NORTH SOUND
MENTAL HEALTH ADMINISTRATION

QUALITY MANAGEMENT OVERSIGHT COMMITTEE

MEETING PACKET

January 22, 2014
1:00 – 3:00 pm

1. Please join my meeting.
https://global.gotomeeting.com/join/390218421

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

Dial +1 (267) 507-0008
Access Code: 390-218-421
Audio PIN: Shown after joining the meeting

Meeting ID: 390-218-421

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.**
- **Manage your BEHAVIOR, be mindful of how you respond to others, understand intent vs. impact, and be responsible for your words and actions.**
- **Demonstrate RESPECT and speak with RESPECT toward each other at all times.**
- **LISTEN, people feel respected when they know you're listening to their point of view.**
- **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: 11/28/12

NORTH SOUND MENTAL HEALTH ADMINISTRATION
QUALITY MANAGEMENT OVERSIGHT COMMITTEE AGENDA

Date: January 22, 2014 **Time: 1:00-3:00 PM**

Location: NSMHA Conference Room **Chair: Rebecca Clark, Skagit County Human Services**

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	• VOA Answering/Screening Snohomish County Crisis Calls. • Other					**3**	*5 min*
Update on Regional Healthcare Alliance	Brief update.	Inform /discuss	Chair/ Greg				*5 min*
Quality Topics							
Compliance Presentation	Seven elements of an effective compliance program.	Inform/ Educate	Lisa Grosso			**4**	*20 minutes*
Depression and Anxiety Symptom –Reduction Outcomes	Discussion of the development of a simple outcomes process using PHQ-9 and GAD 7	Discussion	Kurt Aemmer/ Greg Long			**5**	*15 minutes*
Policy 1702	Final discussion and review of Crisis Policy on Outreach Safety Screening for Dispatch	Discussion/ Action	Sandy Whitcutt			**6**	*10 minutes*
Autism Procedures	Discussion regarding procedures to better handle the increasing number of individuals entering our system with autism.	Discussion	Greg Long/ Charissa Westergard /Sandy Whitcutt			**7**	*15 minutes*
State Fund Reduction Policy Changes	Review of proposed changes in policies to reduce and better manage the decreased State Funds	Discussion	Greg Long/ Charissa Westergard			**8**	*15 minutes*
Group Therapy	Discussion on group therapy being better than individual therapy in many situations, but only a limited amount is being done.	Discussion	Mark McDonald/ Greg Long			**9**	*15 minutes*
Follow up on Medication Formulary Change	Brief discussion to follow up on whether the HCA change requiring prescribers use health plan formularies is creating issues	Discussion	Greg Long/ Charissa Westergard				*5 min*
Other issues							
***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: February 26, 2014- 1:00-3:00 PM **Potential Future Agenda Items:**

North Sound Mental Health Administration (NSMHA)
Quality Management Oversight Committee (QMOC)
NSMHA Conference Room
December 11, 2013
1:00 – 3:00 pm
MEETING SUMMARY

PRESENT:	Rebecca Clark, Skagit County; Mark McDonald, Candy Trautman and David Kincheloe, NSMHA Advisory Board; Eric Chambers; NWESD; Jeff Reynolds, CVAB; Cindy Ferraro, Bridgeways; Seong-ja Garza, Sea Mar; Heather Fennell, Compass; Chuck Davis, Ombuds; Mike Manley, Sunrise and Larry Van Dyke, Skagit Triage Center.
BY PHONE:	Anji Jorstad, Snohomish Co.; Pam Benjamin, WCPC; Eric Love, CCS; Pat Morris, VOA; Danae Bergman, CHS and Kay Burbidge, LWC.
STAFF:	Greg Long, Charissa Westergard, Julie de Losada, Marta Hammond, Jessie Ellis and Barbara Jacobson.
OTHERS PRESENT:	
OTHERS PHONE:	Kim Olander Mayer, Ombuds.

TOPIC	DISCUSSION	ACTION
1. **Introductions, Review of Agenda – Chair**	The meeting was called to order at 1:00 pm and introductions were made. The agenda is approved as presented.	
2. Previous Meeting Summary – Chair	A motion was carried to approve the previous meeting summary as submitted.	Motion carried
3. Announcements and Updates – All	• Greg introduced Jessica Ellis as our new adult care coordinator and Marta Hammond, RN our new healthcare integration care coordinator; to help as we integrate with the overall healthcare system. • Greg noted that the Board approved funding access to the Emergency Department Information Exchange (EDIE) where we will download crisis plans for individuals. As this comes about it will be more vital that crisis plans are completed on all level four individuals and those that it is clinically appropriate for. Staff will need to think what an ED doctor would need to know to help stabilize the crisis situation; the plans are already available by phone from the VOA. Greg noted that the form will need to include that information will be entered in the exchange; this will be HIPPA compliant as they would need this information to treat. David K. noted his concern about advance directives; they should be linked to this. Greg noted there is a data element already where an advanced directive can be called up rather quickly; this can be explored at future meeting. EDIE timeline will be more concrete next week; 42 CFR substance abuse plans fall under this too. • Greg announced that Larry Van Dyke is resigning at the end of January, with a smooth transition planned. He will be missed! • The Regional Healthcare Alliance will meet with hospitals on December 19th to look at the boarding issue.	Informational

4. State Wraparound with Intensive Services (WISe) Plan	Eric C. reported that when the State received a Systems of Care (SOC) grant they created a Data and Quality Team as part of their restructure to address the TR Lawsuit requirements. This team is responsible for developing the State Quality Assurance Plan and their sub-committee met in November to review the draft plan. The sub-committee agreed to a different approach and over the next few months will review the requirements to identify specific measures. The data needs to be collected with the least impact on providers and also look at what we already collect. The next meeting of this subcommittee will be on January 17, 2014 and they are seeking input. Greg noted that NSMHA supports looking at realistically collecting data in this and other initiatives. Jeff R. asked what role peer counselors may have and Julie d. noted that WISe would be available to those under 21 with an expectation that providers hire a youth partner. A barrier to this is that youth and parent partners must be certified to bill Medicaid. We must look at how to implement this. Greg suggested that Julie present to the Advisory Board; Julie will request time on the January agenda.	Informational
5. Discharge Planning Review Report	Charissa reported out on the first focused review on discharge planning done last fall and noted there were a few things that needed improvement; such as more thorough documentation. There were 15 charts reviewed with nine questions developed to measure compliance with NSMHA discharge policy 1540. There will be no corrective action as this is the first review; at the next review more interventions may be needed.	Informational
6. Special Populations Review Report	Charissa reported out on the Special Populations Review that looks at consults done on children, geriatric, some ethnicities and disabled persons. The review looks at the consult being done within the 90 day timeframe and if the consultants' recommendations are incorporated in the Recovery Resiliency Plan (RRP). There has been steady improvement as a region and there will be no corrective actions from this review. Charissa noted that the special population requirement has been removed from the WAC and will most likely go into contracts. Greg stated that NSMHA just found out that DBHR still needs to do more work on this and so there will be no contract change until the end of the contract cycle. Providers will still follow NSMHA Policy around this requirement.	Informational
7. ICRS Policy 1703	Greg noted that policy 1703 describes the nature and duration of crisis services and was last reviewed in 2008. It was reviewed and accepted by Integrated Crisis Response Services (ICRS) and required only small revisions. Chuck D made a motion to accept as presented, Candy T seconded; motion carried.	Motion carried
8. Recovery Resiliency Plan (RRP) Review	There was a WAC revision that eliminated the 180 day review of RRPs and last month NSMHA requested members to consider strategies to ensure a review. Strategies to consider are to continue with the current	Policy to go out.

	standard, at set service hours or service hours per level of care. Discussion around the data programming and child/adult differences occurred and there was a consensus that option one would be best as the Electronic Health Record (EHR) already has the 180 day programmed in. Charissa stated that the policy will be written and sent out for comment period.	
9. State Funding Reductions	Greg handed out a funding allocation chart and noted that the reduction in state funding will have a large impact as state funding is more flexible. This is a concern as state funding is more flexible. The chart shows the allocation of Medicaid and State dollars and most reductions must come from outpatient services. This highlights the importance of getting all those eligible to sign up for Medicaid to bring in more Medicaid funding. David noted that the marginalized population does not even know of this program. Greg noted that there are many who have touched our system but not signed up. Pat M. noted that VOA looks up those calling into Access and if they are not signed up they are provided with detailed information on the exchange. There is also an increase in calls to the 211 information line where they are given exchange information as well. On January 1st VOA will launch a Community Advocate Program as an enhancement to the 211 line where an individual can meet face to face with someone to assist them with these processes. David stated that it is does not seem to be coordinated on any level; providers are getting the word out but outreach to missions, food banks, libraries, etc. by the assisters and other community partners really needs to happen. NSMHA recommends managing state only funds would involve putting a cap on state funded outpatient services to each provider; where they would manage their clients up to that cap. The authorization process would perhaps be shortened to 3 months for those individuals as well. Submit any other suggestions to Greg.	Informational
10. Regional Training Plan	Heather noted the Regional Training Plan is outdated and having training such as suicide assessment, CANs, clinical supervisor training, peer counselor training etc. could better be done on a regional level. Greg noted NSMHA is thinking about purchasing a region-wide online learning system; though in person trainings are also necessary. This would also allow us to track training across agencies and staff; My Learning Point is one such program. If this goes forward NSMHA would release an RFQ for this. DSM V training is being looked at for this year by NSMHA This will go on next month's agenda to continue discussion.	Informational
11. Date and Agenda for Next Meeting	The meeting was adjourned at 2:50 pm. The next meeting is January 22, 2014	

North Sound Mental Health Administration

Regional Support Network for Island, San Juan, Skagit, Snohomish, and Whatcom Counties

Improving the mental health and well being of individuals and families in our communities

117 North First Street, Suite 8 • Mount Vernon, WA 98273 • 360.416.7013

800.684.3555 • Fax 360.416.7017 • TTY 360.419.9008 • Email nsmha@nsmha.org • Web Site http://nsmha.org

MEMORANDUM

TO: Snohomish County Emergency Departments, Adult Protective Services and Home and Community Services

FROM: North Sound Mental Health Administration (Greg Long, Deputy Director and Sandy Whitcutt, Quality Specialist)

SUBJECT: Phone Changes on Crisis Calls for Snohomish County effective January 1, 2014

DATE: December 24, 2013

CC: ICRS, Pat Morris, Richard Wong, VOA; Cammy Hart-Anderson, Ken Starke, Snohomish County Human Services; NSMHA Quality Managers; Joe Valentine, Executive Director, NSMHA

This memo is intended to clarify changes in the process for crisis calls in Snohomish County. As of January 1, 2014, Snohomish County Involuntary Treatment Services will no longer be taking calls directly due to increased workloads.
Calls from community professionals, including those from Emergency Department Professionals, will need to go to the Care Crisis Response Services Triage line at 1-800-747-8654.

Calls made to the 1-800-747-8654 number will be handled first by one of the Care Crisis Triage Clinicians, Masters Level Clinicians trained in responding to the needs of the Emergency Departments and Community Professionals. The Triage Clinician will work with the ED professional and other Community Professional to assist with the voluntary or involuntary outreach needed. The Triage Clinician will then page the Integrated Crisis Response Emergency Services Clinician on call for voluntary outreaches or the Designated Mental Health Professional on call for involuntary evaluations and relay the information from the ED professionals or community professionals to the ES clinician or DMHP.

The ES clinician or DMHP will coordinate their response with the EDs and Community Professionals, as they have done in the past. The ES clinician or DMHP will call in the disposition of the case to the Care Crisis Triage Clinician.

This change in process for Snohomish County will align with the way Emergency Department calls and professional calls are handled regionally. Two additional staff persons have been added at the Crisis Line to assure rapid handling of all phone calls.
Professionals should use the 1-800-747-8654 number when there is a need for an outreach or involuntary evaluation.
Any calls made to the Snohomish County 425-388-7215 number will be electronically transferred directly to Care Crisis Response Services.

North Sound Mental Health Administration (NSMHA) contracts for and oversees voluntary and involuntary crisis response services for mental health in the North Sound Region (Island, San Juan, Skagit, Snohomish and Whatcom counties).
A volunteer of America Care Crisis Response Services manages crisis calls for the region.
Community calls are taken at the 1-800-584-3578 number and professionals call the Triage line at 1-800-747-8654.

Please call or email me if you have any questions related to this change at 360-416-7013 or at sandy_whitcutt@nsmha.org.

Office of the Inspector General
7 Elements of an Effective Compliance Program

1. Designating a Compliance Officer or Contact

The designation of a single person to accept responsibility for the Compliance Program and manage its day-to-day operations is critical to ensuring that the Compliance Program remains visible, active, and accountable. In addition, the designation of a single person enables the health center's Board of Directors and CEO to have a single point of contact for receiving information about the activities of the Compliance Program without confusion regarding whose job it is to address particular aspects of the Compliance Program.

2. Implementing Written Standards and Procedures

The implementation of written standards and procedures ensures that a health center's expectations for individuals affiliated with the health center conduct are clearly communicated. The health center should have written policies and procedures, particularly within the organization's principal risk areas, to ensure that legal requirements are distilled into clear, workable directions. The health center also should have written policies and procedures that address each of the seven elements of its Compliance Program.

3. Conducting Appropriate Training and Education

Training and education provide individuals affiliated with the health center with an understanding of the health center's Compliance Program, legal requirements applicable to the health center, and written policies and procedures. Annual training events create an important opportunity for a health center to convey its organizational values, including its commitment to ethical and legal conduct. The training on the health center's Compliance Program should explain the significant legal risks faced by the health center and the important role that individuals affiliated with the health center have for maintaining compliance. In addition, specific training should be provided to individuals affiliated with the health center whose job functions raise significant risks for the health center, e.g., coding and billing staff, practitioners, and finance staff.

4. Developing Open Lines of Communication

To facilitate detection of potential non-compliant conduct, it is necessary for all individuals affiliated with the health center to feel comfortable in reporting compliance issues. It is critical that health centers create an environment in which individuals affiliated with the health center do not have reason to fear retaliation for reporting or that their reports will not be taken seriously.

5. Conducting Internal Monitoring and Auditing

Monitoring is an ongoing process of reviewing the operations of the health center as they occur in the present. In contrast, auditing consists of conducting reviews of risk areas to determine compliance with legal requirements. An audit provides the health center with a "snapshot" of its compliance at a specific point in time, often in the past.

6. Responding Appropriately to Detected Offenses and Developing Corrective Action

For a Compliance Program to be effective, the Compliance Officer must ensure that the health center has taken steps to correct any potential or actual occurrences of non-compliance. As part of this process, a health center Compliance Officer (or his or her designee) should investigate credible allegations to determine their scope, causes, and seriousness. If possible, non-compliant conduct should be halted immediately and the effects of non-compliance conduct should be mitigated. Any corrective actions taken to address non-compliance should aim to reduce the likelihood of similar instances of non-compliance occurring in the future.

7. Enforcing Disciplinary Standards through Well-Publicized Guidelines

In some cases, it will be appropriate to discipline individuals who violate standards or policies. Enforcing disciplinary standards is important not only to give the Compliance Program credibility, but also to demonstrate a health center's integrity and commitment to compliance and desire to prevent recurrence.

NSMHA COMMITTEE DISCUSSION FORM

AGENDA ITEM: 2014 Automated Symptom Reduction Survey Plan

PRESENTER: Kurt Aemmer

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

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:

1. The 2011 & 2012 NSMHA Customer Satisfaction Surveys revealed that individuals were overall very satisfied with services they have been receiving. The data showed that the highest opportunity for improvement was reflected in the data that measured the level of perceived service outcomes, i.e. *we really like the quality of services, but we are not as confident in whether or not services really helped us.*
2. In planning for future customer satisfaction surveys NSMHA has decided to focus on outcomes, i.e. symptom reduction. This strategy is also consistent with the direction the State & Federal governments are moving in context of the Affordable Care Act, and accountability in general.
3. NSMHA set out to develop & implement a survey process that:
    a. focuses on outcomes by measuring symptom reduction;
    b. allows for automated data retrieval & analysis;
    c. utilizes nationally recognized survey tools/scales which are in the public domain, thus not presenting copyright &/or licensing/cost issues.

CONCLUSIONS/RECOMMENDATIONS:

1. The plan is to implement an automated process that allows:
    a. clinicians, at intake or during the first ongoing session, asking individuals who have been diagnosed with Depression to complete a PHQ-9 questionnaire, and individuals diagnosed with Anxiety to complete a GAD-7 questionnaire;
    b. clinicians to forward the individual total survey scores to their local IT/IS staff;
    c. IS/IT staff the ability to forward to NSMHA the outcome data with all the other data they send;
    d. clinicians to repeat the process every 6 months with each of these individuals;
    e. NSMHA staff to calculate provider and regional symptom reduction (or increase) scores.

TIMELINES:

1. NSMHA Leadership, IS/IT, and Clinical Oversight are collaborating on development & implementation of the survey, and will present the completed plan by March;
2. NSMHA IS/IT will be meeting on 1/24/14 (tomorrow) to discuss/plan for the logistics involved in automating the process;
3. Plan to implement by October, hopefully in early April.

ATTACHMENTS:

1. PHQ-9
2. GAD-7

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
	add columns	+	+	

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off *any problems,* how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

A2663B 10-04-2005

PHQ-9 Patient Depression Questionnaire

For initial diagnosis:

1. Patient completes PHQ-9 Quick Depression Assessment.
2. If there are at least 4 ✓s in the shaded section (including Questions #1 and #2), consider a depressive disorder. Add score to determine severity.

Consider Major Depressive Disorder

- if there are at least 5 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

Consider Other Depressive Disorder

- if there are 2-4 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

Note: Since the questionnaire relies on patient self-report, all responses should be verified by the clinician, and a definitive diagnosis is made on clinical grounds taking into account how well the patient understood the questionnaire, as well as other relevant information from the patient.
Diagnoses of Major Depressive Disorder or Other Depressive Disorder also require impairment of social, occupational, or other important areas of functioning (Question #10) and ruling out normal bereavement, a history of a Manic Episode (Bipolar Disorder), and a physical disorder, medication, or other drug as the biological cause of the depressive symptoms.

To monitor severity over time for newly diagnosed patients or patients in current treatment for depression:

1. Patients may complete questionnaires at baseline and at regular intervals (eg, every 2 weeks) at home and bring them in at their next appointment for scoring or they may complete the questionnaire during each scheduled appointment.
2. Add up ✓s by column. For every ✓: Several days = 1 More than half the days = 2 Nearly every day = 3
3. Add together column scores to get a TOTAL score.
4. Refer to the accompanying **PHQ-9 Scoring Box** to interpret the TOTAL score.
5. Results may be included in patient files to assist you in setting up a treatment goal, determining degree of response, as well as guiding treatment intervention.

Scoring: add up all checked boxes on PHQ-9

For every ✓ Not at all = 0; Several days = 1;
More than half the days = 2; Nearly every day = 3

Interpretation of Total Score

Total Score	Depression Severity
1-4	Minimal depression
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe depression

A2662B 10-04-2005

GAD-7

Over the last 2 weeks, how often have you been bothered by the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

(For office coding: Total Score T____ = ____ + ____ + ____)

NSMHA COMMITTEE DISCUSSION FORM

AGENDA ITEM: ICRS Policy 1702 Outreach Safety Screening for Dispatch

PRESENTER: Sandy Whitcutt or Greg Long

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

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:

The purpose of this policy is to assure a responsive and consistent safety screening process for crisis outreaches for individuals, family members, community members, and ICRS staff as well as addressing the roles of the Volunteers of America (VOA) Care Crisis Response Services (CCRS) Triage Clinician (referred to herein as "CCRS Triage Clinician") and the dispatched Mobile Outreach Team (MOT), Emergency Mental Health Clinician (EMHC) and Designated Mental Health Professional (DMHP).

The policy was revised to address the changes in the WAC. There were only minor changes made to the policy. ICRS was involved in the review process and has approved these changes.
The revised version with changes and the clean version have been attached for your review.

CONCLUSIONS/RECOMMENDATIONS:
Approve the revised policy.

TIMELINES:
If approved, the revised policy will go into effect 60 days after posting on the NSMHA Website.

ATTACHMENTS:
Policy 1702, revised and clean versions

Effective Date: 9/9/2011; 6/17/2008; 8/30/2007; 12/21/2005
Revised Date: 11/26/2013
Review Date: 11/26/2013

North Sound Mental Health Administration

Section 1700 – Integrated Crisis Response Services (ICRS):
ICRS Outreach Safety Screening for Dispatch

Authorizing Source: Per NSMHA and ICRS Management, RCW 71.05.700and 71.05.715, WAC 388-877A-0240, 0260, 0270, and 0280
Cancels:
Providers contracted for Crisis Services must have "policy that complies with NSMHA policies"
Responsible Staff: Deputy Director

Approved by: Executive Director Date:

Signature:

POLICY #1702.00

SUBJECT: ICRS OUTREACH SAFETY SCREENING FOR DISPATCH

PURPOSE

The purpose of this policy is to assure a responsive and consistent safety screening process for crisis outreaches for individuals, family members, community members, and ICRS staff. This policy addresses the roles of the Volunteers of America (VOA) Care Crisis Response Services (CCRS) Triage Clinician (referred to herein as "CCRS Triage Clinician") and the dispatched Mobile Outreach Team (MOT), Emergency Mental Health Clinician (EMHC) and Designated Mental Health Professional (DMHP).

POLICY

The CCRS Triage Clinician will have the responsibility of deciding when face-to-face evaluation and/or stabilization services are needed and dispatch the MOT, EMHC, and/or DMHP staff to a community location. The MOT, EMHC, or DMHP may not decline a referral for face-to-face services but decides if backup or other provisions are needed to mitigate risk.

Outreach services shall be provided within two (2) hours of dispatch by the CCRS Triage Clinician. Any exceptions shall be clearly documented in the individual's record(s) and are subject to North Sound Mental Health Administration (NSMHA) review. The disposition of all cases referred to the MOT, EMHC, or DMHP by a CCRS Triage Clinician, whether it results in face-to-face services or consultation, will be reported to the CCRS Triage Clinician by phone or fax within one (1) hour of the completion of the case.

Once the safety screening has been completed by the CCRS Triage Clinician and the decision is made to dispatch the MOT, EMHC,or DMHP, the dispatched MOT, EMHC,or DMHP assumes responsibility for further assessing the safety of the situation. The MOT, EMHC,or DMHP must provide the most appropriate clinical intervention (via outreach) in the safest manner possible. There is an understanding that each situation is fluid, and that there is often missing information. The system allows for decisions to be re-evaluated in the face of new or different information.

PROCEDURES

I. Initial telephone safety screening for callers that seem to be under the influence of drugs or alcohol

A. If the caller's judgment is significantly impaired and/or the caller has excessive mood lability and they are a risk to themselves or others and they are unable to maintain safety for up to two (2) hours, 911 must be called to initiate law enforcement response.

B. If the risk is elevated, but not immediate, the CCRS Triage Clinician must complete a more thorough risk assessment. Depending on the clinical assessment, degree of risk, and the individual's needs, the individual will be referred to the appropriate services, which may include 911, hospital emergency department, Triage/Crisis Center, crisis appointment, or other community services. If the individual is able to maintain safety for two (2) hours, per VOA's assessment of risk with the use of the safety screening assessment tool, a crisis outreach may be considered.

C. When alcohol or drugs are present (per safety screening assessment tool), the MOT, EMHC, or DMHP will not be dispatched to homes or other unstaffed (less than three staff) locations. Arrangements will be made for the individual in crisis to go to the hospital emergency department or Triage/Crisis Center. Exceptions can be made on a case by case basis, if the CCRS Triage Clinician and the MOT, EMHC, or DMHP agree that an outreach is appropiate in the presence of alcohol or drugs.

II. Initial telephone safety screening for callers that do not seem to be under the influence of drugs or alcohol

A. If the caller is an immediate risk to self or others and unable to maintain safety for up to two (2) hours, 911 must be called to initiate law enforcement response.

B. If the risk is elevated, but not immediate, the CCRS Triage Clinician must complete a more thorough risk assessment. Depending on the clinical assessment, degree of risk, and the individual's needs, the individual will be referred to the appropriate services, which may include 911, hospital emergency department, Triage/Crisis Center, crisis appointment, or other community services. If the individual is able to maintain safety for two (2) hours, per VOA's assessment of risk with the use of the safety screening assessment tool, a crisis outreach may be considered.

C. Ongoing safety screening by the MOT, EMHC and DMHP staff shall occur.

1. Upon dispatch to an unstaffed location, the MOT, EMHC,or DMHP will continue to perform an ongoing risk assessment.

   The MOT, EMHC,or DMHP must assess risk factors.

   a. Risk factors can include:

      i. Location
      ii. Access to weapons

iii. History
iv. Volitility
v. Consistency of known information
vi. Ability to summon assistance if needed (e.g., cell phone coverage)
vii. Time of dispatch
viii. Gender
ix. Age
x. Presence of others at the location
xi. History of ICRS contacts
xii. Presence of animals
xiii. Presence of drugs and/or alcohol

b. The MOT, EMHC,or DMHP must determine (based upon evaluated risk) how and where to see the individual.

2. Options to consider to increase safety include:

a. Arranging for family members or significant others to be present.
b. Moving the location of the outreach to a safer community setting.
c. Arranging for law enforcement to escort the MOT, EMHC, or DMHP..
d. Conducting the outreach with a second ICRS staff person for additional safety.

III. No MOT, EMHC, or DMHP staff shall be required to respond alone to a private home or other private location to stabilize or treat a person in crisis, or to evaluate a person for potential detention under the state's involuntary treatment act. When determined to be necessary for safety, clinical staff who provide outreach to consumers shall engage the use of a second person to accompany them. The second person can be another agency clinical staff, law enforcement officer, or other first responder, such as fire or ambulance personnel. Additionally, the MOT, EMHC, or DMHP who is dispatched on a crisis visit shall have prompt access to information about any history of dangerousness or potential dangerousness of the individual they are being sent to evaluate. At a minimum, information documented in crisis plans or commitment records shall be available without unduly delaying a crisis.

IV. If risk cannot be assessed, clinical staff shall consider other outreach options or arrange to see the individual at a staffed location**.**

V. MOT, EMHC, or DMHP will re-contact the CCRS Triage Clinician regarding changes in dispatch due to elevated risk concerns.

VI. MOT, EMHC,DMHP staff will be provided with wireless phones and participate in annual safety training as addressed in NSMHA Policy #1557.00 Safety Policy.

ATTACHMENTS

None

Effective Date: 9/9/2011; 6/17/2008; 8/30/2007; 12/21/2005
Revised Date: ~~6/6/2011~~9/26/2013
Review Date: ~~8/25/2011~~9/26/2013

North Sound Mental Health Administration

Section 1700 – Integrated Crisis Response Services (ICRS): ICRS Outreach Safety Screening for Dispatch

Authorizing Source: Per NSMHA and ICRS Management,
RCW 71.05.700~~, RCW~~and 71.05.715
WAC 388-~~865-0452, WAC 388-865-0468~~877A-0240, ~~00~~260, ~~and~~ 0270, and 280
Cancels:
Approved by: Executive Director Date:
~~Cancels:~~
Providers contracted for Crisis Services must have_____
"policy that complies with NSMHA policies"
Responsible Staff: Deputy Director Signature:

POLICY #1702.00

SUBJECT: ICRS OUTREACH SAFETY SCREENING FOR DISPATCH

PURPOSE

The purpose of this policy is to assure a responsive and consistent safety screening process for crisis outreaches for individuals, family members, community members, and ~~Integrated Crisis Response Services (~~ICRS~~)~~ staff~~.~~. This policy addresses the roles of~~-~~ the Volunteers of America (VOA) Care Crisis Response Services (CCRS) Triage Clinician (referred to herein as "CCRS Triage Clinician") and the dispatched Mobile Outreach Team (MOT), Emergency Mental Health Clinician (EMHC) and Designated Mental Health Professional (DMHP).

POLICY

The CCRS Triage Clinician will have the responsibility of deciding when face-to-face evaluation and/or stabilization services are needed and dispatch the MOT, EMHC, and/or DMHP staff to a community location~~ outside of the provider's office~~. The MOT, EMHC, or DMHP may not decline a referral for face-to-face services~~,~~ but decides if backup or other provisions are needed to mitigate risk.

Outreach services shall be provided within two (2) hours of dispatch by the CCRS Triage Clinician. Any exceptions shall be clearly documented in the individual's record(s) and are subject to North Sound Mental Health Administration (NSMHA) review. The disposition of all cases referred to the MOT, EMHC, or DMHP by a CCRS Triage Clinician, whether it results in face-to-face services or consultation, will be reported to the CCRS Triage Clinician by phone or fax within one (1) hour of the completion of the case.

Once the safety screening has been completed by the CCRS Triage Clinician~~,~~ and the decision is made to dispatch ~~-~~the MOT, EMHC,or DMHP, the dispatched MOT, EMHC,or DMHP assumes responsibility for further assessing the safety of the situation. The MOT, EMHC,or DMHP must provide the most appropriate clinical intervention (via outreach) in the safest manner possible. There is an understanding that each situation is fluid, and that there is often missing information. The system allows for decisions to be re-evaluated in the face of new or different information.

PROCEDURES

I. Initial telephone safety screening for callers that seem to be under the influence of drugs or alcohol

A. If the caller's judgment is significantly impaired and/or the caller has excessive mood lability and they are a risk to themselves or others and they are unable to maintain safety for up to two (2) hours, 911 must be called to initiate law enforcement response.

B. If the risk is elevated, but not immediate, the CCRS Triage Clinician must complete a more thorough risk assessment. Depending on the clinical assessment, degree of risk, and the individual's needs, the individual will be referred to the appropriate services, which may include 911, hospital emergency department, Triage/Crisis Center, crisis appointment, or other community services. If the individual is able to maintain safety for two (2) hours, per VOA's assessment of risk with the use of the safety screening assessment tool, a crisis outreach may be considered.

C. When alcohol or drugs are present (per safety screening assessment tool), the MOT, EMHC, or DMHP will not be dispatched to homes or other unstaffed (less than three staff) locations. Arrangements will be made for the individual in crisis to go to the hospital emergency department or Triage/Crisis Center. Exceptions can be made on a case by case basis, if the ~~Triage Clinician~~CCRS Triage Clinician and the MOT, EMHC, or DMHP agree that an outreach is appropiate in the presence of alcohol or drugs.

II. Initial telephone safety screening for callers that do not seem to be under the influence of drugs or alcohol

A. If the caller is an immediate risk to self or others and unable to maintain safety for up to two (2) hours, 911 must be called to initiate law enforcement response.

B. If the risk is elevated, but not immediate, the ~~Triage Clinician~~CCRS Triage Clinician must complete a more thorough risk assessment. Depending on the clinical assessment, degree of risk, and the individual's ~~-~~needs,~~-~~ the individual will be referred to the appropriate services, which may include 911, ~~-~~hospital emergency department, Triage/Crisis Center, crisis appointment, or other community services. If the individual is able to maintain safety for two (2) hours, per VOA's assessment of risk with the use of the safety screening assessment tool, a crisis outreach may be considered.

C. Ongoing safety screening by the MOT, EMHC~~,~~ and DMHP staff shall occur.

1. Upon dispatch to an unstaffed location, the MOT, EMHC,or DMHP will continue to perform an ongoing risk assessment.

a. The MOT, EMHC,or DMHP must assess ~~primary and secondary~~ risk factors.

i. ~~Primary r~~Risk ~~factors~~ factors can include:

a) Location
b) Access to ~~weapons~~Weapons
c) History
d) ~~Mood lability~~Volitility
e) Consistency of known information ~~on individual~~

f) Ability to summon assistance if needed (e.g., cell phone coverage)

~~ii. Secondary risk factors include:~~

~~a)~~g) g.Time of dispatch
~~b)~~h) G
ender
~~c)~~i) Age
~~d)~~j) Presence of others at the location
k) ~~i.~~History of ICRS contacts
l) Presence of animals
~~e)~~m) P
Presence of drugs and/or alcohol

~~iii.~~ii. ~~T~~
The MOT, EMHC,or DMHP must determine (based upon evaluated risk) how and where to see the individual.

2. Options to consider to increase safety include:

a. Arranging for family members or significant others to be present.
b. Moving the location of the outreach to a safer community setting.
c. Arranging for law enforcement to escort the MOT, EMHC, or DMHP..
d. Conducting the outreach with a second ICRS staff person for additional safety.

III.No MOT, EMHC, or DMHP staff shall be required to respond alone to a private home or other private location to stabilize or treat a person in crisis, or to evaluate a person for potential detention under the state's involuntary treatment act. When determined to be necessary for safety, clinical staff who provide outreach to consumers shall engage the use of a second person to accompany them. The second person can be another agency clinical staff, law enforcement officer, or other first responder, such as fire or ambulance personnel. Additionally, the MOT, EMHC, or DMHP who is dispatched on a crisis visit shall have prompt access to information about any history of dangerousness or potential dangerousness of the individual they are being sent to evaluate. At a minimum, information documented in crisis plans or commitment records shall be available without unduly delaying a crisis.

IIV.If risk cannot be assessed, clinical staff shall consider other outreach options or arrange to see the individual at a staffed location ~~MOT, an EMHC, or a DMHP may respond to a private location if a second trained individual, as determined by the clinical team supervisor, on-call supervisor, or individual professional acting alone (based on a risk assessment for potential violence), accompanies them. Additionally, the MOT, EMHC, or DMHP who is dipatched on a crisis visit shall have prompt access to information about any history of dangerousness or potential dangerousness of the individual they are being sent to evaluate. At a minimum, information documented in crisis plans or commitment records shall be available without unduly delaying a crisis~~ response. ~~The MOT, EMHC,/DMHP will have the option of:~~

~~a. Changing the outreach location to a more secure situation~~
~~b. Taking a second person, such as another agency clinical staff, law enforcement officer, or other first responder.~~

V.The MOT, EMHC, or DMHP will re-contact the ~~Triage Clinician~~CCRS Triage Clinician regarding changes in dispatch due to elevated risk concerns.

3. ~~M~~VI.MOT, EMHC,DMHP staff will be provided with wireless phones and participate in annual safety training as addressed in NSMHA Policy #1557.00 Safety Policy.

ATTACHMENTS

None

NSMHA COMMITTEE DISCUSSION FORM

AGENDA ITEM: Autism Spectrum Disorder

PRESENTER: Greg Long

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

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:
NSMHA has seen an increase in individuals requesting our services whose primary diagnosis appears to be an Autism Spectrum Disorder. These individuals typically present with a complex diagnostic picture. The difficulty with these complex diagnoses is trying to sort out whether the presenting symptoms indicate a covered diagnosis for NSMHA services or are best accounted for by the Autism Spectrum Disorder (not a covered diagnosis for NSMHA services), which can be extremely challenging to sort out at a single intake appointment. In some instances, this results in the provider requesting a standard year-long authorization to allow time to sort out the issues. However, a year-long authorization can end up being unnecessary to sort out the diagnoses and related needs and NSMHA would like to propose a procedure to clarify diagnosis and needs for individuals thought to have Autism Spectrum Disorder.

CONCLUSIONS/RECOMMENDATIONS:
Proposed procedure:

- Every effort should be made to obtain any historical records related to diagnosis and need clarification and included in the assessment.
- For authorization or denial review requests for individuals with Autism Spectrum Disorder, the provider shall send the intake assessment documentation to NSMHA for review. The intake must provide a thorough diagnostic justification that includes a differential diagnosis rationale.
- If determined to meet Clinical Eligibility and Care Standards by NSMHA, NSMHA shall provide authorization for a period not to exceed 3 months.
- During the authorization period, NSMHA expects further clarification of the diagnostic picture and related needs prior to considering any reauthorization request, which may include an autism evaluation and engagement of related services as appropriate (e.g., ABA [Applied Behavior Analysis], referral and linkage to Apple Health Managed Care Plan for autism services).

TIMELINES:
NSMHA is currently working on a related clinical practice guideline and potentially a policy. We request your feedback by the end of the month.

ATTACHMENTS:

NSMHA COMMITTEE DISCUSSION FORM

AGENDA ITEM: State Funding Plan Changes

PRESENTER: Greg Long

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

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:

Beginning 7/1/14, state funds will be reduced by $4.37 million annually, $374,496 of which is jail funds. Based on this reduction, NSMHA needs to revise the State Only Funding Plan and authorization process. The following is a summary of proposed changes:

- A proportionate and fixed amount of state funds will be allocated to each provider, which the provider will be responsible for managing.
- Priority populations for use of state funds remain the same, but the provider makes determination about appropriateness of reauthorization and length of authorization period.
    - The Reauthorization Exception Review process will be eliminated.
    - Authorization periods shall be limited (not to exceed 3 months) for individuals utilizing state funds unless provider indicates rationale for longer authorization period.
    - Authorization periods may be terminated early.
    - Authorization periods will end with the treatment episode.

On a related note, the State made changes regarding the use of State funds.

- State funds payment by NSMHA for individuals receiving State plan services shall be considered payment in full as long as they meet State funding qualifications and do not have third party resources.
- Additionally, payments of State funds for individuals on spend down shall be considered qualifying medical expenses that have been paid on behalf of the individual by a publicly administered program per Washington Administrative Code (WAC) 182-519-0110(9).

CONCLUSIONS/RECOMMENDATIONS:

Related NSMHA policies are being revised (see attached) and will be sent out to QMOC for the 30 day review and comment period.

TIMELINES:

ATTACHMENTS:

NSMHA Policies 1505 and 1574

Effective Date: 3/8/2007
Revised Date: 2/25/08
Review Date:

North Sound Mental Health Administration

Section 1500 – Clinical: Authorization for Ongoing Outpatient Services

Authorizing Source: CFR 438.210; MHD Contract 2007-09; Provider Contract 2007-09
Cancels:
See Also: Approved by: Executive Director Date: 3/31/08
Responsible Staff: Quality Manager Signature:

POLICY #1505.00

SUBJECT: AUTHORIZATION FOR ONGOING OUTPATIENT SERVICES

PURPOSE

To outline and ensure consistent application of the North Sound Mental Health Administration's (NSMHA) authorization process.

POLICY

NSMHA will authorize an assessment for all persons calling the ACCESS Line who are financially eligible as defined in the Clinical Eligibility and Care Standards (CECS). The consumer will be referred to a NSMHA provider agency for a face-to-face clinical assessment by a mental health professional (MHP). Consumers who are in crisis are referred to the Integrated Crisis Response System (ICRS) as appropriate to the situation. Expedited assessments and authorizations will be available when it is medically necessary. Once the assessment is completed, the decision whether to authorize ongoing outpatient services will be determined by NSMHA.

Role of Provider (each NSMHA contracted provider will):

1. Comply with NSMHA mechanisms to ensure consistent application of review criteria for authorization decisions, including consultation with NSMHA when appropriate.
2. Identify, define, and specify the amount, duration, and scope of each service the consumer will receive in collaboration with the consumer.
3. Provide services that are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished.
4. Ensure services are provided in accordance with NSMHA's level of care guidelines as medically necessary and are not arbitrarily denied or reduced, (for example, the amount, duration, or scope of a required service) based solely upon diagnosis, type of mental illness, or the consumer's mental health condition.
5. Submit requests and supporting documentation in a timely manner so that NSMHA may comply with specified timeframes for decisions as required by federal and state standards.

Role of NSMHA:

1. Ensure consistent application of review criteria for authorization decisions and not arbitrarily deny a service authorization request.
2. Ensure services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished.
3. Not deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or mental health condition of the consumer.
4. Ensure that authorization of a service in an amount, duration, or scope that is less than requested, be made by a health care professional who has appropriate clinical expertise in treating the consumer's condition or disease.

5. NSMHA will comply with specified timeframes for decisions as required by federal and state standards.
6. NSMHA will provide for the following decisions and notices*:

    a. **Standard authorization decisions**. For standard authorization decisions, provide notice as expeditiously as the consumer's health condition requires and within state-established timeframes that may not exceed 14 calendar days following receipt of the request for service, with a possible extension of up to 14 additional calendar days, if the consumer or the provider requests extension. An extension may also be obtained if NSMHA justifies (to the Washington State Mental Health Division upon request) a need for additional information and how the extension is in the consumer's interest.
    b. **Expedited authorization decisions**. For cases in which a provider indicates, or NSMHA or its designee determines, that following the standard timeframe could seriously jeopardize the consumer's life or health or ability to attain, maintain, or regain maximum function, NSMHA must make an expedited authorization decision and provide notice as expeditiously as the consumer's health condition requires and no later than three (3) working days after receipt of the request for service. NSMHA may extend the three (3) working days time period by up to 14 calendar days if the consumer requests an extension. An extension may also be obtained if NSMHA justifies (to the Washington State Mental Health Division upon request) a need for additional information and how the extension is in the consumer's interest.

    * When calculating the number of days from the request for service, the first day is the day after the request for service. For example, the request for service is received on January 14th a standard decision must occur by or on January 28th. For a request that comes in on a Thursday and is identified as expedited, the assessment and authorization decision must be completed by the end of the following Tuesday.

7. NSMHA may place appropriate limits on a service on the basis of criteria applied under the State plan, such as medical necessity; or for the purpose of utilization control, provided the services furnished can reasonably be expected to achieve their purpose, as required by federal and state standards. NSMHA and its contractors will consider what constitutes "medically necessary services" in a manner that is no more restrictive than that used in the Washington State Medicaid program as indicated in State statutes and regulations, the State Plan, and other State policy and procedures. NSMHA, in accordance with these regulations, is responsible for covering services related to the following:

    a. The prevention, diagnosis, and treatment of health impairments.
    b. The ability to achieve age-appropriate growth and development.
    c. The ability to attain, maintain, or regain functional capacity.

8. NSMHA will ensure that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any consumer.

PROCEDURE

Provider Request for Authorization

1. ACCESS clinicians will screen callers requesting service to determine the caller's safety concerns, mental health concerns and financial eligibility. ACCESS clinicians will determine whether following the standard timeframe could seriously jeopardize the consumer's life or health or ability to attain, maintain, or regain maximum function so that, if appropriate, an expedited assessment can be authorized and scheduled.

2. Through ACCESS, all callers who meet financial eligibility, as defined in the CECS, are assisted to make an assessment appointment at the consumer's preferred provider agency. This appointment will be offered to occur within 14 calendar days of the request for services or for expedited assessment to occur as soon as is medically necessary and within three (3) working days to determine clinical eligibility and the appropriate level of care.
3. Authorization requests and any accompanying documentation are completed and sent to NSMHA within 14 calendar days of the initial request for service or within three (3) working days for expedited authorizations.

    a. If seeking information presents a barrier to service the item is left blank and the reason documented in the clinical chart.
    b. If the assessing clinician cannot complete the initial assessment within the first 14 calendar days, the consumer or the assessment clinician may request an extension of up to an additional 14 calendar days.

4. The agency clinician conducting the face-to-face assessment will make an initial recommendation as to whether the person being assessed meets Access to Care Standards (ACS) and medical necessity criteria (as defined in the CECS).
5. If the provider believes ACS and medical necessity are met, they will transmit a completed electronic request for authorization including a full five-axial classification, eligibility criteria, and identified Level of Care to NSMHA. If necessary, NSMHA staff will request additional clinical information to justify the authorization. Each contracted provider will identify a contact person to whom requests for additional information can be made.
6. For expedited authorizations, phone notification will be made to NSMHA (360-416-7013) to alert them to the need for immediate review. Phone notification shall be followed by faxing the authorization request and assessment to NSMHA (360-416-7017) for review. An electronic authorization request shall also be sent once NSMHA provides verbal authorization.
7. All persons who meet the financial criteria, ACS and medical necessity criteria are authorized by NSMHA within one business day of the receipt of the authorization request. NSMHA will notify the consumer and provider of all authorizations and their benefits. (Please note: Not all services are authorized initially. See the Utilization Guidelines, 1565.01 and 1565.02, for services which must be approved by NSMHA prior to provision of the service). If authorized, the person is accepted into services and appropriate appointments are made.
8. If NSMHA reviewers deny a service authorization request or authorize a service in an amount, duration, or scope that is less than requested, they will notify the requesting provider and give the consumer written notice in sufficient time to ensure that state-established timeframes are met.

Provider Request for Adverse Determination

1. If the provider believes ACS and medical necessity are not met, they will send the intake assessment form, ACCESS call sheet and any other available documentation or medical records reviewed in the assessment process to NSMHA staff with the completed NSMHA Review Request form within 14 calendar days (standard) or within three (3) working days (expedited) from the initial request for service.
2. For requests submitted on the last day of the specified timeframe (i.e. the 14th, 3rd or 28th day), phone notification will be made to NSMHA (360-416-7013) to alert them to the need for immediate review.
3. NSMHA staff will review the documentation and determine whether to authorize services.

    a. If services are authorized, NSMHA staff will notify the consumer and provider of the decision to authorize services. The consumer will be notified of their benefit package.

b. If no services are authorized, NSMHA will notify the requesting provider and give the consumer written notice in sufficient time to ensure that state-established timeframes are met.

Extensions

Extensions are defined as the submission of a review request by a provider to NSMHA or an authorization decision by NSMHA past the first 14 calendar days from the initial request for service. Extensions shall be utilized only in rare circumstances and must be of benefit to the consumer. When an extension is utilized, the provider agency must document a rationale for the extension in its authorization or adverse determination request to NSMHA. NSMHA will monitor the use and pattern of extensions and apply corrective action where necessary.

Residential Facility Authorizations:

Discharges from Western State Hospital and Community Hospitals: Residential service providers will notify ACCESS when they schedule an assessment appointment for a consumer to be admitted to their facility from the hospital. If this is more than 14 days ahead of when the person is ready for discharge, ACCESS will retain the information in a pending file. This application will be considered incomplete until the consumer is fully ready to be discharged from hospitals at which time the provider will notify ACCESS and the time requirements will begin. The standard access procedures and timelines will be followed from the date of assessment.

Change in Mental Health Coverage

For consumers who become NSMHA-eligible while already in treatment with a provider agency, a current diagnostic justification must be present in the clinical record. The current assessment and treatment plan must meet or be enhanced to meet Mental Health Division (MHD) and NSMHA standards. Authorization for services will be submitted to NSMHA within 14 days of the time the provider becomes aware of the change in payer. Because authorization periods are for one year, only one annual request for authorization is required to be submitted, regardless if the consumer gains or loses financial eligibility. Providers are responsible for assuring that the appropriate funding source is charged for services depending upon the consumer's financial eligibility.

Consumer Withdrawal of Request for Service

If a consumer requests an assessment for services and during or at the completion of the assessment appointment(s) the consumer indicates they no longer wish to receive services, the consumer will be asked to sign a document to that effect, and documentation of their withdrawal of request will be kept in their record.

ATTACHMENTS

None

Effective Date: 5/29/2009; 9/11/2008; 6/19/2008
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 — Approved by: Executive Director — Date: 4/23/2012
Responsible Staff: Deputy Director — Signature:

POLICY 1574.00

SUBJECT: STATE ONLY FUNDING PLAN – MENTAL HEALTH SERVICES

PURPOSE

To ensure, within available resources, consistent application of~~equal access~~standards region-wide for access 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.

NSMHA funds a variety of outpatient and inpatient services including the following with State-only funds:

A. Access and authorization
B. Court filing fees
C. Crisis Services including Mobile Outreach Teams
D. Evaluation & Treatment Facilities (E&Ts) including out of region E&T costs
E. Flex Funds
F. Inpatient Psychiatric Hospitalization costs
G. Involuntary Treatment Act (ITA) Services
H. Jail Services
I. Medicaid Personal Care
J. Ombuds Services
K. Out of Network Services
L. Outpatient Services to identified populations (as follows in the Procedure section~~Section II~~ below)
M. Peer Centers
N. Rehabilitation Case Management Services related to individuals in ~~transitioning out of~~ Children's Long-term Inpatient Programs (CLIP) or Western State Hospital (WSH)
O. Residential Room and Board costs
~~P. Skagit County Wraparound Services (special grant)~~

State funds payment by NSMHA for individuals receiving State plan services shall be considered payment in full as long as they meet State funding qualifications and do not have third party resources. Additionally, payments of State funds for individuals on a spenddown shall be considered qualifying medical expenses that have been paid on behalf of the individual by a publicly administered program per Washington Administrative Code (WAC) 182-519-0110(9).

Community Mental Health Agencies (CMHAs) shall work with individuals to apply for Medicaid and/or meet their spenddowns. For individuals who are not eligible for Medicaid, consideration shall be given to transitioning them to other programs/services.

PROCEDURE

State funds may be utilized for the following outpatient services on a region-wide basis as medically necessary and within available resources. NSMHA shall allocate a proportionate and fixed amount of State funds to each Community Mental Health Agency (CMHA) on an annual basis. Each CMHA is responsible for management of their allotted funds to provide services to State-funded individuals. If providers exceed their allotted amount, they run the risk of not receiving payment for services provided.

I. The following populations of individuals are eligible for ~~shall be provided~~ outpatient treatment services under State-only funding. ~~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 making a request for initial or re-authorization and individuals in a current authorization period regardless of outpatient episode status who are

1. 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, 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.*~~
2. 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, 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.*~~

NSMHA-contracted Community Mental Health Agencies (CMHAs) shall serve the individuals identified in this section (A 1-2). It is NSMHA's expectation that State funds are prioritized for these individuals and that there are enough available resources to serve all individuals who meet one or both criteria. For initial and re-authorizations, NSMHA shall provide authorization for a period not to exceed 3 months*. For individuals in a current authorization, NSMHA shall allow for continuation of the current authorization for a period not to exceed 3 months*.

B. Individuals with a current authorization ***and*** in a current outpatient episode who

1. Are funded by Medicaid, ~~who are in a current treatment episode authorized by NSMHA and who are~~ but currently 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.*~~

2. ~~Individuals in NSMHA-funded services (including residential placements) who l~~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.*~~

For individuals identified in this section (B 1-2), NSMHA shall allow for continuation of the current authorization for a period not to exceed 3 months from when Medicaid is not active or end of the current authorization period, whichever is sooner*. Due to limited funding, individuals identified in this section are not eligible for initial authorization of outpatient services unless they qualify on some other basis. See Section II below regarding the reauthorization process.

~~B.~~C. ~~Adult i~~Individuals 18 and older, with an income up to 400% of the Federal Poverty Level, may be served in ~~the~~ PACT (Program of Assertive Community Treatment)~~program~~ as long as they were in the program as of October 7, 2011 and have not closed their treatment episode since that time. ~~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.~~

~~C. 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.~~

E. Individuals, in a current outpatient episode or not, admitted to CLIP facilities or WSH, returning to our region upon discharge, and who are in need of care coordination from the CMHA to facilitate inpatient treatment and discharge planning. ~~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.~~ CMHAs~~This~~ should use~~be coded using~~ the Rehabilitation Case Management CPT (Current Procedural Terminology/HCPCS [Healthcare Common Procedure Coding System]) code.

II. Re-authorization

A. The determination whether to request re-authorization is the responsibility of the CMHA to be made in the context of medical necessity and availability of resources.

B. NSMHA shall authorize eligible individuals for State-funded services for a period not to exceed 3 months per re-authorization*.

~~II.~~III. ***Authorization Limit Exceptions**

A. Providers may determine there are exceptional cases for which they want an authorization period longer than 3 months. This determination is left to the provider, but the rationale for the exception must be noted in the electronic authorization request in order for NSMHA to provide authorization for a period longer than 3 months.

i. For individuals who become State-funded during their authorization period, it is the responsibility of the CMHA to request from NSMHA termination of the authorization. For termination of an authorization, see NSMHA Policy 1505 Authorization for Ongoing Outpatient Services.

~~**F. *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) and RRP 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

Effective Date: 5/29/2009; 9/11/2008; 6/19/2008
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 — Approved by: Executive Director — Date: 4/23/2012
Responsible Staff: Deputy Director — Signature:

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. Peer Centers
M. Out of Network Services
N. Flex Funds
O. Outpatient Services to identified populations (as follows in Section II below)
P. Skagit County Wraparound Services (special grant)
Q. 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, 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, 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 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. 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.
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) and RRP Review.

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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.

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ATTACHMENTS

None

NORTH SOUND MENTAL HEALTH ADMINISTRATION

QUALITY MANAGEMENT OVERSIGHT COMMITTEE (QMOC)

January 22, 2014

AGENDA ITEM: Should there be more group therapy in our system of care

REVIEW PROCESS: QMOC (X) Advisory Board ( ) Board of Directors ( )

PRESENTER: Mark McDonald/Greg Long

COMMITTEE ACTION: Action Item ( ) FYI & Discussion (**X**) FYI Only ( )

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:

OBJECTIVE:

To explore why group therapy is such a limited part of our clinical services in the North Sound Region and whether there should be more.

BACKGROUND:

The issue came up at the January NSMHA Board of Directors' Meeting that there is not much group therapy in our system of care. I explained that many consumers were reluctant to be in group treatment for they were hesitant to talk about their problems in front of others. There may also be a perception that group therapy is less desirable than individual treatment by consumers and clinical staff.

Mark McDonald, NSMHA's Advisory Board Chair, had a different point of view stating that it may be better treatment for many individuals. Group treatment overcomes isolation for many individuals; it allows them to learn from each other; it overcomes the stigma of having a mental illness for people consciously and unconsciously come to realize that other people have the same problems; and the group support is more likely to give people hope.

According to NSMHA data, group treatment makes up 6.3% of clinical service hours. Interfaith is the single exception where it comprises 18.6% of clinical hours.

PREVIOUS ACTION(S) TAKEN:

None

CONCLUSIONS/ACTION REQUESTED:

What things could be done to incentivize more group treatment in the Regional System?

FISCAL IMPACT:

ATTACHMENTS:

Table on Group and Individual Treatment by providers.

Percent of Group Treatment Services in FFS based Outpatient Services

Year and Agency	Treatment Type: Total Hours of Service		Percent of Hours of Service		Total Total Hours of Service	Total Percent of Hours of Service
	Individual	Group	Individual	Group		
2011	77,253.2	4,879.4	94.1%	5.9%	82,132.7	100.0%
bridgeways	2,868.9	14.2	99.5%	0.5%	2,883.1	100.0%
Catholic Community Services	8,609.8	141.5	98.4%	1.6%	8,751.3	100.0%
Compass Health	38,883.8	2,879.0	93.1%	6.9%	41,762.8	100.0%
Interfaith	1,189.0	196.5	85.8%	14.2%	1,385.5	100.0%
Lake Whatcom Center (Treatment)	3,686.1	38.4	99.0%	1.0%	3,724.5	100.0%
Sea Mar	5,332.2	821.5	86.6%	13.4%	6,153.7	100.0%
Sunrise Services	8,396.9	350.1	96.0%	4.0%	8,747.0	100.0%
Whatcom Counseling & Psychiatric Clinic	8,286.5	438.3	95.0%	5.0%	8,724.7	100.0%
2012	166,614.8	12,157.2	93.2%	6.8%	178,772.0	100.0%
bridgeways	6,186.3	273.0	95.8%	4.2%	6,459.3	100.0%
Catholic Community Services	20,016.0	836.5	96.0%	4.0%	20,852.5	100.0%
Compass Health	80,939.8	8,243.2	90.8%	9.2%	89,183.0	100.0%
Interfaith	3,083.4	620.3	83.3%	16.7%	3,703.8	100.0%
Lake Whatcom Center (Treatment)	8,240.8	175.9	97.9%	2.1%	8,416.7	100.0%
Sea Mar	9,996.6	644.9	93.9%	6.1%	10,641.5	100.0%
Sunrise Services	20,415.9	1,145.9	94.7%	5.3%	21,561.8	100.0%
Whatcom Counseling & Psychiatric Clinic	17,736.0	217.5	98.8%	1.2%	17,953.5	100.0%
2013	134,240.9	8,597.3	94.0%	6.0%	142,838.2	100.0%
bridgeways	790.4	4.5	99.4%	0.6%	794.9	100.0%
Catholic Community Services	14,535.7	508.0	96.6%	3.4%	15,043.7	100.0%
Compass Health	69,335.2	5,129.2	93.1%	6.9%	74,464.4	100.0%
Interfaith	1,982.2	452.0	81.4%	18.6%	2,434.2	100.0%
Lake Whatcom Center (Treatment)	6,175.6	68.6	98.9%	1.1%	6,244.3	100.0%
Sea Mar	8,188.2	304.7	96.4%	3.6%	8,493.0	100.0%
Sunrise Services	17,970.0	1,607.0	91.8%	8.2%	19,577.0	100.0%
Whatcom Counseling & Psychiatric Clinic	15,263.5	523.3	96.7%	3.3%	15,786.8	100.0%
Grand Total	**378,109.0**	**25,633.9**	**93.7%**	**6.3%**	**403,742.9**	**100.0%**

2013 only includes services through Sept 2013

Group hours of service include all hours of service to each person. Rates are paid assuming 4 person group.