



**NORTH SOUND
MENTAL HEALTH ADMINISTRATION**

**QUALITY MANAGEMENT OVERSIGHT COMMITTEE
MEETING PACKET**

December 14, 2011

1. Please join my meeting.

<https://www3.gotomeeting.com/join/856080566>

2. Use your microphone and speakers (VoIP) - a headset is recommended. Or, call in using your telephone.

Dial +1 (213) 493-0600

Access Code: 856-080-566

Audio PIN: Shown after joining the meeting

Meeting ID: 856-080-566

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: December 14, 2011 **Time: 1:00-3:00 PM**

Location: NSMHA Conference Room

For information Contact Meeting Facilitator: Greg Long, NSMHA, 360-416-7013

Topic	Objective	ACTION NEEDED	Discussion Leader	Handout available pre-mtg	Handout available at mtg	Tab	Time
Introductions	Welcome guests; presenters and new members		Chair				5 min
Review and Approval of Agenda	Ensure agenda is complete and accurate; determine if any adjustments to time estimates are needed. Meeting will start and end on time.	Approve Agenda	Chair	Agenda		1	5 min
Review and Approval of Summary of Previous Meeting	Ensure meeting summary is complete and accurate.	Approve Meeting Summary	Chair	Summary		2	5 min
Announcements and Updates	-Consumer Satisfaction Survey -Other	Inform /discuss	All			3	10 min
Evaluation forms from last meeting, if any	Discuss feedback, if any.	Inform /discuss	Chair/ Greg				5 min
Follow-up on old business, if any	Inform/discuss	Inform /discuss					10 min
Comments from the Chair			Chair				5 min
Quality Topics	Expedited Intake Data		Terry	Committee Discussion Form	XX	4	15 min
Risk Assessments	Improve Risk Assessment throughout Region		Greg	Committee Discussion Form		5	5 min
Motivational Interviewing	Discuss next steps to continue development and deployment		Greg	None			5 min
Periodic and encounter presentation	Review status of performance measures		Diana/ Michael	Committee Discussion Form		6	15 min
CMHA/County change for individuals on LR	Inform/discuss		Greg	None			10 min
Policies	1724 –1540 – 1546 – 1574	Discuss and Approve	Sandy/ Charissa/ Greg	Discussion Forms		7	20 min
Open Forum			Chair				
*Review of Meeting	Were objectives accomplished? How could this meeting be improved? Eval forms						
Date and Agenda for Next Meeting	Ensure meeting date, time and agenda are planned						

Next meeting: January 25, 2012 1:00-3:00 PM

Potential Future Agenda Items;

Draft not yet approved

North Sound Mental Health Administration (NSMHA)
Quality Management Oversight Committee (QMOC)
NSMHA Conference Room
October 26, 2011 – Go to Meeting
1:00 – 3:00 pm
MEETING SUMMARY

PRESENT: Candy Trautman, Fred Plappert, Mark McDonald, NSMHA Advisory Board; Marie Jubie, Sno Co. Agency on Aging, Anne Deacon, Whatcom County; mike Watson, LWC; Katherine Scott, Sea Mar; Rebecca Clark, Skagit Co. Coordinator; Susan Ramaglia, Skagit Co.; Cindy Ferraro, bridgeways; Stacey Alles, Compass; Chuck Davis, ombuds; Kathy McNaughton, CCS; Anne Deacon, Whatcom Co; Nancy Jones, Sno. Co.

BY PHONE: Pam Benjamin, WCPC; Pat Morris, VOA,

STAFF: Greg Long, Charissa Westergard, Kurt Aemmer & Barbara Jacobson

OTHERS PRESENT: Heather Fennell, Compass.

TOPIC	DISCUSSION	ACTION
1. Introductions, Review of Agenda – Chair	Anne convened the meeting at 1:05 pm and introductions were made. There are no additions to the agenda.	
2. Previous Meeting Summary – Chair	Anne asked for any corrections/amendments to the previous meeting summary and they are approved as amended.	Summary approved as amended.
3. Announcements and Updates – All	<ul style="list-style-type: none">• Charissa noted that presently Fairfax accepts no kids under 13 and CA is working with them around this. She mentioned some options we have and Greg noted that we have some under 13 consumers though not a lot. He noted that Children’s has 20 beds now and may expand in the future.• Greg noted the winter is coming and those who want to participate in FEMA disaster planning can let Greg know.• Pat noted there are a few openings left for a SafeTalk training coming up in Lynnwood on Friday 8-12.	Informational
4. Evaluation Forms from Last Meeting – Chair/Greg	Nothing to report.	
5. External Quality Review Organization (EQRO) audit	EQRO audits all of the state Medicaid programs and they were here mid October for a couple days; they went to some providers as well. Greg would like to hear provider feedback. WCPC noted that they had an hour long phone audit so far and it went well. Compass and Bridgeways have been contacted as well. Providers noted that they would like to have reasonable notice that they are coming and an overview of audit specifics to prepare. Greg noted that EQRO looks at our performance projects, computer systems and consumer rights this round. Greg noted that they really like our grievance and appeal process and that they would like us to make our notices clearer and easier to read for consumers. They liked our internal grievance review process and	Discussion

	<p>our dignity and respect initiative. They would like us to write a policy on outpatient seclusion and restraint stating that it does not occur.</p> <p>They were focused on mental health and medical advance directives; they want to see this worked on. Providers would like some training on how to assist consumers in developing their medical and mental health advance directives. Overall NSMHA felt the audit went very well. The final report will not be released for several months and we will review again at that time.</p>	
<p>6. Customer Satisfaction Survey</p>	<p>Kurt thanked the providers for all their work on the survey process and just wants to check in on how things are going.</p> <p>There are no issues mentioned that would impact the results and things seem to be going smoothly.</p>	<p>Informational</p>
<p>7. Ombuds Quarterly Report</p>	<p>The report is attached and reviewed.</p>	<p>Informational</p>
<p>8. Policy 1006, 1551 & 17XX</p>	<ul style="list-style-type: none"> • Greg noted 1006 has been here before and coordinates our policies with providers so providers need not develop their own. There is a motion to approve policy 1006, seconded and motion carried. • Charissa stated that policy 1551 has a change to include a timeline for a special population consultation. There is a motion to approve policy 1551, seconded and motion carried. Greg noted that DBHR conducted a review of policy on improving access for special populations and the draft report has come out and in review by DBHR. Some recommendations may come from this review in the future. • 17XX - This is a new policy developed with the agencies involved and has some changes incorporated from feedback. It is a two person team with a MHP and peer support specialist. This is a service for adults or youth. Has not been well utilized yet and marketing is being worked on to help with this. Our hope is that law enforcement, neighbors, family members, APS workers and other social providers will call on the team. We will forward the brochures from this program which is currently in Whatcom and Skagit Counties with a program in Island County still in the offing. It is noted that there is no language on mandatory dispatch and Pat clarified that they will take the referral and work it though they may or may not be able to make the face to face contact. There is a motion to approve policy 17XX, seconded and motion carried. 	<p>Policy 1006 - Motion carried</p> <p>Policy 1551 – Motion carried</p> <p>Policy 17XX – Motion carried</p>
<p>9. Clinical Outcome Measures</p>	<p>Greg noted we are looking for provider input on what agencies are doing to measure improvement over time for consumers in services. Bridgeways has an annual consumer survey they use and Compass uses PHQ9 G87 on adults and with kids PSC17 and scared tool; PTSD symptom scale, NICHQ Vanderbilt; we are not able to collect the data in Raintree at this time though; we use it to define clinical pathways. Sea Mar clinicians have access to these tools as well. CHPW would most likely have aggregate data. Sea Mar has a consumer survey that they track and report on quarterly. LWC is</p>	<p>Discussion</p>

	<p>working on developing what they will use; such as the IMR measure tool and using with the NOMs to look at our consumers.</p> <p>Greg noted that NSMHA was looking at using the PHQ9 for those with depression; we have put it off for now with the budget issues.</p>	
10. Performance Improvement Project	<p>Charissa noted this PIP is aimed at reducing time between request for services and a medication evaluation if needed. The attached decision tree has been developed from this work and we also encourage getting the PCP involved from the offset.</p> <p>Stacey noted that most don't need anything urgent and Charissa clarified that it is about starting the process and basing the steps on individual need.</p> <p>There is a motion to approve this to go out in numbered memoranda, seconded and motion carried.</p>	Motion carried
11. Open Forum	<p>Marie noted that the Snohomish County .01 % Tax Committee has decided to fund mental health court with some of the one tenth money.</p> <p>There is discussion to combine the November and December meetings into one meeting with the date of December 14th proposed. This date seems to work for most and will go forward.</p> <p>Fred noted the Dignity and Respect website will go live on November 1st and this also launches the poster and poetry contest with a theme of Dignity & Respect Promote Recovery.</p> <p>Heather noted the training modules are outdated and Greg noted this is still in the works.</p> <p>The Advisory Board is going to Compass on November 10th for a site visit to see Bailey Center, triage and Molina.</p> <p>Greg noted he and Charissa are revising the referring of consumers back to PCP policy. He asks how providers code the consult with psychiatrist and PCP and they acknowledge that they bill it as an individual treatment service. A comprehensive community support for telephone consult.</p> <p>Kathy noted the federal push and the Recovery Audit Contractor (RACs) around Medicaid fraud. Around the affordable care act there is stepped up fraud and abuse monitoring. There is a Webinar tomorrow on the RACs. There is discussion on the issue of the disparity between the state and feds on this and Greg stated it may need to be something to go forward to the RSN/DBHR meeting and he will discuss with Michael the coding difference between state and federal for resolution.</p>	Discussion
12. Date and Agenda for Next Meeting/Review of Meeting	<p>The meeting was adjourned at 2:55pm. The November and December meetings will be combined into one meeting on December 14, 2011 from 1-3pm.</p>	

2011 CUSTOMER SATISFACTION SURVEY

QMOC UPDATE

DECEMBER 5, 2011

- I. Thank you to all of the providers for their participation
 - A. All questionnaires were returned to NSMHA in a timely manner, before November 30.
 - B. Almost 2,300 responses/non-responses were received.

- II. Current Status
 - A. As of December 1 all cases were entered in the database, and the empirical data is ready for analysis.
 - B. On December 2nd Kurt began the identification of response categories for analysis of the “Comments” section of the questionnaires:
 1. What responders said they liked most about services
 2. What responders said they liked least about services; &
 3. Other comments
 - C. The intent is to identify the 3 or 4 most liked and least liked aspects of services most frequently noted by the respondents.
 - D. As there are ALMOST 2000 comments to categorize, count & analyze, the process described in part II.B.1 & 2, above, should take a couple of days.

- III. Expected Process Completion Timeline
 - A. December 9 – completion of “Comments” analysis
 - B. December 13 – completion of question response (empirical) data analysis
 - C. December 22 – completion of 1st draft of report
 - D. December 30 – completion of final region-wide survey report

- IV. Final Report
 - A. Region-wide findings will be presented to NSMHA Leadership Team, Clinical Oversight Team, & QMOC in January 2012
 - B. Provider-specific findings will be given to the QMOC representative at the January 2012 QMOC meeting

NSMHA COMMITTEE DISCUSSION FORM

AGENDA ITEM: Expedited Assessment Requests report for 2011

PRESENTER: Terry McDonough

COMMITTEE ACTION: Action Item FYI & Discussion FYI only

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:

- Two reports will be presented; January-June 2011 and July-December 2011
- During the first six months of 2011, EAR totals were similar to those in 2010
 - Jan-June 2010- 160 EARs
 - July-December- 143 EARs
 - Jan-June 2011- 124 EARs
 - July-December 2011- 45 EARs

CONCLUSIONS/RECOMMENDATIONS:

- Most Providers continue to call NSMHA to report EARs and send in completed EARs the majority of the time.
- Some Providers continue to struggle with both reporting and sending EARs to NSMHA.
- NSMHA will continue to track EARs during 2012.
 - Would Providers like quarterly updates from NSMHA regarding the status of EARs requested by VOA, called in to NSMHA and sent in to NSMHA?

TIMELINES:

ATTACHMENTS:

None

NSMHA COMMITTEE DISCUSSION FORM

AGENDA ITEM: Improving Risk Assessments

PRESENTER: Greg Long

COMMITTEE ACTION: Action Item (x) FYI & Discussion () FYI only ()

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:

Six months ago, QMOC discussed ideas on how risk assessments could be improved. We said that we would follow-up that discussion with this request as quality improvement effort.

I would like to request that each provider e-mail to NSMHA any forms or sections of forms they are using for risk assessment. NSMHA will compile these and send them out to all providers. Providers will then have some ideas and examples of what their peer agencies are doing to better assess and hopefully manage risk in the consumers that are being served.

CONCLUSIONS/RECOMMENDATIONS:

NSMHA is requesting that risk assessments be sent to NSMHA by January 11, 2012. NSMHA will compile them and send them out to providers by January 18, 2012.

TIMELINES:

Send Risk Assessments to Greg Long at NSMHA by January 11, 2012.

ATTACHMENTS:

None.

NSMHA COMMITTEE DISCUSSION FORM

AGENDA ITEM: Core Statewide Performance Measures- Timeliness of Encounter and Periodic Submission- October 1, 2010 through September 30th, 2011 Annual report.

PRESENTERS: Diana Striplin/Michael White

COMMITTEE ACTION: Action Item FYI & Discussion FYI only

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:

- DBHR continues to provide reports for 2 Core Statewide Performance Measures regarding the timeliness of Encounter and Periodic Submission. The reports measure the cumulative percentage of encounters and periodics submitted within 60 days.
- NSMHA did not meet the minimum standard of 95% submitted within 60 days for either measure for year 2 (October 2010 through September 2011).
- **Periodics**-NSMHA submitted 68.5% within 60 days. Raintree was unable to overcome sending unique client indicator to the state which caused issues with reporting periodics.

Once the issue was identified the NSMHA began submitting older periodic data, which resulted in a lower percentage reported within 60 days. Since the measure reports cumulative percentage submitted within 60 days we were unable to catch up.

NSMHA had showed improvement in reporting, but does not show periodics submitted in September or October of 2011.

- **Encounters**-NSMHA submitted 63.8% within 60 days. Only one RSN met the 95% minimum standard.

As with periodics, some encounters were not submitted from Raintree to DBHR. Once identified the older data was submitted by NSMHA, which again resulted in a lower percentage submitted within 60 days.

In addition RSNs were allowed to submit older data prior to September 2011, which again lowered the cumulative percentage submitted within 60 days for NSMHA.

NSMHA will continue to submit encounters going forward as well.

NSMHA does not show encounters submitted for October 2011 in the first monthly report from DBHR for the new period of October 2011 through September 2012.

CONCLUSIONS/RECOMMENDATIONS:

- NSMHA will continue to report both periodics and encounters.
- NSMHA will monitor submission on a monthly basis to meet minimum standard of 95% submission within 60 days.
- NSMHA will continue to review and correct issues with submitting encounters and periodics on a timely basis.
- NSMHA may receive corrective action.

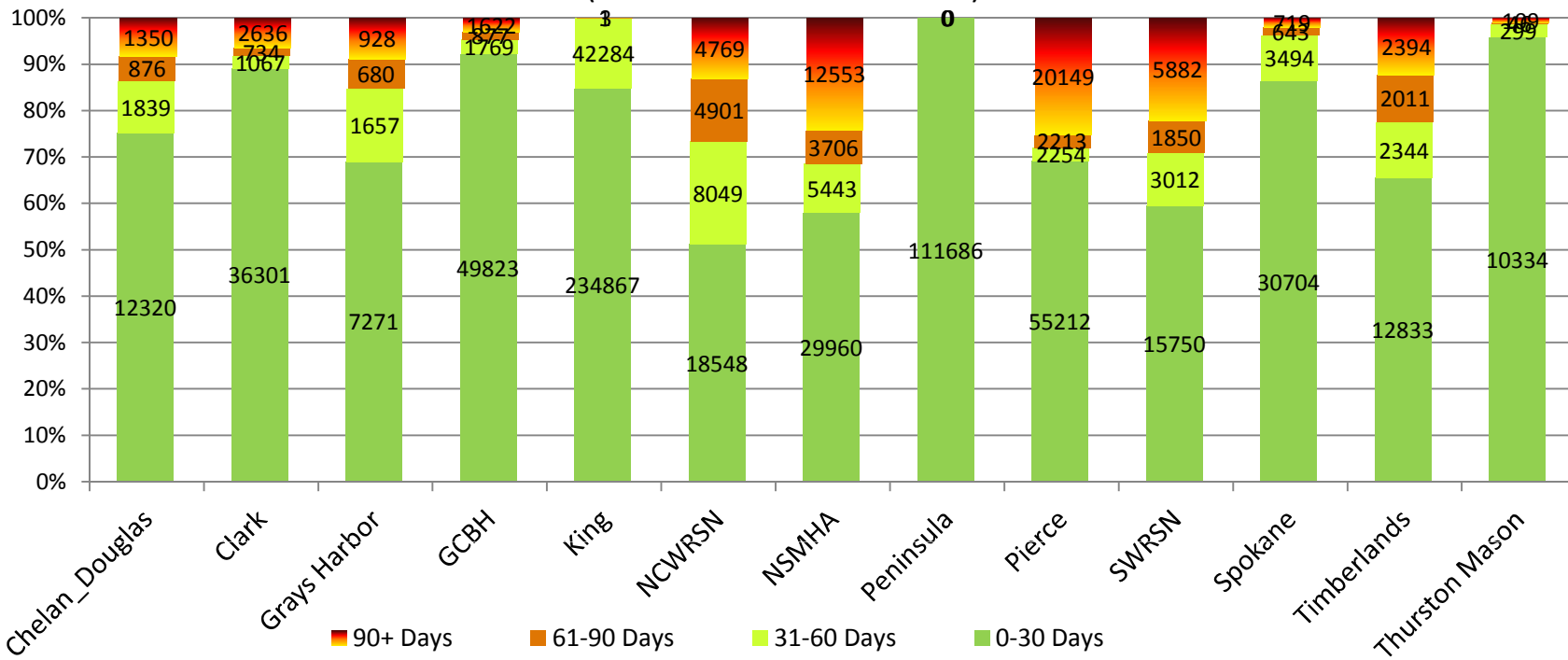
TIMELINES:

ATTACHMENTS:

1. **Core Performance Measure Report-Periodic Submission Delay-Second Year Report 2009-2011.**
2. **Core Performance Measure Report-Encounter Submission Delay-Second Year Report 2009-2011.**

CPM - Periodic Submission Delay - 2009-2011 - Second Year

(For October 2010 forward)



For Date Range: 10/1/2010 thru 9/30/2011 Run Date: 10/18/2011

Cumulative Pcnt submitted within 60 days: (For October 2010 forward)

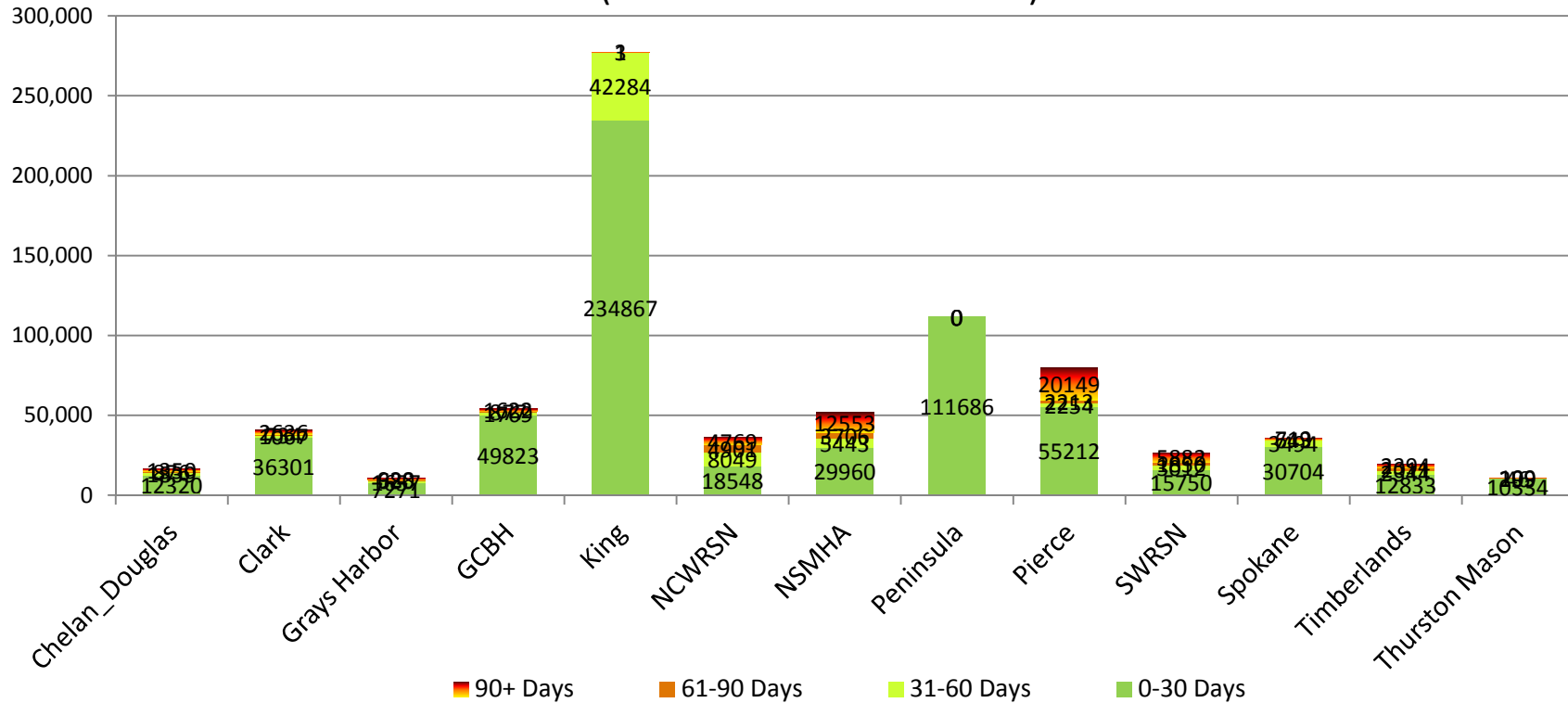
RSN	Chelan_Douglas	Clark	Grays Harbor	GCBH	King	NCWRSN	NSMHA	Peninsula	Pierce	SWRSN	Spokane	Timberlands	Thurston Mason
Cumulative Pcnt submitted within 60 days	86.4%	91.7%	84.7%	95.4%	100.0%	73.3%	68.5%	100.0%	72.0%	70.8%	96.2%	77.5%	98.6%

Cumulative Quarters

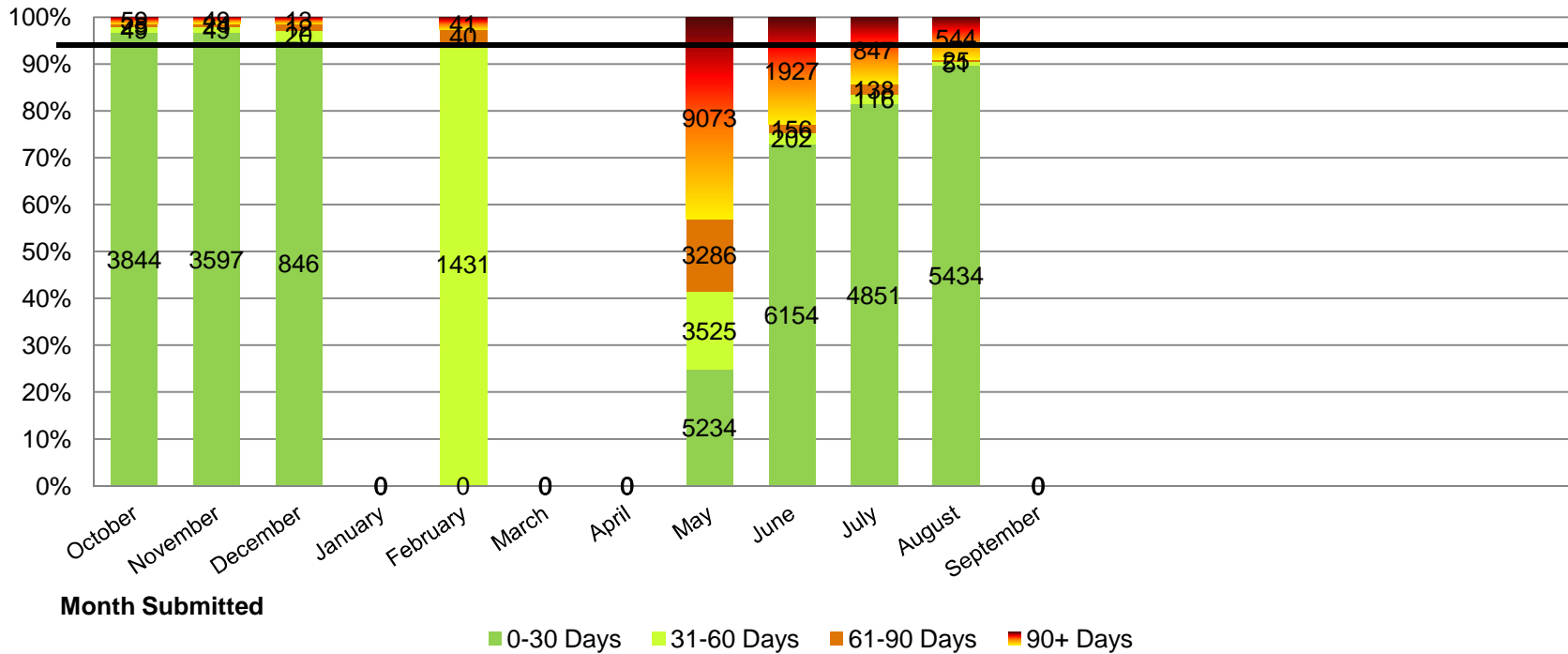
Quarter	Oct - Dec 2010	Oct 2010 - March 2011	Oct 2010 - June 2011	Oct 2010 - Sept 2011
First Quarter	67.5%	88.5%	72.0%	93.7%
Second Quarter	76.1%	85.8%	74.9%	95.1%
Third Quarter	83.1%	89.4%	82.0%	95.8%
Fourth Quarter	86.4%	91.7%	84.7%	95.4%

Periodic Submission Delay - FFY 2011 - Year to Date

(For October 2010 forward)



Consumer Periodics Submission Timeliness: NSMHA



NOTES:

Date Range: 10/1/2010 to 9/30/2011

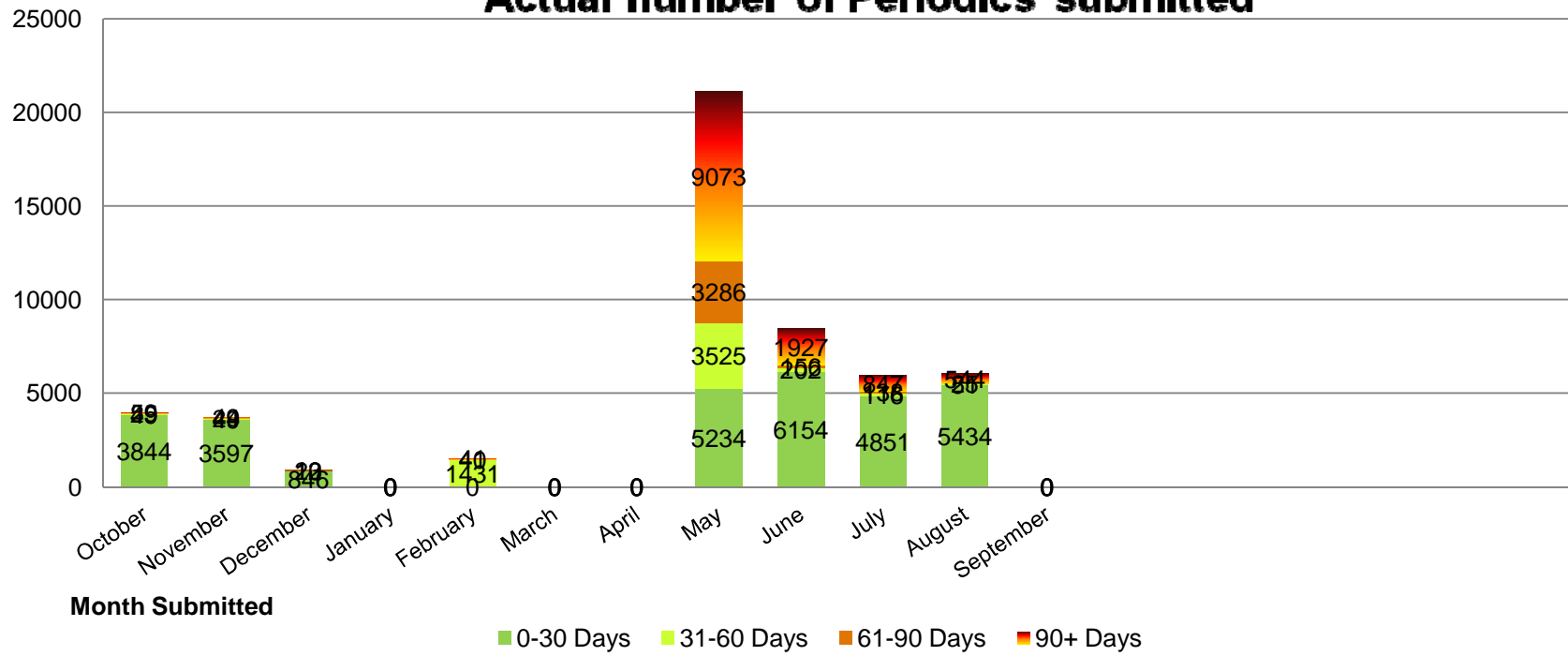
Run Date: 10/18/2011

Months with no data are months where no Periodics were submitted

Report is for FFY 2011, which runs 10/2010 thru 09/2011

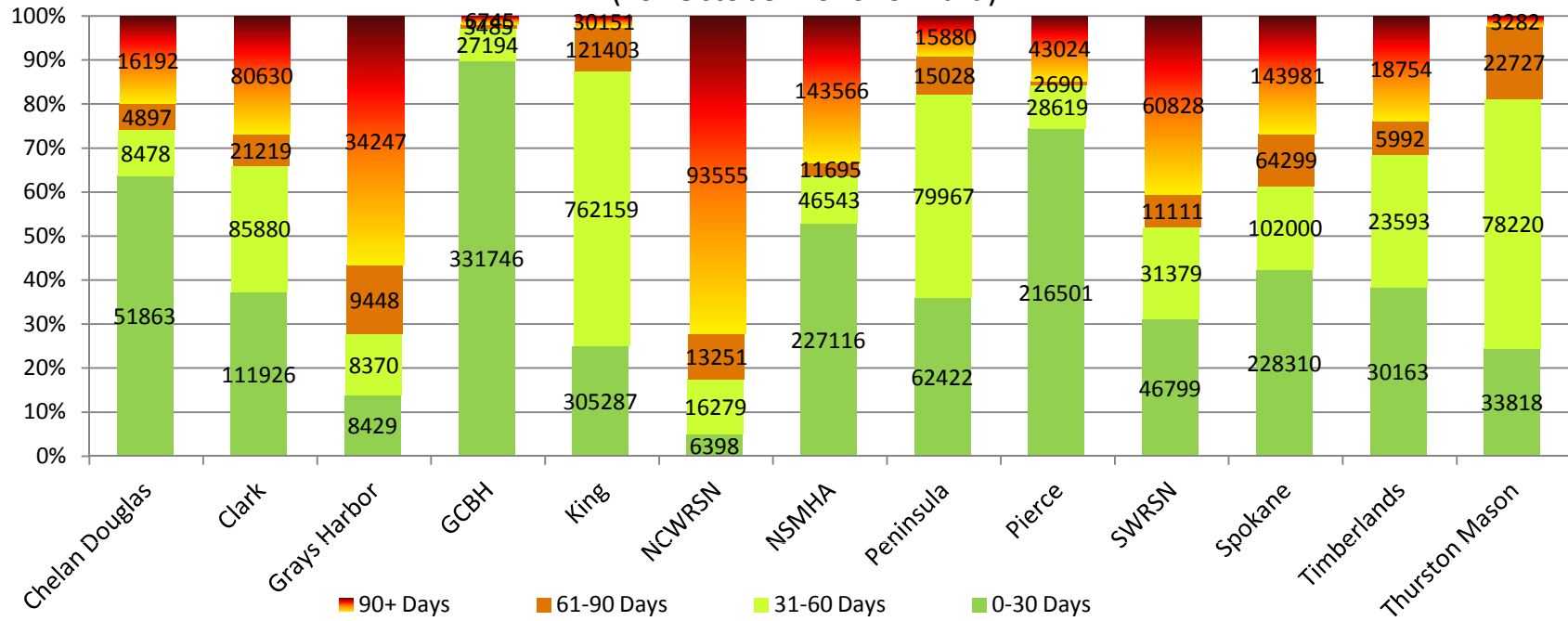
Cumulative Pcnt submitted within 60 days: 68.5%

Actual number of Periodics submitted



CPM - Encounter Submission Delay - 2009-2011 - Second Year

(For October 2010 forward)



NOTES:

For Date Range: 10/1/2010 thru 9/30/2011 Run Date: 10/18/2011

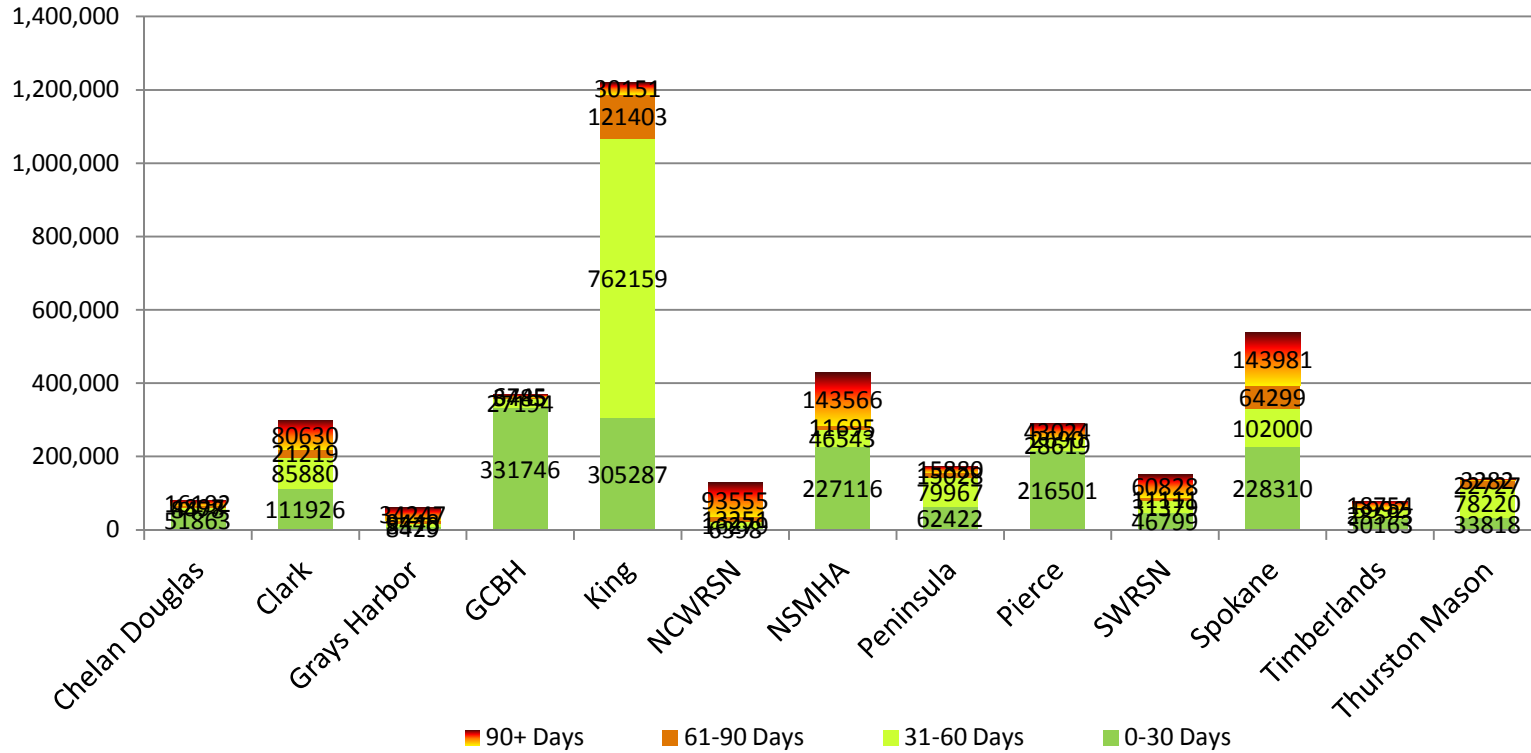
Cumulative Pcnt submitted within 60 days: (For October 2010 forward)

RSN	Chelan Douglas	Clark	Grays Harbor	GCBH	King	NCWRSN	NSMHA	Peninsula	Pierce	SWRSN	Spokane	Timberlands	Thurston Mason
Cumulative Pcnt submitted within 60 days	74.1%	66.0%	27.8%	97.2%	87.6%	17.5%	63.8%	82.2%	84.3%	52.1%	61.3%	68.5%	81.2%

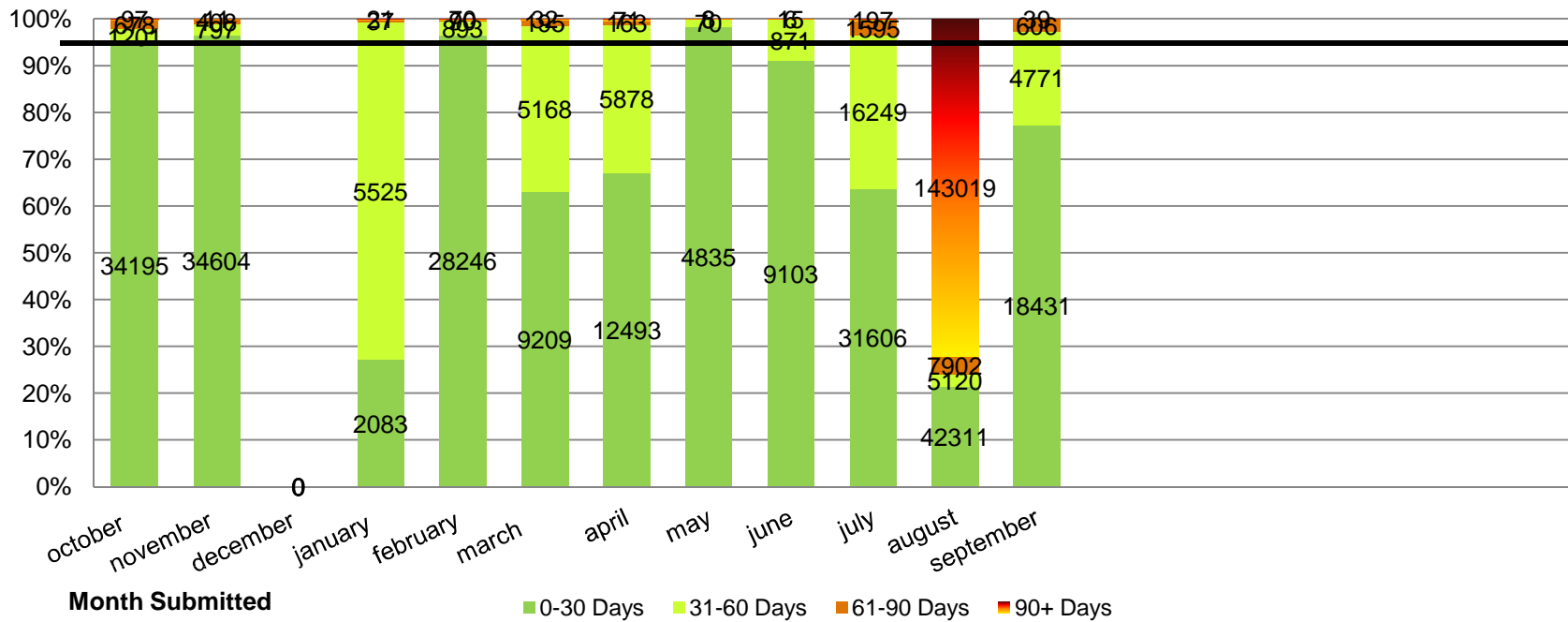
Cumulative Quarters

Quarter	Oct - Dec 2010	Oct 2010 - March 2011	Oct 2010 - June 2011	Oct 2010 - Sept 2011
First Quarter	40.1%	22.5%	14.9%	94.4%
Second Quarter	61.5%	43.2%	24.1%	96.1%
Third Quarter	69.3%	58.2%	22.3%	96.7%
Fourth Quarter	74.1%	66.0%	27.8%	97.2%

Outpatient Encounter Submission Delay - FFY 2011 - Year to Date (For October 2010 forward)



Encounter Submission Timeliness: NSMHA



NOTES:

Date Range: 10/1/2010 to 9/30/2011

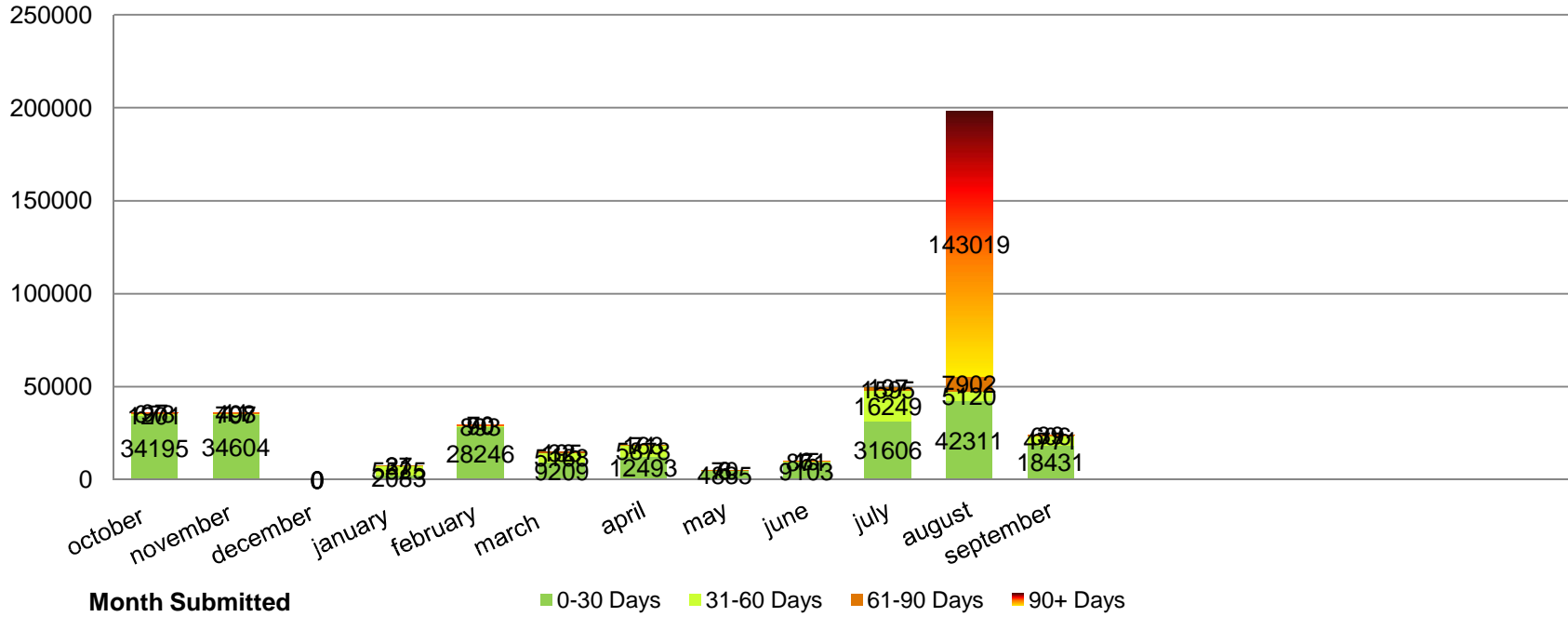
Run Date: 10/18/2011

Months with no data are months where no services were submitted

Report is for FFY 2011, which runs 10/2010 thru 09/2011

Cumulative Pcnt submitted within 60 days: 63.8%

Actual amounts of encounters submitted



NSMHA COMMITTEE DISCUSSION FORM

AGENDA ITEM: ICRS policy 1724 Law Enforcement Coordination

PRESENTER: Sandy Whitcutt or Greg Long

COMMITTEE ACTION: Action Item FYI & Discussion FYI only

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:

This is a new policy drafted after collaboration with law enforcement and DMHPs around coordination in the region. The intent is to assist enforcement officers in the field, when there is mental health involvement. The policy addresses procedures for when officers call in to the Care Crisis line. In addition to the development of this policy, officers have gone through regional training regarding mental health issues. Triage facilities have developed procedures to assist officers in the field. Law enforcement representatives have been included in local crisis oversight meetings to increase the understanding of how these systems work.

CONCLUSIONS/RECOMMENDATIONS:

Approve this policy

TIMELINES:

This policy will go into effect 60 days following the posting on the web.

ATTACHMENTS:

Policy 1724

Effective Date:
Revised Date: 11/18/2011
Review Date: 11/18/2011

North Sound Mental Health Administration

Section 1700 – Crisis Services – ICRS/Law Enforcement Coordination

Authorizing Source: NSMHA

Cancels:

See Also:

Providers must “comply with” this policy

Responsible Staff: Deputy Director

Approved by: Executive Director

Date:

Signature:

POLICY #1724.00

SUBJECT: ICRS/LAW ENFORCEMENT COORDINATION

PURPOSE

The purpose of this policy is to ensure that Volunteers of America Care Crisis Response Services (CCRS), Designated Mental Health Professionals (DMHPs) and Stabilization/Triage facilities are working in a coordinated effort with law enforcement when there is a behavioral health crisis.

POLICY

North Sound Mental Health Administration (NSMHA) is committed to developing partnerships with law enforcement agencies in the Region to improve services to individuals in behavioral health crisis. Law enforcement agencies are often the first responders on the scene when individuals and families are in crisis. To assist them when decisions are needed regarding crisis intervention, law enforcement officers may need to consult with the NSMHA Integrated Crisis Response System (ICRS) to determine the most appropriate course of action.

PROCEDURES

I. CCRS Phone Consult

- A. CCRS: Law enforcement officers, who request ICRS assistance, should contact CCRS at 800-584-3578, and alert them to the nature of the crisis. CCRS clinicians will assist law enforcement officers in determining the next steps. This may include consultation with CCRS, consultation with the DMHP, identifying linkage to appropriate and available resources or simply documenting information with CCRS.
- B. Stabilization/Triage: Law enforcement officers intending to drop off individuals at a Stabilization/Triage facility should contact CCRS clinicians to work with the officer to contact the facility in their county. These facilities are located in Whatcom, Skagit, and Snohomish counties.
 - i. CCRS will initiate a three way call with the Stabilization/Triage Facility and law enforcement officer.
 - ii. The Stabilization/Triage staff will get background information and a description of the current problems from the officer.
 - iii. Stabilization/Triage center staff will obtain a copy of the mental health contact report from the law enforcement officer. The officer will be requested to remain at the facility until a brief screening has been completed and there is a determination that individual meets criteria for admission. The officer may be requested to transport the individual to jail or a hospital when more appropriate.
 - iv. In Skagit and Whatcom counties, the Stabilization/Triage facilities are able to admit voluntary individuals only.
 - v. In Snohomish County, the Stabilization/Triage facility is able to admit both voluntary individuals as well as individuals delivered by law enforcement on a 12-hour hold because it is a secured locked facility.

- vi. Stabilization/Triage facilities will coordinate with law enforcement to facilitate appropriate, safe outcomes for individuals and the community to assure the crisis is resolved. This may include, upon request, providing disposition information to the jurisdiction that delivered the individual to the facility as well as other exchanges of information with appropriate authorization.

II. DMHP Consult

- A. Officers may request to speak directly with the DMHP in their county to discuss a crisis. This is considered a mandatory consult.
- B. Law enforcement mandatory consult procedures for mental health crises:
 - i. Law enforcement will contact CCRS to provide information regarding an individual and/or to request the DMHP.
 - ii. CCRS will contact the DMHP if a consult has been requested.
 - iii. The DMHP will contact law enforcement regarding the consult and any necessary coordination related to the referral/location.
 - iv. If the consult results in a dispatch, the DMHP will have the ability to change the location if safety concerns (loss of ongoing law enforcement presence), medical issues, or other concerns necessitate the need for an alternative location. In cases where there is disagreement between the DMHP and law enforcement, the DMHP supervisor can be contacted.
 - v. If the individual is being transported to the hospital, but is not ready to be seen due to elevated Blood Alcohol Level (BAL), other chemical impairment, or significant medical problems, the DMHP will still accept the consult and coordinate and collaborate with hospital staff. This information shall be documented.
 - vi. If the individual is not ready to be seen (due to elevated BAL or severe medical problems) within 8 hours so the DMHP can make a decision within the 12 hours from point of consult (times that are mandated by law), the case will be closed without a face-to-face evaluation from the DMHP. The DMHP shall call in the status of the individual to CCRS and document the status.
 - vii. When law enforcement is requesting and expecting a DMHP evaluation, the DMHP should inform the hospital that they are conducting an ITA investigation. The DMHP can then conduct a face-to-face investigation or terminate, if in their professional opinion there are no further grounds. (Investigation in RCW 71.05 means the act or process **of systematically searching** for relevant, credible and timely information to determine if: there is evidence that a referred person may suffer from a mental disorder, and there is evidence that the person, as a result of a mental disorder presents a serious harm to him or herself, other person's property, or the referred person may be gravely disabled and refused to seek appropriate treatment options.)
 - viii. The DMHP will continue to consult with hospital staff on the case until resolved, an appropriate less restrictive alternative can be accomplished, or a face-to-face ITA investigation is needed. These consultations shall be documented.
 - ix. The final disposition of the consult will be communicated back to CCRS and can be communicated back to law enforcement by the DMHP if requested as part of the crisis response to the ITA investigation.

ATTACHMENTS

None

NSMHA COMMITTEE DISCUSSION FORM

AGENDA ITEM: Policy 1540 Discharge from Treatment

PRESENTER: Charissa Westergard

COMMITTEE ACTION: Action Item FYI & Discussion FYI only

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:

- Primary revision was to clarify re-engagement efforts for unplanned discharges. These points were discussed and agreed upon at a previous QMOC.
- Addition of calling WSH or CLIP liaison before closing for individuals who go to WSH or CLIP facility.

CONCLUSIONS/RECOMMENDATIONS:

Action item – request recommendation of approval

TIMELINES:

Policy has been out for comment for 30 days; first presentation at QMOC meeting.

ATTACHMENTS:

Policy 1540

POLICY #1540.00

SUBJECT: DISCHARGE FROM TREATMENT

PURPOSE

All North Sound Mental Health Administration (NSMHA) Community Mental Health Agencies (CMHAs) will follow uniform criteria and processes when discontinuing services in order to assure that individuals' needs are met during this phase of treatment.

POLICY

Circumstances in which discharge should be initiated (any one of the following):

1. The individual's documented treatment plan goals and objectives have been substantially met.
2. Per the Statewide Access to Care Standards, the individual no longer has a covered diagnosis (additional criteria for a "B" diagnosis, per Access to Care Standards, are not required for continued stay) and/or [the individual no longer meets](#) GAF/CGAS criteria.
3. Consent for treatment is withdrawn and it is determined that the individual has the capacity to make an informed decision and does not meet criteria for an Involuntary Treatment Act (ITA) evaluation.
4. The probability of successful outcome with continued treatment at this level of care is seriously compromised because the individual is not participating in the treatment process and the individual is not at risk for harm to self or others. Examples may include but are not limited to:
 - a. Refusing medications when clinically indicated;
 - b. Poor attendance of treatment modalities offered and/or not readily participating in the treatment process despite re-engagement efforts by the CMHA;
 - c. There is little evidence that mental health intervention has improved the individual's participation in treatment.

In these instances, appropriate efforts, consistent with level of care and identified risk(s), toward outreach and re-engagement have been attempted and the result documented.

5. There is little evidence that the current treatment is resulting in improved outcomes for the individual. There is no alternate appropriate treatment proposed and further progress at this level is deemed unlikely.
6. When an individual enters an institutional setting (e.g., Western State Hospital, Children's Long-Term Inpatient facility, jail, prison), his or her chart may be closed after 30 days [of physically arriving at WSH or CLIP facility](#) unless:
 - a. The Mental Health Care Provider (MHCP) is [continuing to](#) coordinating care.
 - b. The individual is expected to be discharged/released within the next [90](#) days.
 - c. [The NSMHA Western State Hospital \(WSH\) or Children's Long-term Inpatient Program \(CLIP\) Liaison requests that an individual case remain open.](#)
 - i. [In order to determine if the case is to remain open, the MHCP shall contact the NSMHA liaison to discuss.](#)

The reason for discharge shall be documented in the individual's clinical record. For individuals with identified risk(s), the MHCP shall review the reason for initiating discharge with his or her supervisor.

When discharge is not permitted:

1. The agency assigned to monitor a Less Restrictive or Conditional Release court order (LR/CR) may not discharge an individual on an LR/CR for mental health services. If an individual is receiving services at a CMHA other than the one assigned in the court order, the non-assigned agency shall coordinate with the assigned agency to ensure that the individual continues to receive medically necessary services and the court order continues to be monitored prior to initiating discharge.
2. Individual is engaged in the complaint, grievance, appeal, or fair hearing process. (In the process of discharging an individual from treatment, the individual will be given written notice that outlines his or her options to initiate an appeal, grievance or fair hearing if he or she does not agree with the decision indicated in the notice. See NSMHA policies #1001.00-1005.00 for additional information regarding appeal, complaint, grievance, fair hearing and notice rights and processes).

PROCEDURE

1. The MHCP shall begin discharge planning at admission with every individual/family by:
 - a. Integrating discharge planning into ongoing treatment planning and documentation from the time of admission by identifying including specification of the goals that, once achieved, discharge criteria that will indicate the end of the treatment episode. resolution of the needs that justified the admission.
 - b. Reviewing and, if needed, modifying the Resiliency/Recovery Plan treatment/discharge plan as needed and at a minimum of every 180 days or as clinically indicated.
 - c. Including the family, other natural supports, and professional supports in treatment/discharge planning, including any changes to the plan, and reflecting their needs and desires to the extent clinically indicated and with the consent of the individual.
2. For planned discharges (i.e., the individual has signed a Resiliency/Recovery Plan that includes planning around the transition to discharge or has provided information that indicates the end of the treatment episode):
 - ~~e.a.~~ The transition phase of the discharge plan is initiated ~~the discharge plan, with time frames not to exceed 90 days,~~ prior to discharge and with sufficient time to ensure adequate resources and supports are in place.
 - ~~e.b.~~ The discharge plan identifies ~~y in the plan~~ the continuum of services and the type and frequency of follow-up contacts recommended by the MHCP to assist in successful transition to the next appropriate level of care.
 - i. The MHCP ~~A~~ assures that appropriate medical care and medication management will be provided ~~to individuals who end a treatment episode through planned~~

discharge. The MHCP shall identify the medical personnel who will provide continuing care and shall also arrange or confirm an initial appointment with that provider.

ii. The MHCP shall provide the individual/familys with instructions and information regarding consumer rights, how to access routine services, how to access emergency services, and, if applicable, a copy of the individual's most recent crisis plan as a part of the discharge plan.

f. Planned discharges do not require that the individual/family be notified in writing of the plan to discharge as indicated below for unplanned discharges. His/her signature on the Resiliency/Recovery Plan and participation in discharge planning suffices as notification.

3. For unplanned discharges (i.e., the MHCP has been unable to engage the individual in discharge planning):

g.a. The following individuals shall receive, at minimum, a re-engagement letter at least 30 days prior to closing the treatment episode (referred to as a 30-day re-engagement letter):

i. Individuals at Level of Care 3 and above.

i-ii. Individuals at Level of Care below 3 with moderate risk or transition needs (e.g., transfer of medications, development of community supports).

ii-iii. Individuals with more serious risk or transition needs, regardless of Level of Care, shall receive more intensive re-engagement efforts such as attempts to contact the individual and/or natural supports, as allowable, by phone and/or in person.

1. If it appears that an outreach may have been warranted, but safety or privacy are potential issues, there is a documented rationale for not conducting an outreach and documentation that other types of re-engagement efforts have been utilized.

h.b. Re-engagement efforts for individuals that do not meet the previous criteria shall be determined by the MHCP based on the individual's needs and may include:

i. Letter indicating that his/her episode of care is closed (i.e., no timeframe that the chart will remain open).

i-ii. Any of the re-engagement efforts noted above or others that are deemed appropriate (e.g., 30-day re-engagement letter, phone call, outreach).

c. Individuals shall receive Written correspondence from the CMHA (e.g., re-engagement letters) shall be that is written in terminology understandable to the individual and includes consumer rights, how to access routine services and how to access emergency services. A copy of the written correspondence shall be retained in the individual's clinical record. This notification must be sent to the individual at least 30 days prior to closing the treatment episode except

i-d. No written notification is required as noted previously and in the following circumstances:

- i. NSMHA or the CMHA has confirmation of the individual's death.
- ii. ~~The individual receiving services has agreed to planned discharge and closing of the current treatment episode. In this case, the individual has signed a treatment plan that includes planning around the transition to discharge that outlines mutually agreed upon goals, objectives and interventions. The individual's signature on this plan will serve in place of sending a letter 30 days prior to episode closing.~~
- iii. NSMHA or the CMHA has no knowledge of the individual's whereabouts and returned mail has no forwarding address.
- iv. NSMHA or the CMHA has knowledge the person is currently enrolled in another region or state's Medicaid program.

~~2.4.~~ A discharge summary reflecting the active course of treatment shall be completed and placed in the clinical record at the time the treatment episode is closed.

ATTACHMENTS

None

NSMHA COMMITTEE DISCUSSION FORM

AGENDA ITEM: Policy 1546 Medication Management Transfers to Primary Care Providers

PRESENTER: Charissa Westergard

COMMITTEE ACTION: Action Item (X) FYI & Discussion () FYI only ()

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:

Revised to remove some of the previous inflexibility of the policy yet provide guidelines for transferring medication management services. This should assist in the most effective use of resources and support for PCPs to provide prescriptive services.

- Addition of procedures to support collaboration with the PCP from the beginning of treatment.
- Addition of timelines
 - Minimum period during which an individual on medications should be stable before considering transfer of medication management to PCP
 - Minimum period the individual's treatment episode shall remain open after transfer of medication management services to PCP
- Definition of complex medication regimen – per NSMHA Medical Director, removed “medications being prescribed for off label use” as many medications prescribed for mental health issues fall into this category.

CONCLUSIONS/RECOMMENDATIONS:

Action item – request recommendation for approval

TIMELINES:

Policy has been out for comment for 30 days. First presentation at QMOC meeting.

ATTACHMENTS:

Policy 1546

Effective Date: 11/21/2005
Revised Date: 4/22/09
Review Date: 4/22/09

North Sound Mental Health Administration
Section 1500 – Clinical: Medication Management Transfers to Primary Care Providers

Authorizing Source: 42CFR438.208; NSMHA

Cancels:

See Also:

Providers must have a “policy consistent with” this policy

Responsible Staff: Quality Manager

Approved by Executive Director

Date: 5/6/2009

Signature:

POLICY #1546.00

SUBJECT: MEDICATION MANAGEMENT TRANSFERS TO PRIMARY CARE PROVIDERS

PURPOSE

To provide coordinated medication management for individuals who do not require mental health specialty medication management.

POLICY

For individuals receiving mental health specialty medication management services from a Community Mental Health Agency (CMHA), transfer to a Primary Care Provider (PCP) may be considered when:

1. When an ~~The~~ individual is on a stable medication regimen and there is no longer medical necessity for the specialty care of ~~mental health/psychiatric~~ medication management services at the CMHA.
A stable medication regimen includes:
 - a. Individuals without a complex medication regimen who have not had medication changes for a minimum of three months.
 - ~~a.~~ b. Individuals with a complex medication regimen and/or have multiple psychiatric diagnoses requiring mental health specialty medication expertise who have not had medication changes for a minimum of six months.
 - i. A complex regimen of medications includes, but is not limited to, ~~medications being~~ prescription of ~~or off label use~~; two or more medications in the same class; or three or more psychiatric medications.

Transfer of medication management services to a ~~medical~~ PCP shall occur in a coordinated process as outlined in the Procedure section of this policy.

Mental health specialist prescribers will provide medication management services when an individual has not reached a stable medication regimen as identified above or when there is no PCP willing to accept the transfer.

An individual who only needs mental health specialty medication management services from the CMHA will not be referred or transferred to a PCP unless in accordance with this policy or at the request of the individual.

PROCEDURE

1. For individuals who do not have a PCP, CMHA staff shall refer and assist individuals in obtaining a PCP at the beginning of the treatment episode or as soon as the need is identified.

2. CMHA staff shall obtain and send an Authorization for Release of Information (ROI) to the PCP at the individual's first ongoing appointment after intake or as soon as the individual establishes care with a PCP.

3. CMHA staff shall contact the PCP once a need for mental health medication evaluation is identified to develop a plan for the medication evaluation and ongoing mental health medication management such as:

- a. Collaboration with the PCP so the PCP will provide the medication evaluation and ongoing medication management or;
- b. Collaboration with the PCP so the PCP will provide ongoing medication management after the initial medication evaluation at the CMHA or;
- c. Collaborating with the PCP so the PCP will provide ongoing medication management after medication services can be appropriately transferred from the CMHA to PCP.

4. CMHA staff shall communicate with the PCP throughout the individual's treatment episode including as outlined in NSMHA Policy #1517 Coordination of Care with External Health Care Providers.

5. When it is determined that the process for transferring medication management services to the PCP should begin, the following steps for coordinated transfer shall occur:

- a. The transfer of medication prescribing responsibilities will be discussed with the individual prior to a transfer. The individual's preference will be considered. This discussion will be documented in the clinical record.
 - i. The individual will be informed verbally and in writing of their right to file a complaint or grievance in accordance with the current North Sound Mental Health Administration (NSMHA) policy.
 - ii. The clinical record will document the rationale outlining the reasons the individual is being referred or transferred to a PCP.

~~Consultation, which shall be documented in the clinical record, shall occur between the mental health prescriber and the medical primary care provider prior to the transfer and within confidentiality regulations.~~

- b. Prior to the transfer of medication prescribing responsibilities, the PCP must agree to accept the referral or transfer of the individual. The clinical record shall document this understanding. If the PCP does not agree to accept this referral, the mental health specialist prescriber will continue managing the medications until an alternative arrangement can be developed.
- c. A plan will be developed outlining what happens if the individual becomes unstable on medications and/or the PCP believes it would be better for the mental health specialist prescriber to consult or resume management of medications. The plan must:

- i. Include appropriate steps for the individual to follow if this situation arises after the end of a treatment episode. If these steps are not included in the initial plan, the plan must be updated prior to closing of the treatment episode. It is encouraged that this plan be included in the transition summary for the individual.
- ii. Be developed collaboratively between the individual/guardian, mental health specialist prescriber and PCP.
- iii. Identify a mental health specialist prescriber at the transferring CMHA who will be ~~identified and~~ available to consult with the PCP accepting the transfer, if requested.

- d. Appropriate psychiatric and medication records will be sent to the PCP as permitted by appropriate ROIs.
- e. The CMHA shall keep the individual's treatment episode open long enough, but at least 30 days, after transfer of medication management services to the PCP to ensure medication management services have been successfully transferred to the PCP as documented in the clinical record.

ATTACHMENTS

None

NSMHA COMMITTEE DISCUSSION FORM

AGENDA ITEM: Policy 1574 State Only Funding Plan – Mental Health Services

PRESENTER: Charissa Westergard

COMMITTEE ACTION: Action Item FYI & Discussion FYI only

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:

PACT is now funded predominately by Medicaid Funding. The State has determined that PACT will be funded at 78% Medicaid and 22% State Funds. As a result, the State Funds need to cover all non-Medicaid services for Medicaid consumers and any consumers who are not on Medicaid. Therefore, NSMHA and other RSNs are having to stop enrolling individuals without Medicaid into PACT. The policy was revised to be consistent with this change.

CONCLUSIONS/RECOMMENDATIONS:

Action item – request recommendation for approval

TIMELINES:

Policy has been out for comment for 30 days; first presentation at QMOC meeting.

ATTACHMENTS:

Policy 1574

Effective Date: 9/11/2008; 6/19/2008 Fast Tracked
Revised Date:
Review Date: 5/27/2009

North Sound Mental Health Administration

Section 1500 – Clinical: State Only Funding Plan – Mental Health Services

Authorizing Source: SMH Contract; NSMHA

Cancels:

See Also:

Providers must “comply with” this policy

Responsible Staff: Quality Manager

Approved by: Executive Director

Signature:

Date: 5/29/09

POLICY 1574.00

SUBJECT: STATE ONLY FUNDING PLAN – MENTAL HEALTH SERVICES

PURPOSE

To ensure, within available resources, equal access region-wide to medically necessary outpatient mental health services for individuals with insufficient funding.

POLICY

North Sound Mental Health Administration (NSMHA) shall identify the populations that may receive medically necessary mental health services as well as the services covered by state funds as long as these funds are available. These categories may be revised as State-Only Funding availability changes. Any changes to these categories shall be effective immediately upon written notification.

PROCEDURE

I. NSMHA funds a variety of outpatient and inpatient services including the following with State-Only Funds:

- A. Inpatient Psychiatric Hospital costs
- B. Evaluation & Treatment Facilities (E&Ts)
- C. Crisis Services
- D. Involuntary Treatment Act (ITA) Services
- E. Court filing fees
- F. Access & Authorization
- G. Ombuds Services
- H. Jail Services
- I. Residential Room and Board Costs
- J. Medicaid Personal Care
- K. Out of Region Evaluation & Treatment costs
- L. ~~Program for Assertive Community Treatment (PACT)~~
- M. ~~Peer Drop-In~~ Centers
- N. Out of Network Services
- O. Flex Funds
- P. Outpatient Services to identified populations (as follows in Section II below)
- Q. Skagit County Wraparound Services (special grant)
- R. Children transitioning out of Children’s Long-term Inpatient Programs (CLIP)

II. The following populations of individuals shall be provided outpatient treatment services on a region-wide basis as medically necessary and within available resources. ***Available resources are not sufficient to meet the full need so limits are placed in some of these programs on the number of individuals admitted to these programs and to the length of services provided.***

- A. Individuals discharging, or discharged within the past 30 days, from a Children’s Long-Term Inpatient Program (CLIP) facility or Western State Hospital (WSH) are eligible for services under State-Only Funding for **up to a year from authorization**. If they do not qualify for services under some other funding within ~~the authorization period~~^{a year}, they should be considered for referral to other systems of care or discharged. Individuals’ services may be reauthorized beyond this time period on a case by case basis by NSMHA.*
- B. Individuals currently on a Less Restrictive Alternative (LRA) court order or Conditional Release (CR) are eligible for services under State-Only Funding for **up to a year from authorization**. If they do not qualify for services under some other funding within ~~the authorization period~~^{a year}, they should be considered for referral to other systems of care or discharged. If the LRA or CR is not continued, individuals’ services may be reauthorized beyond this time period on a case by case basis by NSMHA.*
- C. Individuals, funded by Medicaid, who are in a current treatment episode authorized by NSMHA and who are subject to a spenddown from the Department of Social and Health Services (DSHS), are eligible for continuation of previously authorized services under State-Only Funding. Funding may continue until the individual regains Medicaid eligibility or until the expiration of their current authorization period, whichever is earlier. Due to limited funding, individuals on a spenddown making an initial request for NSMHA services are **not** eligible for routine outpatient services unless they qualify on some other basis.

Individuals on a spenddown for six months or less when their authorization period ends may be reauthorized for up to one year. Individuals on a continuous spenddown for more than six months from the time they lose their Medicaid funding, and who do not qualify for services under some other funding, should be considered for referral to other systems of care or discharged. Individuals’ services may be reauthorized beyond this time period on a case by case basis by NSMHA.*

- D. Individuals in NSMHA-funded services (including residential placements) who lose their Medicaid coverage and do not fit any of the previously identified categories may continue to receive previously authorized mental health services under State-Only Funding until the expiration of their current authorization period. If they do not qualify for services under some other funding after losing their Medicaid coverage, they should be considered for referral to other systems of care or discharged. Individuals’ services may be reauthorized beyond this time period on a case by case basis by NSMHA.*

~~E. Adult individuals with serious mental illness will be eligible for PACT if they meet the PACT eligibility standards and NSMHA PACT priorities. Individuals will be served in the program at no charge up to 400% of the Federal Poverty Level. Adult individuals, with an income up to 400% of the Federal Poverty Level, may be served in the PACT program as long as they were in the program as of October 7, 2011. PACT shall work with individuals to apply for Medicaid. For individuals who are not eligible for Medicaid, consideration shall be given to transitioning them to other programs/services.~~

F.E. Skagit Wraparound funding is a special State-Only Funding Grant and will be utilized in accordance with the State Grant, national Fidelity Standards, and the program design as agreed upon by the contractor, NSMHA and the Mental Health Division.

G.F. State-Only Funds can be utilized by the outpatient provider to coordinate care for children who are being discharged from the CLIP facilities back to homes in our region. Services may be provided for up to 60 days prior to discharge from CLIP and for up to three hours of

service. This should be coded using the Rehabilitation Case Management CPT (Current Procedural Terminology)/HCPCS (Healthcare Common Procedure Coding System) code.

III. *Reauthorization Exception Requests

- A. To request reauthorization beyond the designated time period, the provider must submit an electronic authorization request and the following information to NSMHA prior to the expiration of the current authorization period:
 1. Reauthorization Exception Request Form; and,
 2. Most recent [Resiliency/Recovery Plan \(RRP\)](#)~~Individual Service Plan (ISP)~~ and RRP Review.
 3. ~~For an adult in NSMHA-funded intensive services requiring approval (Intensive Outpatient Program, Residential), an Adult Intensive Services Referral Form may be sent in lieu of the Reauthorization Exception Request Form and ISP Review.~~
- B. An authorization request that is not accompanied by the information identified above will not be considered complete and will be decertified by NSMHA. This is not a denial and no notice will be sent. A determination by NSMHA to authorize or deny the reauthorization request shall only occur once a complete request is received.
- C. A provider planning to submit a Reauthorization Exception Request for an individual should also plan, prior to expiration of the current authorization period, for potential discharge as the request may not be granted. Individuals who do not appear eligible for continued services may be covered for up to 30 days to facilitate a thoroughly planned discharge. In this situation, individuals shall receive Notices of Adverse Determination to notify them that they no longer meet medical necessity for NSMHA-funded services.
- D. The authorization period for those individuals for whom exception requests are granted shall be six months. Individuals who have not received Medicaid and have not qualified for services under some other funding at the end of this authorization period should be considered for referral to other systems of care or discharge. Another Reauthorization Exception Request may also be submitted if medically necessary.

ATTACHMENTS

None