NORTH SOUND
MENTAL HEALTH ADMINISTRATION

QUALITY MANAGEMENT OVERSIGHT COMMITTEE

COMMITTEE MEETING PACKET

April 25, 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: April 25, 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 Update • CPET Process Update • LOCUS Training June 11,12, 13, 2007	Inform/discuss	DEBRA/ALL				15 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	1511.00 1557.00 Attached	11		10 min
Regional Training Committee	Review Charter Regional Training Plan and Recruitment	Inform & discuss	DEBRA/CHARISSA	Attach	22		20

CI Report – July-December 2006	Review and discuss	Discuss and approve any recommendations	KURT AEMMER	Attach	38		15 min
Charter Review/Clinical Redesign	Review charter and discuss potentials changes related to increased number of provider/APN	Discussion and Recommendations	DEBRA/GARY/ALL	Attach	handout		10
Crisis Services Policies	QMOC to Review	Review and approve	SANDY WHITCUTT/GREG LONG	Attach	41		15
Date and Agenda for Next Meeting	Ensure meeting date, time and agenda are planned.		All				
*Review of Meeting	Were objectives accomplished? How could this meeting be improved?		All				

Next meeting May 23, 2007, 12:30-2:00

Potential Agenda Items: Policy Sub-Committee Update
Integrated Report

North Sound Mental Health Administration
Quality Management Oversight Committee
NSMHA Conference Room
March 28, 2007
12:30 – 2:30
DRAFT MINUTES

Present:
Gary Williams, Whatcom County
Debra Jaccard, NSMHA
Rochelle Clogston, Compass Health
Mike Manley, Snohomish County Human Services
Susan Ramaglia, Advocate
Chuck Davis, North Sound Ombuds
Deborah Moskowitz, North Sound Ombuds
Karen Kipling, VOA
Mary Good, NSMHA Advisory Board
Rebecca Pate, NSMHA
Nancy Jones, Snohomish County

Excused:
Dr. June LaMarr, the Tulalip Tribes

Not Present:
Maile Acoba, Skagit County
Russ Hardison, Sea Mar
Janet Lutz-Smith, NSMHA Advisory Board
Dan Bilson, NSMHA Advisory Board

Others Present:
Julie de Losada, NSMHA
Charissa Fuller, NSMHA
Angus McLane, Children's Administration
Rebecca Pate, NSMHA

1. **Introductions**
   The meeting was convened at 12:30 pm and introductions were made.

2. **Review and Approval of Agenda**
   The agenda was reviewed and approved.

3. **Review and Approval of February 2007 Minutes**
   The minutes were reviewed and there was some discussion regarding taking action due to not having a quorum. The charter/by-laws where reviewed and there was no language regarding a quorum; therefore, a motion was made to accept the minutes as written, seconded and motion carried.

   Gary requested that QMOC address the issue of language regarding a quorum in the by-laws and bring this forward as an agenda item for consideration.

4. **Announcements**

   - Debra discussed Program for Assertive Community Treatment (PACT) contract with services beginning end of June first of July. She mentioned that Laura Davis, Greg Long, *bridgeways* and Compass staff have been conducting meetings regarding implementation.
   - The Request for Qualifications (RFQ) process begins Monday, April 2 with completion of the process selection April 19. Recommendations will be given to the Planning Committee and the Planning Committee will take them into consideration and forward their recommendations to the Board of Directors.
   - Rochelle said the Behavioral Health Crisis Center in Skagit County is conducting an open house tomorrow, March 29.

- ❖ Debra mentioned the Tribal Conference coming May 2-3 at Skagit Resort and she also mentioned WRAP training coming in May.

5. **Comments from the Chair**
   Gary said he had no comments.

6. **Policy Sub-committee Report**
   Debra said there was nothing to bring forward but will probably have some policies next month.

7. **External Quality Review Organization (EQRO) Final Report**
   Debra informed the group about the EQRO review. The summary recommendations were distributed and discussed with the group. If you wish to view the complete final report, it is available on the NSMHA website at www.nsmha.org/reports/EQRO/NS_PIHP_2006_Final_Report.

   It was asked if NSMHA would know how they ranked with the rest of Washington. Diana said once all RSN reviews are complete a final evaluation report will be published for the state and NSMHA could see how they ranked at that time. It is unknown at this time when that report will be available.

   Debra mentioned that expectations versus reality regarding PIPs will become some issues to deal with in the future. Gary said if the state is not forthcoming with information by June perhaps NSMHA should inquire into the matter.

   Mike asked to what extent does someone determine the elements of an EQRO analysis. Deborah said that would be something to ask the EQRO. Gary said the real issue is does this group perform as the state intended. Debra said the QA/QI process has been maintained throughout the process and commentaries are not happening as much anymore it is more pass/fail process now. She said if you fail corrective actions have to be submitted to the state.

8. **Exhibit N**
   Diana presented her report covering April 1, 2006, through September 30, 2006. It was included in the packets and has gone before NSMHA Quality Management Committee (QMC) and Internal Quality Management Committee (IQMC). She would like some new recommendations from this group.

   - ❖ ***Develop a regional database – for complaints, grievances and fair hearings to track, monitor and analyze data related to complaints, grievances and fair hearings and unduplicate cases.*** A motion was made to accept the recommendation, seconded. Nancy suggested instead of develop use explore the development because of some operational concerns regarding privacy. Gary said development should move forward and address operational issues at a later meeting once the database is created. ***Deborah made an amendment that once the database is developed it be brought back to QMOC for review to ensure privacy and financial issues are met.*** Diana said she would like to develop a database that would add value to NSMHA's system and meet EQRO standards. ***A vote was called for regarding the amendment. It was seconded and the amendment carried. The main motion carried to develop the database.***
   - ❖ ***Review current status of trauma project in the region. A motion was made to accept recommendation, seconded, and motion carried.***

- ***Further study and review dignity and respect in the region.*** ***A motion was made to accept recommendation, seconded*** and Debra said discussion has occurred around training on this issue but a consensus was not reached and Diana said it is complex and multi-layered. ***The motion carried.***
- ***Clarify continuum of care for people in the region with eating disorders*** ***– A motion was made and seconded.*** Mike said he did not understand what this meant. Chuck Davis addressed this through explanation of what constitutes eating disorders. Deborah said resources around this need to be made available throughout the region without sending consumers out of the region, which is occurring currently. Gary said evaluation of eating disorder models with self evaluation should be conducted to include:

  - What really works;
  - What it should look like; and
  - What NSMHA responsibilities would be regarding eating disorders?

  Diana said it is a covered diagnosis in the standards of care but the current questions are:

  - What is NSMHA's responsibility outside of the state/region area?
  - What are the evidenced-based practices that work, etc?

  Gary recommended an amendment. ***Gary made an amendment for an evaluation of best practices, region responsibility and what should be developed within the region and/or out of network relating to eating disorders.*** ***A motion was made to accept the amendment, seconded and motion carried.***
- ***Develop a process to review Clinical Practice Guidelines for Adult ADHD to see that they address client concerns.*** Look at what types are coming in and see what gaps can be identified and address them. Develop a process to review clinical practice guidelines for Adult ADHD to see that they address client concerns. ***A motion was made to accept recommendation, seconded and motion carried.***

Ongoing recommendations:

- Medication management study
- Access process review – put on hold temporarily but will begin now.
- Ombuds recommended discussion be conducted w/mgt level on how consumer input impacted
- Flex funds increase
- Increased reporting in client relationship process
- Broaden system of complaints

Diana said Complaint/Grievance/Fair Hearing policies will have to be re-written soon.

Mike asked if the system will accommodate the changes coming forth within the region. Diana said any action item is appealable and she suspects there will be an increase in appeals and grievances.

9. Quality in Action: Children's Policy Executive Team (CPET) Process and Activities

Debra invited Julie de Losada and Angus McLane to address children's issues. Angus provided background information on himself stating he has a total of 20-25 years of experience in mental health services. His role in children's areas is to develop ways on how to involved families. The goal is to develop a program similar to the Family Assistance and Stabilization Team (FAST) program in King County. Julie said their goal is to reduce hospitalizations. Randy Hart, with Children's Administration, Julie and Angus would like to have the program up and running by October 1. Julie and Angus will be conducting a CHAP program review within the next few months. Angus said since NSMHA is a five-county area the program may wind up with a north and south area location. He said with the large geographical area it would make sense to have more than one location available. One issue currently is children are moved to multiple locations throughout their time in services and Angus said a goal was to find one place that could provide services to allow stabilization of children within the program. Angus stated when criminal behavior is involved ultimately acquiring a way to provide for the child in a safe manner for all is the goal. He said this may require hospitalization, criminal justice system involvement and/or reaching an understanding about what causes these circumstances. Angus said this program is limited to acute intervention. Julie said the difficulties are in placement and the objective is to go and assess the problem. Nancy said the ultimate goal would be to address the problem sooner to prevent the crisis situation or hospitalization. One critical issue is when the child is involved in Children's Administration the next day the facility is open the case file is made immediately available for information regarding the child so a resolution can be reached. Julie said connection has been made with Barbara Andrews from "Training Resources in Partnership" as a resource. Julie said she and Angus are studying how the two entities work to see how our region can make a program that will work for our region. Julie said they are meeting with other RSNs to see how they are working their programs so she and Angus can develop a model program for our region. Julie said a confidentiality workgroup is starting to develop a way for multiple systems to be able to share information and still maintain privacy/confidentiality. The purpose of doing this first is to possibly re-establish the "A-Team". Another workgroup will be the school workgroup to find out how to integrate with them.

10. PI Measures

Diana distributed a handout on performance measures and addressed the group regarding some of the information contained within the handout. She wanted to make the group aware that the state is going to hold NSMHA accountable for certain statewide performance measures and statewide outcomes. Diana stated two areas being addressed are: 1) non-crisis services occur within seven days of hospital discharge, and 2) is there focus on initial survey input. Intake managing is an issue also being addressed and she said the state appears to be measuring NSMHA against itself. She stated NSMHA is moving in the right direction according to data being collected. She said there has been discussion about creating a formal PIP but no recommendation has been made.

11. Crisis Services Policies

This was not discussed.

12. Regional Training Committee

This was not discussed.

13. Date and Agenda for Next Meeting

A motion was made to adjourn the meeting at 2:30, seconded and motion carried. The next meeting will be held on Wednesday, April 25, 2007.

The items added to the agenda were not covered due to time constraints.

Respectfully submitted,

Rebecca Pate

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: 11/21/2005
Revised Date: RevE 4/2/07
Review Date:

North Sound Mental Health Administration

Section 1500 – Clinical: Continuity of Care for Medicaid and Other NSMHA Eligible Clients

Authorizing Source: WAC 388-865-0345
Cancels:
See Also: Approved by: Executive Director Date:
Responsible Staff: Quality Manager Signature:

POLICY #1511.00

SUBJECT: CONTINUITY OF CARE FOR MEDICAID AND OTHER NSMHA ELIGIBLE CLIENTS

PURPOSE

To provide seamless access to medically necessary mental health services for Medicaid and other NSMHA eligible clients regardless of setting.

POLICY

Continuity of care is provided by working closely and collaboratively with the consumer and available natural and community supports. This is particularly true when providing cross-system support or during significant changes in the consumer's life and/or services. Such circumstances include, but are not limited to:

1. Cross system involvement;
2. Homelessness;
3. Involvement with the criminal justice system;
4. The presence of co-occurring disorders;
5. Changes in clinician;
6. Transfers from one agency to another or within the same agency; and
7. Entry into and discharge from inpatient mental health treatment, including Evaluation and Treatment Facilities.

NSMHA requires that children and their parents/caregivers/families are served at the same agency whenever possible.

NSMHA requires that adolescent consumers reaching the age of majority are provided continuity of care without service disruptions or mandatory changes in service providers.

We encourage our providers to assign enrollees to clinicians who are anticipated to provide services to the consumer throughout the authorization period.

Cross system involvement

NSMHA seeks community, county and multi-system input in the planning, implementation and evaluation of mental health services.

Homelessness

It is recognized that special steps need to be taken by NSMHA providers in serving individuals who have a mental illness and are homeless. These special steps frequently involve outreach activities as well as close collaboration with other community providers. The goal of these activities is to ensure that persons who

have a mental illness and are homeless have access to, and can receive the full spectrum of community mental health services as offered through NSMHA providers.

Coordination of Care Between Inpatient and Outpatient Care
NSMHA providers will follow policies regarding continuity of care referred to in policies:

1. 1526.00 – Inpatient Continuity of Care
2. 1529.00 – Children's Long Term Inpatient Program Care Coordination
3. 1536.00 – State Hospital Care and Discharge Coordination

Involvement in the criminal justice system
All consumers referred by, or who are known to be involved in, the criminal justice systems are provided appropriate mental health services.

Co-occurring Disorders
NSMHA provides services in a manner that identifies multiple system service needs and seeks, through collaborative efforts, to ensure the provision of appropriate care to consumers with co-occurring disorders.

Choice of MHCP
Each enrollee is able to choose a participating mental health care provider (MHCP) in accordance with WAC or any successor. If the enrollee does not make a choice, the Contractor or its designee must assign a MHCP no later than 14 working days following the request for mental health services.

CHANGES IN PRIMARY CLINICIAN

Consumer seeking change
NSMHA consumers may change their MHCP primary clinician within the first 90 days of service and once during a 12-month period for any reason. Additionally, NSMHA consumers may change their primary clinician at any time with documented justification.

Primary clinician resigns or on a leave of absence
NSMHA providers ensure that the consumer and treatment team (which includes family members) are informed of the change, prior to the leave or resignation whenever possible, with clinical documentation.

Agency decides to reassign primary clinician
Providers may decide to reassign a primary clinician for various reasons, including but not limited to: consumer need for different treatment services, clinician change in job responsibilities, etc. When this happens, the agency ensures that the consumer and the treatment team (which includes family members) are informed of that change, prior to its occurrence. (See P&P for Advance Notice to Consumers Regarding Agency Unilateral Changes in Treatment)

Inter/Intra Agency Transfers
Providers follow NSMHA procedures when transferring a consumer to another NSMHA agency. Furthermore, the initial agency/program retains overall responsibility for client care until completion of the transfer process. The completion occurs when the receiving agency/program indicates to the initial agency/program it accepts responsibility for overall client care (including medication management, if applicable) and a documented hand off has been made.

During the Inter-agency transfer process, the client will have charts open in both providers. The receiving agency must offer the client an initial assessment appointment within the standard 14 calendar days from the date the referral is made and must follow all other procedures and requirements for new clients except as noted below.

PROCEDURE

Cross-system working relationships:

1. NSMHA provider administrative and clinical staff attend county mental health advisory boards, community forums related to human service development, community network meetings, and other opportunities to secure input in regard to planning and service development.
2. NSMHA providers provide ongoing information to community referral sources to inform them of service availability and referral processes.
3. NSMHA and NSMHA providers participate in the development and implementation of services in conjunction with umbrella human service organizations and allied community providers to ensure that the widest range of quality supports and services are available to recipients of mental health care. Services include facilitated referrals to community health and social programs. Allied community providers include, but are not limited to:

    a. Tribal authorities
    b. Alcohol and substance abuse programs
    c. DSHS: Division of Developmental Disabilities, Division of Aging and Adult Field Services, Division of Children and Family Services, State Psychiatric Hospitals, Division of Vocational Rehabilitation
    d. The local AIDS network
    e. The Area Agency on Aging
    f. Freestanding evaluation and treatment facilities
    g. Local school districts
    h. Local Medicaid managed health care plans including Healthy Options and the Basic Health Plan Plus
    i. County jails, Department of Corrections, the juvenile court
    j. Local hospitals
    k. Nursing homes and other long-term care facilities (such as boarding homes, adult family homes, etc.)

4. Providers coordinate mental health care through the establishment and maintenance of close working relationships with providers such as those mentioned above.

<u>Homelessness</u>

NSMHA providers, as appropriate, will provide documentation of their outreach activities in serving people who are homeless. These activities may include, but are not limited to:

1. Provide outreach and assessment services in their location;
2. Provide screening and diagnostic treatment as soon as practicable;
3. Provide medication monitoring;
4. Provide information regarding food and clothing banks, shelters, mental health centers and other needed services;

5. Assist with safe havens, drop-in centers, clubhouse services and supports, crisis respite beds, residential services and emergency (temporary) housing in absence of permanent housing shortly after engagement;
6. Ensure representative payee services are available for those who need them; and
7. Coordinate with county homeless services regarding vouchers, rental assistance and other homeless services.

Involvement in the Criminal Justice System

Consumers with a mental illness diverted from jails, prisons, or juvenile detention/rehabilitation facilities will be identified and referred to community care:

1. NSMHA providers offering emergency and outpatient services provide crisis outreach, next day appointments, medications, assessments for ongoing care and linkages to community supports.
2. Following assessment, ongoing care is provided.
3. NSMHA providers offering outpatient care provide screening and diagnostic services for persons in the pre-sentencing and diversion process.

Contact with the criminal justice system is monitored by data collected in Client Information System (CIS) from the Crisis Service Contact sheets and through the NSMHA access system.

Providers follow established NSMHA policies and procedures related to access, crisis response and ongoing services for persons who are involved with the criminal justice system.

Maintain collaboration with the Division of Developmental Disabilities (DDD), Children's Administration, Juvenile Rehabilitation Administration (JRA), Educational Service Districts (ESD), Division of Alcohol and Substance Abuse (DASA), and other providers and stakeholders that are integrally involved in providing services to people with mental illness who are in the criminal justice system.

Co-occurring Disorders

NSMHA recognizes that it is important to identify the multiple service needs of mental health consumers, and either directly or through working relationships with other service systems, seek appropriate resources for mental health system consumers.

Through the NSMHA Access system, identify persons experiencing co-occurring disorders and address those disorders through direct service provision by NSMHA and affiliate providers or through referrals to other community programs.

Establish working relationships with other service systems to promote cost sharing and system efficiencies for persons with co-occurring mental health, substance abuse, developmental disability, child welfare needs or related disorders.

1. Where practical and appropriate seek dual licensure and funding for the provision of services through multiple social service systems.
2. In collaboration with other providers establish agreements for the co-location of direct services from service systems other than mental health.

Establish cross-system working relationships for assessment, referral and ongoing treatment with other service systems and providers.

Ensure that the multiple system needs are met for all age groups of consumers: children, adolescents, adults and older adults.

In facilitating the special needs of persons with dual disorders, explore program development and multi-system funding for services to be developed within NSMHA providers in meeting the needs of consumers with co-occurring disorders.

In conjunction with NSMHA, participate in regional planning efforts within the service systems of Children and Family Services, Developmental Disabilities, Aging and Adult Services and Alcohol and Substance Abuse in strengthening collaboration and multi-system involvement in serving mental health consumers.

CHANGES IN PRIMARY CLINICIAN

Consumer seeking change

1. When a consumer requests to change primary care clinician, she/he is asked to communicate this desire to the primary clinician or the primary clinician's supervisor.
2. The consumer will be notified within 10 days of the name of the new primary clinician.
3. The current primary clinician's supervisor or designee will arrange for the first appointment with the new primary clinician.
4. If the consumer's change in primary clinician is due to a complaint or grievance, this will be noted in the agency's complaint and grievance system.
5. Changes in primary clinician will be entered into the CIS.

Primary clinician resigns or is on a leave of absence:

1. If a primary clinician resigns or will be going on a leave of absence, the primary clinician's supervisor or designee will ensure that the consumer is aware of the new primary clinician before that clinician's departure. In the event that the new primary clinician is not known, the supervisor or his/her designee will serve in the primary clinician role until a replacement is found.
2. If a primary clinician will be on an extended leave from the office (greater than 10 business days), that clinician will notify their Level 2+ consumers and their treatment teams (including family members). If that clinician is the only member from their agency serving the consumer, they will also offer a meeting to the team members. If a client has another agency staff on their treatment team, a meeting offer is not required.
3. During the primary clinician's absence (as is true anytime) any member of the treatment team can ask for a team meeting if they feel it is necessary.
4. In the case of a resignation or a formal leave of absence, changes in primary clinician will be entered into the CIS within 10 days of the change.

Agency decides to reassign primary clinician:

1. If change in primary clinician is not by consumer choice, consumer will be notified within 10 days by the primary clinician, their supervisor or designee as to whom the new primary clinician will be.

2. The current primary clinician, supervisor or designee will arrange for the first appointment with the new primary clinician.
3. In the event that the new primary clinician is not known, the supervisor or his/her designee will serve in the primary clinician role until a replacement is found.
4. Changes in primary clinician will be entered into the CIS within 10 days of the change.

Agency Transfers:

1. Prior to initiating a consumer transfer from one agency to another; the consumer will be asked to sign a release of information allowing clinical documentation to be shared between the providers involved.
2. The transferring agency primary clinician coordinates transfer of the consumer to the receiving agency by (a) assisting the consumer through coordination with the NSMHA Access Line and the receiving agency's scheduler to transfer all applicable CIS data and schedule the initial assessment appointment at the new agency, (b) sending completed authorization for release of information and (c) providing the following items to the receiving agency prior to the client's first scheduled appointment at the new agency:

    a. Crisis Plan, if applicable (or client profile)
    b. Last Assessment
    c. Current Treatment Plan
    d. Health and Medical Information form
    e. Behavioral and Development form, if applicable
    f. Progress notes covering the last 30 days of treatment with additional progress notes when clinically indicated
    g. The last three prescriber notes, if applicable
    h. Last Psychiatric Evaluation, if applicable
    i. Last 180 Day Review, if applicable
    j. Medication list (current and historical), if applicable

3. The Access Clinician locates the consumer record from the transferring agency, updates relevant demographic information and confirms current authorization for outpatient services. The Access Clinician contacts the scheduler at the receiving agency and follows standard procedures for obtaining an appointment. At this point the client will be open with both the transferring and receiving providers.
4. When transferring prescriptive services, the transferring agency will provide the consumer with a 30-day script of medications unless this is not clinically indicated and the two providers have agreed to an alternative plan. The receiving agency will schedule a medication evaluation within 30 days unless otherwise indicated by the mutually agreed upon plan. If the consumer no-shows for the medication evaluation, it is the responsibility of the receiving agency to follow up with the consumer.
5. After the initial face to face visit with the consumer, the receiving agency primary clinician completes the Mental Health Assessment and the Health and Medical Information form. S/he then notifies the transferring agency primary clinician that it has accepted responsibility for treatment, including medication management, if applicable, and a documented hand off has been made. Each clinician documents this communication in the consumer's chart. The primary clinician at the transferring agency sends closing documents to CIS for entry.

6. The primary clinician for the receiving agency then reviews and updates the consumer's crisis plan and sends to CIS for entry into the CIS system. The updated plan is then filed in the consumer's chart.

Policy Status

The policy had numerous changes made and Debra Jaccard will review them with the subcommittee via email for final consensus and forwarding to QMC/QMOC – refer to the minutes 2/5/07 for details. The QMC/QMOC Policy Subcommittee made some brief changes (see minutes) - will revisit briefly April 2, 2007.

Forward to QMC with changes.

Effective Date:
Revised Date: 4/2/07
Review Date:

North Sound Mental Health Administration

Section 1500 – Clinical: Continuity of Care for Medicaid and Other NSMHA Eligible Clients

Authorizing Source: Per Contract
Cancels:
See Also: Approved by: Executive Director Date:
Responsible Staff: Quality Manager Signature:

POLICY #1557.00

SUBJECT: CARE ADVOCACY

PURPOSE

The Adult and Child Care Advocates engage in coordination of care for consumers throughout the region, in collaboration with providers, to maximize consumer outcomes. While the Care Advocate may on occasion have contact with a consumer, their primary role is to work with provider/stakeholders in coordinating systems issues that directly impact individual consumers or aggregate consumer populations.

POLICY

The Care Advocate performs a variety of clinical management oversight functions to monitor care received by consumers including the following:

High Utilizers of Outpatient Services
The Care Advocate will assist in determining efficacy and appropriate use of services.

High Risk Consumers—The Care Advocate monitors engagement activities for high-risk consumers who are not engaging in outpatient services and for those individuals who are discharging from inpatient mental health treatment into the community.

Frequent Users of Inpatient Psychiatric Services and Crisis Services—The Care Advocate provides oversight of clinical intervention strategies and transitions for consumers frequently using inpatient psychiatric services and/or crisis services**.**

Coordination of Medical and Psychiatric Care—The Care Advocate monitors for coordination of care between Psychiatric Provider Specialists and Primary Care Providers as necessary and appropriate.

Coordination with Housing Supports and Resources – The Care Advocate participates in regional and community level planning and interventions regarding housing supports and resources.

Special Populations—The Care Advocate participates in population level planning and interventions with special populations, as well as oversight of individual cases as needed.

Inpatient and Community Care—The Care Advocate provides oversight of psychiatric inpatient admission and care coordination with CMHA designated contacts, to promote rapid successful reintegration into the community at discharge. The Care Advocate monitors for appropriate discharge planning activities for consumers who qualify for CMHA involvement.

Care Advocates follow the care of a group of consumers in order to identify service gaps and utilization trends. This group of consumers is identified by their presence in reports, monitors and data sources, and those consumers identified by stakeholders. The Care Advocate will also follow those identified as the highest need consumers on a case-by-case basis to ensure quality care and appropriate utilization of services.

PROCEDURE

The Care Advocate participates in a number of activities including, but not limited to:

1) Monitor the following:
   a. Open Primary Episodes with High Inpatient Counts Report
   b. Top 100 Outpatient Service Utilizers Report
   c. Utilization Management Weekly Reports
   d. Critical Incidents

2) Participation in the following:
   a. Western State Hospital Discharge Planning Meeting
   b. Children's Long Term Inpatient Program Meeting (CLIP)
   c. Hospital Inpatient Meeting
   d. Children's Hospitalization Alternative Program Meeting (CHAP)
   e. Critical Incident Review Committee Meeting
   f. DDD/MH Collaborative Meeting
   g. ADSA/MH Collaborative Meeting
   h. DSHS Meeting (Children's Care Advocate)
   i. DCFS Regional Resource Team Meeting (Children's Care Advocate)

3) Other:
   a. Targeted Chart Reviews to review clinical interventions and services delivered
   b. Collaboration with Utilization Management clinicians to monitor inpatient utilization
   c. Collaboration with (Federal Block Grant) CMHA clinicians working with inpatient units to engage clients in outpatient care services prior to discharge from inpatient settings
   d. Collaboration with Access clinicians regarding consumer access to CMHA care
   e. Participation in an array of quality assurance and quality improvement activities relating to consumers of RSN services
   f. Collaboration with PACT team staff and Advisory Board regarding delivery of services

4) Upon review of consumer records, the Care Advocate may make focused treatment recommendations with required follow up, as necessary.

5) The Care Advocate will make contact regarding client services with provider/stakeholder Quality Managers or the provider/stakeholder assigned designee.

6) In addition, providers may contact the regional Adult and Child Care Advocates for the purpose of informing/consulting with regional staff regarding care and plan of treatment.

7) Ombuds may contact Adult and Child Care Advocates for the purpose of informing/consulting with regional staff regarding care and plan of treatment.

ATTACHMENTS

None

The Policy Subcommittee made some changes on 3/5/07 (see minutes) and will re-review on 4/2/07.

The Policy Subcommittee made some additional changes on 4/2/07. They will review via email after changes are made to accept and move forward to QMC in April.

North Sound
Mental Health Administration

Regional Support Network for Island, San Juan, Skagit, Snohomish & Whatcom Counties
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NSMHA Regional Training Sub-Committee Charter

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Charge to the Group
To support planning throughout the region for training to ensure high quality and effective treatment within NSMHA's values and mission.

Primary Objectives

A biennial Regional Training Plan will be developed and reviewed annually for any needed revisions or updates. The Regional Training Committee will work on strategies to develop uniform training modules for selected topics to be used by all providers in training new staff. The committee will review areas for quality improvement as they are identified that relate to training issues and the committee will also be involved in the development of training programs as needs are identified either by the committee, other regional committees, consumers, county coordinators, external stakeholders or other sources.

Membership
Membership is open to all NSMHA providers. There will be at least one representative from the NSMHA Mental Health Advisory Board. Membership will also be open to one consumer representative as appointed by the NSMHA Mental Health Advisory Board. The Advisory Board representative and the consumer representative may be the same person. There will also be one committee position for a tribal liaison.

Decision-making
All decision-making is according to the consensus model.

Responsibility for Committee Support:

1. NSMHA will chair the meeting.
2. NSMHA support staff will take minutes and provide support to the committee as needed.

Results/Outcomes Expected:
Through the development of consistent and uniform training expectations, cost effective training tools and coordinated planning and promulgation of training opportunities the quality of services in the region will be improved and staff satisfaction regarding their training will increase.

Expected Project Completion Date: Ongoing

Reporting Relationships:
This sub-committee will submit reports to the Regional Quality Management Committee. Reports from the Regional Quality Management Committee will go to the Regional Management Council, Quality Management Oversight Committee and the NSMHA Board of Directors. The Regional Training Committee will present the Regional Training Plan at least annually to QMOC for review and approval.

Workgroups: To be established as needed to deal with specific issues. Workgroups will have a written charge, expected outcomes, and be time limited.

Timelines:
Review of current biennial Regional Training Plan completed by June 30, 2007. New Regional Training Plan due August 1, 2007.

Meeting Schedule
Every other month unless determined otherwise by the group. Time to be determined by the group.

North Sound Mental Health Administration
Regional Training Committee
Training Module

American Indian Policy

DSHS Administrative Policy 7.01

The North Sound Mental Health Administration (NSMHA) in conjunction with the eight federally recognized Tribes in the North Sound Region are committed to inclusive planning and appropriate service delivery to American Indian governments and communities. Following is an overview of the process to ensure this.

Table of Contents:

***Training Objectives**:*

1. Familiarize clinical staff regarding the unique political/legal status of American Indian Tribes.
2. Familiarize clinical staff with social/cultural issues that are unique to American Indian Tribes.
3. Familiarize clinical staff with DSHS Administrative Policy 7.01 and provision of mental health services to American Indian Tribes.
4. Present resources for more in-depth study.

Administrative Policy 7.01
American Indian Policy

Brief History:

Prior to European settlers and other immigrants coming to this country over 150 years ago, the American Indians living in the Northwest had no need for government–to-government rules and regulations. Each American Indian Tribe was a sovereign nation without constraints from any outside governments. With the influx of white settlers into this country, issues such as land rights, sovereignty and citizenship became volatile issues. The numerous wars and battles between the white settlers and the American Indian Tribes resulted in the native peoples losing much of their land and many of their rights. In 1855, the Elliot Bay Treaty moved many Indian People living in the Northwest area onto reservations. For example, The Tulalip Tribe is actually five (5) different tribes that were moved onto the Marysville area reservation and were subsequently named "The Tulalip Tribes". All the tribes in the North Sound area were moved to designated reservations, and many of the tribes had to work hard to regain their Federal Recognition status.

There are eight tribes in the North Sound region that have been able to work with the Federal Bureau of Indian Affairs and the Supreme Court to gain back their Federal Tribal Recognition.

The Federally Recognized Tribes in the North Sound Region are:

The Tulalip Tribes – Marysville, Washington

The Stillaguamish Tribe of Indians – Arlington, Washington

The Swinomish Tribal Community – La Conner, Washington

The Upper Skagit Tribe – Sedro-Woolley, Washington

The Sauk Suaittle Tribe – Darrington, Washington

The Lummi Nation - Bellingham, Washington

The Nooksack Tribe – Sumas, Washington

The Samish Tribe – Anacortes, Washington

There was a tribal request to Washington State to work government-to-government with the current twenty-nine Federally Recognized American Indian Tribes in Washington State. This tribal request then led to the ***Centennial Accord Agreement of 1989*** and later to the current Department of Social and Health Services policy ***Memorandum 7.01.*** The DSHS

Memorandum 7.01 requires that by April 2 of each even-numbered year, prior to the development of the biennial budget request, each administration/department shall develop a biennial service plan for American Indian tribes, communities and participants. This plan is called the ***7.01 Plan*****.** As a result of this plan, the American Indian tribes have a unique status within the public mental health network:

- All Tribal community members in the North Sound Region are eligible for crisis mental health services from the Prepaid Inpatient Health Plan (PHIP) administered by the North Sound Mental Health Administration. Tribal members who receive (or are eligible to receive) Medicaid coupons also qualify for all the mental health services offered by NSMHA contract providers.

- According to Federal and State law, as well as NSMHA contract, contracted providers must inform American Indian and Alaskan Native clients that they may receive traditional/cultural treatment services in addition to or instead of standard services.

- Providers are encouraged to coordinate treatment of Tribal members with Tribal Mental Health departments.

- Collaboration with Tribes helps assure that Native American/Alaskan Native clients receive culturally appropriate services.

1. What is contained in a 7.01 Plan?

As a result of the Centennial Accord and DSHS Memorandum 7.01, The North Sound Mental Health Administration is mandated to work with the Federally Recognized American Indian tribes and all other enrolled American Indian/Alaskan Natives in our five counties. Federal Recognition means that each tribe in North Sound Region (listed above) has been recognized as its own NATION. In addition, any consumer living in the North Sound region who identifies her/himself as American Indian/Alaskan Native (AI/AN) has access to services under these guidelines.

This means each of the eight tribes is able to govern itself and make all decisions regarding their tribal government, community, and individual citizens' needs. As a sovereign nation, tribes are able to provide their own judicial system, police and fire departments, health clinics and behavioral health facilities. Many of the smaller tribes have some direct tribal services and then work government-to-government with County, City and the State of Washington to deliver other services to their tribal members.

The **7.01 Plan** is based on the following premises:

1. The State of Washington is committed to delivering services to American Indians in a manner that is in harmony with existing Federal, State, and Tribal law. Enrolled Tribal members are citizens of the United States and citizens of their respective Tribal Nation.

2. The State of Washington is committed to partnering with tribes in the development of policies and procedures for all programs in DSHS. The intent of the Policy is to minimize potential conflicts for future policies and procedures.

3. The Centennial Accord and the subsequent Memorandum 7.01 will set the basic principals for "government-to-government" consultation with all Washington State DSHS Divisions.

4. Above all, that each DSHS Division or contractor must seek consultation with each Tribe assessing any potential impact of a given policy or practice that may impact tribal law.

The **7.01 Plan** provides a framework for all DSHS Divisions and contracted providers who receive either state and/or federal funds to work with the tribes. The plan contains provisions to:

1. Ensure meaningful input by the tribes, including but not limited to state budgets, policies, manuals, and operational procedures which affect American Indian People;
2. Ensure programs and services provided to American Indian People are culturally relevant and in compliance with this policy;
3. Ensure that programs and services provided to reservation and off-reservation American Indian People are designed to meet American Indian social and health needs;
4. Ensure the agency and contractor/licensee is in compliance with all American Indian-related sections of the Washington State Administrative Codes and other Federal regulations;
5. Develop policies outlining sanctions for failure to comply with any or all of the DSHS American Indian Policy;
6. Develop specific, written protocols establishing how each administrator will contact and work with American Indian Tribes;
7. Provide culturally-specific training to divisions or programs working with American Indian Tribes or communities.

2. The North Sound Mental Health Administration in conjunction with the eight federally recognized Tribes in the North Sound Region are committed to inclusive planning and appropriate service delivery to American Indian governments and communities.

The tribes in the North Sound Region have had the opportunity to sit on the NSMHA Board of Directors as voting members since 1999. To our knowledge, NSMHA is the only Regional Support Network in the state that offers Tribes the choice to become board members.

The North Sound Mental Health Administration's current 7.01 Plan ensures:

a. Optimum access and inclusion in NSMHA contracted mental health programs, including tribal initiated voluntary inpatient certification.
b. Programs provide culturally appropriate Mental Health Treatment to AI/AN People according to the current 7.01 plan.
c. Provision of training opportunities for tribal behavioral health workers and encourage linkages among Tribes, DSHS agencies and county health programs that promote seamless services to treatment access.
d. Efforts to increase numbers of enrolled American Indians as employees of NSMHA contracted PIHP's.
e. Education and training of all concepts in the Centennial Accord and 7.01 planning.
f. Maintenance of the 7.01 plan as a *living, focused, working document*, with optimal tribal participation and involvement in every aspect of the process.
g. Recognition of the government-to-government relationship between Tribes and NSMHA Board of Directors and county services.

3. Designing and delivering mental health services for American Indians/Alaskan Natives:

There are important elements to be considered when designing and providing mental health services to Tribal members:

- The concept of *Cultural Predominance* helps clarify the appropriate starting point for the clinical treatment of American Indians. This means that mental health services encompass belief systems, lifestyle, and perceived problems; and culturally identified service needs determine the choice of services to be provided.

- This position requires the clinician to re-orient away from conventional mental health practices toward services derived from the culture of American Indian being served. Since standard mental health approaches have been shown to be ineffective for a great many American Indian clients, it is necessary for our mental health system to make this shift in perspective in order to become culturally competent.

- ❖ Guidelines for Culturally Congruent Mental Health Services include:

    a. An understanding of the cultural concepts of illness and health which are incorporated into the treatment approach.
    b. Diagnostic or classification systems that are culturally accurate and acceptable to the client, family and community.
    c. Culture-specific symptom patterns that are recognized.

4. The Tribal Voluntary Inpatient Certification Policy:

This policy is an attachment to the current 7.01 plan. The procedure provides a process for the Tribes who wish to initiate and facilitate voluntary hospitalization for members of their Tribal Communities when deemed necessary and appropriate, and to comply with Section 1.6 of the North Sound Mental Health Administration 7.01 Plan. The basic policy consists of six items:

a. The Associated Provider Network and Tribes throughout the North Sound Region commit to actively working together to provide culturally competent/appropriate services.

b. A culturally competent system of care acknowledges and incorporates, at all levels, the importance of culture and cultural differences (WAC 388-856-0150, and NSMHA 7.01 Plan Updated 4/24/03).

c. Hospitalization is considered after all other less restrictive culturally competent/appropriate options have been ruled out as inappropriate or unavailable for the consumer in their current situation.

d. Hospitals wishing to admit consumers with Medicaid funding and those without any source of funding are required to obtain certification from the hospital certification team provided by Volunteers of America for NSMHA.

e. Whenever possible, tribal community members must be evaluated face-to-face within 4 hours of the request by a tribal-designated liaison, able to evaluate mental health conditions. Exceptions to this requirement may be made on a case-by-case basis, but all persons being referred must have a face-to-face contact within 24 hours of the request for certification.

f. The Hospital Certification Team may consult, as necessary, with the assigned Primary Clinician, the Tribal-designated Liaison, NSMHA Quality Specialist, the referring MD, consulting MD, and/or clinicians working in the NSMHA Integrated Crisis Response System.

5. What do culturally competent/culturally congruent services look like?
Culturally competent or culturally congruent services include the following elements:

a. Client-therapist pairs are culturally similar.

b. Service providers have achieved a positive personal cultural integration.

c. Settings of services are easily accessible and culturally familiar to clients.

d. The nature and timing of the intake process reflect cultural priorities and acceptable and inoffensive to clients.

e. The degree of social involvement or enmeshment of mental health workers with the client is culturally determined.

f. The client's religious/spiritual beliefs are understood, supported, and, if culturally appropriate, integrated into the therapeutic process.

g. Traditional healing practices and traditional healers are integrated into the therapeutic process when culturally appropriate.

h. Treatment techniques are culturally comprehensible and acceptable.

i. Therapeutic goals are consistent with the client's cultural values.

j. Therapeutic expectations are consistent with cultural biases toward inner or outer control.

k. Record keeping systems are minimally intrusive and culturally accurate.

l. The support of appropriate American Indian/Alaskan Native (AI/AN) authorities or institutions is obtained.

Conclusion

American Indian/Alaskan Native clients receiving culturally congruent mental health services receive an overall message of personal and cultural validation that honors their heritage, especially the cultural and spiritual aspects. This positive, healing message is not possible when services are culturally incongruent. Cultural congruence ensures that the client's value system, life experiences and expectations about the therapeutic process will be integrated into all aspects of mental health services, which are delivered with dignity and respect.

Administrative Policy 7.01
American Indian Policy

POST-TEST

Please Print.
Name: _____ _____
First Last

Program: _____ Mailstop_____

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1. Memorandum 7.01 is a result of State and Federal Documents:

   ☐ Centennial Accord.
   ☐ New Millennium Agreement
   ☐ American Indian Commerce Clause
   ☐ Indian Child Welfare Act of 1978
   ☐ All of the Above

2. Memorandum 7.01 is only for the tribes in the North Sound Region:

   ☐ True
   ☐ False

3. Who is responsible for the DSHS 7.01 plans?

   ☐ American Indian Sovereign Tribes
   ☐ Just American Indian Tribes that are IHS 638
   ☐ All DSHS Divisions and Tribal Governments
   ☐ Non of the above

4. Tribes who wish to initiate voluntary hospitalization do not have to be certified by the NSMHA Hospital Certification Team:

   ☐ True
   ☐ False

5. Tribal members who receive public mental health services have the right to receive treatment of their mental illness by a tribal shaman, if they wish:

   ☐ True
   ☐ False

6. Each Department within DSHS 7.01 plan must include American Indian input on:
   - ☐ Budgets
   - ☐ Program development
   - ☐ Agency manuals
   - ☐ Cultural relevance
   - ☐ All of the above
   - ☐ None of the above

7. By April 2 of each even-numbered year, prior to the development of the biennial budget request, each administration/department shall develop a biennial service plan for American Indian tribes, communities and participants. What is this plan called?

   - ☐ Centennial Accord of 1998
   - ☐ Elliot Bay treaty of 1854
   - ☐ New Millennium Agreement, Signed by Governor Locke
   - ☐ Non of the above

8. American Indians and Alaskan Natives have a unique status as a result of the DSHS Memorandum 7.01:

   - ☐ True
   - ☐ False

9. Tribal members who receive (or who are eligible to receive) Medicaid coupons also qualify for all the mental health services offered by NSMHA contract providers:

   - ☐ True
   - ☐ False

10. The 7.01 Plan requires which of the following?

    - ☐ Meaningful input by the tribes
    - ☐ Culturally-specific training to divisions or programs working with AI/AN
    - ☐ Programs designed to meet American Indian social and health needs
    - ☐ All of the above
    - ☐ None of the above

1 point per question; 10 points available; 80% or 8 points = pass.

Name _____ Mailstop _____

PLEASE NOTE: This section will not be scored, but will be reviewed by your supervisor.

A. How will you apply the information in this module to your clinical work?

B. What else would you like to know about working with members of American Indian/American Native tribes?

Please detach the post-test and send to your supervisor.

Name _____ Mailstop _____

PLEASE NOTE: This section will not be scored, but will be reviewed by your supervisor.

A. How can the information in this module be applied to your clinical work?

B. Would you like to know more about American Indian Policy?

Please detach this post-test and send to your supervisor.

North Sound Mental Health Administration
Regional Training Committee

Bibliography

Centennial Accord (1989) Legal Document between Washington State Tribes and the State of Washington

Gathering of Wisdoms (2001) 2nd Addition, The Swinomish Tribal Community

Broken Promises Broken Treaties (2001), Overview of American Indian History, presented at Tribal Conference, Sharri Dempsey

The Mental Health Needs of American Indians in Washington State, (2003), The Governors Office of Indian Affairs IPSS, Primary Author: Mile L. Steenhout and Joe St. Charles

North Sound Mental Health Administration, 7.01 Plan 2003-2005, The Eight Tribes in the North Sound Region and NSMHA Board of Directors

The Meriam Commission and Health Care Reform (1926 – 1945, "Getting Stared" Report to congress – Lewis Meriam

Further Documents attached to NSMHA 7.01 Plan 2004-2005,

- Voluntary Inpatient Facilitation by Tribal Mental Health Departments
- Qualifications Provider Mental Health Specialists who treat American Indians/Alaskan Natives

NSMHA Semi-Annual Critical Incident Report
JULY THRU DECEMBER, 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.

HIGHLIGHTS OF CI DATA FROM JULY THROUGH DECEMBER, 2006

Total Number of Reported Critical Incidents (Charts I)

- 4th quarter numbers were skewed by the high frequency of reported "Disruption of Services" incidents, resulting from the November and December Storms **(see chart X)**. There were 9 such incidents in the 4th Quarter, and 2 in the 3rd, compared to 1 in the 2nd Quarter and none in the 1st.

Deaths (Charts IV & V)

- The reported incidents of consumer deaths in Snohomish County during the 3rd and 4th Quarters of 2006 took a sharp decline showing 6 incidents in the 3rd Quarter and 3 in the 4th, from 9 in the preceding quarter. Inversely, reported deaths in Whatcom County rose sharply showing 6 in the 3rd Quarter and 7 in the 4th, up from only 2 in the preceding quarter.

Assaults (Chart VI)

- The number of assaults involving consumers remained stable at or below 3 in the 3rd and 4th Quarters in all Counties except Snohomish. After an all-time low of 1 incident in the 3rd Quarter, Snohomish jumped to 6 in the 4th Quarter.

Elopements (Chart VIII)

- No elopements have been reported since a solitary incident in the 1st Quarter of 2006.

POSSIBLE TRENDS FROM JULY 2003 THROUGH DECMBER 2006
A RETROSPECTIVE VIEW

Total Number of Reported Incidents and Mean Average of Incidents per Quarter (Chart 00):
CIRC review, analysis and reporting of critical incidents spans the last 14 consecutive quarters, or 3 ½ years. The average number of critical incidents per quarter throughout the region during the first 7 quarters was 79.7. The most recent 7 quarters show an average of 63.7. That would show a reduction in total reported critical incidents of approximately 20%.

Total Number of Reported Critical Incidents, System-wide by Quarter 7/03 thru 12/06 (Chart I)

- Following a relatively high number of incidents in the 1st Quarter of 2006 (86), and a low number in the 2nd Quarter (55), the 3rd Quarter and 4th Quarter numbers (70 & 66) hovered below the 3.5-year average of 71.7

- The distribution of data points in the 3rd and 4th Quarters of 2006 mirrored the 2005 numbers for the same quarters. For two years in a row, the 1st quarter numbers spiked, followed by a sharp dip in the 2nd Quarter, with 3rd & 4th numbers hovering closer to the 3.5-year average of 71.7

Deaths (Charts IV & V)
After a 9 quarter high of 9 reported consumer deaths in the 2nd Quarter of 2006, Snohomish County showed a 2-quarter decline to 6 (3rd Quarter) and 3 (4th Quarter). All other counties remained at or below 5 deaths in the 3rd and 4th Quarters of 2006 except Whatcom. Since their all-time low of 2 deaths in the 2nd Quarter, Whatcom County's deaths increased to 6 in the 3rd Quarter and 9 in the 4th. Of note, there seems to be an elevated number of "deaths by natural causes" in middle-aged and elderly consumers in Whatcom County in recent months. Though the numbers are currently too low to determine if any statistical significance exists, CIRC will continue to monitor this possible trend.

ONGOING CRITICAL INCIDENT QUALITY MANAGEMENT RECOMMENDATIONS AND REVIEW ACTIVITIES

- The CIRC reviewed all 132 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

FUTURE DEVELOPMENTS

MHD is now in the process of changing their contract language. The proposed new language indicates that the changes may very well result in an increased scope of redefined critical incident reporting categories and timeliness, completeness and accuracy expectations. As currently proposed by MHD the increase of categories and expectations may add to the workload of provider and regional staff.

Appendix I

R. G. Carey & R. C. Lloyd: "Control charts should have ≥ 20 data points with common cause variation. It is worth looking into the process if you find special cause variation with < 20 points, as you may find you really do not have special cause variation."

Effective Date: 12/21/2005
Revised Date: 1/4/2007
Review Date:

North Sound Mental Health Administration

Section 1700 – Integrated Crisis Services: Crisis Respite Standards for Adults

Authorizing Source: Per NSMHA and ICRS Management
Cancels: Policy #1512-Respite Standards for Adults | Approved by: Executive Director | Date:
Responsible Staff: Sandy Whitcutt, Quality Specialist | Signature:

POLICY #1701.00

SUBJECT: CRISIS RESPITE STANDARDS FOR ADULTS

PURPOSE

The purpose of this policy is to assure consistent, safe, quality Crisis Respite Services across the North Sound Region.

POLICY

Crisis Respite Programs are voluntary programs serving adults having crises. These programs will use the following standards and procedures in providing services to assure access to and quality of Crisis Respite Services.

PROCEDURES AND STANDARDS

I. Crisis Respite facilities must be staffed 24 hours per day.

II. All programs must have the capacity to admit clients into Crisis Respite Services on a 24-hour per day, 7-day per week basis.

III. Crisis Respite staff shall use standardized admission and exclusion criteria in determining eligibility for Crisis Respite Services.

A. At minimum, referral information must contain an assessment of the consumer's potential risk to themselves and others. The risk assessment should include details about any patterns of dangerous behavior.

B. Inclusionary Admission Criteria

1. Must be 18 years of age or older.
2. Must meet criteria of acutely mentally ill, chronically mentally ill, or seriously disturbed as defined by RCW 71.24.025 as the primary presenting problem.
3. Must be determined to be in a state of decompensation or at risk of decompensation due to a situational crisis.
4. Must be manageable in an unlocked, neighborhood-based program without restraints or seclusion.
5. Must be free of significant medical problems for which medical or hospital treatment is indicated for this non-medical facility. They must be able to take care of their basic medical needs, such as wound care or insulin injections.
6. If under the influence of alcohol or drugs, admission will be negotiated taking into consideration the level of impairment of mental/behavioral functioning.
7. Must be able to take oral medications, if prescribed, with minimal supervision.
8. Must be willing and able to comply with house rules regarding violence, weapons, drug/alcohol use, medication compliance, and smoking.

9. If suicidal, must comply with a no-harm contract.
10. Persons in crisis cannot be excluded from receiving Crisis Response Services solely due to intoxication or developmental disability.

C. Exclusionary Admission Criteria

1. The consumer is an imminent danger to others.
2. The consumer is unmanageable in any setting less restrictive than a locked in-patient facility.
3. The consumer refuses to agree to a plan involving Crisis Respite Services.
4. Has a recent history of:

   a) Committing a serious assault that resulted in the provision of medical treatment to either the victim or the perpetrator and/or arrest (within the past 6 months); or
   b) Arson (within the past 3 years) and has been determined by an MHP to currently pose a risk for this behavior.

5. The consumer has a recent history (within 6 months) of committing physical or sexual violence/abuse and/or currently poses a risk for this behavior.
6. The consumer has been assessed to be a Level 1, 2, or 3 sexual offender.
7. The consumer has physical/medical concerns causing inappropriateness for a non-medical setting.

Note: Exceptions to these exclusionary criteria may be granted on a case-by-case basis when both the referring MHP and program staff are in agreement regarding the appropriateness and safety of the placement. All exceptions/rationale will be noted in the record.

IV. For current service recipient's admission to Crisis Respite will include a review of that client's crisis plan (available through the VOA Triage Clinician, 1-800-747-8654.

V. There must be a face-to-face assessment by an MHP at the time of referral for all unknown clients. For enrolled clients to be admitted directly, there must have been face-to-face contact with a clinician within 4 hours prior to the admission. Exceptions to this standard may be made on a case-by-case basis if both the referring MHP and program staff are in agreement regarding the appropriateness of the placement.

VI. Whenever possible, referrals to Crisis Respite will include the following information:

A. Any known behaviors or symptoms that might cause concern or require special care.
B. An evaluation of the person's cognitive status and current level of functioning, including any disorientation, memory impairment, and impaired judgment.
C. History of mental health issues, including suicidality, depression, and anxiety;
D. Social, physical, and emotional strengths and needs;
E. Functional abilities in relationship to activities of daily living.
F. Preferences and choices regarding daily life that are important to the person.
G. Preferences for activities.

H. When such information is not available at admission, program staff will strive to gather such information as services are provided and use this information as clinically appropriate in the provision of services.

VII. Medical Screening

A. A Health and Medical Questionnaire will be completed for all persons admitted into Crisis Respite Services. If the necessary information to complete the form is not available at admission it will be completed as soon as possible thereafter.
B. Based on this screening, appropriate referrals and/or assistance in securing medical services will be provided and documented in the Crisis Respite record.

VIII. All appropriate documentation shall be completed at the time of admission. Admission Documentation will include:

A. Treatment plan will be developed by the case manager in conjunction with Crisis Respite staff detailing the goals that are hoped to be achieved as a result of the Crisis Respite Placement. If there is no case manager, the Crisis Respite staff will develop this treatment plan.
B. Crisis Respite Consent/Program Rules Form
C. Copy of Client Rights (New clients only. One copy given to the client.)
D. Health and Medical Information Form
E. Medication Sheet
F. Inventory of personal effects.
G. Subsequent treatment/supports provided and progress toward achieving these will be documented at least daily during the Crisis Respite Placement.

IX. When intoxicated individuals are referred to Crisis Respite Programs, behavioral indicators and the mix of clients already admitted into services will be considered in determining whether the individual is appropriate for admission.

X. Crisis Respite Programs shall accept out-of-County referrals when space is available. Reference: Cross-Agency Placements.

XI. Discharge Criteria/Procedures

A. Planning for discharge is expected to begin at referral. Updates on the progress of the discharge plan shall be given at the change of shift to each incoming staff by the previous shift. Prior to actual discharge, the on-duty staff will contact the respite program coordinator for discharge approval, including review of current risk and necessary supports.
B. Working in conjunction with the client and whatever other systems/supports are appropriate, staff will develop a written discharge plan to all scheduled discharges. The client will receive a copy of this plan at the time of discharge. This plan will contain at a minimum:

1. A listing of all follow-up appointments (including time, place, telephone number, and name of the person with whom the appointment is scheduled);
2. The names and telephone numbers of any natural supports or other resources which have been identified as helpful during times of crisis;

3. A listing of current medications;
4. The name and telephone number of the client's case manager/primary clinician;
5. The name of the client's prescriber;
6. The telephone number to be used to get refills;
7. The telephone number for the VOA Care Crisis Line;
8. Any additional pertinent information at the time of discharge; and
9. All personal effects and medications will be returned to the client at the time of discharge and the client will sign for their return.

C. Program staff will consult with a mental health professional whenever unplanned discharges are being considered. This consultation will take place whether it is program staff or the client who is initiating this discharge.

XII. When there is a staff-initiated, unplanned discharge from Crisis Respite Services, a face-to-face Crisis Service evaluation or face-to-face evaluation by an MHP or Crisis Services MHP shall be arranged by the Crisis Respite staff.

A. This assessment may need to be conducted at a neutral site away from the Crisis Respite facility.
B. This assessment can be arranged by contacting the crisis line and requesting a crisis outreach assessment.
C. This evaluation shall assess the risk and assure there are adequate supports and treatment plans for this discharged individual.
D. If the consumer refuses this assessment, the need for an involuntary assessment should be discussed with an MHP or the Crisis Line Triage MHP.

XIII. If it is a consumer-initiated, unplanned discharge, consultation with an MHP shall occur as to whether a face-to-face assessment by a Crisis Services MHP or other MHP should occur.

XIV. When clinically indicated, a Crisis Alert will also be filed when unplanned discharges take place.

A. Being determined to be ineligible for Crisis Respite Services does not impact the client's eligibility for other clinically indicated services, such as other Crisis/ITA Services, psychiatric hospitalization, cross-system referral, planning, and coordination.
B. For active clients, Primary Clinicians and/or programs will be informed of all unplanned discharges.

OTHER PROGRAM PROCEDURES AND STANDARDS

I. Staffing

A. Crisis Respite Programs shall have the ability to provide additional staff within 2 hours when this is necessary and sufficient to maintain a Crisis Respite Placement.
B. Crisis Respite Programs will be staffed by those trained in the treatment of individuals experiencing a mental health crisis.

C. Program staff will receive training in admission and screening prior to providing single coverage.
D. Emergency Services/DCR/DMHP staff shall be responsible for providing clinical consultation to Crisis Respite staff and for providing face-to-face interventions/support/evaluations to persons receiving Crisis Respite Services as needed. Emergency Service/DCR/DMHP staff will provide immediate case management services when an issue is outside the scope of practice of crisis residential staff and when a case manager is not available, not assigned, or on weekends and evenings.
E. Staffing levels must meet all appropriate licensing requirements.

II. Length of Stay

Initial admissions to Crisis Respite shall be limited to a maximum of five (5) business days. An extension of up to five (5) business days may be authorized by the Department Director or designee

III. Interactions/Support from Primary Clinicians for Enrolled Clients

A. When enrolled clients are receiving Crisis Respite Services, the primary clinician shall be responsible for coordinating their treatment, medications, and the discharge planning process. Primary clinicians shall contact the client on a daily basis while the client is receiving Crisis Respite Services and are responsible for coordinating services/discharges with Crisis Respite staff.
B. Primary clinicians and program staff shall coordinate reasonable efforts to engage and involve significant others (family members, spouses, friends) during the provision of Crisis Respite Services.
C. When primary clinicians are not available, their supervisor and/or members of their primary program/clinical team shall assume responsibility for the activity described above.

IV. Clinical Responsibility/Support for Unenrolled Clients

A. When unenrolled clients are receiving Crisis Respite Services, the program staff shall be responsible for coordinating treatment (including crisis case management services and referral to ongoing service, as necessary) and the discharge planning process. Emergency services staff will serve as backup and support for program staff during such placements.
B. Program staff shall coordinate reasonable efforts to engage and involve significant others (family members, spouses, friends) during the provision of Crisis Respite Services.
C. Staff will assist clients in doing an inventory of their personal effects at the time of admission. Any high-value items (i.e., jewelry, money, etc.) or item that might be used as a weapon will be placed in a locked cabinet until the client is discharged from the program.

V. Treatment Planning/Documentation

A. Treatment Plan will be developed detailing the goals that are hoped to be achieved as a result of the Crisis Respite Placement.
B. Subsequent treatment/supports provided and progress toward achieving these will be documented at least daily during the Crisis Respite Placement.

VI. **Cross-Agency Placements**

A. Consumers receiving ongoing services through one agency, but placed in another agency's crisis bed, shall continue to receive those services from the original agency, as appropriate during the crisis bed stay. The agency admitting the consumer to its crisis bed shall notify the ongoing service provider of that admission on the next working day to coordinate continuity of care.
B. Once the ongoing service provider has received notification of the crisis bed admission, the consumer's case manager or another agency representative will be responsible for the consumer's ongoing care. Staff will contact the crisis bed house staff within one working day to assist in the development of the crisis care plan and arrange contact with the consumer. At a minimum, this collaborative crisis care plan will detail the roles and responsibilities of staff from the two agencies, frequency of contact for the ongoing care provider (with a minimum of one contact per day), and whether such contact will be face to face or by telephone.

VII. **Medication Management**

Medications will be reviewed and monitored in a manner that meets all applicable contractual, licensing, and regulatory requirements.

ATTACHMENTS

None

Effective Date: 11/29/2005
Revised Date: DRAFT – REV A, 12/11/06
Review Date: 1/4/2007

North Sound Mental Health Administration

Section 1700 – Crisis Services General Policy

Authorizing Source: Per NSMHA and ICRS Management
Cancels: Policy #
See Also:
Approved by: Executive Director Date:
Responsible Staff: Sandy Whitcutt, Quality Specialist
Signature:

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. Twenty-four hour telephone triage support and stabilization.
2. During business hours, enrolled consumers needs shall be addressed initially by primary treaters and supported as needed by emergency outreach and stabilization services.
3. Investigation for Involuntary Detention for mental disorders and chemical dependency
4. Outreach
5. 24-hour/7 day a week Access to Crisis Plans
6. Emergency Walk-In Services during business hours
7. Urgent Appointments
8. Next Business Day Appointments
9. Coordination with Family and Other Natural Supports
10. In-Home/In-Community Stabilization Aides
11. Crisis Residential/Respite Options (for adults only)
12. Psychiatric and Medical Services
13. Cross-System Coordination
14. Cross-RSN Coordination
15. Interpreter Services
16. 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, 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.