NORTH SOUND
MENTAL HEALTH ADMINISTRATION

QUALITY MANAGEMENT OVERSIGHT COMMITTEE

MEETING PACKET

September 25, 2013
1:00 – 3:00 pm

1. Please join my meeting, Wednesday, September 25, 2013 at 1:00 PM Pacific Daylight Time.
https://global.gotomeeting.com/join/582918293

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

Dial +1 (626) 521-0014

Access Code: 582-918-293

Audio PIN: Shown after joining the meeting

Meeting ID: 582-918-293

QMOC GUIDING PRINCIPLES

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

- **Help create an atmosphere that is SAFE.**
- **Maintain an atmosphere that is OPEN.**
- **Manage your BEHAVIOR, be mindful of how you respond to others, understand intent vs. impact, and be responsible for your words and actions.**
- **Demonstrate RESPECT and speak with RESPECT toward each other at all times.**
- **LISTEN, people feel respected when they know you're listening to their point of view.**
- **Practice CANDOR and PATIENCE.**
- **Accept a minimum level of TRUST so we can build on that as we progress.**
- **Be SENSITIVE to each other's role and perspectives.**
- **Promote the TEAM approach toward quality assurance.**
- **Maintain an OPEN DECISION-MAKING PROCESS.**
- **Actively PARTICIPATE at meetings.**
- **Be ACCOUNTABLE for your words and actions.**
- **Keep all stakeholders INFORMED.**

Adopted: 10/27/99
Revised: 11/28/12

NORTH SOUND MENTAL HEALTH ADMINISTRATION
QUALITY MANAGEMENT OVERSIGHT COMMITTEE AGENDA

Date: September 25, 2013 **Time: 1:00-3:00 PM**

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

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

Topic	Objective	ACTION NEEDED	Discussion Leader	Handout available pre-mtg	Handout available at mtg	Tab	Time
Introductions	Welcome guests; presenters and new members		Chair				*5 min*
Review and Approval of Agenda	Ensure agenda is complete and accurate; determine if any adjustments to time estimates are needed. Meeting will start and end on time.	Approve Agenda	Chair	Agenda		**1**	*5 min*
Review and Approval of Summary of Previous Meeting	Ensure meeting summary is complete and accurate.	Approve Meeting Summary	Chair	Summary		**2**	*5 min*
Announcements and Updates							*5 min*
Update on Regional Healthcare Alliance	Brief update.	Inform /discuss	Chair/ Greg				*5 min*
Quality Topics							
Policy 1563 Program of Assertive Community Treatment (PACT)	Discuss and approve the revised policy for PACT. There are a few significant changes due to changes in State funding.	Inform/ Discuss/ Approve	Charissa Westergard	Committee Discussion Form		**3**	*10 min*
Policy 1532 Residential Placement	Discuss and approve revised residential facility policy which clarifies expectations regarding the availability of mental health services to people in the facilities and length of stay.	Inform/ Discuss/ approve	Charissa Westergard	Committee Discussion Form		**4**	*10 min*
WAC changes in P&P and practices	Discuss WAC changes regarding Special Pop Reviews, 180 Day Treatment Plan Reviews, Client Rights, DOH Supervisor Training	Inform/ Educate	Heather Fennell/ NSMHA Staff	none			*15 min*
Care Coordination from Inpatient Care	Discuss and clarify outpatient providers' responsibility to see a patient within 7 days of discharge from inpatient care.	Inform/ Educate	Charissa Westergard	Committee Discussion Form		**5**	*10 min*
ICRS Policy 1706, Safeguarding of Property	Discuss and approve this revised policy which was initially discussed at last month's QMOC.	Inform/ Discuss/ approve	Sandy Whitcutt/ Greg Long	Committee Discussion Form		**6**	*10 min*
Future reductions in State Funds	Begin discussion regarding probable future reductions in State Funds and how the RSNs and providers will handle.	Inform/ Discuss	Mike Manley/ Greg Long	Committee Discussion Form		**7**	*15 min*
2012 QM Plan Summary	This is a brief opportunity for discussion of the 2012 QM Plan summary that was distributed at QMOC last month.	Inform/ Discuss	Greg Long	Committee Discussion Form		**8**	*10 min*
Care management of consumers with specialized needs.	Discussion regarding improved management of people with specialized needs (Eating Disorders, DID, etc.).	Inform/ Discuss	Greg Long	Committee Discussion Form		**9**	*10 min*
Other issues							
***Review of Meeting**	Were objectives accomplished? How could this meeting be improved? Eval forms						
Date and Agenda for Next Meeting	Ensure meeting date, time and agenda are planned						

Next meeting: October 23, 2013 - 1:00-3:00 PM **Potential Future Agenda Items:**

North Sound Mental Health Administration (NSMHA)
Quality Management Oversight Committee (QMOC)
NSMHA Conference Room
August 28, 2013
1:00 – 3:00 pm
MEETING SUMMARY

PRESENT: *Jackie Henderson;* Island County *(Chair)*
Chuck Davis; Ombuds, *Marie Jubie;* NSMHA Advisory Board, *Kathy McNaughton;* Catholic Community Services, *Larry Van Dyke;* Skagit County Crisis Center*, Mike Manley;* Sunrise Mental Health, *David Kincheloe;* Whatcom County, *Mark McDonald;* Whatcom County, *Cindy Ferraro;* Bridgeways Snohomish County, *Dan Bilson;* Whatcom County, *Stacey Alles;* Compass Health Snohomish County, *Heather Fennell;* Compass Health

BY PHONE: *Cami Prince;* Sunrise Community Services, *Kay Burbidge;* Lake Whatcom Center, *Carola Schmid;* Snohomish County, *Richard Sprague;* Whatcom County

STAFF: *Greg Long, Sandy Whitcutt, Joanie Williams*

TOPIC	DISCUSSION	ACTION
1. **Introductions, Review of Agenda – Chair**	Jackie convened the meeting @ 1:03 and opened with introductions, to include individuals joining by phone.	
2. Review and approval of Summary of Previous Meeting **3. Chair**	Additions to agenda: Jackie asked if anyone had anything to add to the agenda. One member asked for an update from NSMHA regarding WAC (Washington Administrative Codes) PMs (Performance Measures). Greg took note. No additional agenda revisions or additions were requested. Motion was made to approve the agenda, motion seconded and approved. An additional motion was made to approve the meeting minutes from July, seconded and approved.	**Agenda approved** **August Agenda approved** **July Minutes approved**
4. Announcements and Updates – All	• More Motivational Interviewing Training Greg stated several people asked for another round of training. The proposal states 2 trainings, a month apart, hopefully in the fall, he said. He will let the group know dates of the training. • Greg announced the NSMHA **Executive Training** which will take place next week, September 5th. He also announced the **Clinical Training classes on 9/6, 9/10 and 9/23** which will be taking place in NSMHA's conference room. Greg elaborated on the training courses and asked the group to respond via email if they would like attend. • Medicaid Sign-up Greg requested the group encourage people to sign up for relevant medical insurance programs and stressed the importance since the law is changing January 1, 2014. There were questions regarding the multiple programs and tax credits. Greg spoke on Classic Medicaid and the new program which is based on income eligibility. Greg said	**Greg to inform members of training dates**

	there could be dual eligibility issues in addition to misunderstandings and difficulties from the HCA (Health Care Alliance) and the Health Plans. He spoke on upcoming trainings which will address some questions. Conversation ensued around the RSNs, (Regional Support Networks) Medicaid and eligibility increasing by 15% over the next two years. Jackie stated that Island County is deriving an action plan to get people signed up. There was conversation around spend-down and individual pay, priority pay, less restrictive orders, the legislature, reduced State funding and the Affordable Care Act. One member asked that the ACA be on the agendas for the next 12 months, the group agreed. • EQRO 9/11 and 9/12, plus calls to Providers to scheduled Greg gave an overview of the EQRO's intentions. Brief conversation ensued and Jackie moved the meeting forward. Greg passed around a hand-out regarding skills for working with certified peer counselors.	**ACA topic will be on agenda for the next 12 months.** Informational
5. Update on Regional Healthcare Alliance	Greg talked about the HCA performing and RFQ for Strategy 1 Dual Services and the groups who qualified. He briefly mentioned Strategy 2, as well.	Informational
6. Policy 1706 Approval	Sandy discussed the ITA (Involuntary Treatment Act) and safeguarding of personal property, the intent of the law, DMHP's (Designated Mental Health Professionals) Peace Officers, Law Enforcement, E&T (Evaluation and Treatment facility), the WAC (Washington Administrative Codes) and revision of policy. Group conversation took place regarding the protection of pets, as well as service dogs. Sandy concluded stating with an overview stating the police department is ultimately responsible for the pet. The question was asked if the steps could be taken to protect the service dog during an ITA or medical emergency and the role of the police. Sandy said this could be further discussed at the ICRS meeting.	**Follow up conversation @ ICRS** **Present again next month to QMOC**
7. Policy 1721 Approval	Sandy spoke and answered questions on the Medical Status Policy, modifications, EDs, individual needs, medical clearance, intent and protocol language, Practitioners, DO's (Doctors of Osteopathy) and DMHPs. Voting on the policy took place and the motion was approved.	**Motion approved**
8. Emergency Department Information Exchange, (EDIE)	Greg stated the BOD (Board of Directors) agreed to access EDIE (Emergency Department Information Exchange). He said any ED (Emergency Department) in the state can look in the Exchange and see where a patient has been seen. Currently, the process of the ED is to call the VOA (Volunteers of America). Greg said the EDs work at quick pace and EDIE can assist with expedience and effectiveness in obtaining information. Greg went on to say NSMHA is working with Michael White in the Systems Department to implement the EDIE program. Questions were asked if the Crisis Plan Policy could potentially change. In depth conversation followed regarding the Care Crisis Line, Medicaid and Medicare policy, integrated service provisions, authorizations,	

	medical records, psychiatric advanced directives, treatment plans, forms, limitations, data base accessibility and expiration dates of records. The group asked additional questions regarding Greg's hand-out. Greg said there are issues to be worked through and there will be further discussion on the topic at other meetings	**Further EDIE discussion to follow at additional meetings**
9. Proposals to DBHR ITA Expansion Mitigation	Greg talked about the changes in the ITA laws from the State. The state is anticipating the increase in detentions and put forth funds for the impact. NSMHA is proposing enhanced service facilities. Greg elaborated on the proposal which will be submitted on Friday. He asked the group if they had questions. Jackie asked about the time line, Greg said we should know something by September 30th, possibly depending on DBHR's response.	Informational
10. 2012 NSMHA Quality Management Summary	Greg referenced the handout and stated the EQRO requested a new quality management summary. He spoke about the stipulated components. Conversation followed. Jackie asked this be brought to the next meeting.	**Agenda Item for next meeting**
11. Other Issues ➢ **Integrated WACs**	Greg spoke on the changes in Integrated WACs. Training is next Friday in Bellingham. He said NSMHA is working on the review. Greg asked if anyone had comments or questions. Heather spoke on changes taking place which she learned in a training class she attended. She went on to say Youth Mental Health First Aid Training courses will start next month. She will get the information to Margaret to distribute.	**Heather getting information to Margaret regarding Youth Mental Health First Aid Training**
12. Review of Meeting	Were objectives accomplished? Jackie asked the group to fill out the survey. One member asked about the CMS letter regarding the RSNs, Greg addressed the question with the latest updates and the anticipated response period.	
13. Open Forum	none	
14. Date and Agenda for Next Meeting	The meeting was adjourned at 2:30pm. The next meeting is September 25, 2013.	

NSMHA COMMITTEE DISCUSSION FORM

AGENDA ITEM:
Policy 1563 Program of Assertive Community Treatment (PACT)

PRESENTER: Charissa Westergard

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

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:
Revision Summary:

- Change in financial eligibility criteria – as a result of changes by Legislature, individuals must have Medicaid or meet exception screening criteria if no Medicaid in order to be eligible for PACT referral.
- Addition of consideration of individuals discharging from Children's Long-Term Inpatient Facility (CLIP) – they were not excluded before, but was an oversight not to include transition age youth as priority consideration.
- Removal of individuals discharging from Program for Adaptive Living Skills (PALS) as this program is no longer in existence.
- Update to reflect addition of half-PACT program in Skagit County

CONCLUSIONS/RECOMMENDATIONS:
No feedback was received on this policy. Request QMOC recommend for approval to BOD.

TIMELINES:
This policy was emailed to QMOC with 30 days for feedback. This is the first presentation of this policy at QMOC.

ATTACHMENTS:
Policy 1563

Effective Date: 3/4/2009; 8/30/2007
Revised Date: 3/23/2010
Review Date: 5/26/2010

North Sound Mental Health Administration

Section 1500 – CLINICAL: Program of Assertive Community Treatment (PACT)

Authorizing Source: DSHS Contract
Cancels:
See Also: Approved by: Executive Director Date: 6/17/2010
Providers must comply with this policy and may develop individualized implementation guidelines as needed
Responsible Staff: Deputy Director Signature:

POLICY #1563.00

SUBJECT: PROGRAM OF ASSERTIVE COMMUNITY TREATMENT (PACT)

PURPOSE

To define PACT treatment, eligibility requirements and admission and discharge processes in this fidelity model program.

POLICY

The North Sound Mental Health Administration (NSMHA) has PACT teams/service areas located in Skagit, Snohomish, and Whatcom Counties. Individuals referred to PACT programs may come from any of NSMHA's five counties, but they must live in the PACT service area to receive PACT services.

PACT teams in the North Sound Region comply with the Washington State PACT Program Standards as a minimum set of regulations (See Attachment 1563.01) in addition to other applicable state and federal regulations. PACT team leaders will collaborate with the designated NSMHA Quality Specialist on designing and implementing PACT programs. PACT teams will participate in fidelity reviews conducted by Washington Institute for Mental Health Research and Training (WIMHRT), Department of Social and Health Services (DSHS) and/or NSMHA in addition to utilization reviews and audits.

PACT is a person-centered, recovery-oriented team model of service delivery. The PACT team has a trans-disciplinary approach and provides the majority of services that individuals need. The team is directed by a team leader and a psychiatric prescriber and includes a sufficient number of staff from the core mental health disciplines: at least one peer specialist, a dual-diagnosis treatment specialist, an employment specialist, Registered Nurses (RNs) and a program or administrative support staff who work in shifts to cover 24 hours per day, 7 days per week to provide intensive services. Regular program hours include 12 hours per day on weekdays and 8 hours per day on weekend days and holidays.

PACT services include the following: comprehensive mental health assessments; individualized treatment planning; service coordination; crisis assessment; symptom assessment and management; medical (psychiatric) prescription, administration, monitoring and documentation; dual-diagnosis substance abuse services; education and work related services; activities of daily living services; social/interpersonal relationship and leisure-time skill training; peer support and wellness recovery services; support services; education, support and consultation to individuals' families and other major supports; individual medical record maintenance; culturally and linguistically appropriate services (CLAS); performance improvement and program evaluation.

PACT programs have a maximum ratio of 10 individuals to one clinical staff person. The PACT team is mobile and delivers services in community locations. Seventy-five percent or more of PACT services are delivered in the community. Individuals receive an average of 120 minutes of contact per week, in an average of 3 contacts per week. Each individual's plan of care will be tailored to his or her individual needs, which may include multiple contacts per day at times. The approach with each individual emphasizes relationship building and active involvement in assisting individuals with severe and persistent

mental illness to make improvements in functioning, to better manage symptoms, to achieve individual goals and to maintain optimism.

Admissions to the PACT team occur at a rate of 4 to 6 individuals per month until the team reaches its target enrollment, for the full PACT program this is 80 to 100 individuals with a minimum average of 90 individuals; 42-50 with a minimum average of 46 individuals in the half-PACT program. Once programs reach capacity, admissions continue as discharges occur. Individuals who have discharged from the PACT program are given rapid readmission if they meet medical necessity to return to the PACT program.

PROCEDURES

ELIGIBILITY CRITERIA

1. **For full eligibility criteria please see attachment 1563.01, pages 7&8.**
2. Individuals admitted to PACT must have a current diagnosis of a severe and persistent mental illness and be experiencing severe symptoms and have significant impairments. The individuals must also experience continuous high service needs and functional impairments, and have not shown to benefit significantly from other outpatient services currently available. Individuals must meet eligibility standards and not meet any exclusionary criteria to be admitted.
3. Individuals must have a current Level of Care of 4, 5, or 6, per the Level of Care Utilization System (LOCUS), in order to be considered for admission. For those individuals for whom it is not possible to include a current LOCUS (Level of Care Utilization System) level, the submitted documentation will be used to determine if it appears the individual is in need of care at a level of 4, 5, or 6.
4. Individuals requesting PACT must have Medicaid with a mental health benefit at the time of admission. For individuals who lost Medicaid while hospitalized or incarcerated, the Medicaid pre-screening portion of the PACT screening form must be completed in order for the referral screeners to determine whether a financial exception may be made.
5. Admission criteria must be in accordance with the Washington State PACT Program Standards.

SCREENING AND ADMISSION PROCESS

Screening forms for each program are available on the NSMHA website at www.nsmha.org or by requesting one from NSMHA. Screening forms may be completed by professionals, family members, individuals or other interested individuals. When a referred individual is receiving services from a NSMHA-contracted provider agency, that agency will be contacted in order to coordinate care for the referred individual. Documentation supporting the need for a PACT level of care, including current symptomology, is necessary in a referral.

Referrals are sent directly to NSMHA and are then routed to the appropriate Team Leader. Referrals are reviewed by a designated NSMHA Quality Specialist and the PACT Team Leader to determine whether or not the individual meets minimum admission criteria within 7 business days of receipt of the referral. This timeline may be extended if additional documentation is required to make a determination. Referrals that meet basic admission criteria are moved on for assessments. If the referral is denied, the NSMHA Quality Specialist notifies the referring party and discusses treatment options with them, and a Notice is sent to the referred individual. If the individual meets minimum criteria, the PACT Team Leader notifies the referral source including the current status of assessments (i.e., an assessment will be scheduled or the individual is on a wait list for assessment and the expected time frame, etc.). After the individual completes the initial PACT assessment, they are either prioritized for admission to the program or referred to services that can assist them at the level of care they require.

If an individual is denied PACT services after the initial assessment a Notice is sent to the individual and the referral source is notified. If agreement between the Team Leader and the NSMHA Quality Specialist cannot be reached about whether or not an individual is appropriate for PACT services, the reasons for recommending denial or admission will be put in writing by the PACT team, signed by the Team Leader, the PACT Psychiatrist and the Executive Director (or formal designee*) of the contracting agency. The NSMHA Medical Director will review the documentation (referral information, assessment, reasons for denial request, and any other additional information available) and make a determination about admission. If the final determination by the NSMHA Medical Director is not acceptable by the PACT contracting agency, a formal contract dispute resolution process may be initiated.

*(*The formal designee must be identified in correspondence to NSMHA from the Executive Director of the PACT-contracted agency)*

Order of admission to the PACT program is based on a number of factors including but not limited to individuals with: current and recent Western State Hospital (WSH) admissions, current and recent Children's Long Term Inpatient Program (CLIP) admissions who are at least 18 years of age, community hospital admissions, jail/prison episodes, residential program participation, intensity of current symptoms and current supports.

LOCUS

For those individuals without a current or accurate LOCUS (Level of Care Utilization System), the LOCUS shall be completed at the time of admission into PACT. This includes individuals who may have a current LOCUS from another Community Mental Health Agency (CMHA). Subsequent completion of the LOCUS shall follow NSMHA Policy #1565 Child and Adolescent Level of Care Utilization System and Level of Care Utilization System.

DISCONTINUATION OF PACT SERVICES

As PACT is a voluntary program, individuals receiving PACT services may request to be disenrolled from the PACT program at any time. PACT staff members are committed to serving individuals who are difficult to engage, and will make every effort to work with enrolled individuals to come to a mutually agreeable plan of care to continue working together. If this is not possible, PACT will assist the individual to find and enroll in other services suitable to the individual prior to closing the individual's episode of treatment in the PACT program. If the individual wishes to re-enroll in the PACT program in the future, they are given a rapid readmission to the program.

Individuals in the PACT program also discontinue PACT services when they move away from the PACT service area. If the individual is moving to an area with another PACT program, the team will attempt to transfer the individual to that area's PACT team. If the move is to an area without a PACT program, the team will assist the individual to arrange other services as necessary to meet the individual's needs.

Transfers to other PACT teams will be arranged by the Team Leader in conjunction with the designated NSMHA Quality Specialist. Referrals of individuals currently receiving services from other PACT teams will be considered on an expedited basis.

All transfers and discharges of PACT participants must be approved by NSMHA prior to the closing of the PACT episode.

COMPLAINTS AND GRIEVANCES

Complaints and grievances involving PACT enrollees will follow NSMHA's general policies on complaints and grievances. See NSMHA policies 1001 thru 1004 for this information. NSMHA, in conjunction with the PACT Advisory Committee, will monitor for trends in complaints and grievances specific to the PACT programs and use this information for continuous quality improvement with the programs.

STAKEHOLDER ADVISORY COMMITTEE

PACT programs shall each have a Stakeholder Advisory Committee whose role is to: promote quality programs; monitor fidelity to the PACT Standards; guide and assist the administering agency's oversight of the PACT program; problem-solve and advocate reducing barriers to PACT implementation; and monitor/review/mediate individual and family grievances or complaints. The Stakeholder Advisory Committee shall include a NSMHA representative.

ATTACHMENTS

1563.01 – WA State Program of Assertive Community Treatment (PACT) Program Standards – (FINAL) 4-16-07

Effective Date: 3/4/2009; 8/30/2007
Revised Date: 3/23/2010
Review Date: 5/26/2010

North Sound Mental Health Administration

Section 1500 – CLINICAL: Program of Assertive Community Treatment (PACT)

Authorizing Source: DSHS~~State~~ Contract
Cancels:
See Also: Approved by: Executive Director Date: 6/17/2010
Providers must comply with this policy and may develop individualized implementation guidelines as needed~~PACT -contracted providers are required to have "policy consistent with" this policy~~
Responsible Staff: Deputy Director~~Quality Manager~~ Signature:

POLICY #1563.00

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needs, which may include multiple contacts per day at times. The approach with each individual emphasizes relationship building and active involvement in assisting individuals with severe and persistent mental illness to make improvements in functioning, to better manage symptoms, to achieve individual goals and to maintain optimism.

Admissions to the PACT team occur at a rate of 4 to 6 individuals per month until the team reaches its target enrollment, for the full PACT program this is 80 to 100 individuals with a minimum average of 90 individuals; 42-50 with a minimum average of 46 individuals in the half-PACT program. Once programs reach capacity, admissions continue as discharges occur. Individuals who have discharged from the PACT program are given rapid readmission if they meet medical necessity to return to the PACT program.

PROCEDURES

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3. Individuals must have a current Level of Care of 4, 5, or 6, per the Level of Care Utilization System (LOCUS), in order to be considered for admission. For those individuals for whom it is not possible to include a current LOCUS (Level of Care Utilization System) level, the submitted documentation will be used to determine if it appears the individual is in need of care at a level of 4, 5, or 6.
4. Individuals requesting PACT must have Medicaid with a mental health benefit at the time of admission. For individuals who lost Medicaid while hospitalized or incarcerated, the Medicaid pre-screening portion of the PACT screening form must be completed in order for the referral screeners to determine whether a financial exception may be made.~~There are no financial eligibility criteria for the PACT program; however, individuals enrolled in a PACT program whose income is above 400% of the federal poverty level and do not have Medicaid coverage will be charged for the services they receive from the PACT team.~~
5. Admission criteria must be in accordance with the Washington State PACT Program Standards.

SCREENING AND ADMISSION PROCESS

Screening forms for each program are available on the NSMHA website at www.nsmha.org or by requesting one from NSMHA. Screening forms may be completed by professionals, family members, individuals or other interested individuals. When a referred individual is receiving services from a NSMHA-contracted provider agency, that agency will be contacted in order to coordinate care for the referred individual. Documentation supporting the need for a PACT level of care, including current symptomology, is necessary in a referral.

Referrals are sent directly to NSMHA and are then routed to the appropriate Team Leader. Referrals are reviewed by a designated NSMHA Quality Specialist and the PACT Team Leader to determine whether or not the individual meets minimum admission criteria within 7 business days of receipt of the referral. This timeline may be extended if additional documentation is required to make a determination. Referrals that meet basic admission criteria are moved on for assessments. If the referral is denied, the NSMHA Quality Specialist notifies the referring party and discusses treatment options with them, and a Notice ~~of Adverse Determination~~ is sent to the referred individual. If the individual meets minimum criteria, the PACT

Team Leader ~~NSMHA Quality Specialist~~ notifies the referral source including the current status of assessments (i.e., an assessment will be scheduled or the individual is on a wait list for assessment and the expected time frame, etc.). After the individual completes the initial PACT assessment, they are either prioritized for admission to the program or referred to services that can assist them at the level of care they require.

If an individual is denied PACT services after the initial assessment a Notice ~~of Adverse Determination~~ is sent to the individual and the referral source is notified. If agreement between the Team Leader and the NSMHA Quality Specialist cannot be reached about whether or not an individual is appropriate for PACT services, the reasons for recommending denial or admission will be put in writing by the PACT team, signed by the Team Leader, the PACT Psychiatrist and the Executive Director (or formal designee*) of the contracting agency. The NSMHA Medical Director will review the documentation (referral information, assessment, reasons for denial request, and any other additional information available) and make a determination about admission. If the final determination by the NSMHA Medical Director is not acceptable by the PACT contracting agency, a formal contract dispute resolution process may be initiated.

*(*The formal designee must be identified in correspondence to NSMHA from the Executive Director of the PACT-contracted agency)*

Order of admission to the PACT program is based on a number of factors including but not limited to individuals with: current and recent Western State Hospital (WSH) admissions, current and recent Children's Long Term Inpatient Program (CLIP) admissions who are at least 18 years of age, ~~Program for Adaptive Living Skills (PALS) admissions,~~ community hospital admissions, jail/prison episodes, residential program participation, intensity of current symptoms and current supports.

LOCUS

For those individuals without a current or accurate LOCUS (Level of Care Utilization System), the LOCUS shall be completed at the time of admission into PACT. This includes individuals who may have a current LOCUS from another Community Mental Health Agency (CMHA). Subsequent completion of the LOCUS shall follow NSMHA Policy #1565 Child and Adolescent Level of Care Utilization System and Level of Care Utilization System.~~in services requiring NSMHA approval (i.e., PACT), a LOCUS will be completed at the time of request for approval instead. Subsequently, the tool will be completed at least every 180 days. If the consumer exits or is not admitted to the services indicated above, then the LOCUS would continue to be completed every 180 days. The LOCUS should be completed any time a consumer experiences events that would impact his/her level of care.~~

~~For consumers entering this program directly upon discharge from Western State Hospital, there is a 30-day period post-discharge in which the LOCUS may be completed.~~

DISCONTINUATION OF PACT SERVICES

As PACT is a voluntary program, individuals receiving PACT services may request to be disenrolled from the PACT program at any time. PACT staff members are committed to serving individuals who are difficult to engage, and will make every effort to work with enrolled individuals to come to a mutually agreeable plan of care to continue working together. If this is not possible, PACT will assist the individual to find and enroll in other services suitable to the individual prior to closing the individual's episode of treatment in ~~from~~ the PACT program. If the individual wishes to re-enroll in the PACT program in the future, they are given a rapid readmission to the program.

Individuals in the PACT program also discontinue PACT services when they move away from the PACT service area. If the individual is moving to an area with another PACT program, the team will attempt to transfer the individual to that area's PACT team. If the move is to an area without a PACT program, the team will assist the individual to arrange other services as necessary to meet the individual's needs.

Transfers to other PACT teams will be arranged by the Team Leader in conjunction with the designated NSMHA Quality Specialist. Referrals of individuals currently receiving services from other PACT teams will be considered on an expedited basis.

All transfers and discharges of PACT participants must be approved by NSMHA prior to the closing of the PACT episode.

COMPLAINTS AND GRIEVANCES

Complaints and grievances involving PACT enrollees will follow NSMHA's general policies on complaints and grievances. See NSMHA policies 1001 thru 1004 for this information. NSMHA, in conjunction with the PACT Advisory Committee, will monitor for trends in complaints and grievances specific to the PACT programs and use this information for continuous quality improvement with the programs.

STAKEHOLDER ADVISORY COMMITTEE

PACT programs shall each have a Stakeholder Advisory Committee whose role is to: promote quality programs; monitor fidelity to the PACT Standards; guide and assist the administering agency's oversight of the PACT program; problem-solve and advocate reducing barriers to PACT implementation; and monitor/review/mediate individual and family grievances or complaints. The Stakeholder Advisory Committee shall include a NSMHA representative.

ATTACHMENTS

1563.01 – WA State Program of Assertive Community Treatment (PACT) Program Standards – (FINAL) 4-16-07

NSMHA COMMITTEE DISCUSSION FORM

AGENDA ITEM: Policy 1532 Residential Placement

PRESENTER: Charissa Westergard

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

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:
Summary of revisions:

- Provide greater clarification regarding the requirement for the provision of mental health services either by the facility staff or in collaboration with a NSMHA outpatient provider. Our policy previously indicated that an individual had to be receiving outpatient mental health services (other from residential staff), but the modality reported by residential settings includes provision of some treatment by residential staff with the ability for additional outpatient services.
- Addition of length of stay guidance as we are finding that longer lengths of stay are preventing use of this resource for the priority populations (individuals discharging from WSH/CLIP, community hospitals, etc.) and there are other resources that may be utilized once someone has stabilized.
- Removal of some WAC detail from policy and replaced with reference to specific WAC as WACs related to these facilities are quite lengthy and cannot be included in their entirety in the policy.
- Change in language from Boarding Home to Assisted Living Facility (ALF) to be consistent with WAC change.

CONCLUSIONS/RECOMMENDATIONS:
There was little feedback received on this policy and what was received was incorporated. Request QMOC recommend this policy for approval to BOD.

TIMELINES:
This policy was emailed to QMOC with 30 days for feedback. This is the first presentation of this policy at QMOC.

ATTACHMENTS:
Policy 1532

Effective Date: 3/3/2008; 7/13/2005
Revised Date: 5/19/2010
Review Date: 5/26/10

North Sound Mental Health Administration

Section 1500 – Clinical: Residential Placement

Authorizing Source: WACs 246-337, 388-78A, 388-865; 388-877; 388-877A; NSMHA Contract
Cancels:
See Also: Approved by: Executive Director Date:
Providers must comply with this policy and may develop individualized implementation guidelines as needed
Responsible Staff: Deputy Directory Signature:

POLICY #1532.00

SUBJECT: RESIDENTIAL PLACEMENT

PURPOSE

To ensure that individuals whose medical necessity requires a residential placement with mental health services due to their mental illness have access to this service until they are clinically appropriate for a less intensive level of care.

POLICY

The North Sound Mental Health Administration (NSMHA) will ensure that, based on available resources, individuals who are in need of housing in supervised residential settings due to their current mental health status receive such placement within the NSMHA provider network. NSMHA will ensure that the placement is at a licensed Residential Treatment Facility (RTF) or Assisted Living Facility (ALF) and is consistent with the individual's Recovery/Resiliency Plan (RRP).

Residential Placement Options

Residential Treatment Facilities

Per WAC 246-337-005, a mental health Residential Treatment Facility (RTF) means a facility providing twenty-four hour evaluation, stabilization and treatment services for individuals with a mental illness and certified by DSHS. For NSMHA-funded residential placement, NSMHA's expectation is that contracted RTFs are certified as an adult residential treatment facility per WAC 388-877A-0197. In addition, the facility must comply with any other applicable statutes, rules, etc.

There must be sufficient numbers of qualified personnel present on a twenty-four hour per day basis to meet the health care needs of the residents served; managing emergency situations; crisis intervention; implementation of mental health care plans; and required monitoring activities. There is a higher level of supportive supervision and services and monitoring at an RTF than at an ALF and a higher level of staff to individual served ratio. A sufficient staff/individual served ratio at an RTF is 1:8.

While an RTF is meant to serve individuals who do not require extensive medical care, an RTF does have a higher level of medical capabilities than an ALF. Hence, an RTF is able to take individuals with more intense medical and/or psychiatric need within patient safety and regulatory requirements.

Placement at an RTF is not meant to be a permanent housing placement and length of stay shall generally be less than 18-24 months. One aspect of recovery planning during the stay shall be preparing the individual for transition to a less intensive living situation such as an ALF, Adult Family Home, supported housing or independent living.

Assisted Living Facilities

Per WAC 388-78A-2020, an Assisted Living Facility (ALF) is any home or other institution for the express or implied purpose of providing housing, basic services, and assuming general responsibility for the safety and well-being of the residents. For NSMHA-funded residential placement, NSMHA's expectation is that

contracted ALFs are licensed per WAC 388-78A and provide services that include mental health care by a sufficient number of qualified staff in accordance with this licensure and the treatment modality, Mental Health Services in a Residential Setting. In addition, the facility must comply with any other applicable statutes, rules, etc.

This residential option is for individuals who require 24-hour supportive supervision and services. Length of stay may be either short (six months or less) or long-term (six months or more) with an emphasis placed on transitioning individuals to more independent settings or maintaining them in their current settings. ALF placements are not intended to be permanent housing placements, but in cases where the individual states permanent ALF placement is their preference, NSMHA Recovery concepts and medical necessity must be considered in conjunction with individual choice.

PROCEDURE

Residential Prioritization Guidelines

NSMHA-funded residential placement shall be prioritized, in the stated order, for the following:

1. Individuals at either Western State Hospital (WSH) or Children's Long-Term Inpatient Program (CLIP)
2. Individuals being discharged from inpatient facilities or Evaluation and Treatment Facilities (E&Ts)
3. Individuals needing a higher level of support than their current services provide and who need residential placement to reasonably improve/stabilize
4. Individuals who are homeless or incarcerated
5. Individuals who utilize a high level of crisis, inpatient and/or jail services, or who are otherwise assessed as being at risk

Residential Referral and Admission

An individual must meet all of the following before being referred for (non-emergent) mental health residential placement:

1. 18 or older
2. Currently meets NSMHA Clinical Eligibility and Care Standards (CECS) including Statewide Access to Care Standards (ACS) or, based on current clinical information, appears to meet NSMHA CECS (see NSMHA Policy #1556 Clinical Eligibility and Care Standards)
3. Due to a covered mental illness, requires 24-hour supervision to live successfully in community settings
4. Ambulatory
5. Cognitive and physical abilities to enable response to fire alarms
6. Not required physical restraint in the past 30 days
7. Is appropriate for care in a residential setting per WAC 388-865-0235 along with WAC 246-337 (RTFs) or WAC 388-78A (ALFs) including:
    a. medically stable and free of physical condition(s) requiring medical or nursing care beyond what the residential facility can provide

8. Has met LOCUS (Level of Care Utilization System)/CALOCUS (Child & Adolescent Level of Care Utilization System) criteria for a Level of Care 5 or 6 within the past six months

For individuals who meet referral criteria, the residential provider shall ensure:

1. Individual receives an assessment by a mental health professional consistent with WAC 388-877-0160 and WAC 388-877A-0130. The assessment assists in determining whether:

    a. Individual meets NSMHA Clinical Eligibility and Care Standards
    b. Individual is appropriate for Level of Care of 5 or 6 due to a mental illness per current LOCUS/ CALOCUS
    c. Individual meets WAC standards for admission per WAC 388-865-0235 Residential and Housing Services

In order for NSMHA to be involved in payment for residential placement, the individual MUST meet NSMHA CECS and be currently receiving mental health services from a NSMHA-contracted provider (the residential facility staff and/or an outpatient service provider; see Coordination of Care section below). A person may live in a facility that contracts with NSMHA and not meet NSMHA CECS and/or be receiving mental health services from a NSMHA-contracted provider, but the resident would be expected to pay for such a placement from their own resources or to utilize a non-NSMHA funding source.

Residential Exclusionary Criteria

1. The individual has a psychiatric condition that requires a more intensive/restrictive option
2. The individual is actively suicidal or homicidal
3. The individual is chemically dependent on alcohol and/or drugs and is in need of detoxification
4. The individual has a primary diagnosis of Mental Retardation (DSM-IV-TR)/Intellectual Disability (DSM-5) or Autistic Disorder (DSM-IV-TR)/Autism Spectrum Disorder (DSM-5)
5. The individual has a recent history of arson, serious property damage or infliction of bodily injury on self or others
    a. This exclusion can be waived based upon the accepting facility's evaluation of the individual's functioning

Coordination of Care

Both RTFs and ALFs are expected to provide or arrange for provision of medically necessary mental health services. For medically necessary mental health services that the RTFs and ALFs are not able to provide by the residential facility staff, arrangements must be made for provision of these services with a NSMHA-contracted provider.

1. When an individual is receiving mental health services from a provider outside of the residential facility, the residential facility staff shall coordinate services with the outpatient provider. This shall include, but not be limited to, a RRP and crisis plan that is developed in collaboration with the resident and outpatient provider.

Residential facilities shall also follow all other applicable NSMHA policies regarding coordination of care with other service providers.

Residential Documentation

NSMHA-contracted residential facilities shall maintain a chart per NSMHA policies along with other required documentation standards for licensed RTFs and ALFs. For documentation that must be

completed within a standard timeline (Recovery/Resiliency Plan, etc), the day of admission to the residential facility shall be considered the start of the timeline.

The chart must also contain documentation that individuals are advised of their rights including:

1. Long-term Care Resident Rights (RCW 70.129) as described in WAC 388-865-0235 Residential and Housing Services
2. Individual Rights per WAC 388-877-0600
3. Resident rights per WAC 246-337-075 for Residential Treatment Facilities
4. Resident rights per WAC 388-78A-2660 for ALFs

Continuing Care/Discharge
Individuals receiving NSMHA-funded services shall meet continued stay criteria per NSMHA Policy 1539 Continued Stay/Reauthorization Criteria in addition to residential placement criteria. The residential facility shall continue to provide placement as long as the resident's condition continues to meet placement criteria at this residential level and no less intensive options would be adequate. Ongoing need for this service modality will be reassessed at least every six months and documented in the clinical record.

Planning for step-down to a lower level of care shall begin at admission and reflected in the RRP. Active transition planning shall be initiated when, but not necessarily limited to:

1. The RRP goals and objectives, which necessitate support from a NSMHA residential facility, have been substantially met.
2. As indicated by LOCUS/CALOCUS scoring the individual appears to be ready for a lower level of care.
3. Further progress at the residential facility is deemed unlikely and the individual can maintain current level of functioning in a less intensive setting.

When a determination is made that the individual may be ready for transition to a less intensive placement, the individual's RRP shall be updated to reflect specific objectives of the transition plan. In the event that the resident is discharged from the residential facility and continues to meet medical necessity criteria for outpatient mental health services, the transition plan shall reflect coordination with the existing outpatient service provider or facilitation of connection with an outpatient provider for continued care.

See NSMHA Policy 1540 Discharge from Treatment for additional policy and procedure regarding discharge from treatment and transition planning.

Seclusion and Restraint
As documented in NSMHA Policy 1541 Rationale and Use of Seclusion and Restraint, no NSMHA-contracted provider shall utilize seclusion or restraint for any purpose other than a freestanding Evaluation & Treatment Facility.

ATTACHMENTS

None

Effective Date: 3/3/2008; 7/13/2005
Revised Date: 5/19/2010
Review Date: 5/26/10

North Sound Mental Health Administration

Section 1500 – Clinical: Residential Placement

Authorizing Source: WACs 246-337, 388-78A, 388-865; 388-877; 388-877A; NSMHA Contract
Cancels:
See Also: Approved by: Executive Director Date: ~~6/17/2010~~
Providers must comply with this policy and may develop individualized implementation guidelines as needed
Responsible Staff: Deputy Directory Signature:

POLICY #1532.00

SUBJECT: RESIDENTIAL PLACEMENT

PURPOSE

To ensure that individuals whose medical necessity requires a residential placement with mental health services ~~in addition to outpatient services~~ due to their mental illness have access to this service until they are clinically appropriate for a less intensive level of care.

POLICY

The North Sound Mental Health Administration (NSMHA) will ensure that, based on available resources, individuals who are in need of housing in supervised residential settings due to their current mental health status receive such placement within the NSMHA provider network. NSMHA will ensure that the placement is at a licensed Residential Treatment Facility (RTF) or Assisted Living Facility (ALF) and is consistent with the individual's Recovery/Resiliency Plan (RRP).

Residential Placement Options

Residential Treatment Facilities

Per WAC 246-337-005, a mental health Residential Treatment Facility (RTF) means a facility providing twenty-four hour evaluation, stabilization and treatment services for individuals with a mental illness and certified by DSHS. For NSMHA-funded residential placement, NSMHA's expectation is that contracted RTFs are certified as an adult residential treatment facility per WAC 388-877A-0197. In addition, the facility must comply with any other applicable statutes, rules, etc.

~~The RTF must ensure residents receive housing, meals and support services including mental health care by adequate numbers of staff authorized and competent to carry out assigned responsibilities.~~ There must be sufficient numbers of qualified personnel present on a twenty-four hour per day basis to meet the health care needs of the residents served; managing emergency situations; crisis intervention; implementation of mental health care plans; and required monitoring activities. There is a higher level of supportive supervision and services and monitoring at an RTF than at ~~a Boarding Home~~an ALF and a higher level of staff to individual served ratio. A sufficient~~The~~ staff/individual served ratio at an RTF is 1:8.

While an RTF is meant to serve individuals who do not require extensive medical care, an RTF does have a higher level of medical capabilities than an ALF. Hence, an RTF is able to take individuals with more intense medical and/or psychiatric need within patient safety and regulatory requirements.

Placement at an RTF is not meant to be a permanent housing placement and length of stay shall generally be less than 18-24 months. One aspect of recovery planning during the stay shall be preparing the

individual for transition to a less intensive living situation such as an ALF, Adult Family Home, supported housing or independent living.

~~**Requirements of a Residential Treatment Facility:**~~

Comment [CWMM1]: I suggest we delete this section as these requirements are spelled out in WAC/RCW, which are referenced throughout the policy

~~1. 24/7 supportive supervision and services~~
~~2. Room and board~~
~~3. Medical referrals~~
~~4. Planned activities~~
~~5. Community access aid and training~~
~~6. Daily routine and self-care training and monitoring~~
~~Provide a higher staff/individuals served ratio~~
~~7. Comply with requirements of WAC 246-337-808, "Resident Care Services"~~
~~8. Provide/arrange all necessary transportation for individuals needing mental health/medical services outside the RTF~~
~~9. Provide on-going groups on mental health issues such as medication education, recovery, and socialization and other topics lead by RTF staff~~
~~10. Maintain a complete clinical/medical file on all individuals served, per WAC 246-337-095, "Resident health care records"~~

Assisted Living Facilities~~Boarding Homes~~

Per WAC 388-78A-2020, an Assisted Living Facility (ALF) is any home or other institution for the express or implied purpose of providing housing, basic services, and assuming general responsibility for the safety and well-being of the residents. For NSMHA-funded residential placement, NSMHA's expectation is that contracted ALFs are licensed per WAC 388-78A and provide services that include mental health care by a sufficient number of qualified staff in accordance with this licensure and the treatment modality, Mental Health Services in a Residential Setting. In addition, the facility must comply with any other applicable statutes, rules, etc.

This residential option is for individuals who require 24-hour supportive supervision and services. Length of stay may be either short (six months or less) or long-term (six months or more) with an emphasis placed on transitioning individuals to more independent settings or maintaining them in their current settings. ALF~~Boarding Home~~ placements are not intended to be permanent housing placements, but in cases where the individual states permanent ~~Boarding Home~~ALF placement is their preference, NSMHA Recovery concepts and medical necessity must be considered in conjunction with individual choice.

~~Boarding homes must provide housing and assume general responsibility for the safety and well-being of each resident consistent with the resident's assessed needs and negotiated service agreement (WAC 388-78A-2170).~~
~~This includes:~~

~~1. A room with a bed (WAC 388-78A-2170)~~
~~2. Meals (WAC 388-78A-2300)~~
~~3. Nutritious snacks (WAC 388-78A-2300)~~
~~4. Activities (WAC 388-78A-2180)~~

~~a. This includes space, staff support, and routine supplies and equipment necessary for each resident to pursue independent or self-directed activities~~
~~b. Group activities at least three times per week that may be planned and facilitated by caregivers consistent with the collective interests of a group of residents~~

5. Housekeeping (WAC 388-78A-2170)
6. Laundry (WAC 388-78A-2170)
7. Secure storage of medications (WAC 388-78A-2260)
8. Monitoring of medication use, but not administration unless by an appropriately licensed individual, i.e. RN or LPN, as outlined in the Disclosure of Services for the Boarding Home.
9. Monitoring of medical conditions and issues, such as prompting regarding glucose testing for blood sugar levels and the self-administration of insulin
10. Basic life skills training (WAC 388-78A-2190) (Specific life skills training provided in each boarding home may vary, and is outlined in the Disclosure of Services for that Boarding Home)

A Boarding Home is **NOT** expected to:

1. Provide mental health services to residents in their facility
2. Administer meds, but are expected to assist with usage and provide secure storage
1. Arrange transportation to mental health/medical appointments outside the Boarding Home
3. Have as high a staff/individual served ratio as a Residential Treatment Facility. Boarding Home WAC 388-78A-2450, says "one staff, 18 years of age or older, trained in CPR and first aid is present and available to assist residents at all times."
4. Maintain a mental health treatment plan/crisis plan as part of their record on the individual

PROCEDURE

Residential Prioritization Guidelines

NSMHA-funded residential placement shall be prioritized, in the stated order, for the following:

1. Individuals at either Western State Hospital (WSH) or Children's Long-Term Inpatient Program (CLIP) or PALS (Program for Adaptive Living Skills)
2. Individuals being discharged from inpatient facilities or Evaluation and Treatment Facilities (E&Ts)
3. Individuals needing a higher level of support than their current services provide and who need residential placement to reasonably improve/stabilize
4. Individuals who are homeless or incarcerated
5. Individuals who utilize a high level of crisis, inpatient and/or jail services, or who are otherwise assessed as being at risk

Residential Referral and Admission

An individual must meet all of the following before being referred for (non-emergent) mental health residential placement:

1. 18 or older
2. Currently meets NSMHA Clinical Eligibility and Care Standards (CECS) including Statewide Access to Care Standards (ACS) or, based on current clinical information, appears to meet NSMHA CECS (see NSMHA Policy #1556 Clinical Eligibility and Care Standards) receiving or will be receiving outpatient mental health services from a NSMHA-contracted provider
3. Due to a covered mental illness, requires 24-hour supervision to live successfully in community settings
4. Ambulatory

5. Cognitive and physical abilities to enable response to fire alarms
6. Not required physical restraint in the past 30 days
7. Is appropriate for care in a residential setting per WAC 388-865-0235 along with WAC 246-337 (RTFs) or WAC 388-78A (ALFs) including:
    a. medically stable and free of physical condition(s) requiring medical or nursing care beyond what the residential facility can provide

8. Has met LOCUS (Level of Care Utilization System)/CALOCUS (Child & Adolescent Level of Care Utilization System) criteria for a ~~score of~~ Level of Care 5 or 6 within the past six months

For individuals who meet referral criteria, the residential provider shall ensure:

1. Individual receive~~d~~s an ~~multi-axial~~ assessment by a mental health professional consistent with WAC 388-877-0160 and WAC 388-877A-0130. The assessment assists in determining whether:~~is eligible to receive ongoing mental health services from a community based mental health provider~~

    a. Individual meets NSMHA Clinical Eligibility and Care Standards
    b. Individual is appropriate for Level of Care of 5 or 6 due to a mental illness per current LOCUS/ CALOCUS~~upon admission to residential placement~~
    c. Individual meets WAC standards for admission per WAC 388-865-0235 Residential and Housing Services

In order for NSMHA to be involved in payment for residential placement, the individual MUST meet NSMHA CECS and be currently receiving ~~outpatient~~ mental health services from a NSMHA-contracted provider (the residential facility staff and/or an outpatient service provider; see Coordination of Care section below). A person may live in a facility that contracts with NSMHA and not meet NSMHA CECS and/or be receiving ~~outpatient~~ mental health services from a NSMHA-contracted provider, but the resident would be expected to pay for such a placement from their own resources or to utilize a non-NSMHA funding source.

Residential Exclusionary Criteria

1. The individual has a psychiatric condition that requires a more intensive/restrictive option
2. The individual is actively suicidal or homicidal
3. The individual is chemically dependent on alcohol and/or drugs and is in need of detoxification
4. The individual has a primary diagnosis of Mental Retardation (DSM-IV-TR)/Intellectual Disability (DSM-5) or Autistic Disorder (DSM-IV-TR)/Autism Spectrum Disorder (DSM-5)~~Developmental Disability/Mental Retardation or autism~~
5. The individual has a recent history of arson, serious property damage or infliction of bodily injury on self or others
    a. This exclusion can be waived based upon the accepting facility's evaluation of the individual's functioning

Comment [CWMM2]: 1)Given that transition from DSM-IV to 5 is in process, both categories are listed

Coordination of Care

Both RTFs and ALFs are expected to provide or arrange for provision of medically necessary mental health services. For medically necessary mental health services that the RTFs and ALFs are not able to provide by the residential facility staff, arrangements must be made for provision of these services with a NSMHA-contracted provider.

1. When an individual is receiving mental health services from a provider outside of the residential facility, the residential facility staff shall coordinate services with the outpatient provider. This shall include, but not be limited to, a RRP and crisis plan that is developed in collaboration with the resident and outpatient provider.

Residential facilities shall also follow all other applicable NSMHA policies regarding coordination of care with other service providers.

Residential Documentation

NSMHA-contracted residential facilities shall maintain a chart per NSMHA policies along with other required documentation standards for licensed RTFs and ALFs. For documentation that must be completed within a standard timeline (Recovery/Resiliency Plan, etc), the day of admission to the residential facility shall be considered the start of the timeline.

~~Preliminary Recovery/Resiliency Plan (RRP) is developed at the time of assessment. A completed RRP is signed/approved by the individual within 30 days of admission. (WAC 388-865-0425, "Individual Service Plan" or "Initial Resident Service Plan" (WAC 388-78A-2130(1)~~

The chart must also contain documentation that individuals are advised of their rights including:

1. Long-term Care Resident Rights (RCW 70.129) as described in WAC 388-865-0235 Residential and Housing Services
2. Individual Rights per WAC 388-877-0600
3. Resident rights per WAC 246-337-075 for Residential Treatment Facilities
4. Resident rights per WAC 388-78A-2660 for ALFs

Continuing Care/Discharge ~~Criteria~~

Individuals receiving NSMHA-funded services shall meet continued stay criteria per NSMHA Policy 1539 Continued Stay/Reauthorization Criteria in addition to residential placement criteria. The residential facility shall continue to provide placement as long as the resident's condition continues to meet placement criteria at this residential level and no less intensive options would be adequate. Ongoing need for this service modality will be reassessed at least every six months and documented in the clinical record. ~~The method of this reassessment will be described in the Residential Services policy and procedure for each program.~~

Planning for step-down to a lower level of care shall begin at admission and reflected in the RRP. Active transition planning shall be initiated when, but not necessarily limited to:

1. The RRP goals and objectives, which necessitate support from a NSMHA residential facility, have been substantially met.
2. As indicated by LOCUS/CALOCUS scoring the individual appears to be ready for a lower level of care.
3. Further progress at the residential facility is deemed unlikely and the individual can maintain current level of functioning in a less intensive setting.

When a determination is made that the individual may be ready for transition to a less intensive placement, the individual's RRP shall be updated to reflect specific objectives of the transition plan. In the event that the resident is discharged from the residential facility and continues to meet medical necessity criteria for outpatient mental health services, the transition plan shall reflect coordination with the existing outpatient

service provider or facilitation of connection with an outpatient provider for continued care.~~provision remains with the provider agency that was providing outpatient mental health services during the residential placement.~~

See NSMHA Policy 1540 Discharge from Treatment for additional policy and procedure regarding discharge from treatment and transition planning.

Seclusion and Restraint

As documented in NSMHA Policy 1541 Rationale and Use of Seclusion and Restraint, no NSMHA-contracted provider shall utilize seclusion or restraint for any purpose other than a freestanding Evaluation & Treatment Facility.

ATTACHMENTS

None

NSMHA COMMITTEE DISCUSSION FORM

AGENDA ITEM: Care Transitions Program

PRESENTER: Charissa Westergard

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

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:
NSMHA has contracted with Compass Health for a program, Care Transitions, to facilitate engagement of individuals discharging from inpatient psychiatric care to ensure follow up with a NSMHA outpatient provider.

While outpatient follow up after discharge from inpatient psychiatric care is a Statewide performance measure that we have been struggling to meet, implementation of the Care Transitions program was not implemented solely to meet the performance measure. The primary goal of the program is to ensure that we are doing the best we can to promptly engage individuals and ensure outpatient follow up care in order to prevent re-hospitalization.

In order to meet this goal, it is imperative that outpatient providers engage with individuals in a timely manner. The Care Transitions Program is a mechanism to support the individual and outpatient provider in the engagement process and is not meant to alleviate the outpatient provider responsibility for follow up.

The Care Transitions Team will contact the outpatient provider-identified contact to facilitate the inpatient to outpatient transition for enrolled individuals. For those individuals that are not enrolled with a NSMHA provider, Care Transitions will assist with the assessment process.

CONCLUSIONS/RECOMMENDATIONS:
Outpatient providers still need to meet the timeline of following up with an individual within seven days of discharge from inpatient psychiatric care regardless of whether the Care Transitions program has delivered a qualifying service.

TIMELINES:
N/A

ATTACHMENTS:
None

NSMHA COMMITTEE DISCUSSION FORM

AGENDA ITEM: ICRS Policy 1706, Safeguarding of Property

PRESENTER: Sandy Whitcutt of Greg Long

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

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:

NSMHA providers of crisis services and providers who operate psychiatric inpatient Evaluation and Treatment (E&T) facilities need to ensure that reasonable precautions are taken to safeguard an individual's property. This policy addresses the processes needed to ensure the safeguarding of property by both the Designated Mental Health Professional (DMHP) when an individual has been taken into custody to be evaluated, as well as for providers at the E&T when an individual has been detained to the E&T.

This policy was due for minor revision to include the new WAC source.
It was approved by ICRS sub policy and ICRS.
QMOC requested a revision be made to the policy to reflect the use of service animals. The policy was revised by ICRS and is being presented to QMOC with the revision.

CONCLUSIONS/RECOMMENDATIONS:

TIMELINES: If approved, this policy will go into effect 60 days after posting on the web.

ATTACHMENTS:
Policy 1706

Effective Date: 3/3/2008; 8/30/2007
Revised Date: 1/24/13
Review Date: 1/24/13

North Sound Mental Health Administration

Section1700 – Crisis Services: Safeguarding of Property

Authorizing Source: WAC 388-877-0280(3) & RCW 71.05.220, 71.05.700-71.05.715
Cancels:
See Also:
Providers must "comply" with this policy
Approved by: Executive Director
Date:
Responsible Staff: Deputy Director
Signature:

POLICY #1706.00

SUBJECT: SAFEGUARDING OF PROPERTY

PURPOSE

NSMHA providers of crisis services and providers who operate psychiatric inpatient Evaluation and Treatment (E&T) facilities shall have appropriate policies and processes to ensure that reasonable precautions are taken to safeguard an individual's property.

POLICY

When a Peace Officer or Designated Mental Health Professional (DMHP) escorts an individual to a facility to be evaluated, the DMHP must take reasonable precautions to safeguard the individual's property.

Providers who operate E&T facilities shall take reasonable precautions to inventory and safeguard the s property of the individual detained to that facility.

PROCEDURE

1. Agencies employing DMHPs s shall provide adequate training and have protocols regarding:

    a. Safeguarding the individual's property in the immediate vicinity, if involved, at the point of apprehension;
    b. DMHPs will make every reasonable effort to ensure individuals and service animals (per ADA definition) will be kept together.
    c. Safeguarding belongings not in the immediate vicinity, if made aware that there may be possible danger to those belongings; the DMHP may coordinate with law enforcement and/or other available collateral supports to address these needs;
    d. Taking reasonable precautions, if made aware, to lock and otherwise secure the individual's home or other property as soon as possible after the individual's initial detention; the DMHP may coordinate with law enforcement and/or other available collateral supports to address these needs;
    e. Ensuring that requirements for crisis outreaches to home visits (RCW.71.05.700 through 71.05.715) are met; and
    f. Documenting, if made aware, the actions taken to safeguard the individual's property.

2. At the time an individual is involuntarily admitted to an E&T facility, a copy of the inventory, signed by the E&T facilities' staff member completing it, shall be given to the individual detained. In addition, the inventory contents shall be open to inspection to any responsible relative, subject to limitations, if any, specifically imposed by the detained individual. For purposes of this section, "responsible relative" includes the guardian, conservator, attorney, spouse, parent, adult child, or adult brother or sister of

the individual. The facility shall not disclose the contents of the inventory to any other person without the consent of the individual or order of the court.

3. NSMHA will monitor providers' policies and practices through the auditing process.

ATTACHMENTS

None

Effective Date: 3/3/2008; ~~8/30/2007~~
Revised Date: ~~7/30/2007~~1/324/13
Review Date: 1/324/13

North Sound Mental Health Administration

Section1700 – Crisis Services: Safeguarding of Property

Authorizing Source: WAC 388-8~~7765~~-028~~045~~(3) & RCW 71.05.220, 71.05.700-71.05.715
Cancels:
See Also:
Providers must "comply" with this policy
Responsible Staff: Deputy Director

Approved by: Executive Director
Signature:

Date: ~~3/3/2008~~

POLICY #1706.00

SUBJECT: SAFEGUARDING OF PROPERTY

PURPOSE~~POLICY~~

NSMHA ~~shall ensure that its~~ providers of crisis services and providers who operate ~~e~~p~~P~~sychiatric i~~I~~npatient Evaluation and ~~t~~Treatment (E&T) facilities shall have appropriate policies and processes to ensure that reasonable precautions are taken to safeguard an individual's~~consumers'~~ property.

POLICY~~PURPOSE~~

When a Peace Officer or Designated Mental Health Professional (DMHP) ~~or Designated Crisis Responder (DCR)~~ escorts an individual~~consumer~~ to a facility to be evaluated, the DMHP~~/DCR~~ must take reasonable precautions to safeguard the individual's~~consumer's~~ property.

Providers who operate ~~e~~Evaluation and ~~t~~Treatment E&T facilities shall take~~will ensure that~~ reasonable precautions ~~are taken~~ to inventory and ~~to~~ safeguard the ~~consumer~~'s property of the individual detained to that facility.

PROCEDURE

1. Agencies employing DMHPs ~~/DCR~~s shall~~will~~ provide adequate training and have protocols regarding:

    a. ~~Make reasonable attempts to S~~sSafeguarding the individual's~~consumer's~~ property in the immediate vicinity, ~~f~~ if involved, at the point of apprehension;
    ~~a.~~b. DMHPs will make every reasonable effort to ensure individuals and service animals (per ADA definition) will be kept together.
    ~~b.~~c. ~~Safeguarding Make reasonable attempts to s~~Safeguarding belongings not in the immediate vicinity, if made aware that there may be possible danger to those belongings; the DMHP may coordinate with law enforcement and/or other available collateral supports to address these needs;
    d. Taking reasonable precautions, if made aware, to lock and otherwise secure the individual's~~consumer's~~ home or other property as soon as possible after the individual's~~consumer's~~ initial detention; the DMHP may coordinate with law enforcement and/or other available collateral supports to address these needs;
    ~~c.~~e. Ensuring that requirements for crisis outreaches to home visits (RCW.71.05.700 through 71.05.715) are met; and
    ~~d.~~f. Documenting~~ing~~, ~~that during the course of the investigation, the steps that were~~, if made aware, the actions taken to safeguard the individual's~~consumer's~~ property~~. on the crisis contact sheet~~.

2. At the time an individual is involuntarily admitted to an E&T facility, a copy of the inventory, signed by the E&T facilities' staff member completing it, shall be given to the individual~~person~~ detained. ~~and shall, i~~In addition, the inventory contents shall be open to inspection to any responsible relative, subject to limitations, if any, specifically imposed by the detained individual.~~person~~. For purposes of this section, "responsible relative" includes the guardian, conservator, attorney, spouse, parent, adult child, or adult brother or sister of the individual. The facility shall not disclose the contents of the inventory to any other person without the consent of the individual~~patient~~ or order of the court.
3. NSMHA will monitor providers' policies and ~~is~~ practices through the auditing process.

ATTACHMENTS

None

NORTH SOUND MENTAL HEALTH ADMINISTRATION

QUALITY MANAGEMENT OVERSIGHT COMMITTEE (QMOC)

September 25, 2013

AGENDA ITEM: Clinical Issues regarding upcoming reduction in State Funds

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

PRESENTER: Mike Manley/Greg Long

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

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:

OBJECTIVE:
To begin planning regarding the probable reductions in State Funds and how this will effect clinical services.

BACKGROUND:
As a result of the implementation of the Affordable Care Act with more people being on Medicaid, the State has reduced the amount of State funds coming to the RSNs. NSMHA will be especially hard hit by the method the State has used to reduce the State Funds among the RSNs. NSMHA does not know specifically how large this reduction will be, but it is likely to be in the range of $3-$4 million/yr.

State Funds are used to fund some crisis services, all of ITA court costs, residential room and board, flex funds, services for people coming out of WSH and CLIP who don't have Medicaid, Medicaid Personal Care, people on LRs/CRs and people on spend downs. Many of these areas cannot be reduced and in fact the costs are going up.

The largest area to reduce is the use of State Funds for people in outpatient care who don't have Medicaid. A major component of this is people who go on spend downs. Technically, these people lose their Medicaid eligibility because they have incomes higher than the Federal poverty level. When they spend the required amount on health care, they regain their Medicaid eligibility. Reducing or eliminating State Funds for these people places these individuals and providers in a difficult position of having treatment abruptly ending and potential patient abandonment. King County RSN states that they have not funded people on spend downs for several years and they leave it to their providers to manage these people.

Another area that can be reduced is flex funds for it is not a required service.

PREVIOUS ACTION(S) TAKEN: None

CONCLUSIONS/ACTION REQUESTED:
No action is requested at this time. North Sound providers may want to discuss with King County providers how they manage this.

FISCAL IMPACT: Significant but unknown

ATTACHMENTS: None.

NORTH SOUND MENTAL HEALTH ADMINISTRATION
QUALITY MANAGEMENT OVERSIGHT COMMITTEE (QMOC)

AGENDA ITEM: 2012 NSMHA Quality Management Plan

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

PRESENTER: Greg Long

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

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:
Please be aware that this document in done in landscape format on 8.5 x 14 paper. This may be better viewed on your computer. If you need a hard copy version and you printer does not produce these types of documents, please contact NSMHA.

OBJECTIVE:
To provide opportunity to comment on this summary document that did not occur last month**.**
To provide a broad summary of NSMHA Quality Management Activities.
To meet the EQRO recommendation.

BACKGROUND:
NSMHA use to do a bi-annual Quality Management Plan. This has been dropped as a requirement for several years, but is now a requirement again. EQRO requested that we develop a yearly quality management program summary.

This document contains nothing new that was not reported in 2012 or 2013. All of these reports and findings were presented to QMOC or other committees. It is a summary of NSMHA's Quality Management Activities for 2012. Since a major portion of NSMHA's responsibility is quality management, especially if this is defined broadly, this becomes a large and complex document. Only a brief summary is provided in this document. More detailed information is contained in the specific document reporting on that QM process.

PREVIOUS ACTION(S) TAKEN: None

CONCLUSIONS/ACTION REQUESTED:
- NSMHA wants QMOC to be aware of this document and the many QM activities it summarizes.
- NSMHA would like approval of this summary of 2012 QM Activities
- In future years, NSMHA will attempt to have this summary out by April of the following year. Hence the 2013 QM Summary would be presented to QMOC in April 2014.

FISCAL IMPACT: None

ATTACHMENTS: 2012 NSMHA Quality Management Plan

2012 Quality Management Summary

This report summarizes many of the 2012 Quality Management Activities conducted by the North Sound Mental Health Administration. Greater details and a full report are available on request for any of these quality management processes which gives the goal, methodology, tools, findings, actions and corrective actions. This summary report covers the following areas: EQRO Recommendations and Findings, NSMHA Strategic Plan, NSMHA Administrative Audits, NSMHA Clinical Quality Management Audits, Consumer Grievances, Trainings, Encounter Validation/Service Verification Audit. This summary reports on the activities from NSMHA Strategic Plan and NSMHA Work plan.

Work Plan Task #	Task Name	Task Description	Staff Lead	Abstract of Results	Recommendations/ Future Actions
EQRO Report and Recommendations					
	EQRO Report	All health plans including RSNs are required to have an independent review conducted by an EQRO every year. The Division of Behavioral Health and Recovery (DBHR) contracts with Acumentra Health to perform external quality review (EQR) of managed mental health services provided for Washington Medicaid enrollees. The major EQR activities are: -- review of the RSN's compliance with federal and state regulations and contract provisions governing managed care -- evaluation of the RSN's performance improvement projects (PIPs) -- an Information Systems Capabilities Assessment (ISCA) for each RSN --EQRO conducted an Encounter Validation/Service Verification to assure the encounter validation process that NSMHA conducted.	Lisa Grosso	The compliance review found that in 2011, NSMHA fully met all eight of the compliance protocols with the following scores (1-5 scale with 5 being best score): --Network 5 --Coordination 4.7 -- Authorization 5 -- Provider 5 --Delegation 5 --Guidelines 4.7 --QA/PI 4.8 Acumentra Health reviewed one non-clinical and one clinical Performance Improvement Project (PIP) conducted by NSMHA, both continued from previous years. The RSN scored 96/100 on the non-clinical PIP, Non-clinical—Improved Delivery of Non-Crisis Outpatient Appointments after a Psychiatric Hospitalization. The RSN scored 89/100 on the clinical PIP: Decrease in the Days to Medication Evaluation Appointment after Request for Service. Both scores qualify as fully meeting this standard. ----The EQRO conducted an Information Systems ISCA in 2011 resulting in 13 recommendations. NSMHA had successfully implemented two recommendations related to concluding its contract with Raintree Systems and was in the process of implementing six other recommendations. NSMHA had made no progress in addressing four recommendations related to hardware systems, data security and encounter data auditing. ----EQRO found very high rates of match between RSN and chart data for the encounters and charts reviewed. These findings were similar to what the NSMHA team found for the same 83 encounters.	Numerous strengths were cited and there were no findings. The following compliance recommendations were made: --NSMHA needs to routinely review its practice guidelines to ensure that they still apply to enrollees' needs and include any updated clinical recommendations. --NSMHA needs to perform a more comprehensive annual QA/PI evaluation. --NSMHA needs to continue to closely monitor the timeliness and completeness of enrollees' treatment plans. NSMHA will make these changes. --EQRO recommended that the RSN establish a testing system, including code review, to ensure that EDV systems are working before using those systems in the field.
NSMHA Strategic Plan					
	Strategic Plan	NSMHA developed a new strategic plan in 2012	Joe Valentine	With the hiring of a new Executive Director in 2012, NSMHA developed a new 3 year Strategic Plan. The plan was approved by the Planning Committee, the Advisory Board and NSMHA Board of Directors. The plan lays out 4 strategic goals which NSMHA is committed to accomplish. These include: Organizational Structure and Health Care Reform, improving access to services, increase peer support and consumer involvement and workforce development. In addition, the following three goals were set as important priorities: improve NSMHA's information technology capabilities, implement a NSMHA Communications and Marketing Plan and collaborate and partner with the 8 North Sound Sovereign Tribes to establish a culturally competent work force and service delivery system that promotes a tribal centric mental health system.	Since the Strategic Plan was approved in late 2012, implementation will begin in 2013. These goals will be divided into strategies and objectives in the coming years.

Work Plan Task #	Task Name	Task Description	Staff Lead	Abstract of Results	Recommendations/ Future Actions
Performance Measures					
	Regional Performance Measures	NSMHA has three Regional Performance Measures: -Increasing the diversion rate from inpatient care -Increasing the crisis bed utilization rate -Increasing the rate of identification of co-occurring disorders	Diana Striplin	The Region exceeded its target for diversion from inpatient for 10/1/2011-9/30/2012. NSMHA was forced to change the crisis bed utilization measure, baseline and targets due to changes in the crisis system. For 10/1.2011 -9/30/2012 NSMHA also exceeded its target for the identification of co-occurring disorders.	NSMHA will continue these performance measures for the next year.
	State-Wide Performance Measures	NSMHA has two State-Wide performance measures. -A Medicaid enrollee will be seen for non-crisis services with 7 days of discharge from inpatient care. -Encounter Validation-for encounter validation see section on encounter validation	Diana Striplin/ Michael White	NSMHA did not meet performance for the 7 day measure and has designed a special intervention to improve performance on this measure.	NSMHA will implement this intervention for the 7-day measure.
NSMHA Administrative Audits					
	Administrative Audits	During 2012 the following audits were conducted: All outpatient Contractors, all Mental Health Block Grant Contractors, Crisis Center/Triage Facilities, Evaluation & Treatment Center and County Jail Services.	Margaret Rojas	The following Contractors were placed in Remedial Action or were given recommendations during the 2012 audit: CCSNW-Recommendations were made to the Wraparound program, there were no findings during this audit. NSMHA will review for the incorporation of recommendations during the next audit cycle. Compass Health-Placed in Remedial Action in the following programs, DD Crisis, Crisis Triage and PACT services; a corrective action plan was submitted and accepted. Interfaith-Placed in Remedial Action in the following area: Complaint and Grievance; Corrective Action plan was submitted and accepted. Pioneer Human Services-Placed in Remedial Action in the organization's Compliance Plan; Corrective action plan was submitted and accepted. Tulalip (MHBG) Recommendation was made on establishing communication pathways between program and fiscal staff. NSMHA will review for the incorporation of the recommendation during the next audit cycle. VOA Recommendation was made on VOA's complaint and grievance documentation. NSMHA will review for the incorporation of the recommendation during the next audit cycle. WCPC-Placed in Remedial Action in the following area: Supported Employment; corrective action plan was submitted and accepted.	NSMHA is required to audit once per contract cycle. The next audit will take place in 2014.
06.13.01	Conduct Utilization Reviews	A 63 standard tool was utilized to review 415 randomly selected outpatient charts across providers to evaluate the quality of clinical services.	Charissa Westergard	Regionally, 5 standards were below 90%, though 4 of these standards were above 85%. -If during the intake the individual reports having no PCP, a referral to a PCP is offered - 87.3% -The RRP was developed within 30 days of the first ongoing outpatient appointment - 88.3% -Goals for treatment are based upon identified mental health needs - 89.2% -The RRP is strength-based - 72.2% -The clinical/medical record contains documentation that individuals and, as appropriate, family members are informed about the medication prescribed and possible side effects in language that is understandable to the individual - 89.8% All providers had aggregate compliance scores above 90%. The number of standards below 90% by provider ranged between 2 and 14.	Remedial actions were taken with 6 of 8 providers on the standards for which they were below 90%. All of these providers submitted corrective action plans. All providers will be reviewed next year for improvement and compliance.

Work Plan Task #	Task Name	Task Description	Staff Lead	Abstract of Results	Recommendations/ Future Actions
06.05.03	Crisis outreach/ensure that crisis dispatch does not exceed two hours	Providers need to ensure that crisis dispatch times to individuals are not exceeding 2 hours or have adequate justification of why there is an exception to 2 hours. Once dispatched, voluntary or involuntary service ICRS providers try to maintain or improve on a 95% standard of under 2 hours both regionally and by agency.	Sandy Whitcutt	All providers are meeting the goal. Regionally at 97% up from 96.9% from 2011. Providers have also been able to stay above the 95% individually.	Continue monitoring looking for any changes at provider sites or in region.
06.05.01	Care Crisis Monthly reports	As part of ICRS, Care Crisis (VOA) is responsible for responding to calls from the community, triaging those calls, dispatching cases to Emergency Services staff in the appropriate counties and monitoring timely response from ES staff within 10 minutes. Care Crisis is also responsible for documenting the disposition of the dispatch from ES/DMHP and recording the time the S worker/DMHP arrived at the outreach location.	Sandy Whitcutt	Total calls for the first 9 months has averaged 6979 a month. The percentage of abandoned calls for the first 9 months has been 3.37%. This percentage is below the national average of 5%.	This will continue to be monitored through the ICRS for any trends.
06.05.02	Crisis calls will be dispatched in a timely manner	Care Crisis (VOA) is responsible for dispatching cases to Emergency Services staff in the appropriate counties and monitoring timely response from ES staff(within 10 minutes). Care Crisis is also responsible for documenting the disposition of the dispatch from the DMHP/ES worker and recording the time the DMHP/ES worker arrived at the outreach location. This is reviewed as part of the annual audit.	Sandy Whitcutt	Care Crisis response continues to reflect consistent response to crisis calls, to include documentation of the nature of the crisis, proper paging of the ES worker in the field, good coordination with the ES worker, law enforcement and the community. Documentation continues to detail the call. Dispatching rationale remains clear. There appears to be improved disposition call back from the ES worker within the two hours. This was a recommendation made to ICRS last year.	Continue to monitor both in the audit, as well as, through ICRS reports.
06.05.07.04	Monitor Crisis stabilization use	Crisis stabilization beds are located in Whatcom, Skagit and Snohomish Counties. These programs continue to work to increase utilization. In addition to reporting to ICRS, the programs are also audited to monitor the utilization and quality requirements through chart reviews at each site. This occurs during the annual audit.	Sandy Whitcutt	WCPC: There was evidence of follow up on some of the 2011 recommendations. There are continued recommendations that have been noted on the audit. Pioneer: the program continues to develop. Utilization remains high; referrals have increased. There are some recommendations for the program noted in the audit results. The Snohomish stabilization/triage facility has continued to work on coordination with law enforcement, marketing and has been working on capacity. The average length-of-stay continues to be closely monitored by the facility. There were recommendations from 2011 not met and corrective action was put in place.	Programs will continue to be reviewed during the audits, corrective actions will be addressed this year and programs will be reviewed in December and January due to recommendations and corrective actions.
06.05.07	Crisis stabilization beds will have full utilization /data	Data reports from WCPC, Pioneer and Compass reported via dashboard to ICRS	Sandy Whitcutt	WCPC: Data for this program was not reported due to the changeover to EMR, but utilization remains an issue due to the structure of the facility. Pioneer: Stabilization has been averaging 56% for first six months. Snohomish: Utilization has been averaging 45% for the first six months.	Continue to closely monitor and address the low usage. Crisis system review will also address the programs and this is part of the performance measures. Requests will be made to providers to look at ways to increase utilization.
03.15.03	Ensuring provider compliance with denial standards	Consistent application of eligibility standards for outpatient services across the region by age, levels of care.	Sandy Whitcutt	During first 9 months there were 247 requests, 126 were adult denial requests, 121 were child denial requests. 235 or 95.7% were upheld. 12 or 4.3% were overturned. There were 94 extensions. The number of upheld requests was 95% reflecting consistency in documentation.	A process for corrective action, as well as, identifying regional excellence needs to be developed for agencies.
05.04.04	Encounter validation review	In order to maintain and improve a robust and accurate data collection and reporting system, encounters were done as part of utilization review during August and September 2012, from a random sample	Sandy Whitcutt	Encounters were reviewed at each provider site. The sample was developed by Michael (see report). The encounter tool was again slightly modified this year to assist in ease of entering the data and ensure completion of data in each field. There were also guideline changes made for 2012. The results were reported to the state. A high degree of validity was found between the data and the clinical records.	Recommendations from the review are reported by Michael White. No actions are needed at this time. This study will be repeated next year. Greg added this.

Work Plan Task #	Task Name	Task Description	Staff Lead	Abstract of Results	Recommendations/ Future Actions
06.02.02	Supported employment workgroup	The workgroup, comprised of WCPC and Sunrise fidelity staff, reviews data, addresses ongoing employment issues, shares strategies and works on performance improvement. Both programs are responsible for submitting quarterly reports to NSMHA with employment outcomes.	Sandy Whitcutt	Sunrise Supported program: 38 new enrollees this year; 27 new job starts. Sunrise continues to have full utilization of the program, works actively with DVR and continues to market the program. WCPC does not have cumulative data but reports there have been 18 new enrollees, 10 new job starts. There has not been full utilization of the program but now have two employment specialists and supervisor.	Monitoring of both programs occurs during the audit. Due to the low numbers, another review of WCPC will be completed December 2012 and reported to leadership. Follow up discussion will take place regarding any revisions to the WCPC program.
01.04.04	NSMHA ICRS Meeting	ICRS is a long standing regional committee comprised of NSMHA and supervisors from mental health agencies in the region who provide crisis services (Compass, WCPC, Snohomish County, Pioneer and VOA) who meet bi-monthly to discuss regional crisis issues, address policy with the ultimate goal of maintaining an integrated responsive crisis system.	Sandy Whitcutt	This year ICRS has continued to focus on delivery of services to include law enforcement issues, triage programs and MOT. It has also focused on clarification of IOP/PACT/ICRS/ED roles, Inpatient medical responsibilities, ED/ICRS clarification, single bed certification, parent initiated treatment (PIT). The crisis module was updated. Multiple policies were updated. A new ICRS dashboard was created to chart all of the data and monitor trends.	In 2013, a crisis system review will begin looking at the strengths and areas of improvement needed in the crisis system. The ICRS committee will continue to be integral to this review. Any recommendations will be brought forward to leadership and distributed to ICRS members.
01.14.27	Local crisis oversight meetings	In order to address county specific ICRS issues, Skagit, Snohomish, and recently, Whatcom Counties have developed a local crisis oversight. This meeting is comprised of the county coordinator, hospital representation, law enforcement, interested outpatient providers, crisis providers, VOA and NSMHA. When specific issues arise, other community representation is invited to the meetings. Meetings are generally held every two months at all sites.	Sandy Whitcutt	Skagit oversight has been meeting for a number of years and has well developed relationships; issues this year have been about dementia and boarding. Snohomish oversight has also been meeting a number of years and has increased membership to outpatient providers. This year there has been an increased focus on the role of ED's, as well as, continued focus with Law enforcement. Whatcom has just recently started an oversight meeting; the first meeting taking place in July 2012. The group has expressed an interest in looking at data to look at detention rates, improve relationships with crisis and outpatient programs.	Continued attendance to assist with quality and policy issues
06.02.01	Monitor Fidelity supported employment	WCPC and Sunrise continue to manage these programs in Snohomish, Skagit and Whatcom Counties. The programs are reviewed for fidelity standards. This currently occurs during their audit.	Sandy Whitcutt	Sunrise Fidelity results showed a mean score of 3.7 out of 5, for individual charts and 4.2 out of 5 for organization, a slight drop from 2011, due to the newness of the charts reviewed. There were no recommendations but will be monitored next year for improvement. WCPC scored 3.4 out of 5 for individual charting and 3.9 out of 5 for organization. Due to recommendations last year, a finding was made to increase referrals, as well as, show improvement in employment as an outcome.	Continue monitoring next year for both fidelity compliance and increasing the number of consumers getting employment.
06.05.07.01	Monitoring of the Mobile Outreach Teams (MOT)	The number of interventions per month are reported to ICRS through NSMHA . Additionally, both programs were audited this year.	Sandy Whitcutt	During the audit, there were strengths in chart documentation in assessing the situation, making referrals and providing resources. The areas needing improvement were in development of a recovery plan, offering follow up care and reporting data. For Pioneer during the audit, strengths were seen in documentation, in consultation to caretakers, stabilizing the crisis, responding rapidly making referrals and follow up care. Areas needing improvement were in development of a recovery plan and completion of a plan.	Continue to monitor during the audit. A crisis review will take place in 2013, and the effectiveness of the program should be reviewed, with revisions to follow.
06.05.07.02	Monitor MOT advisory workgroup	A workgroup was created with participation from the MOT providers, ICRS representation, county coordinators, and NSMHA to address issues associated with the program.	Sandy Whitcutt	WCPC has not been able to generate a report to NSMHA but indicates they have provided services to 169 individuals from January to September and has done marketing. Pioneer reports serving 98 individuals to September 2012. Both programs did a customer satisfaction survey; with low numbers of return but both programs are seeing good satisfaction.	Continue to do a quarterly workgroup. WCPC data will need to be reported to see if the data presented for 2012 is reliable.
06.07.01	Monitor use of Seclusion and Restraints at the E and T	The regional Evaluation and Treatment Program (E &T) provides needed care for individuals requiring involuntary treatment. This facility program makes a concerted effort to attempt less restrictive options prior to use of seclusion and restraint. The effort is to minimize the use. When there is the need to use seclusion and restraint, it is monitored closely for appropriateness. This area has been monitored by NSMHA for many years. It is done through daily reporting and review of charts. It is also discussed at ICRS on a routine basis.	Sandy Whitcutt	Data is submitted daily to NSMHA, and a report is generated monthly, then reviewed by NSMHA and ICRS. This area is also a focus during the audit. The average census for 9 months was 14.99. The number of seclusions during this timeframe was 101, comparing to 136 for 10 months in 2011. The number of restraints was 15 during this period, comparing to 33 for 10 months in 2011. The numbers have been trending down. The E and T reports they have been doing more training, as a recommendation of the 2011 audit requesting charting reflect better rationale and has improved this year.	This area is monitored and will continue to be monitored closely for any inconsistencies or sudden increase in the use of seclusion and restraints. This is done through reports and the audit.

Work Plan Task #	Task Name	Task Description	Staff Lead	Abstract of Results	Recommendations/ Future Actions
01.07.06	Conduct focused review of special populations	This review is done to ensure individuals receive culturally competent services. A random sample was pulled for all providers. The review is looking to see: 1) if the documentation reflects that the consult was done within the required timeline and 2) that the consultant's recommendations were incorporated into the care plan.	Sandy Whitcutt	The review was conducted in September and October 2012. Regional compliance on question 1 was 69%, comparing to 66% for 2011. Regional compliance for question 2 was 63%, comparing to 79% in 2011. Providers were in corrective action in 2011. The results of the 2012 review will be brought to QMOC for review and recommendations for improvement in December 2012.	Providers were put in corrective actions in the areas that they fell below. Providers have sent NSMHA responses. Another review will be conducted in the fall of 2013.
06.09.01	WSH census management	The NSMHA Adult Care Coordinator works with inpatient psychiatric facilities, Western State Hospital (WSH), and the Western State Hospital liaisons to ensure that individuals receive care in the least restrictive environment possible. Individuals referred to WSH from the North Sound region are screened by NSMHA to review the admission with the inpatient facilities as the individual moves to the 90 MR. The review with the facilities addresses other diversion strategies attempted and the current status of the individual prior to going to WSH.	Sandy Whitcutt	NSMHA by contract is currently allocated 101 slots at Western State Hospital (WSH). In 2011, NSMHA had an average of 12 approved referrals per month. 2011 continued to have the region be at or under the census cap for most of the year. For 2012, for the first six months, the average has been 6.6 approved referrals, but there were 17 referrals in May. NSMHA did briefly go over the cap, but the liaisons and community hospitals worked hard at other discharge options. Additionally, due to critical incidents at WSH, admissions were slowed and again liaisons and the community hospitals worked on other options. NSMHA continues to screen all referrals and provide liaison discharge services.	Continue the current screening process for referrals in 2013. This continues to appear to assist with addressing less restrictive options.
02.01.08.02	Report Customer Satisfaction Survey to LT & QMOC	Complete 2011 report and present findings to LT & QMOC.	Kurt Aemmer	Report completed Feb. 4, 2012; Presented to LT Feb. 7, 2012; Presented to QMOC Feb. 22, 2012. Key findings: 1. The positive response rates were very similar, per provider, per question across the region. 2. Consumers across the region are very satisfied with the services they are receiving. 3. The majority of consumers' surveyed reported services have changed their lives for the positive, though the positive response rate in these 6 questions was lower than the positive response rate in the 8 questions that measured satisfaction. 4. Data was gathered and analyzed region-wide. However, the raw data (completed questionnaires) will be forwarded to the providers to augment their quality improvement efforts. 5. 29% (N=1,459) of adults who responded to the "Interest in Peer Support Services" question expressed interest. Only 7% (N=360) of youth expressed interest. 6. *Overall participation rate was 45%, significantly lower than the range of rates published in the 2009 Clark County RSN Customer Satisfaction Report (75% - 77%, 2007, 08 & 09).	Develop strategies to increase participation rates in 2013 survey. NSMHA will look at strategy to focus more on evaluating outcomes.
03.15.04	Maintain effective incident reporting process	Update P&P per 2012 contract language requirements; screen all provider reports; synthesize and forward all applicable reports to DBHR; facilitate CIRC meetings as scheduled; send all required follow-up reports to DBHR; Complete 3rd & 4th qtr. 2011 and 1st & 2nd qtr. semi-annual reports, present reports to LT & QMOC according to schedule.	Kurt Aemmer	Fast-track P&P update implemented in time for required Oct. 1 implementation date; subsequent requirements added, and final P&P approved at Nov. 28th QMOC. All CI were screened & forwarded to DBHR where indicated. 3rd & 4th qtr. 2011 and 1st & 2nd qtr. 2012 semi-annual reports were completed and reported to LT on Feb. 28th & July 14th; to QMOC on Apr. 25th & Aug. 22nd. 3rd & 4th qtr. 2011 key findings - 21 investigated CI; 1st & 2nd qtr. 2012 key findings - 14 CI investigated. As the nature of CI categories has progressively shifted from being Quality Improvement focused to Risk Management focused, and the applicable operational definitions of these categories have narrowed since 2010, the volume of reported CI has continued to decrease.	Continue process.

Work Plan Task #	Task Name	Task Description	Staff Lead	Abstract of Results	Recommendations/ Future Actions
3.15.09	Monitor & process MHP Waivers & Exceptions process	Screen provider exception & waiver requests, sign RSN's support where indicated, & submit to DSHS for approval.	Kurt Aemmer	DSHS has tightened up documentation of supervised experience requirements in an effort to reduce the volume of clinicians without advanced degrees being employed as MHPs throughout the state. Currently, there remains only two clinicians who do not hold advanced degrees functioning as MHPs in the North Sound Region. Both hold MHP waivers which are current. There are only four more clinicians who hold waivers or exceptions because they are either receiving there master's degree soon, or they have an advanced degree but need to accumulate the required years of experience under the supervision of an MHP.	Continue process.
6.12.01	Second Opinions	Screen 2nd opinion requests, and facilitate second opinions when appropriate.	Kurt Aemmer	After a continuous increase in the avg. number of requests per quarter, per year; from 2009 (3.5), 2010 (5.0), 2011 (5.8), a sudden decrease occurred in the 1st two quarters of 2012 (1). Unless the request was rescinded by the consumer, or the consumer had special schedule request(s) & chose to waive the required 30-day window, 100% of the requested 2nd opinions have been completed in the required 30 days since the 2nd quarter of 2009. There were 10 requests in 2012. Seven were completed. One was initiated, but not completed because the consumer showed up late for the appointment. There were two no-shows. The second no-show was the follow-up appointment for the individual who appeared late for his first appointment, described above. There was a 50% agreement rate (2/4) among prescribers 2nd opinion consultants, and a 100% agreement rate (1/1) among masters level MHPs.	Continue to manage and report on the number and type of second opinion requests.
06.06.01	Residential services	45 charts were reviewed across the four residential facilities utilizing a 19 standard tool to monitor the appropriateness of this level of care and mental healthcare provided to residents.	Charissa Westergard	Aggregate scores -Aurora House 80% -Greenhouse 94% -Haven House 59% -LWC 93% All four facilities struggled with documentation that supported the LOCUS scoring. Other areas that were an issue for more than one of the facilities were: -Having an appropriate plan to address identified drug/alcohol issues. -Provision of recovery oriented treatment services. -Provision of treatment that is likely to assist the individual in meeting their identified goals.	Remedial action was taken in 2011 and will be applied for standards falling below the 90% benchmark in 2013 as well.
06.08.01	Medicaid Personal Care	Service approved/disapproved; semi-annual written report on number of approved/denied MPC requests. Monitor MPC input into CIS	Terry McDonough	Presented report to LT in Nov 2012. Current MPC cases are approx. one quarter of what they were previously. There are currently 24 clients receiving NSMHA-funded MPC payments. NSMHA's MPC expenses for 2012 were approx. $14,000/ month.	Continue review and authorize MPC Services in 2013.
06.08.03	Medicaid Personal Care	Monitor expenses to remain w/in budget and develop semi-annual written report.	Terry McDonough	Presented report to LT in Nov 2012. Verified w/Shari that NSMHA is w/in budget for 2012.	Continue task in 2013.
06.10.01	Provide Out of Network Services	Maintain ongoing spreadsheet on how many get services and provide written report.	Terry McDonough	During 2012 there were four Out of Network requests that NSMHA agreed to fund. All four of these people were clients who had received Out of Network services in 2011.	Continue task in 2013.
06.10.03	Provide Out of Network Services	Maintain spreadsheet data on why we use Out of Network services and need of service; prepare written report.	Terry McDonough	Of the four Out of Network clients that NSMHA funded in 2012, two were receiving Dissociative Identity Disorder services and two were receiving services regarding their hearing impairment.	Continue task in 2013.
01.07.09	VOA Inpatient Utilization Management Review	Review of VOA's Inpatient Utilization Management chart documentation/activities to determine if consistent with NSMHA guidelines.	Charissa Westergard	VOA received 2,086 requests for hospitalization in 2011. 672 of these requests were for voluntary hospitalization and subject to the UM process. 30 Inpatient UM charts were reviewed with all standards scoring above 90%.	This process is stable and functioning well. Will monitor at least every two years in the future.

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01.07.15	CA/LOCUS (Child & Adolescent/Level of Care Utilization System) Review	Chart review to determine if documentation supports CA/LOCUS scoring.	Charissa Westergard	212 charts were reviewed across the region, approx. 66% LOCUS and 34% CALOCUS. Overall reviewer and provider scoring agreement was at or above 90% for all but one provider (Sea Mar at 87%). Scoring of the Co-Morbidity dimension results in the most disagreement between reviewer and provider.	Discontinue task for 2013 in favor of monitoring LOC data and CA/LOCUS inter-rater reliability testing.
01.11.02	Monitor PACT programs	PACT chart review at both programs.	Charissa Westergard	14 charts reviewed at the Whatcom County PACT (50 slot program). Overall score of 3.9 out of 4 with lowest score of 3.6 on standard assessing peer counselor activities. This was primarily related to a change in peer counselors during the period reviewed. 15 charts reviewed at Snohomish County PACT (100 slot program). Overall score of 3.5 with the lowest rating of 3.1 on peer counselor related activities. Remedial action was implemented related to areas that require improvement, including maintaining a fully staffed team and increased admissions.	NSMHA staff will follow-up on the corrective action process with the Snohomish County PACT. Audit both PACTs next year since they are critical and intensive programs.
6.21	Youth Care Coordination	Make care linkages throughout system, assist stakeholders & consumers in navigating the system and monitor for use of medically necessary services beginning with the least restrictive options for all youth with special focus on high utilizing youth.	Angela Fraser-Powell	Care Coordination contacts that required RSN level intervention to resolve the issue/concern, took the form of multiple calls and/or meetings with family, treatment team and other allied systems to develop a plan and hopefully reduce barriers to address the needs, while still receiving medically necessary services. Currently, this information is tracked case by case via spreadsheet format and not yet in CIS although this is in process. It is the hope that once in CIS, more meaningful data might be gathered.	**Continue care coordination to assure access and quality of care for youth and their families. **CIS database for care coordination would replace the spreadsheet method and potentially produce more meaningful data. Parameters TBD by Clinical Oversight team.
6.20.00	Adult Care Coordination	Make care linkages throughout system, assist stakeholders & consumers in navigating the system and monitor for use of medically necessary services beginning with the least restrictive options for all adults with special focus on high utilizing adults.	Angela Fraser-Powell (for 2012 only due to vacant position).	Adult Care Coordination is also tracked case by case via spreadsheet format and is not yet in CIS system. In late October 2011, the Adult Care Coordination position became vacant, precipitating a need for Adult Care Coordination functions to have a primary contact and then be distributed across the remaining staff of the Clinical Oversight team until a replacement could be hired. While the reorganization of duties created less rich spreadsheet data regarding interventions and types of coordinated care for individuals, adult consumer needs remained a priority and were appropriately and thoroughly addressed.	**Continue care coordination to assure access and quality of care for adults. **CIS database for Care Coordination activates; would replace the spreadsheet method and potentially produce more meaningful data. Parameters TBD by Clinical Oversight team. **In mid September of 2012, a new Adult Care Coordinator was hired and has assumed all functions of the role.
6.12.01	CLIP Referrals	Coordinate CLIP referrals, make recommendations and coordinate admissions with CLIP Administration.	Angela Fraser-Powell	Regional CLIP Committee & Coordinator continued to meet the contract expectations with regard to coordinating CLIP referrals and, where appropriate, diverting to less restrictive options or recommending to CLIP Administration . In 2012, a total of 23 youth were screened through various processes for a possible CLIP admit. Of the 23 total, 11 North Sound youth were screened through the RSN Voluntary process, 9 were recommended by the RSN and subsequently certified for a treatment episode by CLIP Administration. The remaining 2 of 11 youth were screened but diverted into more intensive community based services. Of the 23 total screened, 11 were screened and admitted through the Involuntary process between an acute care hospital team and CLIP Administration. And lastly, 1 North Sound youth was admitted to CLIP via an RCW 10.77 court process. While most of the CLIP functions continue as in 2011, CLIP policy updates at the state level and workgroups born out of the CLIP Improvement Team (CLIP IT) have changed some aspects of CLIP such as treatment episodes being reduced to 6 months from the previous 1 year. CLIP IT workgroups have worked on several items including an agreement to have pre-admission meetings involving the community team, CLIP Administration and the receiving CLIP facility to engage the community team more immediately and set goals prior to admit.	Revise local CLIP policy to reflect the changes.

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6.12.02	CLIP Coordination	Coordinate with CLIP facilities and other systems partners from admit to discharge.	Angela Fraser-Powell	CLIP Care Coordinator continued to meet the contract expectations with regard to working with CLIP and community teams to coordinate care for youth from before the admission process through to discharge, and beyond. This mainly involves attending monthly CLIP / other meetings, making contacts with community services based on youth & family needs in a timely manner prior to discharge for every youth who goes in CLIP. Youth who go to CLIP on a voluntary basis remains a slightly smaller number than those that enter through an ITA process.	Some CLIP data is entered into CIS. Determine specific reports that can be run from this data.
6.16.02	EPSDT	Data review regarding physician referral sheet and call log.	Angela Fraser-Powell	EPSDT Program is a federal preventative health care benefit designed to screen consumers under age 21 in order to identify physical and/or mental health/CD problems through screenings and referrals. EPSDT is one doorway a consumer might become engaged in mental health services and receive care coordination. 2010 contract change stipulated that MH providers would contact and log EPSDT referred individuals within 10 working days for the purposes of engagement and loop closing in addition to continuing to send a letter back to the physician from the initial MH assessment with the diagnosis information. EPSDT has been historically difficult to monitor / capture meaningful data as numbers of EPSDT identified youth tend to be very low. The bulk of charts identified as EPSDT tend to come from a single provider mainly due to their sending youth to the PCP after the initial mental health assessment, at which time a youth becomes labeled EPSDT. This is problematic as the contract states the referral should originate from the PCP in order to truly be labeled as an EPSDT referral; it continues to be rare occurrence when a youth is referred directly from the PCP. A review of charts was performed for time period 5/1/2011 through 4/30/2012, a sample of 40 were reviewed region wide and while good care coordination could be noted region wide, it was difficult to obtain accurate data as many charts were inappropriately marked as EPSDT.	Chart pull instructions to be revised for 2013 so only those charts where the referral originated from the PCP will be reviewed.
Training					
	Motivational Interviewing Training	NSMHA provider basic (16 hrs.) and advanced (16 hrs.) of Motivational Interviewing Training for 100 clinical staff from our provider network. This was provided by NW Addiction Transfer LLC. In addition, ongoing webinars were provided focusing on specific motivational interviewing topics.	Greg Long/ Angela Fraser-Powell	The basic and advanced training was well attended and well received by clinical staff and classes were all filled. The webinars on specific topics were only marginally attended with 3-16 participants.	Need to consider strategies for continuing to promote this evidence-based counseling technique in the coming years.
	Illness Management and Recovery	NSMHA provided a 2.5 hour Introduction to Illness Management and Recovery (IMR) and a 16 hour intensive training on IMR.	Greg Long/ Catherine Youngbuck	The Introductory IMR Training was moderately attended with 22 attendees. The two day intensive training was well attended with 27 participants.	Conduct IMR Consultation and Supervision for a year in 2013-2014.

Work Plan Task #	Task Name	Task Description	Staff Lead	Abstract of Results	Recommendations/ Future Actions
Consumer Grievances					
	Grievance System	Maintain and Oversee Grievance System. NSMHA continues to maintain a robust grievance system . Maintains system for both provider and RSN level grievances, notices, appeals, and fair hearings. NSMHA anticipates some items considered complaints will be processed and reported as grievances in the future. NSMHA maintains an internal grievance review committee, started a monthly Ombuds meeting, and provides quality management recommendations. Providers also use their data for continuous quality improvement in reports to NSMHA. NSMHA also reports to the Mental Health Division every 6 months. NSMHA also oversaw provider processes in the audit process and highlighted strengths, recommendations, and findings for provider processes.	Diana Striplin	NSMHA makes system recommendations for further review or continuous quality improvement related to grievance system information. One area identified was to review expertise for specialty areas such as DID and Eating Disorders. NSMHAs' plan is to review expertise within the network but not restrict ourselves to the network. Information has also been one factor in development of one of our current PIPs for medication management. NSMHA and providers continued with the Dignity and Respect Initiative and Campaign in 2012. In addition quality improvement may be identified in the Internal Grievance Committee. Each provider also provides a report to NSMHA every 6 months with items they identified for further study and review or quality improvement related to complaints or grievances.	The North Sound Regional Grievance System will have to be significantly redesigned for both policy and reporting requirements as DBHR makes contractual changes, develops reporting processes, grievance system documents, and WAC revisions.
Service Verification and Encounter Validation					
05.04.04	Encounter Validation Review	In order to maintain and improve a robust and accurate data collection and reporting system, encounters were done as part of utilization review during August and September 2012, from a random sample.	Michael White & Sandy Whitcutt	Encounters were reviewed at each provider site. The sample was developed by Michael (see report). The encounter tool was again slightly modified this year to assist in ease of entering the data, and ensure completion of data in each field. There were also guideline changes made for 2012. The results were reported to the state. There were no findings from review.	Recommendations from the review are reported by Michael White. NSMHA continues its iterative process of improving on the reviewing of encounters throughout the system. Lessons learned from EQRO Encounter Data Validation training will be incorporated in future EDV reviews done by NSMHA staff.
NSMHA Compliance Activities					
	Compliance Communication and Training	NSMHA's commitment to compliance includes: communicating to all employees, consultants, independent contractors and subcontractors clear ethical guidelines; provide training and education regarding applicable State and Federal laws, regulations, and policies; and provide monitoring and oversight to help ensure that we meet our compliance commitment. We promote open and free communication regarding our ethical and compliance standards and provide a work environment free from retaliation.	Lisa Grosso	Created separate NSMHA Compliance Exclusions distribution list with tribal and network provider agency Compliance, Quality Management and HR representatives. Created standard E-mail with links and directions to the OIG List of Excluded Individuals and Entities (LEIE) website and the System for Award Management (SAM). Excluded Parties List System (EPLS), is transmitted quarterly. Reviewed and briefed the OIG Health Care Fraud Prevention and Enforcement Action Team (HEAT) Provider Compliance Training initiative resource to Leadership Team and Staff, Planning and Quality Management Oversight Committee, issuing Numbered Memorandum to network provider agencies requiring inclusion in Compliance Plans. Established direct E-mail to Compliance Officer, compliance_officer@nsmha.org, updating website. Compliance Officer attended 2012 Spring and Fall Medicaid Quality Management (MQM) Conference/DBHR RSN Training; Presented Compliance Training module Spring 2012 titled "How to Jump Start Your Compliance Investigation." Subscribed to the National Council Compliance Watch Newsletter, distributed to all Staff by e-mail every two months. Conducted annual Compliance/Program Integrity Training for All Staff, with separate training date for stragglers.	Re-validate distribution list annually. Develop and conduct Compliance/Program Integrity Training for Boards and Committees. Continue to participate in semi-annual MQM Conference/DBHR RSN Training. Research credentialing certification program for Compliance Officer. Conduct Annual Compliance/Program Integrity Training of All Staff and incorporate Compliance Training areas of focus in monthly All Staff meeting.
	Compliance Investigations	Investigate all potential incidents of non-compliance, including reviews of relevant documents and interviews of relevant people.	Lisa Grosso	There were 7 reports of alleged fraud or abuse reported, with 2 cases still pending, 1 investigated by the State with no substantiation found; 3 investigated and no fraud substantiated; and 1 investigated and fraud found at under $5000 with recoupment effected. 4 cases were reported by Staff, 2 by Provider Agency and 1 by State Agency.	Raise awareness in the enrollee community through establishment of a dedicated direct and toll free number and voice mail for reporting to the Compliance Officer and recurring tag-line listing in eNewsletter.

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	Compliance Audits	Detect and prevent fraud and abuse through auditing and monitoring processes and review and oversight activities. Conduct annual Administrative, Fiscal, Quality Assurance/Performance Improvement (QA/PI) and Encounter Data Validation (EDV) on-site provider contract reviews designed to ensure contractor compliance.	Lisa Grosso	Conducted review of Compliance Program, policy and procedures for each network provider agency as part of the administrative audit, with particular emphasis in the relevant risk areas identified by the Office of Inspector General (OIG) in its "Compliance Guidance to Medicare + Choice Organizations."	Complete review of Compliance Program policy and incorporate updates as outlined by change to contracts/regulations. Conduct Biennial review of Compliance Program policy and procedures for network provider agencies.

NORTH SOUND MENTAL HEALTH ADMINISTRATION

QUALITY MANAGEMENT OVERSIGHT COMMITTEE (QMOC)

AGENDA ITEM: Improved Care Management of Individuals with Specialized Needs

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

PRESENTER: Greg Long

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

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:

OBJECTIVE:
To better manage the care of people with specialized needs.

BACKGROUND:
The public mental health system serves thousands of people each year successfully. However, NSMHA has been having growing concerns that a few dozen people who have very specialized treatment needs are not getting appropriate consultation or specialized outpatient treatment soon enough. Currently, there are two people in residential eating disorder treatment who were tried in general outpatient services for fairly extensive periods of time without their getting specialized consultation to guide the outpatient treatment. When the outpatient treatment was unsuccessful, there was an urgent demand for residential care. These two individuals will cost our system over $200,000 this year and will need extensive specialized outpatient follow-up.

There are also 4-5 families demanding treatment for autism from the RSN now. There are also people in treatment for other disorders that have untreated autism. Many of the psychiatric symptoms stem from the untreated or managed autism.

In regards to people with autism, all children who are diagnosed with autism or suspected of having autism should be referred to either of the Health Care Authorities (HCA) autism assessment programs. All adults should be referred to their Apple Health (formerly Healthy Options) Medical Plans. HCA and the Division of Behavioral Health and Recovery (DBHR) have acknowledged that autism assessment and treatment is not a covered service under the RSN Health Plan Benefits. Not facilitating these specialized services prevents people from getting the needed assessment and treatment for this disorder. This was discussed with HCA and this is their recommendation.

PREVIOUS ACTION(S) TAKEN: Previously, it was discussed at QMOC that there are not enough of these specialized cases for agencies to hire specially trained staff. QMOC discussed and recommended to the agencies that they sub-contract for consultation for their staff or for out of network outpatient services by a specialist.

CONCLUSIONS/ACTION REQUESTED:
NSMHA is recommending that each agency:

1. Submit a written plan for how they are going to identify specialized needs earlier and manage people with specialized needs who are not progressing satisfactorily in treatment by January 15, 2014 including:
    a. Designate a specific person on staff to consult with their staff and NSMHA staff on when, who and how to get specialized consultation or out of network sub-contracted outpatient assessment and treatment services for these select individuals.
    b. Each agency to describe how they are going to regularly monitor people in these specialized, sub-contracted services.
    c. Develop or revise written policies guiding the management of these specialized clients.
2. Each agency to develop a list of several potential consultants that they have confidence in their areas of service for eating disorders and other specialized diagnoses.

FISCAL IMPACT: Unpredictable. However, in the long run, better outpatient treatment should reduce costs by reducing more costly inpatient and residential treatment.

ATTACHMENTS: None