NORTH SOUND
MENTAL HEALTH ADMINISTRATION

QUALITY MANAGEMENT OVERSIGHT COMMITTEE

MEETING PACKET

August 24, 2011

The meeting for August is in person here at NSMHA; if you are unable to attend in person GoToMeeting is available.

1. Please join my meeting.
https://www3.gotomeeting.com/join/121378470

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

Dial +1 (630) 869-1010
Access Code: 121-378-470
Audio PIN: Shown after joining the meeting

Meeting ID: 121-378-470

QMOC GUIDING PRINCIPLES

The QMOC charge is to guide the quality assurance and quality improvement activities of mental health services within the NSMHA region. In assessing the necessary data and making appropriate recommendations, the QMOC members agree to the following:

- **Help create an atmosphere that is SAFE.**
- **Maintain an atmosphere that is OPEN.**
- **Demonstrate RESPECT and speak with RESPECT toward each other at all times.**
- **Practice CANDOR and PATIENCE.**
- **Accept a minimum level of TRUST so we can build on that as we progress.**
- **Be SENSITIVE to each other's role and perspectives.**
- **Promote the TEAM approach toward quality assurance.**
- **Maintain an OPEN DECISION-MAKING PROCESS.**
- **Actively PARTICIPATE at meetings.**
- **Be ACCOUNTABLE for your words and actions.**
- **Keep all stakeholders INFORMED.**

Adopted: 10-27-99
Revised: 01-17-01

NORTH SOUND MENTAL HEALTH ADMINISTRATION
QUALITY MANAGEMENT OVERSIGHT COMMITTEE AGENDA

Date: August 24, 2011 **Time: 1:00-3:00 PM**
Location: NSMHA Conference Room
For information Contact Meeting Facilitator: Greg Long, NSMHA, 360-416-7013

Topic	Objective	ACTION NEEDED	Discussion Leader	Handout available pre-mtg	Handout available at mtg	Tab	Time
Introductions	Welcome guests; presenters and new members		Chair				*5 min*
Review and Approval of Agenda	Ensure agenda is complete and accurate; determine if any adjustments to time estimates are needed. Meeting will start and end on time.	Approve Agenda	Chair	Agenda		**1**	*5 min*
Review and Approval of Summary of Previous Meeting	Ensure meeting summary is complete and accurate.	Approve Meeting Summary	Chair	Summary		**2**	*5 min*
Announcements and Updates	Inform QMOC of news, events; Binder Updates, if any; Advisory Board News; Provider One update, if any; ICRS System review; others updates? Quality Management Plan 2010-2013 Update --Child Psychiatric Consultations for Primary Care Providers	Inform /discuss	All				*10 min*
Evaluation forms from last meeting, if any	Discuss feedback, if any.		Chair/ Greg				*5 min*
Comments from the Chair			Chair				*5 min*
Quality Topics							
Motivational Interviewing Training	Inform/discuss before training begins in early September	Final Problem Solving	Angela/ Greg				*10 min*
Consumer Satisfaction Survey	Inform/Discus to prepare for 2 wk survey in late October.	Prepared to train staff to do survey	Kurt/ Greg	X		**4**	*15 min*
Crisis Polices 1702, 1562 & 1719	Inform/discuss	Approval	Sandy	X		**5**	*15 min*
PIPs	Inform/discuss/approval of new PIP or new intervention	Approval	Charissa	X		**6**	*15 min*
Critical Incident Semi-annual Report	Inform/discuss	Present semi—annual Report	Kurt	X		**7**	*10min*
Semi-Annual Second Opinion Report	Inform/discuss	Present semi—annual Report	Kurt	X		**8**	*10 min*
Open Access	Progress Report						*10 min*
Open Forum			Chair				
Review of Meeting	Were objectives accomplished? How could this meeting be improved? Eval forms						*5 min*
Date & Agenda for next meeting	Ensure meeting date, time and agenda are planned						

Next meeting September 28, 2011 – 1:00-3:00 PM – Go to Meeting **Potential Future Agenda Items**

Draft not yet approved

North Sound Mental Health Administration (NSMHA)
Quality Management Oversight Committee (QMOC)
NSMHA Conference Room
June 22, 2011 – Go to Meeting
1:00 – 3:00 pm
MEETING SUMMARY

MEMBERS PRESENT: **Anne Deacon**, Whatcom County; **Chuck Davis**, ombuds; **Stacey Alles**, Compass; **Pat Morris**, VOA; **Mike Manley**, Sunrise; **Mark McDonald, Marie Jubie, Fred Plappert, Candy Trautman**, NSMHA Advisory Board; **Cammy Hart-Anderson**, Snohomish Co.; **Kay Burbidge,** LWC; **Rebecca Clark**, Skagit County.

MEMBERS BY PHONE: **Pam Benjamin,** WCPC; **Susan Ramaglia,** NSMHA Advisory Board; **David Small**, Sea Mar; **Richard Sprague**, Interfaith.

STAFF PRESENT: **Greg Long, Charissa Westergard, Diana Striplin** &**Barbara Jacobson**, recorder.

OTHERS PRESENT: **Camilla Prince**, Sunrise.

TOPIC	DISCUSSION	ACTION
1. **Introductions, Review of Agenda – Chair**	Anne convened the meeting at 1:05 pm and introductions were made. No additions to the agenda are mentioned.	
2. **Previous Meeting Summary – Chair**	Anne asked for any corrections/amendments to the previous meeting summary and a motion was made to approve as submitted.	Summary approved as submitted.
3. **Announcements and Updates – All**	• **Motivational interviewing**-The BOD approved this training proposal and we will be contracting with the Addiction Technology Transfer Center. This will fund training for up to 100 people in our region, also includes two days of follow up trainings for 40 supervisors with meetings and tapings. Greg noted that we would be purchasing digital recorders for this training and asked if providers had them already; they do not so we will purchase 30-40 of them. • **Customer Satisfaction Survey** – NSMHA will purchase the rights to the CSQ8 national instrument to conduct surveys in the region. This is what Clark County used and you can review it online. Our goal is to conduct the survey the first two weeks of October with 8 basic questions. Agency staff would need to distribute in waiting rooms and NSMHA will tabulate and distribute results. We are hoping to get 6000 responses over the two weeks. Greg is asked if the focus will be outpatient or more and he stated that he will be looking into this; most likely outpatient. • **Peer counselor-** Greg noted that Margaret will take the lead on a taskforce we will put together to set up guidelines for use and employment of peer counselors in our region. We are hoping to start this in the fall. • **Personality Disorder Diagnoses –** Greg noted that NSMHA had sent out a memo and asked for feedback on the memo. He stated that they are behavior traits and in the DSM IV it is cautioned that it is long standing	Informational

	patterns of behavior. Marie J. also cautioned against waiting too long to diagnosis as well. • **NAMI Peer –** There is a handout provided by Susan R for all to read. • **SOCI –** Greg noted that the Systems of Care Institute training is being held on July 27-28 at UW in Bellingham and Secretary Susan Dreyfus of DSHS will be a keynote; she is a large proponent of wraparound.	
4. Evaluation Forms from Last Meeting – Chair/Greg	Anne noted that there were three respondents last time and she read a comment that GTM needs improvement. Anne noted that GTM is to help all be able to participate.	Informational
5. Comments from the Chair – Anne Deacon	No comments or updates at this time.	Informational
6. Advisory Board Report	Candy gave a brief update on the Advisory Board and noted that they met on June 7th and approved all recommendations to go forward to the BOD. The August 2nd meeting will be a Board Retreat with the next regular meeting to occur on September 6th.	Informational
	Quality Topics	
7. Expedited Assessment	Greg noted this is a 6 month report. Medicaid eligibles' are entitled to expedited assessments and we do a small percentage of these. He noted that agencies are doing well in handling those of an urgent nature and Terry M. works with providers on improving this process. The report is attached for all to review.	Informational
8. MPC Policy #1576	This is an update to the policy that revises who is approved for MPC services. In December of 2010 we tightened up and more closely follow the federal regulations now; in that condition needs to be solely psychiatric to qualify. Mike M asked how many will no longer get this support and Greg noted that they are getting shifted back to HCS for funding not losing funding. This is more about the funding source and HCS has stepped up with the shift working well with a few exceptions. NSMHA was funding more than a 100 a year ago and we are under 50 now. The final revisions are attached and we are asking for approval. There is a motion to accept the revised policy; seconded and motion carried.	Motion carried.
9. 2011 CIRC P&P #1009 Revision	Greg stated that DBHR came and audited our program and was very pleased with our process; they recommended that we add the language that The Center for Medicaid/Medicare Services (CMS) has asked for. The language to be added to our policies is to address fraud and abuse and the changes are highlighted in red on the attachment. There was a motion to accept the revisions to the policy as presented; seconded and motion carried.	Motion carried.
10. Performance Measures	Diana gave a status report of the data and the plan NSMHA is working on. The state gave us five performance measures and we chose three to work on in addition. They are an increase in diversion, increase of crisis respite utilization and improving co-occurring identification. We plan to review the data at NSMHA and provider level; and look at interventions. We will send each agency a letter with their data and possible intervention suggestions. She noted that we are improving in all three areas. The diversion rates have improved over baseline and it is asked if this improvement is a good thing in that we know where the diversions are going. NSMHA is looking at this as one of the interventions to see where	Informational

	the diversions are going. Greg noted this comes from the sheet that the DMHPs fill out and this measure would not measure where they went. Pat noted that dispatches are not just for hospitalization and voluntary evaluations and they might also go to the jail for a consult. There is an increase in the use of Crisis respite; contracts require an 85% utilization and we are up to about 71%. Co-occurring disorder identification is discussed. We have been below the state average of about 17% consistently and there are issues with the definition of dependence. Over 40% of our UR reviews showed in the records that this was noted with interventions and we believe this number is low. The period for looking at these measures is October 2010 through September 2011and the new contract may change this. Diana asked for feedback on the letter NSMHA will be sending out and Stacey noted that she hopes it will be a collaborative process versus a memorandum.	
11. Performance Improvement Project (PIPs) Update	Charissa noted that PIPs are a federal requirement and we must have two that we are working on. We are working on a decrease in days to getting a medication evaluation appointment and we came up with a decision tree for providers to use as an intervention and there has been some improvement. NSMHA would like to convene a workgroup on this, so please let Charissa know by next Wednesday if you would like to participate in this. The other is the inpatient PIP which is to work on improving the rate of an outpatient appointment within 7 days of discharge. This has been a challenge as we must coordinate with hospitals and we do not contract with them. The rate of follow up has been declining which could be related to the E&T closure. We will delay the workgroup as we gather more information on a task for this that NSMHA is working on. Stacey asked if this measurement takes into account the no shows and is it indicating the need for provider follow up or having to do with the hospitals. Charissa noted that a lot has to do with the hospitals as they have their own system which does not coordinate well with our needs for follow up.	Informational Charissa will send an email about the workgroup to all.
12. Clinical Guidelines	Anne noted that there are four guideline options listed and we need to choose two. She noted that bullets 1 and 3 have been discussed often and are tied to the budget as well. Bullets 2 and 4 are clinical and diagnostic treatment issues. Marie noted she feels the depression in youth is important especially in regards to medication in youth. Mike M. asked what has been most effective; process or diagnostic guidelines. Greg noted we have not researched the effectiveness and what is the impact of clinical guidelines. They are on the website for all to review. Rebecca noted could wrap bullets 1 and 3 and look at them all at once; and Anne recommends bullets 1 and 3 as well. Stacey noted that bullet 1 is already in policy and this might be duplicative. Greg noted that this was discussed and that doing them as a clinical guideline could be action steps for clinicians instead of the policy politics. Candy asked for examples of how they have made a difference and Greg noted we have 8 guidelines now and we ended up adopting national guidelines. We must develop/adopt contractually two each year; though we have not studied the effectiveness of having them available. We monitor by	Motion carried.

	UR chart reviews if have they met core requirements of the clinical guideline. There is a motion to adopt bullet points one and three for clinical guidelines; seconded and discussion called. There is a quick tally of preferences and bullets 1 & 3 are preferred; though there is still concern about them being in policy already. Greg noted that the most benefit comes from managing inpatient and the back door of outpatient services; especially during the budget times. By doing this as a clinical guideline we could provide detailed procedures to the existing policies for clinicians. Stacey noted that if during their development we discover policies that may need to be modified; this would be worthwhile; Greg stated there is that possibility. Anne noted that we have the motion and second and called for the vote; motion carried.	
13.Access to Outpatient	Greg noted that this is follow up to a prior meeting and we need to decide upon an option today. There is a brief discussion on the two options and a tally is taken with option 1 being preferred. There is a motion to accept option 1; seconded and motion carried.	Motion carried.
14.Short term treatment for Level 1 & 2	Greg stated that NSMHA would like input on how best to manage transitioning consumers out of services. We need to work on short term treatment with treatment plans with measurable objectives. Greg noted that this has a lot to do with the basic frame of treatment that the consumer is presented with when they come into services. We are pushing that when the lower level consumers come into services that we are clear that services are short term recovery based and the goal is to titrate off of services. Stacey noted the work they have been doing to refocus clinicians on this and she stated would be helpful to have a change in the UR review process; as there seems to be contradictory message. For the lower level consumers we need to focus on the primary presenting issue; not treat all their needs. Greg stated this is a good point that NSMHA will need to look at; how to manage requirements that NSMHA has. Greg noted this is for level 1-2 consumers who are more able to manage their lives and the UR process may need to be tailored to level of need. It is noted that insurance companies have guidelines for the lower level, such as 10-12 sessions and that is the way we want to head. Anne recommended that his component be woven into the clinical guidelines that are being developed around that to avoid parallel processes. All agree that it can be woven in and Greg suggests that all look at things in the system we can do to improve so all can get good care and give him your feedback.	
15.Open Forum	Nothing mentioned.	
16.Date and Agenda for Next Meeting/ Review of Meeting	The meeting was adjourned at 3:05 pm. The next meeting is July 27, 2011. • Future agenda item: Update the unanimous vote to perhaps a 1-5 scale for each vote.	

NSMHA Committee Discussion Form

Agenda Item: 2011 NSMHA Customer Satisfaction Survey Implementation

Presenter: Kurt Aemmer

Committee Action: **Action Item** ☐ **FYI & Discussion** ☒ **FYI Only** ☐

Significant Points or Executive Summary:

1. NSMHA is conducting a simple 15 question survey using questions from two widely used national surveys to collect consumer satisfaction data. This initiative is modeled after one that has been conducted in Clark County RSN for several years.
2. Survey is scheduled for the last two weeks of October 2011
3. Review of Implementation Outline & Survey form prototypes

Conclusions/Recommendations:

1. Provider Quality Managers will need to orient all staff to the survey process & their respective roles in the process during the month of September & the first week of October.

Timelines:

August 24 - October 28 2011

Attachments:

1. 2011 NSMHA Customer Satisfaction Survey Implementation Outline
2. English version of survey questionnaire prototype

North Sound Mental Health Administration Satisfaction Survey

Parent, Caregiver or Guardian Version

We want to know what you think about the services you or your child (or adult you care for) have received here over the past 90 days. Even if this is your first visit, we would still like to hear from you! Your answers are confidential. No one will be told how you answered. Your service will not be affected by your answers. We will combine your answers with others' to give us a better understanding of how well our services are working for people in the North Sound Region (Snohomish, Skagit, San Juan, Island, & Whatcom Counties).

IF YOU HAVE ALREADY COMPLETED THIS SURVEY THIS MONTH, PLEASE  ***HERE***

Please tell us about yourself:
I **am a [] parent [] foster parent [] legal guardian caregiver [] other**

Please tell us about your child or the person you care for:
He/she is [] Male [] Female and is _____ years old

He/she is (Please check all that apply):
[] American Indian or Alaska Native [] Caucasian/White [] African American/Black
[] Hispanic [] Asian or Pacific Islander [] Other race or ethnicity

	For these questions, please circle or mark the number that best describes your opinion.	Strongly Disagree (1)	Disagree (2)	Undecided (3)	Agree (4)	Strongly Agree (5)	Doesn't Apply (NA)
	As a result of the services I received...						
1	...My child is better at handling daily life.	1	2	3	4	5	NA
2	...My child gets along better with family members.	1	2	3	4	5	NA
3	...My child gets along better with friends & other people.	1	2	3	4	5	NA
4	...My child is doing better in school &/or work.	1	2	3	4	5	NA
5	...My child is better able to cope when things go wrong.	1	2	3	4	5	NA
6	...I am satisfied with our family life right now.	1	2	3	4	5	NA

PLEASE ANSWER THE QUESTIONS THAT FOLLOW ON THE BACK...
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North Sound Mental Health Administration Satisfaction Survey

Youth (ages 13 – 20) Version

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6	...I am satisfied with my family life right now.	1	2	3	4	5	NA

Please answer question #7, below, <u>only if you are 18 or older</u>. If you are 17 or younger, go ahead & skip it. Please circle or mark 'Yes' or 'No.'

Peer support services are provided by individuals who have experienced mental illness first-hand, & are using their experience to support others facing similar issues.

7	I am interested in receiving peer support services	Yes 1	No 2

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North Sound Mental Health Administration Satisfaction Survey

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For these Customer Satisfaction Questionnaire (CSQ-8 scales) questions,* please circle or mark your answers to all of the following questions.

1. How would you rate the quality of the service you received?

4	**3**	**2**	**1**
Excellent	Good	Fair	Poor

2. Did you get the kind of service you wanted?

1	**2**	**3**	**4**
No, definitely not	No, not really	Yes, generally	Yes, definitely

3. To what extent has our program met your needs?

4	**3**	**2**	**1**
Almost all my needs have been met	Most of my needs have been met	Only a few of my needs have been met	None of my needs have been met

4. If a friend were in need, would you recommend our program to him or her?

1	**2**	**3**	**4**
No, definitely not	No, I don't think so	Yes, I think so	Yes, definitely

5. How satisfied are you with the amount of help you received?

1	**2**	**3**	**4**
Quite dissatisfied	Indifferent or mildly dissatisfied	Mostly satisfied	Yes, definitely

6. Have the services you received helped you deal more effectively with your problems?

4	**3**	**2**	**1**
Yes, they helped a great deal	Yes, they helped somewhat	No, they really didn't help	No, they seemed to make things worse

7. In an overall, general sense, how satisfied are you with the services you received?

4	**3**	**2**	**1**
Very satisfied	Mostly satisfied	Indifferent, or mildly dissatisfied	Quite dissatisfied

8. If you were to seek help again, would you come back to our program?

1	**2**	**3**	**4**
No, definitely not	No, I don't think so	Yes, I think so	Yes, definitely

Your comments are welcome!

The thing I like mostly about services I have received here in the past 90 days is:

The thing I like least about services I have received here in the past 90 days is:

Other Comments:

Thank you very much for completing this survey!

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7	I am interested in receiving peer support services	Yes 1	No 2

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2. Did you get the kind of service you wanted?

1	**2**	**3**	**4**
No, definitely not	No, not really	Yes, generally	Yes, definitely

3. To what extent has our program met your needs?

4	**3**	**2**	**1**
Almost all my needs have been met	Most of my needs have been met	Only a few of my needs have been met	None of my needs have been met

4. If a friend were in need, would you recommend our program to him or her?

1	**2**	**3**	**4**
No, definitely not	No, I don't think so	Yes, I think so	Yes, definitely

5. How satisfied are you with the amount of help you received?

1	**2**	**3**	**4**
Quite dissatisfied	Indifferent or mildly dissatisfied	Mostly satisfied	Yes, definitely

6. Have the services you received helped you deal more effectively with your problems?

4	**3**	**2**	**1**
Yes, they helped a great deal	Yes, they helped somewhat	No, they really didn't help	No, they seemed to make things worse

7. In an overall, general sense, how satisfied are you with the services you received?

4	**3**	**2**	**1**
Very satisfied	Mostly satisfied	Indifferent, or mildly dissatisfied	Quite dissatisfied

8. If you were to seek help again, would you come back to our program?

1	**2**	**3**	**4**
No, definitely not	No, I don't think so	Yes, I think so	Yes, definitely

Your comments are welcome!

The thing I like mostly about services I have received here in the past 90 days is:

The thing I like least about services I have received here in the past 90 days is:

Other Comments:

Thank you very much for completing this survey!

North Sound Mental Health Administration Satisfaction Survey

Parent, Caregiver or Guardian Version

We want to know what you think about the services you or your child (or adult you care for) have received here over the past 90 days. Even if this is your first visit, we would still like to hear from you! Your answers are confidential. No one will be told how you answered. Your service will not be affected by your answers. We will combine your answers with others' to give us a better understanding of how well our services are working for people in the North Sound Region (Snohomish, Skagit, San Juan, Island, & Whatcom Counties).

IF YOU HAVE ALREADY COMPLETED THIS SURVEY THIS MONTH, PLEASE  ***HERE***

Please tell us about yourself:
I **am a [] parent [] foster parent [] legal guardian caregiver [] other**

Please tell us about your child or the person you care for:
He/she is [] Male [] Female and is _____ years old

He/she is (Please check all that apply):
[] American Indian or Alaska Native [] Caucasian/White [] African American/Black
[] Hispanic [] Asian or Pacific Islander [] Other race or ethnicity

	For these questions, please circle or mark the number that best describes your opinion.	Strongly Disagree (1)	Disagree (2)	Undecided (3)	Agree (4)	Strongly Agree (5)	Doesn't Apply (NA)
	As a result of the services I received...						
1	...My child is better at handling daily life.	1	2	3	4	5	NA
2	...My child gets along better with family members.	1	2	3	4	5	NA
3	...My child gets along better with friends & other people.	1	2	3	4	5	NA
4	...My child is doing better in school &/or work.	1	2	3	4	5	NA
5	...My child is better able to cope when things go wrong.	1	2	3	4	5	NA
6	...I am satisfied with our family life right now.	1	2	3	4	5	NA

PLEASE ANSWER THE QUESTIONS THAT FOLLOW ON THE BACK...
AND IF YOU WOULD LIKE TO MAKE COMMENTS, PLEASE WRITE THEM THERE AS WELL

North Sound Mental Health Administration Satisfaction Survey

Youth (ages 13 – 20) Version

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As a result of the services I received...							
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3	...I get along better with friends & other people.	1	2	3	4	5	NA
4	...I am doing better in school &/or work.	1	2	3	4	5	NA
5	...I am better able to cope when things go wrong.	1	2	3	4	5	NA
6	...I am satisfied with my family life right now.	1	2	3	4	5	NA

Please answer question #7, below, <u>only if you are 18 or older</u>. If you are 17 or younger, go ahead & skip it. Please circle or mark 'Yes' or 'No.'

Peer support services are provided by individuals who have experienced mental illness first-hand, & are using their experience to support others facing similar issues.

7	I am interested in receiving peer support services	Yes 1	No 2

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North Sound Mental Health Administration Satisfaction Survey

Adult (ages 21+) Version

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1. How would you rate the quality of the service you received?

4	**3**	**2**	**1**
Excellent	Good	Fair	Poor

2. Did you get the kind of service you wanted?

1	**2**	**3**	**4**
No, definitely not	No, not really	Yes, generally	Yes, definitely

3. To what extent has our program met your needs?

4	**3**	**2**	**1**
Almost all my needs have been met	Most of my needs have been met	Only a few of my needs have been met	None of my needs have been met

4. If a friend were in need, would you recommend our program to him or her?

1	**2**	**3**	**4**
No, definitely not	No, I don't think so	Yes, I think so	Yes, definitely

5. How satisfied are you with the amount of help you received?

1	**2**	**3**	**4**
Quite dissatisfied	Indifferent or mildly dissatisfied	Mostly satisfied	Yes, definitely

6. Have the services you received helped you deal more effectively with your problems?

4	**3**	**2**	**1**
Yes, they helped a great deal	Yes, they helped somewhat	No, they really didn't help	No, they seemed to make things worse

7. In an overall, general sense, how satisfied are you with the services you received?

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Very satisfied	Mostly satisfied	Indifferent, or mildly dissatisfied	Quite dissatisfied

8. If you were to seek help again, would you come back to our program?

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No, definitely not	No, I don't think so	Yes, I think so	Yes, definitely

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Excellent	Good	Fair	Poor

2. Did you get the kind of service you wanted?

1	**2**	**3**	**4**
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3. To what extent has our program met your needs?

4	**3**	**2**	**1**
Almost all my needs have been met	Most of my needs have been met	Only a few of my needs have been met	None of my needs have been met

4. If a friend were in need, would you recommend our program to him or her?

1	**2**	**3**	**4**
No, definitely not	No, I don't think so	Yes, I think so	Yes, definitely

5. How satisfied are you with the amount of help you received?

1	**2**	**3**	**4**
Quite dissatisfied	Indifferent or mildly dissatisfied	Mostly satisfied	Yes, definitely

6. Have the services you received helped you deal more effectively with your problems?

4	**3**	**2**	**1**
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7. In an overall, general sense, how satisfied are you with the services you received?

4	**3**	**2**	**1**
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8. If you were to seek help again, would you come back to our program?

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Other Comments:

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NSMHA COMMITTEE DISCUSSION FORM

AGENDA ITEM: Policy 1702 - ICRS safety screening

PRESENTER: Sandy Whitcutt or Greg Long

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

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:
This policy addresses both VOA's role and the ICRS outreach worker's role when performing an outreach to the community. The revisions are updating some of the language from Marty's law regarding outreach worker's safety.

CONCLUSIONS/RECOMMENDATIONS: Approve with revisions.

TIMELINES: This is the first time this has been to QMOC.

ATTACHMENTS: Policy 1702

Effective Date: 6/17/2008; 8/30/2007; 12/21/2005
Revised Date: 1/27/2011, 6/6/2011
Review Date: 8/27/2009

North Sound Mental Health Administration

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

Authorizing Source: Per NSMHA and ICRS Management, RCW 71.05.700, RCW 71.05.715, WAC 388-865-0452, WAC 388-865-0468
Approved by: Executive Director Date:
Cancels:
Providers contracted for Crisis Services must have "policy that complies ~~consistent~~ 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~~consumers~~, family members, community members, and Integrated Crisis Response Services (ICRS) staff. ~~as well as procedures for dispatching~~. This policy addresses the roles of ~~both~~ the Volunteers of America Care Crisis Response Services Triage Clinician (referred to herein as "Triage Clinician") and the dispatched Mobile Outreach Team (MOT), Emergency Mental Health Clinician (EMHC)~~outreach worker~~and~~/~~Designated Mental Health Professional (DMHP)~~/Designated Crisis Responder (DCR)~~.

POLICY

The 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 ~~outreach worker/DCR/~~DMHP staff to a community location outside of the provider's office. The MOT, EMHC, or ~~outreach worker/~~DMHP~~/DCR~~ may not decline a referral for face-to-face services, but decides if backup or other provisions are needed to mitigate risk~~assure safety~~.

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

Once the safety screening has been completed by the Triage Clinician, and the decision is made to dispatch the MOT, ~~an~~ EMHC,~~outreach worker/~~or DMHP~~/DCR~~, the dispatched~~at~~ MOT, EMHC,~~outreach worker/~~or DMHP~~/DCR~~ assumes responsibility for further assessing the safety of the situation. The MOT, EMHC,~~outreach worker/~~or DMHP~~/DCR~~ 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 hours, 911 must be called to initiate law enforcement response.

B. If the risk is elevated, but not immediate, the Triage Clinician must complete a more thorough risk assessment. Depending on the clinical assessment, degree of risk, and the ~~consumer's~~ individual's needs, the individual~~consumer~~ will be referred to the appropriate services, which may include 911, hospital emergency department, Triage/Crisis Center, ~~emergency department,~~ crisis appointment, or other community services. If the individual~~consumer~~ 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.~~, after using VOA has assessed risk with the standard use of the safety screening assessment tool (Attachment 1702.01).~~

C. When alcohol or drugs are present (per safety screening assessment tool), the MOT, EMHC,~~outreach worker~~ or DMHP~~/DCR~~ will not be dispatched to homes or other unstaffed (less than three staff) locations. Arrangements will be made for the individual~~person~~ 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 and the MOT, EMHC, or DMHP agree that an outreach is appropiate in the presence of alcohol or drugs.

~~Outreach to community hospitals and outreach related to detoxification centers for placement in the secure detox center.~~

~~A. Refer to Integrated Policy #1718.00.~~

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 hours, 911 must be called to initiate law enforcement response.

B. If the risk is elevated, but not immediate, the Triage Clinician must complete a more thorough risk assessment. Depending on the clinical assessment, degree of risk, and the individual's ~~consumer's~~ needs, the individual~~consumer~~ 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~~consumer~~ 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.~~, after VOA has assessed riskusing with the standard safety screening assessment tool (Attachment 1702.01).~~

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

1. Upon dispatch to an unstaffed location,~~When~~ the MOT, EMHC,~~ICRS outreach worker/~~or DMHP~~/DCR~~ will continue to perform an ongoing risk assessment.~~has been dispatched by Triage Clinician to an unstaffed location,~~

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

i. Primary risk factors include:

a) Location
b) Weapons
c) History
d) Mood lability
e) Consistency of known information
f) Ability to summon assistance (e.g., cell phone coverage)

ii. Secondary risk factors include:

a) Time of dispatch
b) Gender
c) Age
d) Presence of others at the location
e) History of ICRS contacts

iii. TheMOT, EMHC,~~outreach worker/~~or DMHP~~/DCR~~ must determine (based upon evaluated risk) how and where to see the individual~~consumer~~.

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 ~~outreach worker~~ MOT, EMHC, ~~/~~or DMHP~~/DCR~~.
d. Conducting the outreach with a second ICRS staff person for additional safety.

3. No MOT, EMHC,~~outreach worker/~~or DMHP~~/DCR~~ staff shall~~will~~ 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~~. unless a~~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.~~unstaffed community location when elevated risk is deemed to be present.~~ 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 ~~that is~~ documented in crisis plans or commitment records shall be~~and is~~ available without unduly delaying a crisis response. The MOT, EMHC,~~outreach worker~~/DMHP~~/DCR~~ 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,~~MH worker, or up to and including~~ law enforcement officer, or other first responder.

~~c. Accessing the crisis plans and consumer history of contact with the Mental HealthH system via Triage Clinician.~~

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

4. MOT, EMHC,~~Outreach workers/~~DMHP~~/DCR~~ staff will be provided with wireless phones and participate in annual safety training as addressed in NSMHA Policy #1557.00 Safety Policy.

ATTACHMENTS

~~1702.01 – NONE None~~

NSMHA COMMITTEE DISCUSSION FORM

AGENDA ITEM: Policy 1562 Monitoring of Court Orders

PRESENTER: Sandy Whitcutt or Greg Long

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

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:
This policy addresses the roles of inpatient facilities, community mental health organizations, ICRS, in monitoring individuals on court orders. It also addresses procedures between CMHA's and ICRS. There have been some changes in the WAC language that is part of this revision. ICRS has worked on this policy, it was then sent to QMOC policy sub to review.

CONCLUSIONS/RECOMMENDATIONS: Approve this policy with revisions.

TIMELINES: 60 days following a numbered memo.

ATTACHMENTS: POLICY 1562

Effective Date: 11/16/2009; 3/5/2009; 8/30/2007
Revised Date: 1/28/2008
Review Date: 1/28/2008

North Sound Mental Health Administration

Section 1500– Clinical: Monitoring of Less Restrictive Orders

Authorizing Source: WAC 388-865-0245 2(a)(b); WAC 388-865-0466; WAC 388-865-0484; RCW 71.05.340; ~~3(b)~~RCW 71.05.320; RCW 71.05.700-715
Cancels:
See Also: Approved by: Executive Director Date: 2/3/2010
Providers must "comply with" this policy
Responsible Staff: Deputy Director~~Quality Manager~~ Signature:

POLICY#1562.00

SUBJECT: MONITORING OF COURT~~LESS RESTRICTIVE~~ ORDERS

PURPOSE

The purpose of this policy is to ensure a process to monitor compliance of those individuals on conditional release (CR) or less restrictive alternative (LR) court orders.

POLICY

For individuals involuntarily committed under RCW (Revised Code of Washington) 71.05 or RCW 71.34, inpatient psychiatric facilities are required to provide notice of discharge and copies of CRs/LRs to the DMHP (Designated Mental Health Professional)~~/DCR~~ office responsible for the detention and the DMHP~~/DCR~~ office where the individual is expected to reside. This notification is required to occur as soon as possible and no later than one business day after the individual's discharge from the inpatient psychiatric facility.

Inpatient psychiatric facilities are also expected to contact Community Mental Health Agencies (CMHAs) to request the CMHA assume responsibility of the CR/LR, at a minimum, prior to the individual's discharge. However, once a CMHA becomes aware of an individual's LR/CR, lack of notification by the inpatient facility to the CMHA prior to the individual's discharge does not eliminate responsibility to follow up with the individual on the CR/LR (see Procedure section).

In order to provide services to individuals on a CR/LR, CMHAs must be licensed to provide the psychiatric and medical service component of community support services and be certified by the Department of Social and Health Services (DSHS) to provide involuntary treatment services consistent with WACs (Washington Administrative Codes) 388-865-0466 and 388-865-0484.

In order to ensure integrated, medically necessary services are delivered to individuals on a CR/LR, CMHAs will need to work closely with DMHPs~~/DCRs~~ and other allied professionals in the community.

PROCEDURE

1. The inpatient psychiatric facility is expected to contact the CMHA to request the CMHA assume responsibility of the LR/CR. This contact may be an oral or written request and is expected to occur prior to the individual's discharge from the inpatient facility.~~is required to the CMHA from an inpatient psychiatric facility placing the individual on a CR/LR. A request for services is an oral or written request made to a CMHA asking the CMHA to assume responsibility of the CR/LR. The inpatient psychiatric facility should contact the CMHA as the inpatient facility prepares for discharges involving a CR/LR. A request for services should be made to the CMHA contact able to make decisions regarding acceptance of the individual being placed on the CR/LR.~~

~~1.~~2. Although a CMHA may decline to assume responsibility of the CR/LR~~a request for services~~ if there is clinical rationale to do so, this should be a rare occurrence. Any CMHA declining the request from an inpatient facility will need to notify NSMHA prior to notifying the inpatient facility of the decision. The CMHA, declining the request, will need to offer alternative service options to the inpatient psychiatric facility.

~~2.~~3. ~~Once~~If the CMHA has agreed to serve the individual, the inpatient facility must contact Volunteers of America (VOA) Access Line to complete a request for service.

~~3.~~4. CMHAs shall ensure periodic evaluation of each committed individual for release from or continuation of an involuntary treatment order by documenting the individual's adherence to the conditions of the CR/LR~~A~~ in accordance with current WACs.~~in accordance with WAC 388-865-0466).~~

~~4.~~5. For an individual placed on a CR/LR who is not currently in an open outpatient treatment episode with a North Sound Mental Health Administration (NSMHA) CMHA:

a. The CMHA is responsible for providing follow up services with the individual when a request for service at that CMHA has been made (refer to North Sound Mental Health Administration [NSMHA] Policy #1502 Accessibility, Engagement and Utilization of Services for High Need Individuals Not Engaging in Treatment).

   i. The CMHA clinician will coordinate appropriate follow up needs with his/her supervisor.
   ii. The CMHA clinician will report the follow up response to the DMHP ~~DCR~~ office.
   iii. The CMHA and DMHP~~/DCR~~ offices may need to coordinate on further follow up needs as appropriate. This could include outreach, crisis alerts, affidavits, etc.

b. The DMHP~~/DCR~~ office is responsible for determining appropriate~~providing~~ follow up services with the individual when no request for service to a specific CMHA has been made.

   i. Upon notification of an individual being placed on a CR/LR~~A,~~ who has not requested services at a CMHA, the DMHP~~/DCR~~ office will attempt to contact the individual and document the attempts.
   ii. The DMHP~~/DCR~~ office will advise the individual of his or her rights and responsibilities while on a CR/LR and provide ~~ensure that~~ the individual with the VOA Access Line number to be referred to a regional CMHA.
   iii. If the individual cannot be contacted by telephone and letter, the DMHP~~/DCR~~ shall coordinate additional follow up with his/her supervisor.
   ~~i.~~iv. If the individual refuses to comply with the conditions of the CR/LR, ~~or needs follow up by~~ the DMHP~~/DCR office~~ may revoke the individual based on clinical and safety needs.

~~5.~~6. For an individual on a CR/LR who is currently in an open outpatient treatment episode with a NSMHA CMHA:

a. The CMHA clinician shall contact the DMHP~~/DCR~~ office to coordinate monitoring of the CR/LR~~A~~ as soon as they become aware the individual has been placed on a CR/LR. The CMHA clinician does not need to contact the DMHP~~/DCR~~ office if notification of the CR/LR came from that office.

b. The DMHP~~/DCR~~ office shall contact the CMHA assigned to the CR/LR to coordinate monitoring of the CR/LR as soon as they are aware the individual has been placed on a CR/LR.

7. In coordinating to monitor individuals on CRs/LRs, both CMHA clinicians and DMHPs~~/DCRs~~ shall prioritize the following:

~~c.~~a. Closely monitoring an individual's adherence with the CR/LR, including assessing the need for revocation based on likelihood of serious harm, failing to adhere to conditions, or substantial deterioration in functioning; and/or substantial decompensation with a reasonable probability that the decompensation can be reversed by further treatment [RCW 71.05.340(3)(b)]; and,

~~d.~~b. Providing DMHPs~~/DCRs~~ with information needed to support petitions for further court-ordered less restrictive treatment.

~~6.~~8. CMHAs shall notify the DMHP~~/DCR~~ if noncompliance with the LR/CR impairs the individual sufficiently to warrant detention or evaluation and petitioning for revocation of the CR/LR.

~~7.~~9. DMHPs~~/DCRs~~ shall maintain a system which tracks CRs/LRs as they are approaching expiration, and encourage a careful review by CMHA clinicians of the need to petition for extension of the CR/LR. Petitioning to extend the CR/LR shall occur whenever the individual continues to meet the criteria for further commitment and when further less restrictive treatment will support the person's recovery. In this circumstance, the CMHA clinician shall request the initiation of an investigation by the DMHP~~/DCR~~ two to three weeks prior to the expiration of the CR/LR. This investigation may involve consultation with the treatment provider(s) and consideration of information provided by natural supports and other systems to determine if further involuntary treatment is warranted by extending the CR/LR.

~~8.~~10. CMHA clinicians shall be fully educated and aware of the ability to continue or extend a CR/LR, even when the individual's circumstances do not warrant hospitalization or meet acute care criteria. The individual's past history of decompensation without continued involuntary outpatient treatment is important to consider when determining if the criteria for grave disability can be met.

~~9.~~11. A CMHA assigned to monitor an individual on an LR/CR may not discharge the individual while they are on the LR/CR. CMHAs involved in the care of an individual on an LR/CR, but who are not the CMHA assigned to monitor the order, will need to coordinate care with the assigned CMHA (see NSMHA Policy #1540 Discharge from Treatment for information related to discharge).

ATTACHMENTS

None

NSMHA COMMITTEE DISCUSSION FORM

AGENDA ITEM: ICRS Policy 1719 (Utilization of Crisis Stabilization/Triage Beds used for Hospital discharge Planning)

PRESENTER: Sandy Whitcutt or Greg Long

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

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:
This policy pertains to individual's coming out of Western State or community Hospitals, who may require more time to stabilize, before they return to the community. Since the policy was first written, Stabilization/Triage Programs in the region have gone through many changes, which are now reflected in this policy. The policy has been revised by ICRS, will meet the standards at all three programs.

CONCLUSIONS/RECOMMENDATIONS: Approve with revisions.

TIMELINES: Within 60 days after the numbered memo has been submitted.

ATTACHMENTS: Policy 1719.

Effective Date: 11/8/2007
Revised Date: 5/5/2010, 4/29/11, 6/6/11
Reviewed Date: 10/27/2010

North Sound Mental Health Administration

Section 1700 – ICRS: Utilization of Crisis Stabilization for Hospital Discharge Planning

Authorizing Source: Per NSMHA & ICRS
Cancels:
See Also:

Approved by: Executive Director Date:
Responsible Staff: Deputy Director Signature:

POLICY #1719.00

SUBJECT: UTILIZATION OF CRISIS STABILIZATION /TRIAGE BEDS FOR HOSPITAL DISCHARGE PLANNING

PURPOSE

To identify a coordinated discharge procedure between hospitals and contracted community crisis stabilization/triage programs in the North Sound Mental Health Administration (NSMHA) region to assure rapid and safe discharges from hospitals to less restrictive options.

POLICY

Crisis stabilization/triage beds will be utilized to provide a temporary step-down placement for those individuals who are anticipating discharge from the hospital setting, but continue to need stabilization services prior to their return to community living. The intent of this service is to improve the transition for the individual into the community, reducing the risk for re-hospitalization.

Priority will be given to those individuals who are ready for discharge from Western State Hospital (WSH). The use of the stabilization program is also available to the Snohomish County Evaluation and Treatment Center (E&T) and community hospitals on a case-by-case basis.

Crisis stabilization/triage programs do not need to reserve beds for people potentially being discharged from hospitals. However, use of these beds as an aid to transitioning people out of inpatient care is an important function for these programs. Crisis stabilization/triage staff shall work collaboratively with WSH Liaisons and E&T/community hospital discharge planners to coordinate rapid discharge from inpatient facilities.

The preference is to provide crisis stabilization/triage bed placement for individuals living in the county where the crisis stabilization/triage program is located, but consideration will be given to individuals from other counties in the NSMHA region requiring crisis stabilization/triage bed placement who meet the other conditions outlined in this policy. Exceptions to the use of the beds will be considered on a case-by-case basis, after review by the Crisis Stabilization/Triage Program Manager.or designee.

PROCEDURE

1. **Admission Criteria:**

    A. WSH Liaisons and E&T/community hospital personnel will complete comprehensive discharge planning prior to contacting the crisis stabilization/triage program in the individual's county of residence.

1. The discharge plan will include a housing plan, which addresses proposed living arrangements and the funding arrangements for the proposed housing and ongoing living costs.
2. The discharge plan will address relapse prevention/intervention strategies including assessment of Less Restrictive/Conditional Release (LR/CR) needs and hospital readmission protocol for the individual.

B. The individual must have a source of funding that addresses basic needs including the ability to obtain any prescribed medications and other medical equipment.
C. The individual must have an open outpatient episode or a scheduled assessment ~~within 7 days,~~ for ~~admission to~~ outpatient services with a NSMHA-contracted provider within seven calendar days of inpatient discharge, prior to their admission to crisis stabilization/triage beds for step-down from a hospital.
D. WSH Liaisons and E&T/community hospital personnel will coordinate with the Crisis Stabilization/Triage Program Manager or designee to address the needs of the individual and the rationale for the use of the crisis stabilization/triage bed.
E. Crisis stabilization/triage admissions will meet the inclusionary criteria defined in NSMHA Policy #1701.
F. Crisis stabilization~~/triage~~~~triage~~ bed placements after discharge from an inpatient setting are a transitional placement. Crisis stabilization~~/triage~~~~triage~~ beds used for the purpose of step-down from inpatient~~programs~~ will initially be given up to 5 calendar days. Anything beyond five calendar days is considered an extension, which shall be utilized only on a very limited basis.~~Extensions should be utilized on a rare basis and will need to have documented clinical justification for the extension. Stabilization programs should not exceed 14 calendar days.~~
    1. Crisis stabilization/triage staff shall maintain a log of all extensions.~~Any extension should be kept on a log by the crisis stabilization/triage staff.~~
        i. The~~is~~ log must~~should~~ include the name of the individual, the dates of admission, ~~the date the~~ extension and discharge ~~was requested~~, and the name of the crisis stabilization/triage staff making the determination to extend the stay.~~clinician requesting the extension.~~
    2. The clinical justification for any extensions ~~requests~~ must be documented in the crisis stabilization/triage facility~~bed~~ clinical record. ~~with supporting clinical justification~~.
    ~~3. Crisis stabilization/triage staff will work with outpatient providers and community programs to have a planful discharge.~~
    ~~4.~~3. ~~NSMHA will request that c~~Crisis stabilization/triage facilities shall provide a monthly report and/or log of extensions ~~requests~~ to NSMHA. NSMHA shall~~will~~ perform periodic utilization reviews on those individuals requiring extensions to ensure that extensions for crisis stabilization~~step down~~ beds used as step down from inpatient are being used when clinically appropriate.

2. Exclusionary Criteria:

A. Individuals who appear to have housing needs that are expected to exceed 14 calendar days to resolve would not be considered for this program.
B. Exclusionary criteria, as defined in policy NSMHA #1701, apply in this policy.

3. Stabilization/Triage Services:

Individuals~~Consumers~~ in this program shall~~ould~~ have a~~n outpatient~~ case manager at the facility assigned to assist with the coordination and transition needs of the individual ~~consumer~~ to ensure a planful discharge. Examples of this coordination may~~would~~ include:

A. Facilitating transition into the community;
B. Assistance with enrollment into outpatient treatment programs that may include Mental Health or Chemical Dependency programs as appropriate;
C. Facilitation of connection to community supports and resources that address basic needs (e.g. food, housing) and other needs (e.g. socialization, medical care).

ATTACHMENTS:

NONE

NSMHA COMMITTEE DISCUSSION FORM

AGENDA ITEM: Performance Improvement Projects (PIPs)

PRESENTER: Charissa Westergard

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

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:
Clinical PIP – Decrease in the Days to First Prescriber Appointment after Request for Service

- A workgroup was convened to develop a new intervention; see attachment for 3 proposals

Nonclinical PIP – Improved Delivery of Non-Crisis Outpatient Appointments after a Psychiatric Hospitalization

- At June QMOC, NSMHA recommended delaying a workgroup for this project as we were awaiting news on funding for a previously recommended intervention for this project. However, there is still no news on this funding. Rather than continuing to delay and, because this issue is likely to continue to be addressed as a Performance Measure, NSMHA recommends discontinuing this project as a formal PIP and starting a new PIP.

CONCLUSIONS/RECOMMENDATIONS:
Clinical PIP – Decrease in the Days to First Prescriber Appointment after Request for Service

- Workgroup recommends the first option identified on attachment (Planful Discharge) be implemented.
- This is the first presentation of intervention options to QMOC. Request recommendation for which intervention to pursue be made today if possible.

Nonclinical PIP – Improved Delivery of Non-Crisis Outpatient Appointments After a Psychiatric Hospitalization

- Please email Julie de Losada (Julie_de_Losada@nsmha.org) or call 360-416-7013 x223 by September 6th if interested in participating in a workgroup to develop a new PIP and/or if you have ideas for a new PIP.

TIMELINES:
See above

ATTACHMENTS:
Proposed PIP Interventions 8.18.11

Performance Improvement Project Workgroup

Decrease in the Days to Medication Evaluation Appointment after Request for Service

Proposed Interventions

Planful discharge – discharge planning begins at admission and involves helping people develop and utilize other resources in preparation for discharge. Planful discharge will assist with improving the flow of people through treatment ensuring that NSMHA system resources are available in a more timely manner. Planful discharge as a proposed intervention for this project is identified as including the following elements:

- Revision to the Decision Tree to include elements that emphasize discharge planning. Addition of action boxes that identify:
    - Reminder to start discharge planning at admission
    - Referral to PCP within 30 days of first ongoing appointment for individuals who do not have a PCP
    - Contact with PCP once potential need for medication evaluation is identified
        - Releases of information sent by 1st ongoing appointment
        - Collaborating with PCP so that PCP can provide medication evaluation and ongoing medication management when appropriate
        - Collaborating with PCP so that PCP can provide ongoing medication management after initial medication evaluation at CMHA
        - Collaborating with PCP so that PCP can provide ongoing medication management after medication services can be appropriately transferred from CMHA to PCP including:
            - Ongoing communication (e.g., phone calls between CMHA prescriber and PCP, phone calls between CMHA clinician and PCP/PCP staff, faxing notes) with PCP while CMHA is prescribing
            - Transition period (e.g., 90 days) where individual is open at CMHA while obtaining medication management from PCP
                - Ongoing communication and consultation during transition period to improve PCP's comfort with prescribing
    - Revision of related NSMHA policies to be consistent with the above recommendations

Regional consultation – develop availability for PCPs/prescribers external to the NSMHA system to consult with NSMHA system prescribers. This intervention is meant to provide support for PCPs who are prescribing for individuals with mental health concerns so that they may continue medication management when appropriate rather than refer. Fewer referrals helps improve the availability of NSMHA system resources and ensure that medication services are available in a more timely manner.

- Secure email format recommended - this allows for CMHA prescribers to respond during designated time of day or when they have unscheduled down time; also may be utilized more readily by external prescribers
    - CMHA prescribers would be scheduled on a rotating basis to respond to email consultation requests from prescribers external to the NSMHA system or this

could be conducted as a pilot if there is an agency or agencies interested (i.e., would not be regional)
    - Frequency of consultation time would need to be identified prior to implementation of this intervention
- Will require marketing by NSMHA and CMHAs to ensure utilization
- Questions regarding funding to implement this intervention

Education of external systems (e.g., PCPs) – similar concept to regional consultation in the intervention is meant to assist PCPs, etc in knowing when to refer an individual for medication services at a CMHA as not everyone they refer for medication services may meet medical necessity for ongoing medication services. The difference between this intervention and regional consultation is regional consultation takes place on a case-by-case basis and this is a global, generalized approach.

- Requires development of materials to provide to PCPs
    - Identification/explanation of Access to Care Standards, Recovery Model, services available based on medical necessity, levels of care, length of stay
- Face to face presentations by NSMHA and CMHA staff
- Materials and presentations would need to emphasize and build on the relationship between CMHA and PCP as a partnership

NSMHA COMMITTEE DISCUSSION FORM

AGENDA ITEM: 1st & 2nd Quarter 2011 Semi-Annual CIRC Report
PRESENTER: Kurt Aemmer
COMMITTEE ACTION: **Action Item ( ) FYI & Discussion (x) FYI only ()**
SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:

1. Frequency of Critical Incidents in the North Sound Region remained low, due to CI categories redefined in October, 2010
2. Decision not to expand DBHR categories for region, as CIRC survey reflects that providers are maintaining or developing their own internal critical incident review processes
3. NSMHA underwent a very successful CIRC audit by DBHR in April, 2011

CONCLUSIONS/RECOMMENDATIONS:

1. CIRC & NSMHA Providers continue to have a high-functioning review & reporting process/continue process
2. Postpone any internal expansion of categories until budgetary changes are known

TIMELINES: January – June, 2011

ATTACHMENTS: 1st & 2nd Quarter 2011 Semi-Annual CIRC Report

NSMHA Semi-Annual CIRC Report

January - June 2011

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 a semi-annual basis.

HIGHLIGHTS OF CI DATA FROM JANUARY – JUNE 2011

CIRC screened seventeen (17) reported CI in the 1st half of 2011. Four (4) of the reported CI were determined to not meet the formal definition of a CI, so thirteen (13) were reviewed in committee. One (1) of the thirteen (13) reported to DBHR did not meet the definition of a reportable CI, however it was reported to NSMHA at the request of the Complaint & Grievance Committee (C&GC), forwarded to DBHR under the "judgment" language in the DSHS contract [*NSMHA designated reporting staff shall utilize professional judgment and report incidents that fall outside the scope of this section*], and investigated by CIRC at the request of the NSMHA C&GC. (APPENDIX I & II)

- The total number of reported CI continues to decrease significantly from seventy-four (74) in the 1st half of 2010 to forty-two (42) in the 2nd half of 2010, and seventeen (17) in the 1st half of 2011. (See NOTABLE CHANGES IN PROCESS, below).

CIRC INVOLVEMENT IN REGION-WIDE QUALITY IMPROVEMENT ACTIVITIES

- **Preventing elopements from E&Ts:** Gains have been held in the quality improvement efforts to prevent elopements from E&Ts. Since the relatively large number of elopements in 2005 (8), and the subsequent quality improvement efforts, there have not been more than 2 elopements in any quarter. There were 2 in the 2nd Quarter of 2007. Other than that quarter, there has been zero or one elopement per quarter. There was only 1 reported in all of 2008, and none in 2009, 2010, or the 1st half of 2011. ***NSMHA recognizes the continued excellent work of E&T staff in addressing this issue!***

NOTABLE CHANGES IN PROCESS

- **In October (4th Quarter) of 2010 DBHR (Division of Behavioral Health and Recovery) updated RSN contract language, resulting in significant changes in reportable CI categories, and the operational definitions pertaining to the categories that remained.**
- **Conclusions from the most recent (July – December 2010) Semi-annual Report:**
  - DBHR has successfully reduced CI reporting requirements, allowing for reduced resource expenditure by DSHS, RSNs and RSN mental health providers, consistent with recent state budget cuts, by shifting its CI reporting process and philosophy reflected in the new DBHR contract language toward a greater focus on Risk Management. However, in its current form, it significantly reduces NSMHA CIRC's capacity to indentify and address regional quality of services needs.
  - The process could be altered/expanded internally to shift the focus more toward Quality Improvement, allowing the external (DBHR) focus to remain primarily on Risk Management. However, this would require an increased expenditure of Provider and RSN resources.

- **Recommendations from the most recent (July – December 2010) Semi-annual Report:**
  - An analysis of the changes in DBHR philosophy and range of categories, and category dispositions were undertaken in an effort to determine whether or not a strategy needs to be developed to mitigate the concerns stated in "Conclusions," above. The analysis was presented to the NSMHA Leadership Team on 2/1/11 for discussion.
- **Recommended actions resulting from the 2/1/11 Leadership Team discussion:**
  - Find out what each agency is doing as far as what CIs they are collecting – Kurt Aemmer
  - Look at adding a check in the audits to look for CI issues – Margaret Rojas
- **Findings:**
  - All but one provider are currently addressing CI beyond the scope of DBHR requirements, with their quality management programs. One is currently developing a process to do so. (See APPENDIX IV)
  - The provider internal CI review processes are being reviewed in their annual administrative audits in 2011, however as of this date, only one provider has been audited. NSMHA intends to further develop the annual administrative audit in 2011 for a more formalized process in 2012.

DBHR CIRC AUDIT

On April 12, 2011 NSMHA underwent a very successful audit conducted by DBHR. The auditors were very complimentary of the CIRC process, and there were no negative findings. The auditors recommended that two items from the new contract language be added to the CIRC Policy & Procedure. Those two items were added before the auditors completed their review. (See APPENDIX III). The revisions were taken to the May NSMHA Quality Oversight Committee meetings where they were recommended for approval.

Attachments: APPENDIX I: Table Showing # of Reported Critical Incidents by County, by Quarter, January – March 2011
APPENDIX II: Table Showing # of Reported Critical Incidents by County, by Quarter, April – June 2011
APPENDIX III: DBHR Review Report Summary
APPENDIX IV: Survey of Internal Provider Critical Incident Review Processes

APPENDIX I: Table Showing # of Reported Critical Incidents by County, by Quarter Jan. – Mar. 2011

County of Incident	Unauthorized leave by a non-offender from an E & T	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	Alleged consumer abuse or neglect	Assault of a consumer by a staff	Assault of a staff by a consumer resulting in hospitalization	Suicide attempt on DSHS owned, licensed or contracted by DSHS requiring medical care	Violent act perpetrated by a consumer	Alleged financial exploitation involving a consumer, agency or other	Incident involving a consumer reported by the media, or having potential for media interest	Crime involving a consumer reported by the media, or having potential for media interest	Natural disaster presenting substantial threat to facility operation or consumer safety	Breach of consumer information	Totals
San Juan	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Island	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Skagit	0	0	0	0	0	0	0	2	0	0	0	0	1	3
Whatcom	0	0	0	0	0	0	0	1	0	0	1	0	0	2
Snohomish	0	1	0	2	0	0	0	1	0	0	0	0	0	4
Other	0	0	0	0	0	0	0	0	0	0	0	0	0	0
1st QUARTER TOTALS	0	1	0	2	0	0	0	4	0	0	1	0	1	9

APPENDIX II: Table Showing # of Reported Critical Incidents by County, by Quarter Apr. – June 2011

County of Incident	Unauthorized leave by a non-offender from an E & T	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	Alleged consumer abuse or neglect	Assault of a consumer by a staff	Assault of a staff by a consumer resulting in hospitalization	Suicide attempt on DSHS owned, licensed or contracted by DSHS requiring medical care	Violent act perpetrated by a consumer	Alleged financial exploitation involving a consumer, agency or other	Incident involving a consumer reported by the media, or having potential for media interest	Crime involving a consumer reported by the media, or having potential for media interest	Natural disaster presenting substantial threat to facility operation or consumer safety	Breach of consumer information	Totals
San Juan	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Island	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Skagit	0	0	0	0	0	0	0	2	0	0	0	0	0	2
Whatcom	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Snohomish	0	1*	0	1	0	0	0	0	0	0	0	0	0	2
Other	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2nd QUARTER TOTALS	0	1	0	1	0	0	0	2	0	0	0	0	0	4

***This CI occurred in April, but was reported by Compass Health in June at the request of the NSMHA Complaint & Grievance Coordinator as a serious injury. After consultation with the DBHR CI Manager it was determined that this incident was not considered to be a serious injury. It was, however, reported to DBHR and investigated by CIRC whose findings were forwarded to the Complaint & Grievance Committee.**

APPENDIX III: DBHR Review Report Summary

DIVISION OF BEHAVIOR HEALTH AND RECOVERY DIVISION

North Sound Regional Support Network
Review Report Summary

April 2011

❍ Approved ❍ Approved with attached changes	
David Dickinson, Division Director	(Date)

TITLE

Washington State Regional Support Networks (RSN Review Report: Serious and Emergent Incident Reporting and Investigations, and Follow-up).

REVIEWS PERFORMED BY

Clint Catron, Incident Manager, 360-725-1956
Darleen Vernon, Ph.D., DBHR Compliance Officer, 360-725-1039

Purpose

This report complies with DBHR Regional Support Networks (RSN) Contract, based on multiple federal and state authorities.
The **general** purpose of these reviews is to provide the DBHR with information and assurance regarding the health and safety of patients and staff, while receiving mental health services from community providers.
The **specific** purpose of these reviews is to assess the degree to which Regional Support Networks are reporting, managing, documenting and following up on all serious and emergent incidents, per RSN contract and authority.

Scope

To expedite the division's evaluation of the Regional Support Networks, these reviews will be of limited scope.
With respect to the 'Serious and Emergent Incident Reporting' portion of the RSN contract, RSN's Incident Reporting procedures and policies, and other authorities as identified.

Report Summary

- **Policies and Procedures**.
  North Sound Regional Support Network (RSN) incident reporting policies and procedures were compliant and met the standards based on the RSN contract. The item missing in the procedures was Breach of Client information protocols. The Breach of Client information is a new reportable incident type for the RSN's and accompanies a new protocol. North Sound RSN staff added the protocol to the policy soon after the review.

- **Incident Reporting Process and Documentation of Report**.
  The incident reporting process and documentation, as identified by the checklist and taken from the 10% sample from 2010, were compliant in all areas.

  The timeliness of the incident reports submitted were compliant and met the standards based on that portion of the RSN contract. The Contractor is required to notify the DBHR Incident Manager within one (1) working day of becoming aware of an incident. All nine (9) incidents in the sample were reported within one working day based on the provider documentation reported to the RSN.

  The notification documentation identified in the brief narrative of the incident report is well written and informative. The only information missing from the report is client treatment status and history. The RSN includes this information in their monthly incident review, but will include this content within the brief narrative in the future. Relevant information such as Provider response to the incident, and any actions taken to prevent future incidents is documented in the brief narrative.

  All investigations, notifications and referrals are documented in the identified fields of the report. Documentation of these aspects is detailed and thorough, and it's clear who is being notified, the purpose for referrals, and what the RSN plans to investigate.

  Reviews are completed in a timely manner: the average review is completed within 52 days from the date of the incident (well below the all-RSN average of 60 days). North Sound RSN reviews incident reports once a month by the Critical Incident Review Committee (CIRC). Depending on the type of incident, the CIRC may direct the Provider's quality committee to complete a formal review and submit findings within five (5) business days. Because the brief narrative is so detailed in the actions taken by the Provider, the RSN reports the date of the review and whether any actions were taken by the CIRC.

- **Staff knowledge of Incident Reporting**.

  North Sound RSN staff responsible for reporting incidents is aware of what constitutes an incident. RSN administrative staff is quite knowledgeable about policies and procedures surrounding incident reporting as well as the definitions in the RSN contract. They are also aware of the importance of maintaining timeliness in reporting critical incidents. RSN reporting staff has shown knowledge of the various fields, as well as the information required within those fields contained in the DBHR Incident Reporting System. RSN staff has multiple years working with critical incidents; including reporting protocols, documenting follow up information, and closures. RSN staff acknowledged both verbally and in writing that they understand all aspects of incident reporting.

- **Reconciliation of Provider reports**.

  DBHR is confident that Provider reports contain all necessary information in order for the RSN to report fully documented incident reports in a timely manner.

  All sample incidents reported by the Providers met the definition of incidents contained in the RSN contract. These incidents were all reported to DBHR by the North Sound RSN. The Provider incident reports contained all minimum required elements; date, location, and type of incident, as well as reporting Provider, client treatment status, and any preventative actions taken by the Provider. This information is consistent with reporting requirements and enables the RSN to complete a fully compliant incident report.

- **Training Records**.

  All training records and attendance logs relevant to incident reporting are documented and filed in separate folders.

- **Review Outcome**.

  This RSN had few improvements to make as a result of the review but quickly made them. The reviewers also discussed complaint and grievance reporting with the RSN's quality manager and the linkage between them and incident reporting.

End of Report Summary

APPENDIX IV: Survey of Internal Provider Critical Incident Review Processes

PROVIDER	SOURCE	INTERNAL PROCESS EXISTS	CATEGORIES OF CI REVIEWED
Bridgeways	C. Ainsley	Yes	Suicide attempts, & deaths under unusual circumstances
CCS	K. McNaughton	Yes	Multiple
Compass Health	H. Fennell	Yes	Multiple
Interfaith	R. Sprague	Yes	Multiple
Lake Whatcom Center	K. Burbidge	Currently being developed	TBD
Sea Mar	D. Small	Yes	Suicide attempts & other sentinel events as required by JCAHO
Sunrise Services	C. Van Buren	Yes	Suicide attempts, & deaths under unusual circumstances
WCPC	P. Benjamin	Yes	Suicide attempts, & deaths under unusual circumstances

NSMHA Committee Discussion Form

Agenda Item: 1st & 2nd Quarter 2011 Semi-annual Second Opinion Report

Presenter: Kurt Aemmer

Committee Action: **Action Item** ☐ **FYI & Discussion** ☒ **FYI Only** ☐

Significant Points or Executive Summary:

1. Frequency of 2nd opinion requests returned to pre 2008 levels
2. Recent, historic discerpancy between the number of requests & number of consults provided evened out, sinificantly

Conclusions/Recommendations:

1. Cooperation between providers and NSMHA continues to allow for 2nd opionions to be consistently completed in a timely basis. This is much appreciated by NSMHA.
2. Process continues to run smoothly./Continue to utilize current process.

Timelines:

January - June, 2011

Attachments:

1st & 2nd Quarter 2011 Semi-annual Second Opinion Report

NORTH SOUND MENTAL HEALTH ADMINISTRATION
SEMI-ANNUAL SECOND OPINION REPORT
January – June 2011

Introduction

In accordance with the 2011 NSMHA Comprehensive Work Plan, this is the third formal edition of ongoing semi-annual reports that will be due on July 31 and January 31 in subsequent years.

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 October of 2004. Prior to 2010, frequency of 2nd Opinion requests was reported annually during EQRO Surveys (APPENDIX I).

In the 2nd Quarter of 2008 there was a marked increase of the average number of requests per quarter, from 2.4 to 4.5, with an all-time high of 9 in the 3rd Quarter of 2010. However, in the 1st Quarter of 2011 the frequency of requests dipped to four (4), then further to one (1) in the second quarter (APPENDIX I).

1st & 2nd Quarter 2011 Findings

1. There were six (6) requests in the 1st Quarter & only one (1) in the 2nd Quarter, resulting in the moving average decreasing from six (6) to three & a half (3.5) (APPENDIX I).

2. Except in one (1) case where the requesting individual waived their right to a 2nd Opinion in 30-days or rescinded the request altogether, all 2nd opinion consults occurred within 30 days of the request.
3. It would appear that the best method for analyzing the evenness of 2nd Opinion distribution would be to compare the number of requests generated by a provider with the number of 2nd Opinion consults conducted by the same provider. In essence larger providers generating more requests should proportionately conduct consults. For most providers, this rule generally applies. However, until 2010 there had been an ongoing disparity in the number of requests generated by Compass Health Snohomish County, the largest provider, and the relatively high number of consults conducted by Bridgeways and Interfaith, two of the smaller providers. This apparent trend began to level out slightly with Compass Health Snohomish conducting more consults than it generated, and Bridgeways generating more requests than consults conducted in the 2nd half of 2010. In the 1st half of 2011 Compass Health Snohomish County generated only 3 requests. One was withdrawn and the remaining 2 were conducted "internally." Further, no consults were conducted by Bridgeways or Interfaith, so the aforementioned apparent trend appears to have dissipated in the last year. **NSMHA recognizes Compass Health's increased appropriate facilitation of internal 2nd Opinions. Their efforts demonstrate a willingness to even out the distribution of labor among providers, and a notable trust level among their consumers who are willing to receive "in-house" consultations.**

Conclusions

1. Second Opinions are being managed by NSMHA in a systematic, timely and appropriate manner.

Recommendations

1. Continue with current process.

Attachment:

1. APPENDIX I - Bar Chart Showing Frequency of Second Opinion Requests & Average Number of Requests for the Year

APPENDIX I
Line Chart Showing Frequency of Second Opinion Requests
&
Average Number of Requests for the Year
4th Quarter 2004 - 2nd Quarter 2011