

**NORTH SOUND MENTAL HEALTH ADMINISTRATION
QUALITY MANAGEMENT COMMITTEE AGENDA**

Date: October 19, 2006

Time: 11-1 PM

Location: NSMHA Conference Room

For Information Contact Meeting Facilitator Greg Long/Debra Jaccard NSMHA, 360-416-7013

Topic	Objective	ACTION NEEDED	Discussion Leader	Handout available pre-mtg	Handout available at mtg	Tab	Time
Introductions	Welcome guests, presenters and new members		Chair				5 min
Review and Approval of Agenda	Ensure agenda is complete and accurate, time adjustments made/additions/deletions Meeting will start and end on time.	Approve agenda	Chair	Agenda			5 min
Review and Approval of Minutes of Previous Meeting	Ensure minutes are complete and accurate	Approve minutes	Chair	Minutes			5 min
Announcements	Inform QMC of news, events and other important items <ul style="list-style-type: none"> • Children's E&T • Outcomes • Other • Clinical Redesign Update • EQRO 		All				5 min
Update on Progress of Authorization Process	Inform QMC of Authorization Committee work and progression of automated authorizations	Review policy and process diagram	Sandy/Terry Charissa	Updated Policy			5 min
Ombuds Report	Inform QMC of Ombuds data	Informational	Chuck Davis		At meeting		15 min
Semi-annual CIRC Report	QMC to Review & Discuss	Approve with comments to QMOC	Kurt	CIRC Report			10 min
Policy Sub-Committee Report	Review charter, clarify committee composition, date of next meeting	Review summary of first meeting	Stacey/Pam /Debra		At meeting		5 min

Consent for Treatment to Make an Outpatient Appt.	Introduce and discuss topic of recent concern	Discussion/ Providers to take back to agencies	Debra/Greg				5 min
QRT Report	Present and discuss QRT information	Determine Next Steps	Deborah M.		At meeting		10 min
WRAP Presentation	Consumer presentation on WRAP training	Informational	James Mead/Betty Scott		At meeting		20 min
Practice Guidelines Recommendations from IQMC	Introduce IQMC suggestions/ Obtain QMC suggestions for guideline development	Introduce topic/discussion	Debra Jaccard		At meeting		10 min
Medication Management IQMC Template Process		Informational/ Discussion	Diana Striplin/ Debra Jacard		At meeting		10 min
Date and Agenda for Next Meeting	Ensure meeting date, time and agenda are planned.		All				5
*Review of Meeting	Were objectives accomplished? How could this meeting be improved?		All				5

Next meeting: November 16, 2006, 11-1.

Potential Agenda Items for Next Meeting:

Integrated Report November-December
Policy Sub-Committee Monthly Report
PIPS
EQRO Check-In

Quality Management Committee Minutes

Date: September 21st, 2006

Attending: Debra Jaccard, NSMHA; Eric Love, CCS; Kathy McNaughton, CCS; Deborah Moskowitz, North Sound Ombuds; Stacey Alles, Compass Health; Amy Leonard, Compass Health; Pam Benjamin, WCPC; Kay Burbidge, LWC; Michael Watson, LWC; Mike Manley, Snohomish County; Bob Brown, VOA; Pat Morris, VOA; Tom Sebastian, Compass Health; Terry McDonough, NSMHA/Snohomish County; Greg Long, NSMHA; Julie de Losada, NSMHA; Nathalie Gauteron, *bridgeways*; Diana Striplin, NSMHA; Kurt Aemmer, NSMHA; Angela Fraser-Holtz, NSMHA; Laura Davis, NSMHA; Shannon Solar, NSMHA.

Excused: Russ Hardison, Sea Mar.

Timekeeper: Eric Love.

Topic	Discussion	Discussion Leader	Action
Convene	Debra convened the meeting at 11:05 am and introductions were made.	Debra	
Review Previous Minutes	The minutes from the previous meeting were reviewed and approved as written.	Debra	
Announcements	<p>Debra introduced the new NSMHA quality specialists, Laura Davis, an adult care advocate, Kurt Aemmer, who is doing risk management and will be the contact for critical incidents, and Angela Fraser-Holtz, a child specialist.</p> <p>Greg noted the state accepted NSMHA/King County RSN’s proposal for a Children’s E&T, but Snohomish County does not want the Mukilteo E&T to be used for this facility as was the original plan. Tom added we are looking at a couple of facilities and noted has been a learning process, but all involved definitely want to make this facility happen.</p> <p>Diana spoke about outcomes from the state on performance indicators and the Telesage study on consumer satisfactions. Outcomes data is available online on MHD’s website, Diana noted some of it may be included in her integrated report. Diana noted there is an outcome group which will be combined with a PI group and someone from a provider agency would be welcome to this group. Diana noted our region came in second in the state in initial data outcomes. Consumer outcome measures will be reported in the QM plan.</p> <p>Nathalie announced Robert Bjorklund is leaving <i>bridgeways</i> and his position as a Clinical Director. Nathalie will act as interim direction until the position is filled.</p> <p>Julie noted while she is on maternity leave, Susan Shoeld will be the point of contact for CHAP and CLIP issues (425-388-7346). For general advocacy/care issues, Angela Fraser-Holtz at NSMHA is the point of contact. Sandy Whitcutt at NSMHA will be the point of contact for UR issues. Julie noted there is a link on NMSHA’s website with trainings in our region and if any want to add trainings, e-mail reception@nsmha.org.</p> <p>Greg announced the state has funded and promoted a training for consumers called RAP (recovery action plan). This</p>	All	

DRAFT MINUTES – NOT YET APPROVED BY COMMITTEE

	<p>training encourages consumers to work together with other consumers to get their lives back on track. Greg noted that the state is likely going to be asking RSN's and providers for money for putting on these trainings. Greg noted James Mead from NSMHA Advisory Board and Betty Scott are involved in this program. Greg noted a consumer conference was held last weekend and over 200 consumers were present. Greg added the final plan from the system transformation division should be out tomorrow.</p>		
<p>Update of Progress of Authorization Process</p>	<p>Terry noted this process is working and being refined, there is one more auth workgroup meeting October 5th at 10:30 am, at which time the policy will be reviewed and finalized. Terry noted that the re-auth process is not as well developed as the initial process and more work will be done. Greg asked how this process has been working for providers. Tom noted that they have not been receiving any feedback from NSMHA and do not know if authorizations are approved or not. Pam asked what to do with people they have not heard from. Terry noted all have been authorized so far, and unless they providers hear differently they are authorized. Terry noted a letter will be developed with NSMHA's decisions on the authorizations and sent out hopefully this month - retroactive letters will be sent for all authorizations. Michael noted we need an agreed contact person at each agency.</p> <p>Greg noted if 180's are overdue, clinicians must close before reauthorization – Michael Watson noted the reauth dates don't always match up well with authorization dates since the system has changed the auth process several times.</p>	<p>Terry</p>	
<p>EPSDT Update and Consumer Information Brochure</p>	<p>Julie noted EPSDT has been around a long time, state and fed government are paying more attention to it and we are as well. The current policy needs to be updated. Julie noted that NSMHA wants to reduce provider responsibility - when a child's family needs a notice about child needing EPSDT, NSMHA will send out a DSHS-originated flyer on EPSDT. This will be sent whenever someone is authorized for care so they automatically all receive it. Stacey asked if the provider still needs to contact medical care providers, Julie noted if the child has one they need to be contacted. The RFQ initially said all EPSDT charts need to be audited, MHD contracts overruled that, stating NSMHA can select a sampling to be audited, these needs to be done over the contracting period. An auditing tool will be developed. Diana asked if there is a blurb that can be given during the appeal process. Julie will research whether more info is needed than that on the flyer.</p>	<p>Julie</p>	
<p>Contracting & Funding redesign workplan meeting schedule</p>	<p>Greg noted this is an ongoing process – massive data being is collected. A third meeting on clinical design will be held tomorrow. A finance group will then meet to determine how much to charge for desired services. Greg noted we will need one meeting in mid to late October when the system design group meets with the finance group to determine the mix of services we will purchase. Mike Manley asked about entitlement to MH services for the Medicaid population (if medically necessary). This system redesign process needs to regulate the amount of services people have access to when they are entitled to. Mike asked how an agency can have a cap when a certain population is entitled to service. Greg noted Dale Jarvis is proposing a data driven system, each agency will have a spending cap that needs to be monitored monthly. Greg noted this may mean a person goes to another agency. If an agency is over spending one month, adjustments need to be made. Greg noted complexities in that we do not have the same services available across the region. Diana suggested something could be created for an individual in an area without high-intensity program. Diana noted capacity/funding is not stagnant –if inpatient is managed better, there will be more money for outpatient. Medical necessity a driver since that is state-mandated. Greg noted the systems population does not fluctuate very much – projections are that we will receive the same funding, Mike Manley noted the incentive structure is being flipped on its head. Previously, providers were suppressing demand due to financial restrictions, now the opposite is in place. Greg agreed, noting this is why the UR process is in place. Diana noted there has to be an incentive flow for funding – people need to be rewarded for good work. Mike Watson</p>	<p>Greg</p>	

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	noted incentives have not been discussed in the workgroup yet.		
Policy Subcommittee report	<p>Debra noted this subcommittee met for the first time yesterday. The charter was reviewed and future meeting dates were set, they will be two weeks prior to QMC. The whole list of policies were reviewed and a list of “A” and “B” priorities was made. Stacey and Pam will be representatives. Stacey noted the group discussed the possibility of the QMOC policy subcommittee group combining with the QMC group to streamline the process and asked how this committee felt.</p> <p>Mike Watson noted if we are changing the way that the system is contracted, there may be an increase of policies and procedures for individual agencies, and we would want to keep the group small. Diana made a recommendation to invite the QMOC subcommittee to the QMC subcommittee which will be examined later if the system changes.</p> <p>Greg passed out ICRS policies 1701 and 1703, Stacey made a motion to approve the policies to move forward to QMOC, motion carried.</p> <p>Greg noted agencies need policy if they operate the program. Kathy asked NSMHA to update their policy grid and remove unnecessary policies.</p>	Debra	<i>ICRS policies 1701 + 1703 approved to move forward to QMOC</i>
Letter to NSMHA from Richard Kellogg, MHD	<p>Debra noted Richard Kellogg sent NSMHA a letter addressing importance of access to care, EPDST and GAF, MHD will be auditing on these issues. Debra asked the group how they felt we should proceed. Greg noted the importance of getting agency plan on the use of state money, this spending can not be done arbitrarily. Greg noted WEIMERT has a website for training on GAF rating which is a good resource. (LINK: http://depts.washington.edu/washinst/Training/CGAS/GAF%20Index.htm)</p>	Debra/Greg	
Treatment Plan workgroup Update	<p>Julie passed out the treatment plan workgroup definitions and a summary of their work. The group struggled with UR requirements and following a recovery model vs. medical model. The workgroup is recommending to QMC that while the treatment plan meets external auditing requirements that it primarily meets individual needs, in consumer friendly language as much as possible. The definition of “measurable” was discussed at length –Julie consulted MHD for clarification - the language can be descriptive, not necessarily numeric, can be in consumer-given language as long as prog notes reflect changes. Julie noted this workgroup wanted to reduce paperwork for clinicians. A request of change is given because of a problem with a treatment plan starts a huge process. This workgroup will meet in six months to review. Stacey asked if MHD was consulted about culture, age, and disability issues only being required in treatment plan if they are an issue. Julie noted she will ask if that interpretation is ok with MHD. Charissa Fuller will be the contact in Julie’s absence.</p>	Julie	<i>Treatment plan recommendations approved to move forward to QMOC</i>
Exhibit N	<p>Diana noted MHD reporting timelines for Complaint/Grievance/Appeals has increased, and what we are required to report has increased. Greg noted we need to keep our data intact. We need to sort out the multiple timelines MHD has sent and come up with a plan. Diana noted complaint/grievance people from each agency need to meet sometime after the October 6th State Quality Meeting which Diana attends. Diana suggested meeting after next months QMC from 1-3 pm, this is tentative as Diana needs to discuss the issue with Michael.</p>	Diana	
Performance Improvement Projects	<p>Diana noted she attended a PIP training put on by the state and summarized that PIP’s need to be scientific, they are going to be big projects, they need to be relevant, they require project plan and resource analysis, etc. Improvements over time need to be demonstrated. All PIP’s must be service-related. Debra noted there will be a meeting on this at NSMHA Oct. 17 at 11:00 on PIP’s if any want to be involved.</p>	Diana	

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<p>Co-occurring disorder screenings and assessments</p>	<p>Greg noted the first training was held on the COD tool for adults. Stacey noted the data has not given needed clarification on what they need to report on. This is a huge cross-system change, it will be difficult to find when something was tracked. Tom suggested this issue be discussed at the next Authorization workgroup. Stacey noted we need to a regional process, people need to be trained beginning in November. Greg noted NSMHA will form a workgroup. A meeting will be held at 12:30 p.m. October 5th following the authorization workgroup meeting. Tom noted the state is going to greatly increase codes on an impossible timeline. Mike Watson noted there are significant changes – services are being renamed, modifiers are added. Kathy noted these technical changes result in changes in paperwork and staff training. Debra noted NSMHA will research the coding issue and email the group.</p>	<p>Greg</p>	<p><i>NSMHA to research state coding requirements for COD screening</i></p>
<p>Cross-System Coordination</p>	<p>Greg noted we are required cross-system plans in state contract, NSMHA has hired Tom Yost as a part-time planner. NSMHA has met with the Division of Vocational Rehabilitation and they would like to come to meet with this group. Kathy will begin attending the Children’s Policy Executive Team meetings. Greg noted all are welcome to any cross-system meetings.</p>		
<p>Adjourn/Next Meeting</p>	<p>The meeting was adjourned at .The next meeting will be held Thursday October 19th at 11:00 am. Policy Subcommittee will be October 9th at 2:30 p.m.</p>		

Effective Date:
Revised Date: 11/15/2005
Review Date:

North Sound Mental Health Administration
Section 1500 – Clinical: Authorization for Ongoing Outpatient Services

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

Approved by: Executive Director
Motion #:

Date: 11/21/2005

POLICY #1505.00

SUBJECT: AUTHORIZATION FOR ONGOING OUTPATIENT SERVICES

PURPOSE

To ensure consistent application of the NSMHA Clinical Eligibility and Care Standards.

POLICY

All persons calling the NSMHA Access Center who are financially eligible as defined in the Clinical Eligibility and Care Standards and who are not in crisis are authorized for an intake and referred to a NSMHA provider agency for this face-to-face clinical assessment by a mental health professional. (Individuals who are in crisis are referred to the Integrated Crisis Response System as appropriate to the situation.). Expedited assessments and authorizations are available when it is medically necessary.

Callers who are not financially eligible are referred to other agency programs that do not require Medicaid or State Mental Health funding and/or other community providers as appropriate.

Following completion of the assessment, providers will determine if the individual meets medical necessity as defined by the NSMHA Clinical Eligibility and Care Standards (CECS). The provider will send a completed electronic request for authorization to NSMHA.

If the provider believes that CECS criteria are not met, the provider will send the assessment, access call sheet and any other appropriate documentation or medical records to the NSMHA Utilization Review office. The decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested will be made by a NSMHA staff. This NSMHA person will be a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease.

NSMHA will notify the consumer and provider of all authorizations and their benefits.

NSMHA will notify the requesting provider, and give the enrollee written notice of any NSMHA action to deny the service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice to the provider need not be in writing.

Each NSMHA contracted provider will:

1. Identify, define, and specify the amount, duration, and scope of each service that the provider is required to offer.
2. Ensure that all services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished.

3. Providers may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the beneficiary.
4. 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.

NSMHA specifies the process for initial and continuing authorization for services. Providers must:

1. Have in place, and follow, written policies and procedures consistent with NSMHA policies and procedures.
2. Comply with NSMHA mechanisms to ensure consistent application of review criteria for authorization decisions; including consultation with NSMHA when appropriate.

NSMHA will comply with specified timeframes for decisions as required by federal and state standards.

NSMHA will provide for the following decisions and notices:

1. **Standard authorization decisions.** For standard authorization decisions, provide notice as expeditiously as the enrollee'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 enrollee, 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 enrollee's interest.
2. **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 enrollee's life or health or ability to attain, maintain, or regain maximum function, NSMHA must make an expedited authorization decision and provide notice as expeditiously as the enrollee's health condition requires 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 enrollee 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 enrollee's interest.

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 enrollee.

PROCEDURE

1. Access clinicians will screen callers requesting service to determine the caller’s mental health concerns and financial status. Access clinicians will determine whether following the standard timeframe could

- seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function so that an expedited assessment can be authorized and scheduled.
2. All callers who meet financial eligibility as defined in the Clinical Eligibility and Care Standards that do not require immediate referral to the Integrated Crisis Response System are assisted to make an assessment appointment at the appropriate provider that is offered to occur within **13 calendar days** of their request for services or for expedited assessment to occur as soon as is medically necessary and within three calendar days to determine clinical eligibility and the appropriate level of care.
 3. Assessment documents are completed within thirteen (13) calendar days of the initial request for service or within three days for expedited for expedited authorizations. ..
 - a. If seeking information presents a barrier to service or if it is an expedited assessment the item is left blank and the reason documented in the clinical chart.
 - b. If the assessing clinician cannot complete the initial assessment, the consumer or the assessor may request an extension of up to 14 days. NSMHA must track the number and reason for extensions. Therefore, the extension request must be documented in the electronic record to NSMHA. NSMHA will take appropriate action if the number of extensions is excessive or unwarranted.
 4. The agency clinician conducting the face-to-face assessment will make an initial recommendation as to whether the person being assessed meets NSMHA Clinical Eligibility and Care Standards.
 5. The provider will transmit a completed electronic request for authorization including a full five-axis classification, eligibility criteria, and requested Level of Care to NSMHA for authorization. If necessary, NSMHA Utilization Review 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 authorization. Phone notification should be followed by faxing the authorization request and assessment to NSMHA (360-416-7017) for review.
 7. All persons who meet the financial and Clinical Eligibility and Care Standards are authorized by NSMHA within 24 hours. If authorized, the person is accepted into services and appropriate appointments are made.
 8. For individuals that do not appear to meet the financial and Clinical Eligibility and Care Standards, the intake assessment form, access call sheet and any other available documentation or medical records reviewed in the assessment process will be faxed to NSMHA Utilization Review staff with the completed NSMHA Denial Determination form within thirteen (13) calendar days from the initial request for service or immediately following completion by the end of that day for an expedited assessment.
 9. NSMHA Utilization Review staff will make the final determination of whether the person being assessed meets NSMHA Clinical Eligibility and Care Standards.
 - a. If the NSMHA staff, upon review, determine the person to meet the criteria they will notify the consumer and provider that the individual is authorized for services. The consumer will be notified of their benefit package.
 - b. If the decision is to deny the authorization request or to authorize a service in an amount, duration, or scope that is less than requested the NSMHA staff will notify the requesting provider, and give the enrollee written notice in sufficient time to ensure that State-established timeframes are met for standard or expedited authorization.
 - c. NSMHA staff will maintain written records of all denied requests for service.

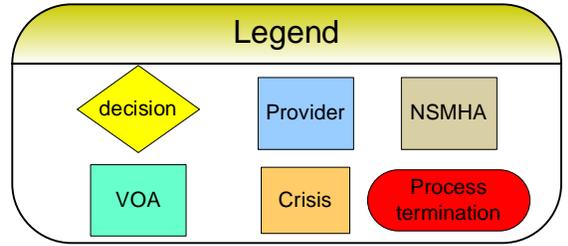
ATTACHMENTS

None

NSMHA Authorization Process

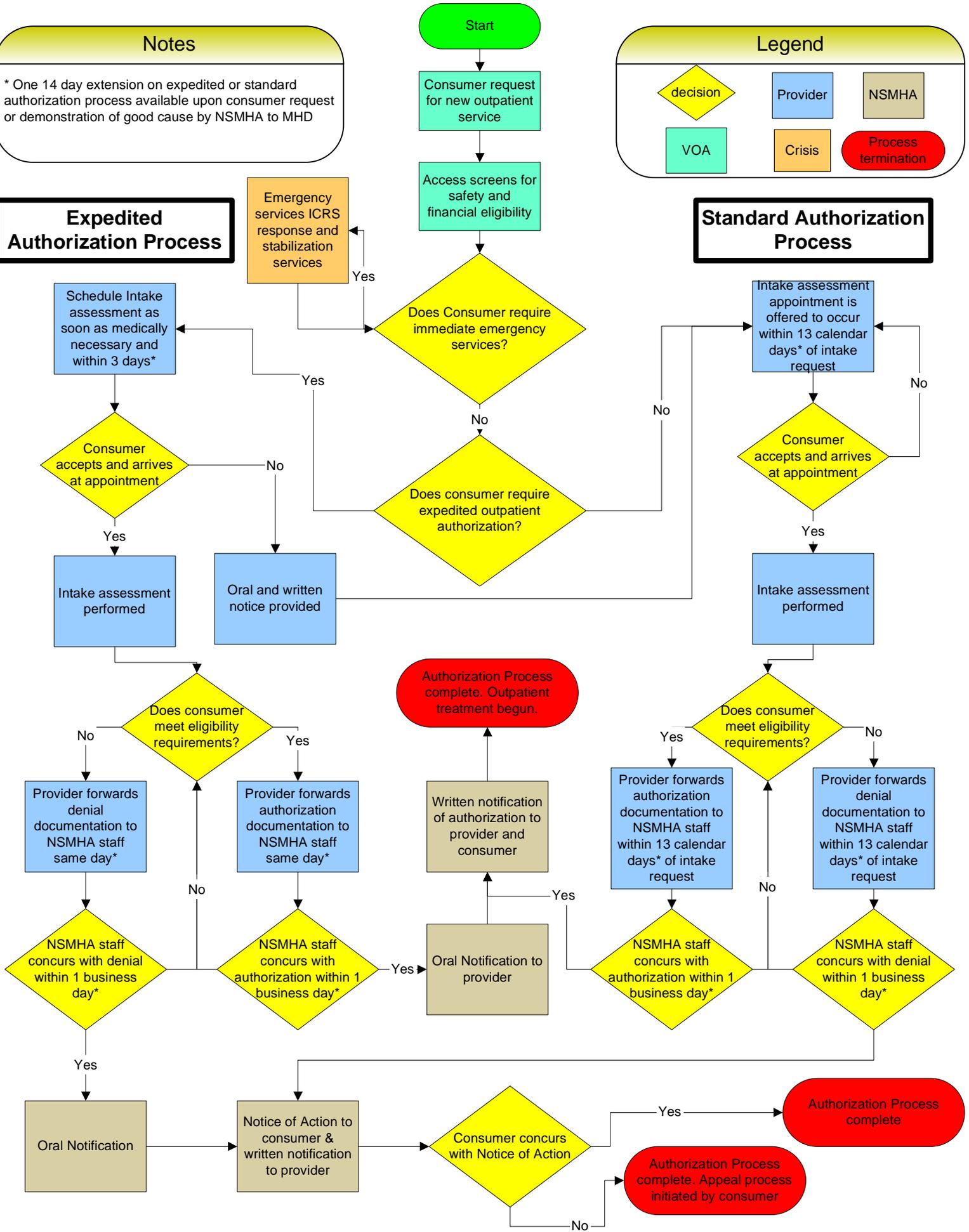
Notes

* One 14 day extension on expedited or standard authorization process available upon consumer request or demonstration of good cause by NSMHA to MHD



Expedited Authorization Process

Standard Authorization Process



NSMA Semi-Annual Critical Incident Report
JANUARY THRU JUNE, 2006

PURPOSE: To inform NSMHA Executive Board and Executive Director, county coordinators, CIRC, QMC, QMOC, and other stakeholders in the region interested in critical incident data and activities on a semi-annual basis.

HIGHLIGHT OF CI DATA FROM JANUARY THROUGH JUNE, 2006

Total Number of Critical Incidents, System-wide by Quarter 7/03 thru 6/06 (chart 1)

- Although the number of total reported incidents in the 1st quarter (86) was relatively high compared to the previous 10 quarters. 2nd quarter showed a significant decrease to 55

Total Number of Critical Incidents by County (chart 2)

- Snohomish County reported 30 critical incidents in the 2nd quarter, down from 38 in the 1st quarter
- Whatcom County reported 10 critical incidents in the 2nd quarter, down from 23 in the 1st quarter
- Skagit, Island, and San Juan Counties each reported 11 or less critical incidents in both 1st and 2nd quarters

Deaths (chart 3)

- Snohomish reported 9 deaths in the 2nd quarter, up from 7 in the 1st quarter
- All other counties reported a range of 0-3 in the 2nd quarter, with a reduction of at least 1 death per county from the 1st quarter to the 2nd

POSSIBLE TRENDS FROM JULY 2003 THROUGH JUNE 2006; A RETROSPECTIVE VIEW

In the 1st quarter of 2006 NSMHA expanded the “Other Critical Incidents” category (chart 7) into three specific categories for more focused monitoring. Those new categories include: Disruption of Services (chart 8), Property Damage (chart 9), and Other Negative Media (chart 10). Whether by coincidence or possibly as a result of a Hawthorn Effect, the number of reported critical incidents previously monitored in the “Other” category decreased from an mean average of 9.9 per quarter to only 4 per quarter in the combined 1st and 2nd quarters of this year.

Total Number of Critical Incidents by Quarter, 7/03 thru 6/06 (chart 1): The greatest quarter-to-quarter decrease in the total number of incidents occurred in the 1st to 2nd quarters in 2005 and 2006.

Total Number of Critical Incidents by County (chart 2): The total number of reported critical incidents has remained relatively consistent over the last 12 quarters in all counties except Whatcom. The smaller counties (San Juan and Island) range from 0-5 incidents in a given quarter. Skagit has

shown a range of 5-15, and Snohomish, a range of 25-46. These numbers would seem to reflect the varied consumer populations in those counties. From the 4th quarter of 2003 to the 3rd quarter of 2005, Whatcom County showed a constant downward trend from 34 (4th quarter 2003) to 5 (3rd quarter of 2005), and has averaged 13 incidents per quarter over the past 3 quarters.

Deaths (chart 3): The numbers of deaths were 4 or less in all counties in 1st quarter 2006, falling to 3 or less in all counties except Snohomish and Whatcom. Snohomish seems to be in an upward trend since 4th quarter of 2005, which saw 4, then 7 in 1st quarter 06, and 9 in 2nd quarter 06. In the same period Whatcom County reported deaths have been steadily dropping. Only 2 deaths were reported by Whatcom in the 2nd quarter of 2006.

CRITICAL INCIDENT REVIEW PROCESS UPDATES AND INITIATIVES

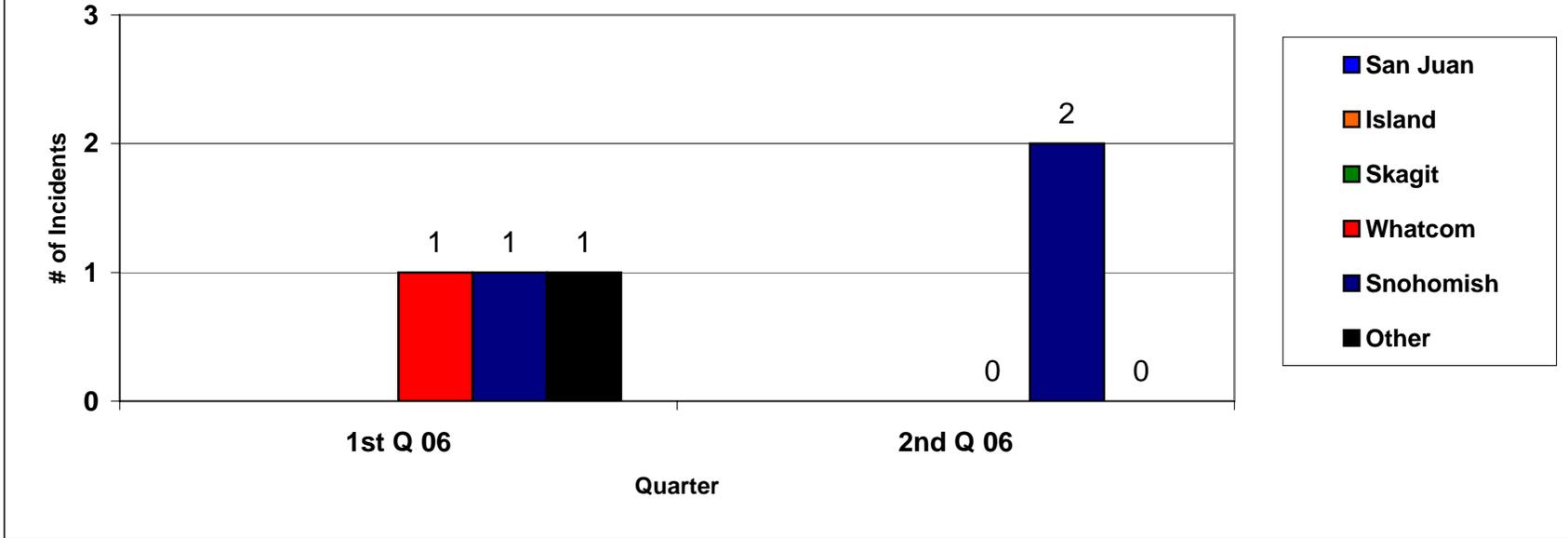
In the 2nd quarter a specific type of incident occurred for the first time in the region. A Laptop was stolen from the car of an employee of a data processing partner resulting in the loss of PHI on 8,000 consumers from an NSMHA subcontracted provider.

- Following the incident the provider and subcontracted data processing partner followed the standard critical incident reporting protocol, notifying NSMHA and MHD
- A contract was entered into with a company who specializes in implementing corrective action in this type of occurrence
- Letters were sent to all involved consumers notifying them of the of the lost of their PHI
- An ad was placed in newspapers across the state to notify those consumers who could not be contacted by mail
- A state-wide call center was set up to field questions and complaints about the incident
- NSMHA and MHD have been monitoring the situation and are receiving bi-weekly corrective action status reports from the data processing company
- To our knowledge no PHI has not been used inappropriately

ONGOING CRITICAL INCIDENT QUALITY MANAGEMENT RECOMMENDATIONS AND REVIEW ACTIVITIES

- The CIRC reviewed all 141 reported incidents and all provider incident reviews
- The CIRC continues to further investigate incidents and the circumstances surrounding their occurrence to ensure compliance with policies and processes affecting the quality of consumer care, health and safety
- The CIRC highlights and pursues specific incidents that provide examples of region-wide need or challenges in consumer care that may be impacted by provider directed system changes or policy development
- The CIRC and critical incident review process continue to work in tandem and cooperation with other NSMHA quality assurance and improvement activities including denial review requests, utilization review, formal audits and selected projects aimed at improved consumer outcomes and decreased risk to consumers
- The CIRC continues to be active in spearheading new ways to utilize Critical Incident Data to best facilitate quality improvement activities for the benefit of consumers in the NSMHA region
- The CIRC continues to follow specific incidents of concern that affect consumers

**# of Reported Other Negative Media Incidents by County by Quarter
January 2006 through June 2006**



County of Incident	1st Q 06	2nd Q 06
San Juan	0	0
Island	0	0
Skagit	0	0
Whatcom	1	0
Snohomish	1	2
Other	1	0
Total	3	1

Note: A bar chart was used to display data as Excel Chart Wizard will not show more than one color where values for two or more different counties are on the same plain between two data points.

