHA and provider's quality management processes. Complaint, grievance, appeal, denial, and fair hearing data and reports are reviewed in the NSMHA Internal Quality Management Committee (IQMC), Regional Quality Management Committee (RQMC), and Quality Management Oversight Committee (QMOC).

The identification of system implications or trends, areas for further study and review, or areas for quality improvement may be generated at each level of the process. In addition, complaint data has become increasingly more central to individual providers' internal quality management processes.

Single complaints or grievances with system implications, patterns or clusters of complaints or grievances, and/or overall complaint and grievance data are used to identify areas for further study and review or quality improvement.

The Complaint, Grievance, Appeal, Denial, and Fair Hearing Report for October 2005 through March 2006 was reviewed by IQMC, RQMC, and QMOC. A brief summary of recommendations or activities are presented below.

A. **Inpatient Capacity** Recommendation for further study and review of inpatient capacity (Ombuds services raised concerns regarding inpatient capacity). After review in RQMC, the recommendation was made to refer inpatient capacity to Management Council and/or the NSMHA Planning Committee. RQMC consensus was that we cannot compartmentalize approaches to this issue and that we need to create capacity and review the systems that are in place regarding inpatient services.

B. **Dignity and Respect and Consumer Rights** Recommendation to monitor dignity and respect and consumer rights issues over the next 6 months and in future reporting cycles

C. **Trauma** Recommendation to discuss and evaluate the status of the trauma project (There continues to be some complaints concerning the availability of trauma services).

D. **Flex Funds** Recommendation to increase flex funds (Ombuds services report that at times flex funds were unavailable when needed to assist consumers)

E. **System Tensions and Frustrations** Ombuds services recommendation that the NSMHA and providers work jointly on issues that are causing systems frustration for example funding, documentation, time availability, case load sizes, and medication management capacity concerns to decrease system tensions from impacting consumers. The recommendation is to refer this to management council so that there is a discussion regarding ways to prevent future system tensions from impacting consumers (per ombuds report).

In addition, several NSMHA grievances with system implications were discussed in the NSMHA Internal Quality Management Committee and Regional Quality Management Committees. These discussions are summarized below.

A. Adult Attention Deficit Hyperactivity Disorder

The NSMHA received several grievances related to the treatment for Adult Attention Deficit Hyperactivity Disorder (ADHD) over the last several reporting periods. The NSMHA IQMC recommended to RQMC that Clinical Practice Guidelines for Adult Attention Deficit Hyperactivity Disorder be prioritized for development. This recommendation and the guidelines were approved and adopted by RQMC.

B. Eating Disorders

The NSMHA also received several grievances related to the treatment for eating disorders over the last several reporting periods. The NSMHA IQMC has discussed the need to clarify the continuum of care for eating disorders on a region wide basis. Initially, IQMC recommended to RQMC that Clinical Practice Guidelines for eating disorders be prioritized for development.

At the time, this area was not prioritized for development. The NSMHA will revisit this issue in future IQMC and RQMC meetings.

IV. FOLLOW UP FROM PREVIOUS COMPLAINT, GRIEVANCE, APPEAL, and FAIR HEARING QUALITY MANAGEMENT RECOMMENDATIONS and ACTIVITIES

A brief summary of follow up to previous recommendations or activities is presented below.

A. Medication Management Services

As outlined in the previous reports, medication management services, including access and triage to medication management services, medication management capacity, and discharge from medication management services has been identified as an area for further study and review. (Ombuds services identified concerns about access to prescribers and medication services and the number of complaints in this category has shown an increase over time).

Update: *A review of the data shows that complaints regarding physicians and medications accounted for the most complaints in the current reporting period and the most complaints over the past year. The NSMHA Internal Quality Management Committee (IQMC) completed a plan to study medication management services and clarify any issues. The plan was reviewed by the NSMHA Medical Directors Committee and RQMC. In addition to this study process, the NSMHA and providers, for the next contracting period, has adopted a modified fee for service model that will purchase an increase in medication management services.*

B. Region Wide Access Process

As outlined in previous reports, the processes used to gather information and records during the access process
(From the initial call to access through the assessment process) has been identified as an area for further study and review. (This recommendation was made in light of the need to establish consumer eligibility for services within a short time frame with the goal of maximizing the potential for complete information when establishing consumer eligibility for services).

Update: *As discussed in the last report the region wide Access system is undergoing a process of transition from Compass Health to the Volunteers of America. The NSMHA is also restructuring the process for Authorization of Outpatient*

Services. When these transition processes are complete the NSMHA will review this recommendation to determine how to proceed.

C. **Increased Reliability in the Reporting Process**

As outlined in the last report, increased reliability in the reporting process is an area identified for continuous quality improvement. Training by Ombuds services on their use of the complaint type categories was identified as a first step. Ombuds services provided this initial training to the Regional Quality Management Committee.

Update: *The NSMHA, Ombuds Services, and providers continue to have the goal of increased reliability in the reporting process. Providers have requested further discussion, training and clarification of the reporting procedures. Since the last report, the NSMHA also provided region wide training to Ombuds and providers with the goal of increasing the reliability of the reporting process. The NSMHA anticipates continued training in this area and will continue to identify next steps in the RQMC. In addition the NSMHA and Ombuds services plan to meet to work on continued standardization of the reporting format.*

D. **Outpatient Discharge Process**

As discussed previously in this report, the NSMHA outlined the need for standardization of the outpatient discharge process (based in part on Ombuds services complaints from consumers and in part on new requirements). The NSMHA and providers began a subcommittee of the Regional Quality Management Committee (RQMC) to clarify discharge policies and procedures.

Policies regarding continued stay/authorization criteria, criteria for closing an episode of care/planned discharge from treatment, and medication management transfers to primary care physicians have been completed.

Update: *The policy regarding 30-day written notice of termination to consumers was approved by RQMC.*

E. **Broad and Consistent Reporting of Complaints**

As outlined above and in previous reports, the NSMHA has made it a goal to work towards broad and consistent reporting of complaints and grievances across multiple reporting sources. Part of this goal includes capturing concerns that occur at the provider level when consumers are not involved in Ombuds services.

As there have been few emergency services complaints reported by some NSMHA providers, broad and consistent reporting of emergency services complaints was identified as an area for quality improvement and addressed through the NSMHA Integrated Crisis Response System (ICRS) Committee. Broad and consistent reporting of complaints that involve children was also identified as an area for quality improvement

Update: *The NSMHA continues to track the number and percentages of complaint and grievance occurrences and cases reported by Ombuds services and providers. The percentage of cases and occurrences reported by Ombuds services is the lowest since 1993 when we began keeping this data.*

As outlined above, the NSMHA Ombuds services refined their reporting to reflect only complaints about publicly funded Mental Health Services, which may account for some of the reduction in the percentage of cases and occurrences reported through Ombuds service. The NSMHA and Ombuds services will work to refine this aspect of reporting for future reports. In addition, the NSMHA has operationalzed the term "case" to reflect the number of unduplicated people during a reporting period. This may also have impacted reporting (See Attachment E-for additional information about cases and occurrences over time).

The NSMHA also continues to track the number of emergency services complaints reported by each reporting source. Results for the latest reporting period show that emergency services complaints by some provider's remains low. (See Attachment E--for additional information about emergency services reporting over time).

Although the number of occurrences and cases reported that involve children showed a slight decrease since the last reporting period, the number of cases and occurrences involving children during the past year has shown an increase as compared with previous years. (See Attachment C—Table 1 for information about complaint reporting for children over time).

F. Trauma Services

In previous reports, we have discussed quality improvement efforts related to complaint and grievance data in the area of treatment for trauma and trauma-based disorders. In previous reports we also reported that the NSMHA and providers established a trauma disorder workgroup and that although the workgroup has ended, the Regional Quality Management Committee (RQMC) will continue to work to increase the access to and quality of services for those with trauma-based disorders. We also reported that RQMC and QMOC approved four recommendations.

Update: *The NSMHA and providers, through the RQMC, have continued to focus on trauma and work on objectives established by the trauma workgroup. Progress on objectives since the last report includes:*

- ***Posttraumatic Stress Disorder (PTSD) Clinical Guidelines:*** *The final revisions to the Posttraumatic Stress Disorder (PTSD) clinical guidelines for adults were completed, and the guidelines were approved by QMC, QMOC, and adopted by the NSMHA Board*
- ***Trauma Screening Tool:*** *There has been continued implementation of the trauma screening tool when trauma is suspected or reported*
- ***Trauma Training:*** *The NSMHA Regional Training Plan module for PTSD was completed and is now part of the regional training plan*
- ***"Quality in Action" Presentations to QMOC by the Three Trauma Pilot Projects:*** *There have been no new presentations since Whatcom Counseling and Psychiatric Clinic's presentation regarding their trauma pilot project.*

G. Dignity and Respect

As outlined on previous reports, Dignity and Respect has been identified as a training priority on the NSMHA Regional Training Plan.

Update: *The 2006-2007 Regional Training Plan has been approved and Dignity and Respect continues to be a prioritized training topic.*

H. Region Wide Diagnostic Practice Standards

As outlined in the previous reports the NSMHA has instituted the practice of reviewing appeals that result in the reversal of the original denial decision by the region. Based in part on this review, the NSMHA and providers adopted a set of practice standards for the diagnostic process designed to provide consistent, uniform and complete diagnosis during the assessment process.

Update: ***The NSMHA and providers continue to evaluate the consistency of the diagnostic formulation during the assessment process to ensure consistent regional application of eligibility standards outlined in the statewide Access to Care Standards.***

V. PROVIDER QUALITY IMPROVEMENT ACTIVITIES and OMBUDS RECOMMENDATIONS

As outlined in previous reports, the Providers continue to provide semi-annual information to the NSMHA about how they use complaint and grievance information in their internal quality management processes. The NSMHA has also begun to collect information about how this information is integrated into provider Quality Management Plans.

A. Provider Quality Improvement Activities

The NSMHA continued to receive positive examples from providers about how they are incorporating complaint data into their quality management processes and how consumer concerns can lead to areas for further study and review or as areas identified for continuous quality improvement. Some examples are:

- Compass Health is doing further analysis on complaints regarding Physicians and Medications to clarify what sub-categories can be identified, and compare that information with previous reporting periods. They will also be reviewing the data based on program to identify if there are a cluster of complaints about a prescriber or prescribers in a particular program.

- Compass Health has also made efforts to increase the number of complaints tracked that did not come through Ombuds services, as a way of ensuring that a) consumers feel comfortable expressing complaints and b) they are recording and capturing the fact that they receive, address, and resolve complaints on a regular basis.

- Catholic Community Services (CCS) has identified the need for increased attention to vulnerabilities during transition times when clinicians leave their employment to assist clients and their families to connect to their new clinician.

- CCS also identified the continued need for effective strategies for engaging parents in the treatment of their children and teens if parents are fearful or ambivalent about being involved.

- CCS is also working to increase their consistency of complaint reporting across multiple locations and requests continued work region wide to clarify reporting categories.

- Lake Whatcom Center (LWC) has continued to further define and separate the landlord/tenant program and representative payee program from their clinical services, as a result of a NSMHA level grievance.

- LWC also revised their clients' rights training which staff receive within ten days of hire and invited Ombuds services, Chuck Davis, to provide information on respect and dignity at all staff training. .

- Sea Mar has identified the goal of reducing turnover of psychiatric staff and finding a regular, permanent prescriber who can get to know their consumers and establish an ongoing working relationship regarding medications.

- Sea Mar has also addressed Dignity and Respect issues through in-service trainings at their all staff meetings to reaffirm their organization's commitment to treating all clients in a respectful, dignified manner.

B. <u>Ombuds Services Recommendations</u>

The NSMHA Ombuds services also provide a semi-annual summary of their data and recommendations for quality improvement. Some of Ombuds services recommendations for quality improvement focus include:

(1). Physicians & Medications Issues- Ombuds Services recommend that the NSMHA continue its plan for further study and review of medication management services and medication management capacity. Ombuds services also continue to report complaints regarding the transition of medications to primary care physicians.

(2). Dignity & Respect-Ombuds services recommend the NSMHA continue efforts towards addressing dignity and respect.

(3). Eating Disorders- Ombuds services recommend that the NSMHA develop a plan for treating clients with eating disorders, which is currently being considered by quality and management committees..

VI. FUTURE PLANS

A. The NSMHA continues to work towards broad and consistent reporting of complaints across multiple reporting sources and will continue to work towards increased reliability in reporting.

B. The NSMHA Internal Quality Management Committee (IQMC) will review the current complaint and grievance data and report, make recommendations for further study and review or quality improvement, and present these recommendations to the Regional Quality Management Committee and Regional Quality Management and Oversight Committee.

C. In addition to reviewing the aggregate data in these reports to identify any trends, individual complaints, grievances, or appeals with system implications, or patterns or clusters of complaints, grievances, or appeals with system implications will be reviewed and used to generate quality improvement activities or identify areas for further study and review. The NSMHA will continue to work closely with Ombuds services to address any emerging patterns or clusters of complaints and incorporate this information into quality management processes.

D. The NSMHA will also continue the practice of reviewing appeals that result in the reversal of the original denial decision in order to ensure this process is reliable, adheres to standards, and identifies areas for potential quality improvement.

E. The NSMHA and providers will continue to collaborate to use information about complaints, grievances, appeals, denials, and fair hearings as opportunities for quality improvement.

F. The NSMHA will also continue to work with the Mental Health Division to clarify changes in the reporting format and changes in the contract regarding the grievance system. The NSMHA will update the Complaint, Grievance, Appeal, and Fair Hearing Polices to reflect these changes.

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.

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- **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.

Effective Date:
Revised Date: DRAFT – REV A, 12/11/06
Review Date:

North Sound Mental Health Administration

Section 1700: ICRS – Crisis Services General Policy

Authorizing Source:
Cancels: Policy #
See Also:
Responsible Staff: Deputy Director

Approved by: Executive Director
Date:
Motion #

POLICY #1704.00

SUBJECT: CRISIS SERVICES-GENERAL POLICY

PURPOSE

To provide an integrated, coordinated and seamless crisis response system for the NSMHA and its member counties: Island, San Juan, Skagit, Snohomish, and Whatcom (the "NSMHA Service Area").

POLICY

Crisis Services are an integrated system of voluntary and involuntary short-term emergency mental health services that are available 24-hours a day, 7-days a week to anyone in the North Sound Region aimed at resolving crises rapidly and using the least restrictive setting that assures consumer, family, staff and public safety.

PROCEDURE

The NSMHA intends that crisis services will be delivered in accordance with the following principles:

1. Crisis response services shall include both voluntary and involuntary service options.
2. Crisis response services shall be delivered across social service systems in a fully integrated, seamless, and consistent manner.
3. A person in crisis will be treated as a whole person, rather than focusing on categorical problems.
4. A crisis will be self-defined, rather than needing to meet categorical criteria.
5. A person in crisis will have easy and timely access to appropriate attention and care.
6. The Crisis Response Program will be able to refer to a complete continuum of care in order to respond to a variety of needs.
7. A person in crisis will be referred to the least restrictive resource available to effectively manage the crisis.
8. The Crisis Response Program will be community based.
9. Crisis Response services will be available to both adults and children.
10. Crisis services and information will be available 24 hours a day, 365 days a year throughout NSMHA/PHP.
11. Crisis Services will be fully integrated and coordinated at both the local and regional level.
12. All crisis services will be culturally competent and responsive.
13. Standards of care will be adhered to.
14. Individuals experiencing a psychiatric crisis will be stabilized in the least restrictive setting, in the person's home, or any in-vivo setting.
15. Crisis services will be provided in a seamless manner recognizing the uniqueness of each individual case.
16. ICRS will utilize a flexible array of services and supports, formal and informal, which fit the needs of the individual.
17. ICRS will be responsive and supportive of family members and persons experiencing a crisis.

Any individual is eligible for crisis services who is currently located in NSMHA geographical area, who is in a self-defined crisis, who meets the criteria of WAC 388-865, is referred for evaluation for ITA services, or is willing to accept voluntary crisis intervention services regardless of age, county of residence, enrollment status with another RSN, funding source, and/or ability to pay.

ICRS SERVICE COMPONENTS-Crisis response services include both voluntary and involuntary options and are available 24 hours a day/7 days a week. These services are provided by the various members of the ICRS, in coordination with the outpatient mental health providers to ensure continuity of care. These services are available Region-wide, however there is variability in the delivery approach of some services in some counties within the Region. An array of services available based on medical necessity is provided with the goal of serving the individual in the least restrictive environment possible to effectively and safely resolve the crisis.

1. Emergency Services During Business Hours for all people including enrolled Consumers
2. Investigation for Involuntary Detention for mental disorders and chemical dependency
3. Outreach
4. 24-hour/7 day a week Access to Crisis Plans
5. Emergency Walk-In Services during business hours
6. Urgent Appointments
7. Next Business Day Appointments
8. Coordination with Family and Other Natural Supports
9. In-Home/In-Community Stabilization Aides
10. Crisis Residential/Respite Options (for adults only)
11. Psychiatric and Medical Services
12. Cross-System Coordination
13. Cross-RSN Coordination
14. Interpreter Services
15. Special Population Consultation Services as required

NSMHA shall maintain and staff the Integrated Crisis Response Committee in accordance with NSMHA Quality Management system charter as a sub-committee of the Quality Management Committee. This committee shall consist of ICRS management staff from county-specific mental health crisis response, ITA, and community mental health systems, NSMHA, APN, and Volunteers of America. Additional representatives from other service systems and agencies may be invited to participate in this committee on an as needed basis.

The Regional ICRS Committee is responsible for establishing policies and procedures, including a documentation protocol that will be used by CONTRACTORs to ensure documentation of referral information, as well as, information detailing the services provided and the outcome of the intervention.

The contractors will purchase crisis services where the contractor has no formal crisis arrangements.

Voluntary crisis services and Involuntary Treatment Act services are provided in accordance with federal and state laws including the 1915(b) waiver, state administrative codes, Mental Health Division Contracts, NSMHA Contracts and attachments, the Clinical Care and Eligibility Standards and policies established by the regional Integrated Crisis Response Management Team.

QMC/QMOC Preliminary Study Summary
12/18/2006

NSMHA Performance Improvement Project #4
Restraint and Seclusion at the Freestanding E&Ts

Origin:
Performance Improvement Project #4 Restraint and Seclusion at the Freestanding Evaluation and Treatment (E&T) Centers was begun in May 2005. This project began as NSMHA became aware of specific areas of concern and one incident of consumer death while in five-point restraint at one of the E&Ts in the region. Also, Washington state implemented changes to seclusion and restraint standards at Western State Hospital, which highlighted the region's need to continue to reduce the use of seclusion and restraint as a best practice standard. The purpose of this project was to have zero incidents of injury or death while in seclusion or restraint and reduce use of both seclusion and restraint by ten percent. Three policies were developed/updated and implemented to facilitate the desired change including: Nursing Assessment Policy, Medical Clearance Admission Policy and Seclusion and Restraint Policy. The study population included all consumers admitted to the E&Ts.

Data Collection and Results:

Incidents of Death or Injury/Illness
All incidents of consumer death or injury/illness in the region are reported to NSMHA through the Critical Incident Reporting process. Critical incidents are reviewed by NSMHA staff upon receipt and again by the Critical Incident Review Committee. Any incidents of death or injury/illness reported by the E&Ts were reviewed again at the point the data was analyzed. It was determined that none of the reported incidents from the E&Ts occurred while the consumer was in seclusion or restraint.

Incidents of Seclusion and Restraint
Incidents of both seclusion and restraint have decreased by more than ten percent at both E&T sites. Mukilteo E&T had a 45.80% decrease in the average number of seclusions and a 25.05% decrease in the average number of restraints. North Sound E&T had a 39.20% decrease in average number of seclusions and a 47.43% decline in the average number of restraints. Statistical analysis indicates a strong correlation between the implementation of face-to-face monitoring, an update to the Seclusion and Restraint Policy, and reduction in the number of seclusions and restraints.

Factors impacting results
One factor that affects the comparability of the initial and repeat measurements is an error in counting seclusion and restraint events at Mukilteo E&T during the baseline period. During part of this time, events of seclusion and restraint were being counted twice when they were initiated prior to midnight and continued after midnight. The specific time period that this occurred is not known, but collection was corrected and did not occur during the entire baseline period. This error inflated the number of seclusion and restraint events during the baseline period resulting in inflated improvement for Mukilteo. Although the data for Mukilteo may not be as accurate as initially thought, we can generalize that some improvement likely occurred given the results from North Sound.

Some quality improvement measures were initiated by the provider agency at various times during the project. In December 2005, the Seclusion and Restraint Review Tool (see attached) was put into practice. This tool is completed by the night shift nurse supervisor, an RN, who then submits it to their quality

management department for review. The provider quality department provides feedback to the E&T staff to assure adherence to the policy practice standards.

Also, in January 2006, the E&T Director began a monthly audit of charts of clients who had been in seclusion and/or restraint. The Director provides written feedback to staff regarding ways to improve adherence to seclusion and restraint policy. These measures were not planned and may have an impact on the reported improvements.

Extrapolation of this study results may be somewhat limited given that the population served at the E&Ts is fairly homogeneous. The consumers are nearly all involuntarily detained and are covered by Medicaid or are uninsured, which is not the case for all inpatient programs.

Conclusions/Recommendations:
While a month's worth of data remains to be compiled and computed, it is clear that this Performance Improvement Project has proven extremely successful. This is demonstrated by:

- No events of injury/illness or death related to a seclusion and restraint event
- The goal of 10% reduction of use of seclusion and restraint was met at both E&Ts
- Mukilteo E&T had a 45.80% decrease in the average number of seclusions and North Sound E&T had a 39.20% decrease in average number of seclusions with a 47.43% decline in the average number of restraints
- Data processed through several statistical analyses has proven statistically significant

This project and its results have resulted in additional questions. Future plans may include investigating these issues further in conjunction with current research, with the goal of proposing new interventions.