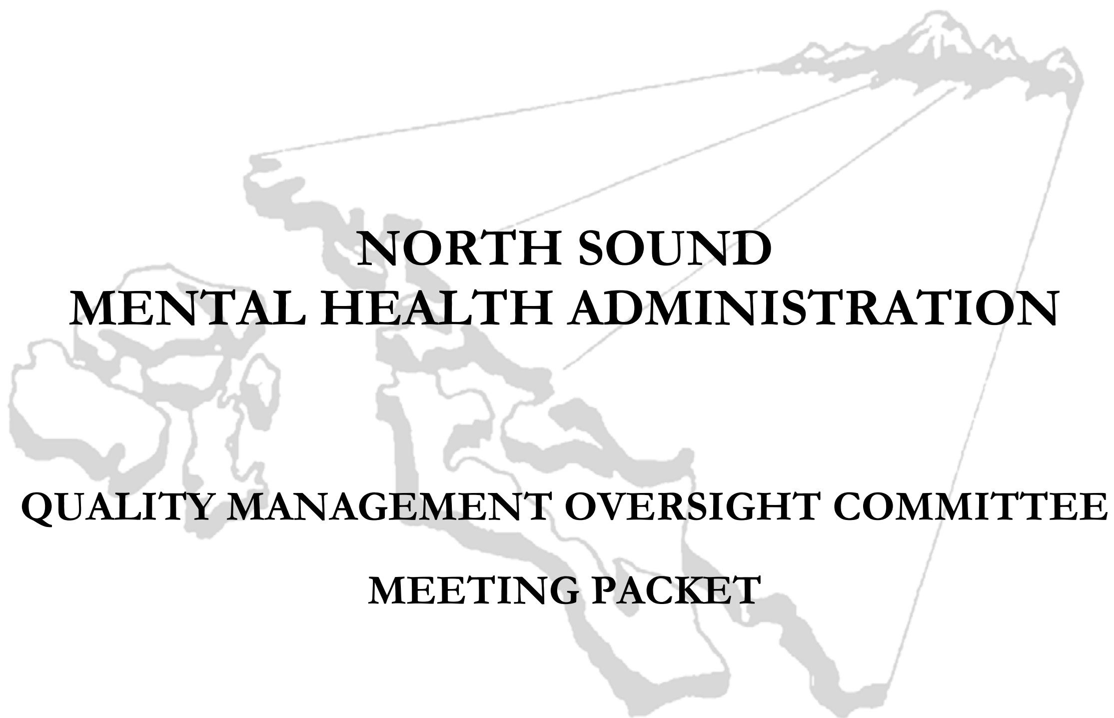

NORTH SOUND
MENTAL HEALTH ADMINISTRATION

QUALITY MANAGEMENT OVERSIGHT COMMITTEE

MEETING PACKET

April 22, 2015
1:00 – 3:00 pm

1. Please join my meeting.
   https://global.gotomeeting.com/meeting/join/282127541

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

United States: +1 (312) 878-3078

Access Code: 282-127-541

Audio PIN: Shown after joining the meeting
Meeting ID: 282-127-541

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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

Date: April 22, 2015 **Time:** 1:00-3:00 PM
Location: NSMHA Conference Room **Chair:** Anji Jorstad, Snohomish County Human Services
For information Contact Meeting Facilitator: Charissa Westergard, 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	• Introduction of Betsy Kruse, NSMHA Deputy Director • Engagement Coordinator RFP • Outpatient coordination with Inpatient – email attachment	Inform/ Discuss	All				*10 min*
Quality Topics							
HB 1879	Update on the status of this legislation	Inform	Julie de Losada	N/A	N/A		*10 min*
Outpatient/ Inpatient Coordination	Review outpatient provider requirements for follow up after individual discharges from inpatient	Discuss	Charissa Westergard	Email			*10 min*
Rural King County Residents	Identify which King County locations are prudent for NSMHA to serve	Discuss	Charissa Westergard	Discussion Form & Map		**3**	*10 min*
Recovery/ Resiliency Plan Reviews	Discuss changing the requirement related to frequency/timing of Recovery/Resiliency Plan reviews	Discuss	Charissa Westergard	Discussion Form		**4**	*15 min*
Second Opinions	Review of 2014 annual report	Inform	Kurt Aemmer	Discussion Form & Report		**5**	*10 min*
Critical Incidents	Review of 2014 annual report	Inform	Kurt Aemmer	Discussion Form & Report		**6**	*10 min*
Residential Review	Summary of NSMHA 2014 review of contracted residential facilities	Inform	Charissa Westergard	Discussion Form & Report		**7**	*10 min*
Access for Deaf & Hard of Hearing	Discuss what possible communication alternatives there may be to TTY	Discuss	Charissa Westergard /Cindy Ferraro	N/A	N/A		*10 min*
Other issues							*10 min*
***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: May 27, 2015 - 1:00-3:00 PM

Draft not yet approved

North Sound Mental Health Administration (NSMHA)
Quality Management Oversight Committee (QMOC)
NSMHA Conference Room
March 25, 2015
1:00 – 3:00 pm
MEETING SUMMARY

PRESENT: Mark McDonald, Greg Wennerberg, Candy Trautman and Jennifer Yuen, NSMHA Advisory Board; Anji Jorstad, Snohomish County; Eric Chambers, NWESD; Kate Scott, Sea Mar; Richard Sprague, Interfaith; Stacey Alles, Compass Health; Chuck Davis, Ombuds; Kathy McNaughton, CCS and Robert Sullivan, Pioneer H.S.
BY PHONE: Cammy Prince, Sunrise, Kay Burbidge, LWC; Pat Morris, VOA and Kim Olander, Ombuds.
STAFF: Charissa Westergard, Sandy Whitcutt, Jessie Ellis, Julie de Losada and Barbara Jacobson.
OTHERS PRESENT: Rachelle McCarty, NSMHA consultant and Heather Fennell, Compass Health.

TOPIC	DISCUSSION	ACTION
1. **Introductions, Review of Agenda – Chair**	Chair, AnjiJ convened the meeting; introductions made. No revisions or additions to the agenda mentioned.	
2. Previous Meeting Summary – Chair	ChuckD presented a motion to accept the previous meeting summary as submitted, seconded by EricC; motion carried.	Approved
3. Announcements and Updates – All	• The Regional Training Community will be meeting at 3:00 pm directly after this meeting. • The Integrated Provider Meeting is this Friday at 10:30 am at Skagit Publishing. • The Medical Directors meeting is April 2, 2015 at 2:30 pm. • Concept paper proposals for the Co-occurring Pilot are due by March 31. The timeline will be driven by the proposals received, looking at 9-12 month pilot projects.	Informational
4. Evaluation Forms from Last Meeting – Chair	Briefly reviewed.	Informational
5. Evidence-Based Practice (EBP) Reporting	Julie noted the 2012 legislation that requires increased utilization and practice of EBPs in children under 21 in the juvenile justice, child welfare and mental health systems. Julie gave brief overview of some of the barriers to practicing at fidelity also noting this is an unfunded mandate. Julie briefly reviewed some of the barriers that have occurred and noted the attached report has an update coming out in the next few weeks. She noted that the state would like to move toward tracking in real time using the clinicians National Providers Identifier (NPI) number. We need to make decisions on where it is best to focus on what practices for this region that will channel forward to the training committee. StaceyA noted that CBT+ is one to consider as it has board applicability across multiple diagnoses. Barriers discussed with the largest seeming to be accountability so it does	Julie to arrange presentation from UW

	not come back on the agency as a liability as guidance from the State is vague. On the list of EBPs for mental health, some are not able to be billed to Medicaid. Turnover is a barrier to keeping up on training; we want to keep training local and accessible. How will we capture data and how will we monitor need to be considered. The goal of the mandate is that by 2019, 45% of youth are treated with EBPs. Julie recommended a time limited workgroup to develop strategies and come up with guidance or mapping around EBPs able to bill to Medicaid and be compliant with the law. Agencies should keep moving forward as they are comfortable until the workgroup comes up with guidance. Charissa stated we should develop strategies for all ages as it will likely transfer to all in the future. Julie inquired of the group if they would like a presentation from the EBP Institute at UW to review the report of the geo-mapping of EBPs. She will arrange a webinar to occur before a QMOC meeting for this.	
6. EBP Training Priorities	Jessie gave a brief overview of the training committees work on promoting EBPs in the region. Illness Management Recovery (IMR) and Motivational Interviewing (MI) are scheduled. These will be trainings with consultation afterward to ensure that they will be used going forward. Coming from agency feedback CBT+ and Common Elements Treatment Approach (CETA) are two we are looking to do this year.	Informational
7. Performance Improvement Project (PIP)	Julie and RachelleM reported on the Non-Clinical PIP of transition age youth (TAY - 16-20) that looked at workforce development to improve outcomes. Rachelle reviewed the three measures; provider pre and post self-tests, followed by training modules, another self-test and 4 months of extended follow up that showed that overall the improvements were maintained. She gave a brief overview of the barriers encountered and successes. Julie requested recommendations on continuing the PIP or retiring; agency specific breakout of data was called for. It is felt that it is important because some youth do not connect with services once they become adults; this needs to be looked at to identify patterns. We do not have any specialized programs for TAY; there is an opportunity to develop a TAY program specific to WISe. If we retire this PIP a new one could focus on increased care coordination. Julie noted the included survey from Portland State University and that Youth N Action has submitted a proposal for youth to survey youth. A focus group of clinicians and supervisors is recommended to determine if this PIP will be continued or retired and what will work going forward, she will send an email to get those interested. Julie noted that NSMHA is hiring a QI that will work on the PIPs as part of their job.	
8. Distance Standards	Charissa addressed the issue from the contract amendment brought up last month regarding distance from agencies. She noted that each provider does not have to comply; it is a region wide standard. NSMHA will be looking at this as we go forward to make sure the region still	

	meets the standard.	
9. Crisis Plans	These were due for an update and needed some revision as they are now transmitted to ERs. She reviewed some of the changes; it incorporates both child and adult aspects and is more recovery based. The workgroup kept in mind the cost to the data systems when reviewing; it will entail a cost. The clinical crisis recommendation form will transmit the client form does not. The form goes to IT next to see if it will transmit to the ERs through their EDIE system. Suggested edits to the clinical crisis plan: • Add a co-occurring checkbox • Revise medication non-compliance checkbox to something more recovery oriented such as medication adherence. • Remove can we contact, yes or no • Check box for allergies • Complete the last question to read "What intervention strategies prior to inpatient care have been investigated?" The client crisis plan that is not transmitted can be formatted to agency or program as long as the required elements are there. The clinical plan that is transmitted is standardized for the region. QMOC would like to see this again after CIS feedback.	Informational
10. Medication Formularies	In January 2014 medications started going through the health plan formularies and Charissa is checking in to see if there have been any issues such as when an exception is needed. No issues were noted after the initial transition, let Charissa know of anything that comes up.	Informational
11. Rural King Co Residents	NSMHA has received requests for service from some rural King County residents that reside closer to our providers. NSMHA has been doing this when requested and involves a small number of individuals on Hwy 2. King County will not reimburse NSMHA for these rare occasions and is expected to have a minimal fiscal impact. NSMHA will review yearly to see if it is having any impact.	Informational
12. Open Forum		Discussion
13. Date and Agenda for Next Meeting	The meeting was adjourned at 2:50 pm. The next meeting is April 22, 2015.	

QMOC

Charissa Westergard, MS, MHP

From: Charissa Westergard, MS, MHP
Sent: Monday, April 06, 2015 2:44 PM
To: Cindy Ferraro; Kathy McNaughton; Heather Waters (hwaters@chs-nw.org); Stacey Alles ; 'Richard Sprague'; Cindy Paffumi; Kay Burbidge ; 'Michael Watson '; Jodie DesBiens; callen@nwesd.org; Mike Manley (mikem@sunriseemail.com); Katherine Scott
Cc: Marci Bloomquist
Subject: Appts for individuals discharging from inpatient psychiatric

Importance: High

Good afternoon,

It has come to my attention that recently a few individuals discharging from inpatient psychiatric care have been told by agencies that the agency cannot provide an intake appointment within 7 ***calendar*** days even with clear direction from VOA that this is the policy (see NSMHA Policy 1572 http://nsmha.org/Policies/Sections/1500/1572.00.pdf). I have included the relevant excerpt from the policy:

Outpatient Service Requirements Related to Inpatient Utilization

7. Non-crisis services must be offered to consumers within seven calendar days of discharge from an inpatient unit.
8. CMHA staff shall advocate for an adequate (enough to last until the outpatient prescriber appointment) supply of medication to be supplied and dispensed in a manner that assures safety. A follow-up psychiatric appointment is established within 7 working days of discharge, or as needed to assure continuity of medications and care.

This has occurred at more than one agency so I request that all agencies take a moment to review this requirement with relevant staff. I am also aware that the number of referrals in a given time period can really stretch your resources to complete intakes within required timelines. These are issues that we are working to address, but in the meantime, we need to be sure that individuals discharging from the hospital are always obtaining an intake within the required timelines.

Please let me know if you have any questions or concerns.

Thanks,
Charissa

Charissa Westergard MS, MHP
Adult Mental Health Program Manager
North Sound Mental Health Administration
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Mount Vernon, WA 98273
Charissa_Westergard@nsmha.org
360.416.7013 x628 - Fax 360.416.7017

NORTH SOUND MENTAL HEALTH ADMINISTRATION
COMMITTEE DISCUSSION FORM

AGENDA ITEM: Serving Rural King County Residents

REVIEW PROCESS: **QMOC (X)** Planning Committee ( ) Advisory Board ( ) Board of Directors ( )

PRESENTER: Charissa Westergard

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

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:

OBJECTIVE:
Identify areas of rural East King County NSMHA is willing to serve in our region.

BACKGROUND:
There are some parts of rural East King County whose residents are closer, geographically, to North Sound mental health services. Because the number of individuals this applies to is a small number (both because the requests are limited and the geographic areas are very rural), NSMHA has often been agreeing to pay our contracted providers to serve these individuals rather than requiring the individual to contact a provider contracted with King Regional Support Network. Rather than continue reviewing these requests on a case-by-case basis, NSMHA would like to provide VOA Access with a list of the identified areas NSMHA is willing to cover.

PREVIOUS ACTION(S) TAKEN:
This was discussed at March QMOC and the following concerns were raised:

- Potential fiscal impact
- What does King RSN think about this
- Whether this opens the door to having to serve out of region residents in other areas or for other reasons

CONCLUSIONS/ACTION REQUESTED:
To address the concerns noted at March QMOC:

- NSMHA believes that the fiscal impact will continue to be minimal as it has been historically.
    - Based on current inpatient billing instructions, NSMHA would not be responsible for those costs should they occur.
    - These individuals would be more likely to utilize North Sound crisis services than King crisis services anyway and do not currently have to be a North Sound resident to do so.
    - If a King County resident, who NSMHA authorized for services, should need intensive outpatient services, NSMHA would contact King RSN at that time for reimbursement. NSMHA providers would be paid by NSMHA for services they deliver regardless of whether King RSN agreed to reimburse or not.
    - It is unlikely NSMHA would ever pursue this option, but NSMHA could take action to terminate services and the authorization. If this were ever to occur, NSMHA would insure coordination of new services with King RSN as needed.
- At this time, it does not seem necessary to contact King RSN about any type of agreement as the time and resources to work out an agreement for an unlikely scenario seems prohibitive.

- NSMHA is under no obligation to consider serving out of region residents for other reasons or in other areas.

Recommend serving only those individuals living on Hwy 2 (Baring and Skykomish) who request our services. These are the individuals who appear most likely to need North Sound services as they have to travel through Monroe to get to King County. NSMHA is committed to serving these individuals as it is a significant and unreasonable barrier for individuals in these areas to get services in King County.

ATTACHMENTS:
Map

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98224 – Baring
98288 – Skykomish

NSMHA COMMITTEE DISCUSSION FORM

AGENDA ITEM: Recovery/Resiliency Plan Review Timelines

PRESENTER: Charissa Westergard

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

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:
The issue of Recovery/Resiliency Plan (RRP) review timelines came up at February QMOC. NSMHA was asked to review the necessity of requiring the RRP be reviewed every 180 days and within 45 days of the current authorization expiration. These two timeline requirements sometimes result in the RRP being reviewed twice in a very short time period without any resulting clinical or administrative benefit and results in increased burden for clinicians.

CONCLUSIONS/RECOMMENDATIONS:
NSMHA reviewed the existing requirements and determined that the requirement to review the RRP every 180 days can be eliminated. The requirement to conduct an RRP review within 45 days of the current authorization expiration, for individuals who will be continuing in services, will remain. This review information will still need to be submitted via the CIS and will continue to be a requirement for reauthorization determinations.

NSMHA also proposes that individuals who are authorized for a year should have, at the minimum, a RRP review that occurs approximately at the midpoint of the authorization. This could still be submitted via CIS, but would not be required for any authorization decisions.

TIMELINES:

ATTACHMENTS:
None

NSMHA COMMITTEE DISCUSSION FORM

AGENDA ITEM: 2014 Annual 2nd Opinion Report

PRESENTER: Kurt Aemmer

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

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:

1. Twenty-one (21) 2nd opinions were requested.
2. Nineteen (19) met appropriateness criteria.
3. Eleven (11) were completed (including the one described in item #5, below).
4. Eight (8) requests were rescinded.
5. Ten (10) completed reports were submitted to NSMHA. One (1) remains outstanding, in spite of 3 reminders having been sent to the provider.
6. For the 19th consecutive quarter, 100% of the consults have been completed within the required 30-day window, except in cases where the requesting individual waived this right because of special circumstances.
7. The "Agreement Rate" between the original opinion and the 2nd opinion was 55%, following a rate of 71% in 2013, closer to the historic rate of 56% from 2010 – 2012.

CONCLUSIONS/RECOMMENDATIONS:

1. The process continues to run smoothly with providers scheduling and completing the 2nd opinion consults in a timely manner. **Thanks to the providers in the North Sound Region, the right to have a timely 2nd opinion consultation completed within the 30-day window continues to be protected.**
2. In 2014 agreement rate data will be redefined. The data will be collected and analyzed using three categories:
   a. *Total Agreement*
   b. *Partial Agreement*
   c. *Total disagreement*

TIMELINES: The expansion of the agreement rate categories from 2 (agreement or non-agreement) to 3 (delineated above) will begin with all reports completed on or after 1/1/15.

ATTACHMENTS:

- **North Sound Mental Health Administration 2014 Annual Second Opinion Report January 1, 2014 – December 31, 2014**

NORTH SOUND MENTAL HEALTH ADMINISTRATION
2014 ANNUAL SECOND OPINION REPORT
January 1, 2014 - December 31, 2014

Introduction

At any time during the course of outpatient mental health treatment, the principals to treatment (e.g., consumer, custodial parents of children and adolescents, others with legal custody, NSMHA, a NSMHA-contracted Community Mental Health Agency [CMHA], or primary Mental Health Care Provider [MHCP]) may submit a request for a second opinion regarding any outpatient clinical decision to NSMHA either verbally or in writing. If other parties (family member, primary medical health provider) desire a second opinion, the request is made through the MHCP. NSMHA-contracted CMHA staff and Ombuds are available to assist consumers, custodial parents and legal guardians in accessing a timely second opinion.

Second opinions may be requested for many reasons, including situations in which:

1. There is a question regarding medical necessity;
2. There is a question regarding the reasonableness or necessity of recommended interventions and/or medications;
3. There is a question regarding a diagnosis or plan of care;
4. The clinical indications for a diagnosis are not clear or a diagnosis is in doubt due to conflicting test results;
5. The treatment interventions in progress are not improving the condition of the consumer within an appropriate period of time given the diagnosis and plan of care.

Historic Findings

NSMHA has been monitoring the requests for and provision of 2nd Opinions since September of 2004. Prior to 2013, frequency of 2nd Opinion requests was reported annually during External Quality Review Organization (EQRO) Surveys (APPENDIX I).

1. Since 2008 the average number of requests per quarter peaked at 5.8 in 2011, fell to 2.5 in 2012, and then returned to 5.5 in 2013. In 2014 the average number of requests per quarter dropped to 4 per quarter. (APPENDIX I).
2. Subsequent to the last semi-annual report in 2012, the NSMHA Leadership Team requested that findings from the 1st opinions be compared with findings from the 2nd opinions to determine a rate of agreement between the two. From 2010-12 the agreement rate was 56%. In 2013 the rate increased to 71.4%. In 2014 the agreement rate dropped down to 55% (APPENDIX II).
3. Since the 2nd Qtr. Of 2010, all 2nd opinions have been completed within 30 days of the request, except in cases where the request was rescinded or the original appointment was postponed at the request of the individual making the original request (APPENDIX I).

2014 Findings

1. There were 21 requests in 2014.
2. The agreement rate was 55%, down from 71% in 2013, more consistent with the historic rate of 56% seen in the preceding 3 years (2010-12).
3. For the 19th consecutive quarter, the 30-day completion rate remained at 100% (APPENDIX I).
4. Eleven requests pertained to questions regarding the reasonableness or necessity of recommended interventions and/or medications. This type of request accounted for 52% of the total number of requests, with the other three types/reasons combined accounting for the remaining 48%.

Conclusions: *The following conclusions must be drawn with caution due to the small frequency in which the 2nd onions are requested.*

1. Second opinion requests continue to occur with too little frequency to draw any conclusions as to what may be indicated by what appears to be a significant fluctuation in frequency.
2. The agreement rate between the original practitioners and the 2nd opinion consultants decreased by 16 % in 2014 from the 2013 rate. As the historic rate had been consistently around 55% prior to 2013, the apparent spike in 2013 could reflect special cause variation, or variation that has a cause aside from the variation inherent in the process (or "common cause variation"). It should be noted that "agreement" is only counted when the 2nd opinion is in total agreement with the first. There were a few cases where the 2nd opinion basically agreed with the 1st, but there were some additional recommendations identified to be considered. Thus, it could be argued that the actual agreement rate could be considerably higher if a more liberal operational definition were used. Please see recommendation #2, below.
3. NSMHA providers continue to schedule and complete 2nd opinions in a timely manner, ensuring the protection of a consumer's right to receive 2nd opinions within 30 days of the request.
4. The main reasons individuals request 2nd opinions pertain to questions about their medications. However, the frequency of these requests are so low, they do not allow for the identification of more specific trends related to these requests.

Recommendations

1. Continue the process.
2. Redefine the "agreement rate" by expanding the measurements from 2 to 3 categories, e.g. total agreement, partial agreement & total disagreement.

Attachments:

APPENDIX I: Table Showing Number of Requests & 30-Day Completion Rate, January - December 31, 2014
APPENDIX II: Table Showing 2013 & Historic Agreement Rates, January 1, 2010 – December 31, 2014
APPENDIX III: Table Showing Types of/Reasons for Requests, 2014

APPENDIX I
Table Showing
Number of Requests & 30-Day Completion Rates, by Quarter
January 1, 2014 – December 31, 2014

QUARTER/YEAR	TOTAL # OF REQUESTS	# OF REQUESTS MEETING APPROPRIATE CRITERIA	2014 AVERAGE # REQUESTS	# COMPLETED IN 30 DAYS	# RESCINDED OR 30 DAY WINDOW WAIVED BY CONSUMER	30 DAY COMPLETION RATE
1st QTR 2014	6	5	4	5	0	100.0%
2nd QTR 2014	3	3	4	1	2	100.0%
3rd QTR 2014	9*	8	4	4	4	100.0%
4th QTR 2014	3	3	4	2	1	100.0%

Note:

1) * One 2nd opinion was requested 7/25/14 & completed 9/19/14 as an internal consult at Compass Health, and not counted in the data reflecting RSN facilitated 2nd Opinions.

2) **An additional 2nd opinion completed at one provider was reportedly completed within the 30-day window, but in spite of 3 RSN requests a copy of the finished consult has not been forwarded to the RSN.

3) Unless request was rescinded or the individual waived the 30-day completion window, there has been a 100% 30-day completion rare every quarter since one of three was late in the 1st Quarter of 2010 resulting in a 67% rate that quarter.

APPENDIX II
Table Showing 2013 & Historic Agreement Rates

January 1, 2010 – December 31, 2014

QUARTER/YEAR	AGREEMENT RATE	# REPORTS	# REPORTS AGREE
2010 - 2012 AGREEMENT RATE	**56.0%**	**27**	**15**
1st QTR 2013	100%	2	2
2nd QTR 2013	67%	3	2
3rd QTR 2013	0%	1	0
4th QTR 2013	100%	1	1
2013 AGREEMENT RATE	**71.4%**	**7**	**5**
1st QTR 2014	40%	5	2
2nd QTR 2014	100%	1	1
3rd QTR 2014	67%	3	2
4th QTR 2014	50%	2	1
2014 AGREEMENT RATE	**55.0%**	**11**	**6**

APPENDIX III
Table Showing
Frequency of Requests by Type (Reason)
January 1, 2014 – December 31, 2014

Type of or Reason for Request	**#**
There is a question regarding medical necessity	**5**
There is a question regarding the reasonableness or necessity of recommended interventions and/or medications	**11**
There is a question regarding a diagnosis or plan of care	**3**
The clinical indications for a diagnosis are not clear or a diagnosis is in doubt due to conflicting test results	**0**
The treatment interventions in progress are not improving the condition of the consumer within an appropriate period of time given the diagnosis and plan of care	**0**
The request was not consistent with the approved reasons, above	**2**

NSMHA COMMITTEE DISCUSSION FORM

AGENDA ITEM: 2014 Annual CIRC Report

PRESENTER: Kurt Aemmer

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

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:

1. Forty-seven (47) Critical Incidents (CI) were reported and screened
2. Nine (9) were determined to not meet NSMHA/DBHR reporting criteria
3. Thirty-eight (38) were reported to DBHR and investigated by CIRC
4. Eighteen (18), 48%, of the 38 CI reported to DBHR fell into the Media (I & II) categories, i.e. they had already been reported in the media (I) or they were deemed to present a high likelihood that they would be reported (II). *Note: Three (3) of the fourteen (14) Media I CI also involved violent acts perpetrated by a consumer, but are not reflected in item #5a, below.*
5. Of the remaining twenty (20) reported CI:
   a. Fourteen (14) involved violent acts; deaths or non-fatal injuries; suicide attempts requiring hospitalization; or threats to staff.
   b. Three (3) were life safety events that resulted in disruption of services.
   c. Two (2) involved breach or loss of consumer data.
   d. One (1) involved alleged client abuse by a staff
6. **Quality Improvement:** One provider experienced two losses of consumer data within a period of weeks. Both involved clinicians who while in the process of taking consumer records off site to catch up on their clinical documentation, had the documents stolen. As this category of CI rarely happens, and loss of data is a patient rights issue, the NSMHA Executive Director send a letter to the provider, on behalf of CIRC, strongly recommending they update their Policies & Procedures on protecting client records. The provider updated the Policies & Procedures, and conducted training on the updates to all staff. There were no subsequent breaches/losses in 2014.

CONCLUSIONS/RECOMMENDATIONS:

1. As 9 of the 47 potential CI reported to NSMHA by providers were determined by CIRC (often in consultation from the DBHR CI Manager) to not meet any of the operational definitions of any of the delineated categories, i.e. they were screened out, NSMHA and DBHR consider this to be "good faith over-reporting."
2. The DBHR CI Manager continues refer to NSMHA and providers as the standard against which all other RSNs are judged for the following reasons:
   a. good faith reporting;
   b. timeliness and completeness of reports and follow-up reports; and,
   c. consistent timeliness in same-day email/phone notifications of Category I CI.

TIMELINES: N/A

ATTACHMENTS: 2014 NSMHA Annual CIRC Report

NSMHA Annual CIRC Report
2014

PURPOSE: To inform NSMHA Board of Directors, Executive Director, County Coordinators, the Critical Incident Review Committee (CIRC), the Quality Management Oversight Committee (QMOC), and other stakeholders in the region interested in critical incident (CI) data and activities on an annual basis.

HIGHLIGHTS OF CI DATA FROM 2014

CIRC screened forty-seven (47) reported CI in 2014. Nine (9) of the reported CI were determined to not meet the formal definition of a CI, so thirty-eight (38) were reported to Division of Behavioral Health & Recovery (DBHR) and investigated by CIRC (APPENDIX I). The previous year, forty-four (44) CI were reported by providers, six (6) were screened out, and CIRC reported thirty-eight (38) CI to DBHR. In 2014 eighteen (18) of the thirty-eight (38) actual critical incidents, (47%) fell within the "media event" categories. Of the remaining twenty (20) CI, fourteen (14) involved violent acts; deaths or non-fatal injuries; suicide attempts requiring hospitalization; or threats to staff. Three (3) were life safety events that resulted in a disruption of services. Two (2) involved breaches or losses of client data, and one (1) a case of alleged client abuse by a provider. Note: *Three (3) of the fourteen (14) Media I events also involved violent acts perpetrated by a consumer (APPENDIX I).

QUALITY IMPROVEMENT

In 2014 there were two incidents involving breach or loss of consumer information. Both were instances where clinicians from the same provider agency had taken parts of client records home to update their documentation, but their cars were broken into and the documents stolen. The two incidents occurred within a matter of weeks. In both cases the provider appropriately reported the losses with all required entities. As this category of incidents occurs so infrequently, and they involve a patient's rights issue, a letter was sent to the provider from the NSMHA Executive Director on behalf of CIRC directing the provider to re-evaluate their protocols, and make P&P changes where necessary to avoid this kind of incident from happening again. The provider responded appropriately by updating their related P&Ps, putting greater restrictions on removing consumer records from the agency, and then conducted agency-wide training on the new protocols.

APPENDIX I: Table Showing # of Reported CI by County, January 1 - December 31, 2014

County of Incident	Death or serious injury of a consumer, staff or public citizen on DSHS owned, licensed or contracted property	Unauthorized leave by an offender from an E & T	Violent act perpetrated by a consumer	Event involving a consumer or staff that has already attracted media attention (Media I)	Alleged consumer abuse or neglect	Natural disaster presenting substantial threat to facility operation or consumer safety	Breach or loss of consumer information	Alleged financial exploitation involving a consumer, agency or other	Suicide attempt on DSHS owned, licensed or contracted by DSHS requiring medical care	Event involving consumer or staff likely to attract media attention (Media II)	Credible threat to a staff member	Incident referred to the Medicaid Fraud Control Unit by the RSN or subcontractor	Life safety event that requires evacuation or that is a substantial disruption to the facility	Totals
San Juan	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Island	0	0	0	2*	0	0	0	0	0	0	0	0	0	**2**
Skagit	0	0	3	2	1	0	0	0	0	1	0	0	0	**7**
Whatcom	0	0	1	4	0	0	0	0	2	0	3	0	0	**10**
Snohomish	1	0	3	5*	0	0	1	0	0	3	1	0	3	**17**
Other (King)	0	0	0	1	0	0	1	0	0	0	0	0	0	**2**
2014 TOTALS	**1**	**0**	**7**	**14**	**1**	**0**	**2**	**0**	**2**	**4**	**4**	**0**	**3**	**38**

NSMHA COMMITTEE DISCUSSION FORM

AGENDA ITEM: 2014 Residential Review Report

PRESENTER: Charissa Westergard

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

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:
NSMHA conducts an annual review at each of the four residential facilities for which we contract with Compass Health (Aurora House, Greenhouse, and Haven House) and Lake Whatcom Center (LWC). The focus of these reviews is on Recovery/Resiliency Planning and service delivery.

The 2014 review was conducted in November and December. The attached report includes detailed information about areas of strength and challenges by facility. Haven House and LWC demonstrated significant improvements and/or maintained good performance in many areas. Areas where most, but not necessarily all, of the facilities have a need for continued improvement efforts include:

- Current and accurate LOCUS (Level of Care Utilization System) scores.
- Recovery/Resiliency Plans (RRP) thoroughly address individual needs and are recovery-oriented.
- RRPs address substance use issues.
- Crisis plans that are consistent with the individual's level of need.
- Delivery of services that are recovery-oriented, address the individuals identified needs, and occur at the needed intensity.

CONCLUSIONS/RECOMMENDATIONS:
NSMHA will be requesting corrective action plans for each of the facilities for any standards falling below 90% (performance benchmark).

TIMELINES:
Letters to the agencies should be forthcoming in the next month.

ATTACHMENTS:
2014 Residential Review Report

Residential Treatment Facilities Review 2014

Regional Summary

During November and December 2014, North Sound Mental Health Administration (NSMHA) conducted a review of the Region's residential facilities. Aurora House, Greenhouse and Haven House, which are all part of Compass Health, were reviewed, as was Lake Whatcom Center. In all, a total of 57 charts were reviewed, using the NSMHA High Need Utilization Review tool. This tool is comprised of 19 standards focusing on areas important in providing services to individuals requiring residential treatment placement. The expected benchmark for these standards was 90% for the 2014 Review, the same benchmark that has been used during the Regional reviews since 2012.

The 2014 aggregate scores for the Residential programs were as follows:

- Aurora House - 44%
- Greenhouse - 52%
- Haven House - 83%
- Lake Whatcom Center - 92%

Compared to 2013 review results, the scores at Lake Whatcom Center and Haven House increased while the scores at Aurora House and Greenhouse decreased.

Aurora House and Greenhouse

The decreases in the aggregate review scores at both facilities are related to several areas, most notably:

- LOCUS (Level of Care Utilization System) scores not being accurate or current.
- Recovery/Resiliency Plans lacking recovery orientation and not thoroughly addressing the individual's identified needs. At Aurora House, this included the plan not addressing substance use issues.
- Treatment services provided lacking in recovery orientation and not reasonably expected to assist the individual in meeting goals/addressing needs.
- Intensity/frequency of services not corresponding with the individual's needs over time.
- Crisis Plans not congruent to the individual's level of need.

Aurora House improved in identifying which individuals needed a residential level of care (i.e., the treatment provided cannot be safely provided in a less restrictive environment).

Greenhouse did well with coordination efforts.

Haven House

Increases in review scores at Haven House are related to scores that were sustained or improved in:

- Recovery/Resiliency Plans and services provided address the individual's needs and services are expected to assist the individual in meeting these needs/achieving their goals.
- Recovery/Resiliency Plans and services provided are both recovery-oriented.
- Intensity/frequency of interventions better correspond with the individual's needs.
- Coordination with other systems.

While Recovery/Resiliency Plan thoroughness improved, this is an area Haven House should continue to focus their efforts to get to the 90% benchmark. This caveat applies to the intensity/frequency of interventions as well. Other notable areas needing additional improvement at Haven House include:

- Accurate LOCUS (Level of Care Utilization System) scores.
- Addressing substance use issues on the Recovery/Resiliency Plan.
- Developing crisis plans that correspond to individual's needs.

Lake Whatcom Center

Increases in review scores at Lake Whatcom Center are related to sustained or improved scores in the following areas:

- Recovery/Resiliency Plans based on current identified needs.
- Services provided being recovery-oriented* and reasonably expected to help the individual meet their goals.
- Identifying an appropriate plan to address substance use issues*.
- Intensity/frequency of interventions that correspond to the individual's needs.
- Crisis plans that correspond to the individual's needs.
- Coordination with other systems.

*While improved, these areas require continued effort to achieve the 90% benchmark. LWC also needs to focus some improvement efforts on ensuring accurate and current LOCUS (Level of Care Utilization System) scores.

Recommendations

During the review period, individual changes to charts were addressed via Request for Change (RFC) requests sent to the Provider. These RFCs identified specific areas of treatment or documentation that needed to be addressed by Provider staff. Provider staff responses to these RFCs are received and processed at NSMHA by the reviewer

to determine that requested changes have indeed been implemented. Once the desired change has been effected in the record, the RFC response is accepted.

As noted in the summary above and the data that is attached to this report, there are several areas that need to be addressed by each Provider on a broader level than the individual chart. There appear to be two main areas of concern. The first area is ensuring accurate identification of the individual’s level of care, which will assist in assuring the individual’s needs are met with the most appropriate services and in utilizing regional resources most efficiently. The second area is developing individualized and recovery-oriented Recovery/Resiliency Plans that are followed with corresponding services. To facilitate these improvements, remedial action will be initiated for any standard below 90% in the 2014 review. Formal request for corrective action plans from each agency will follow from this report.

NSMHA Residential Review Data

	% Yes Answers by Agency			
	Aurora House	Green House	Haven House	LWRTC
# charts reviewed				
2010	7	13	6	25
2011	10	13	3	12
2012	12	14	4	15
2013	14	14	7	15
2014	15	15	12	15
LOCUS level of 3 or higher for IOP or 5 or higher for Residential Placement, unless there is documentation supporting a step-down plan to transition the individual into a lower level of care.				
2010	29%	100%	66%	76%
2011	78%	N/A	100%	92%
2012	100%	100%	100%	100%
2013	64%	93%	57%	100%
2014	67%	73%	83%	100%
The scoring of the LOCUS tool is supported by the documentation in the chart (*new for 2012)				
2010	N/A	N/A	N/A	N/A
2011	N/A	N/A	N/A	N/A
2012	64%	36%	0%	73%
2013	78%	85%	100%	80%
2014	50%	43%	67%	79%
The LOCUS is updated when the client's needs/situation change				
2010	14%	91%	83%	60%
2011	20%	N/A	N/A	82%
2012	64%	100%	100%	92%
2013	64%	92%	86%	91%
2014	40%	83%	90%	80%

NSMHA Residential Review Data

	% Yes Answers by Agency			
	Aurora House	Green House	Haven House	LWRTC
Goals for treatment are based on current identified needs				
2010	71%	75%	34%	76%
2011	90%	85%	100%	100%
2012	100%	100%	75%	100%
2013	71%	79%	50%	100%
2014	47%	47%	75%	100%
The treatment provided can reasonably be expected to help the client achieve their goals				
2010	14%	75%	17%	32%
2011	44%	83%	100%	75%
2012	50%	100%	50%	93%
2013	86%	71%	71%	67%
2014	7%	27%	92%	92%
Are treatment plan goals and related services recovery oriented? (Per goals on the treatment plan and documentation of services delivered in progress notes) "Services provided are designed to rehabilitate individuals who are experiencing severe mental illness symptoms in the community." (*This standard was discontinued after 2010 and replaced with the 2 standards below)				
2010	57%	38%	17%	36%
Are treatment plan goals recovery oriented (*new for 2011)				
2010	N/A	N/A	N/A	N/A
2011	100%	85%	100%	100%
2012	92%	100%	50%	93%
2013	86%	79%	50%	87%
2014	53%	67%	92%	80%

NSMHA Residential Review Data

	% Yes Answers by Agency			
	Aurora House	Green House	Haven House	LWRTC
Are treatment services recovery oriented (*new for 2012)				
2010	N/A	N/A	N/A	N/A
2011	N/A	N/A	N/A	N/A
2012	58%	100%	25%	73%
2013	64%	79%	57%	53%
2014	7%	7%	100%	73%
If this consumer is assessed as having drug/alcohol issues there is an appropriate plan to address them				
2010	N/A	N/A	100%	78%
2011	100%	100%	N/A	83%
2012	58%	50%	0%	89%
2013	60%	100%	75%	57%
2014	14%	N/A	50%	83%
Intensity and frequency of interventions correspond with the consumer's needs and severity of symptoms and vary over time as appropriate?				
2010	43%	92%	17%	52%
2011	100%	N/A	67%	82%
2012	100%	100%	50%	100%
2013	77%	100%	57%	77%
2014	15%	29%	75%	100%
Client Crisis Plan is appropriate to client level of need				
2010	14%	0%	34%	32%
2011	0%	8%	67%	46%
2012	67%	100%	75%	93%
2013	64%	86%	57%	100%
2014	20%	23%	58%	100%

NSMHA Residential Review Data

	% Yes Answers by Agency			
	Aurora House	Green House	Haven House	LWRTC
If the consumer is a frequent user of crisis services (4 or more contacts with ICRS staff/month) there is evidence of coordination of care between the outpatient clinician and ICRS staff.				
2010	N/A	N/A	N/A	N/A
2011	100%	N/A	100%	N/A
2012	100%	0%	0%	100%
2013	50%	N/A	100%	N/A
2014	0%	100%	100%	100%
If the consumer has repeated cancellations and/or "no-shows" there is evidence that the intensity of the efforts to reengage the consumer are congruent with the consumer's identified need/risk.				
2010	N/A	N/A	N/A	N/A
2011	100%	N/A	N/A	N/A
2012	100%	0%	0%	100%
2013	N/A	100%	100%	100%
2014	N/A	N/A	N/A	100%
There is evidence of coordination with other involved systems as needed, unless declined by consumer.				
2010	100%	92%	17%	87%
2011	N/A	N/A	100%	N/A
2012	82%	100%	50%	100%
2013	100%	100%	75%	100%
2014	75%	79%	100%	100%
If prescribed by agency staff the intensity of medication monitoring is sufficient to meet the consumer's need (medical necessity)				
2010	100%	100%	100%	100%
2011	N/A	N/A	N/A	N/A
2012	100%	100%	100%	100%
2013	100%	100%	100%	100%
2014	87%	100%	100%	100%

NSMHA Residential Review Data

	% Yes Answers by Agency			
	Aurora House	Green House	Haven House	LWRTC
If the consumer has been hospitalized, there is evidence of joint discharge planning between the hospital and outpatient treatment team.				
2010	N/A	N/A	N/A	0%
2011	0%	N/A	0%	100%
2012	0%	100%	0%	100%
2013	100%	100%	100%	100%
2014	0%	100%	100%	100%
If the consumer has been hospitalized within the region for more than 7 calendar days, there is documentation of at least once clinician contact with the consumer prior to discharge.				
2010	N/A	N/A	N/A	0%
2011	0%	N/A	N/A	100%
2012	0%	0%	0%	100%
2013	100%	100%	100%	100%
2014	0%	N/A	100%	100%
If the consumer has been hospitalized they had an outpatient appointment scheduled within 7 days of discharge				
2010	N/A	N/A	N/A	75%
2011	100%	N/A	N/A	100%
2012	100%	0%	0%	100%
2013	100%	100%	100%	100%
2014	100%	N/A	100%	N/A

NSMHA Residential Review Data

	% Yes Answers by Agency			
	Aurora House	Green House	Haven House	LWRTC
If the consumer has been hospitalized a med appointment has been scheduled within 7 business days of discharge or as needed to assure continuity of meds and care (if agency staff are prescribing)				
2010	N/A	N/A	N/A	75%
2011	100%	N/A	N/A	100%
2012	100%	100%	100%	100%
2013	100%	100%	100%	100%
2014	100%	N/A	100%	N/A
For residential placement: the treatment provided cannot safely be provided in a less restrictive environment.				
2010	29%	83%	50%	76%
2011	90%	N/A	100%	80%
2012	83%	100%	25%	100%
2013	64%	46%	86%	100%
2014	85%	40%	73%	100%