North Sound Mental Health Administration (NSMHA)
Quality Management Oversight Committee (QMOC)
NSMHA Conference Room
September 25, 2013
1:00 – 3:00 pm
MEETING SUMMARY

PRESENT: Rebecca Clark, Skagit Co.; Heather Fennell, Compass Health; Dan Bilson, Whatcom Co. representative; Chuck Davis, Ombuds; Candy Trautman and Mark McDonald; NSMHA Advisory Board; Eric Chambers, NWESD; Kathy McNaughton, CCS; Larry Van Dyke, Skagit Triage; Mike Manley, Sunrise and Cindy Ferraro, Bridgeways.
BY PHONE: Pat Morris, VOA; Pam Benjamin, WCPC; Kay Burbidge, LWC; Jeff Reynolds, CVAB; Chris Starets-Foote, Compass; Carola Schmid, Snohomish Co.; Danae Bergman, CHS; Kate Scott, Sea Mar; Anne Deacon, Whatcom Co.; Cammy Prince, Sunrise and Jenny Billings, LWC.
STAFF: Greg Long, Charissa Westergard, Julie de Losada and Barbara Jacobson.
OTHERS PRESENT: Buck Evans, NWESD.

TOPIC	DISCUSSION	ACTION
1. **Introductions, Review of Agenda – Chair**	The meeting was called to order at 1:00 pm and introductions were made. Updates to the agenda were called for and none were mentioned.	
2. Previous Meeting Summary – Chair	The motion was carried to approve the meeting summary as submitted.	Motion carried.
3. Announcements and Updates – All	• Greg noted that Valley General in Monroe is slated to open a 16 bed Gero-Psych unit in January 2014. • Greg received an email from Steve Smith at Fairfax announcing their 30 bed inpatient unit at Providence is set to open by March 2014. • Greg noted that NSMHA was contacted by US Health in regard to opening a 75 bed inpatient unit in south Snohomish; they have since changed their plans and now want to open a 75 bed unit in Marysville. This is for some time in the future and would be for just about every special population. • Greg noted that Centers for Medicare/Medicaid Services (CMS) has agreed to the state's request for a postponement to the 90 day corrective action plan and they are now in discussion. • Greg passed out a reminder for the motivational interviewing training that is being held in Snohomish and Skagit counties, October through December. This series of trainings will not have an allotment of slots per provider. There will be a total of 50 this round. • Exhibit N training starts after this meeting for the April through September time period. • The Healthcare Exchange is opening October 1st which should bring more people into Medicaid services.	Informational
4. Regional Health Alliance (RHA)	The Healthcare Authority (HCA) has acknowledged the importance of the Regional Health Alliances (RHA) and is seeking input from them. There is a Puget Sound Alliance and Whatcom Alliance for Healthcare	Informational

	Advancement (WAHA) close to us. The North Sound Regional Health Alliance subcommittee is working on a series of meetings to reduce single bed certs (SBC); at this point it is to engage hospitals in the discussions.	
5. Policy 1563 (PACT)	This PACT policy was sent out for review with some changes; the biggest of which is an individual must be Medicaid eligible now for this program. Some old language was removed and language for the half PACT was added. Chuck presented a motion to approve as submitted to forward to the Board of Directors; Heather seconded and motion carried.	Motion carried.
6. Policy 1532 Residential Placement	Changes to clarify the expectations for mental health services provided by the residential facility staff or in conjunction with the outpatient service provider. Length of stay guidance was added as individuals are staying longer in residential facilities. WAC language references were called out. There was a motion to approve as submitted to forward to the Board of Directors; seconded. Motion carried.	Motion carried.
7. Changes to WACs & Policies	WAC changes have occurred in merging gambling, substance abuse and mental health into behavioral health WACs. Heather is seeking clarity on what NSMHA will be requiring and when for training and other changes. Charissa noted we are seeking clarity from the state on which we need to follow and what they will rewrite; as new WACs were written without repealing some of the old. There are things that consensus can't be reached on and the state will need to look at further. The 180 day review and special pops sections need clarity. Let Charissa know of other items that you come across. Discussion occurred around WAC changes that leave some things in limbo as they took effect September 1st. More information on this to come.	Informational
8. Care Coordination from Inpatient Care	Charissa noted NSMHA has contracted with Compass Health on the Care Transitions Program for outpatient follow-up. It is one of the state performance measures which we did not meet. This is to clarify that even if care transitions is providing service to an individual the outpatient provider is still required to provide a service within 7 days of discharge from inpatient.	Informational
9. Policy 1706 Safeguarding of Property	Greg noted that this policy was presented at the last meeting and it was requested that a provision for service animals be added to keep the individual and the service animal together; the additional language added was discussed. Kathy noted that DMHPs may need training around this. Carola noted that the hospital would determine if the service animal could stay. DMHP should document any actions around this. Greg will check with Kathy Kay at Skagit Valley Hospital around this. Candy made a motion to approve as submitted; seconded. Motion carried.	Motion carried.
10. Future Reductions in State Funds	Greg noted that the RSNs will see reduced state funds due to the Affordable Care Act (ACA) as many more are anticipated to go on Medicaid. The state will decrease state funds and increase Medicaid. The state also gets a Medicaid match so they want to take advantage of that. NSMHA will take a larger hit as we fund outpatient services more than other regions; the state formula hits us hardest. We estimate a 3-4 million	Informational

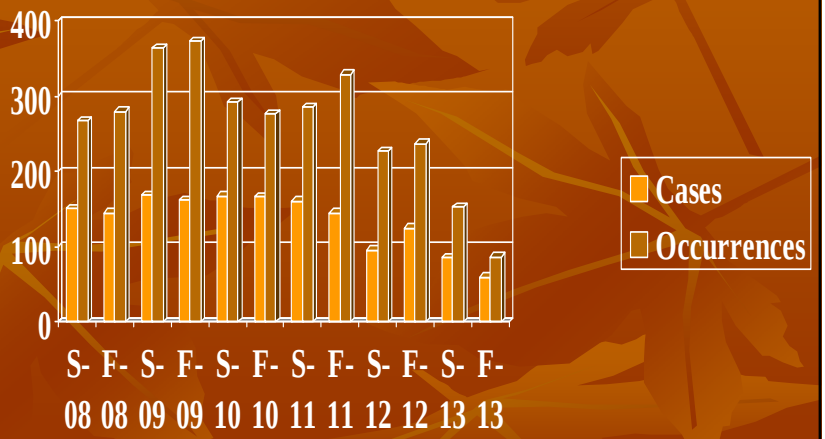
	dollar reduction of our $17 million. We don't know the amount yet however. Mike noted that currently with state funding we are able to seamlessly serve individuals when they lose Medicaid funding. The continuity of care will be impacted; such as medication management. He noted his concern over NSMHA authorization and the loss of funding. Greg noted we may have to change our authorization process; instead of a timeframe it may have to be as long as they are financially eligible. Other counties don't cover those on spend-down or otherwise ineligible and Greg suggests that providers start to look at other options as NSMHA does. Heather asked how much of $17 million goes to spend-downs and flex funds. Greg noted state funds cover all ITA services; some crisis services; room and board, flex funds, etc. and the TR lawsuit may also have some things that will take state funds. Greg will request the data on the spend-down and flex funds. Mike noted providers may need guidance from NSMHA on how to serve the additional demand. Currently 20 percent of encounters are to non-Medicaid. NSMHA has funding to cover this until July 1st to work on this. This will be added to the agenda as new information comes up.	
11. 2012 Quality Management Plan	Greg noted this is a follow up from last meeting and shows a summary of quality management activities that NSMHA does. EQRO asked NSMHA to start doing this again. Let Greg know if you would like more information.	Informational
12. Care Management of Individuals with Specialized Needs.	Greg noted those with specialized diagnoses such as eating disorders, DID (Dissociative Identity Disorder) and PTSD often don't receive appropriate treatment. Providers often don't have a specialized clinician to address these. NSMHA wants providers to proactively manage these individuals and intervene earlier with consultation and subcontracting so it does not come to an emergency situation; such as with eating disorders. NSMHA is seeking feedback on the recommendation to tighten up the system. Greg noted that HCA has system for treating autistic kids and that autistic adults should be served by the medical providers. Discussion occurred around how best to serve these individuals. Heather noted that providers already follow the out of network policies. Consensus seems to be that providers communicate and share contacts on trusted consultants to subcontract with as needed.	Discussion
13. Other Issues	Dan would like some data on kids diagnoses and services. He noted that 20 percent of population are schizophrenic and with dementia. What is some of the data for kids.	
14. Date and Agenda for Next Meeting	Rebecca reviewed the evaluations from the last meeting. The meeting was adjourned at 3:00 pm. The next meeting is October 23, 2013. Future agenda item: Medicaid fee schedule for health plan reimbursement; what is code for case managers.	

NORTH SOUND REGIONAL OMBUDS & QUALITY REVIEW TEAM REPORT

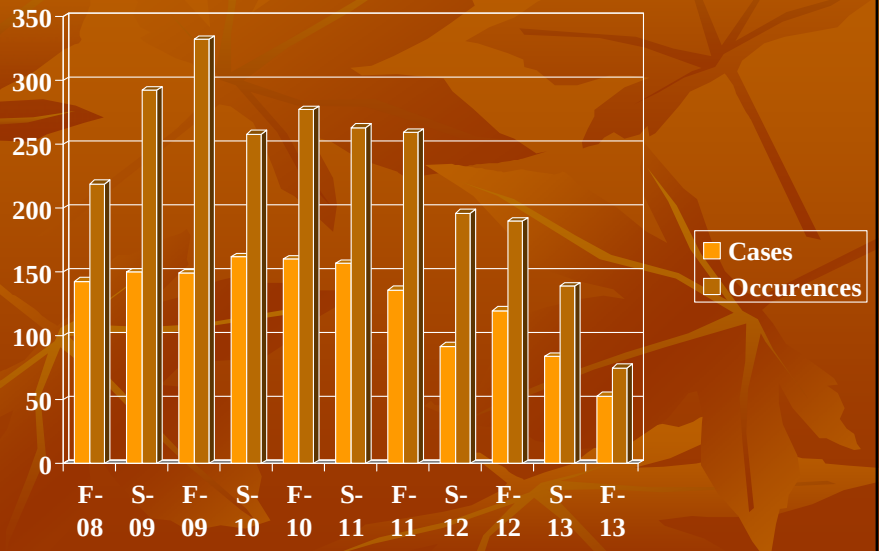
FALL 2013

April 1 through September 30, 2013

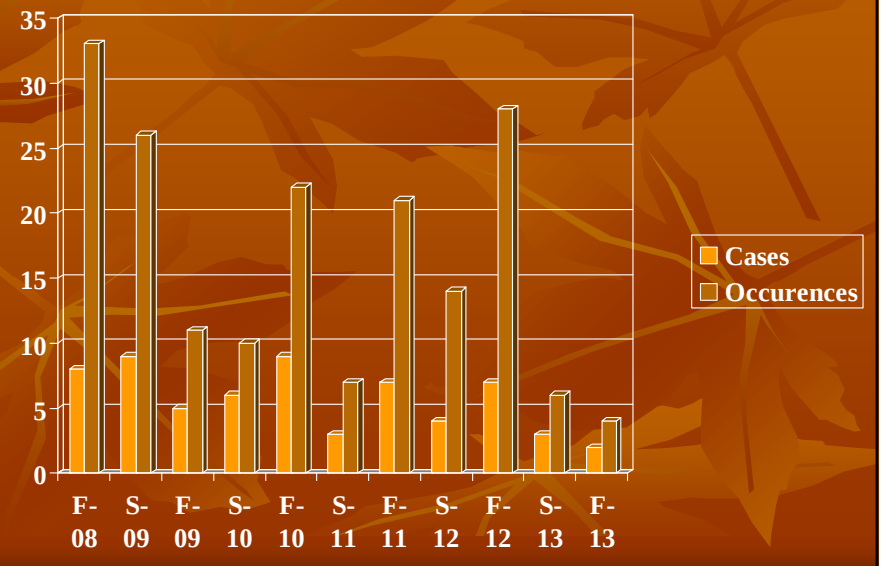
Semiannual Complaints & Grievances Overview

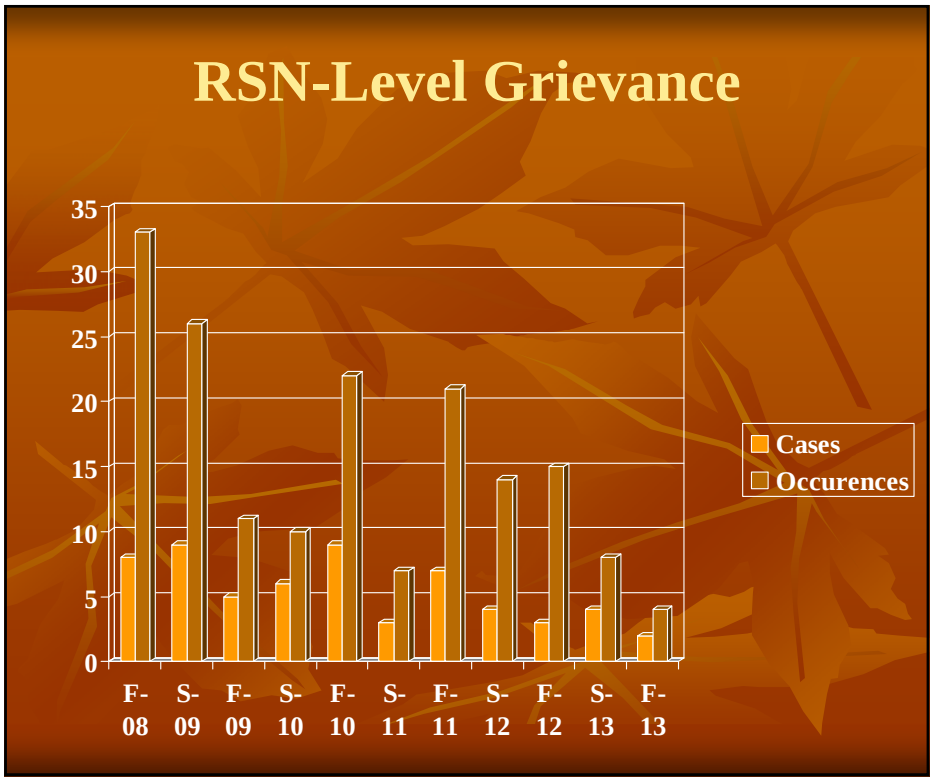


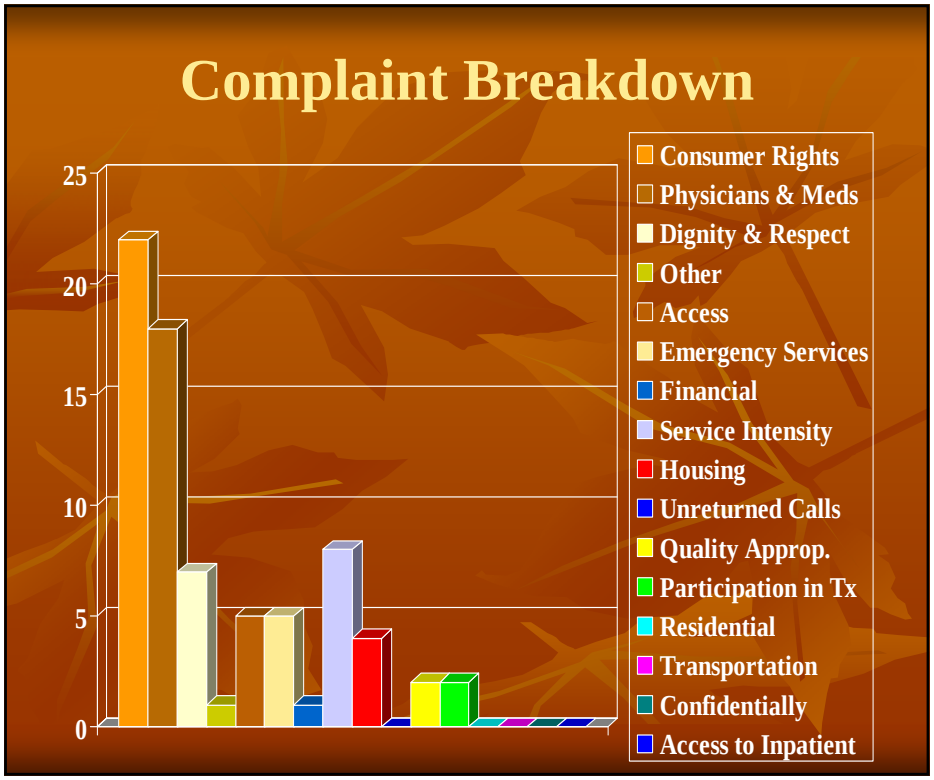
Complaint Issues



Provider-Level Grievance



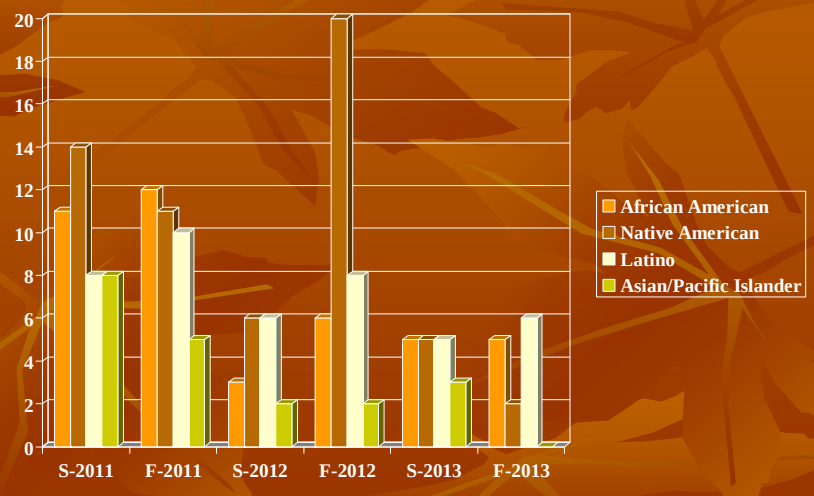

RSN-Level Grievance
35
30
25
20
15
10
5
0
F-08
S-09
F-09
S-10
F-10
S-11
F-11
S-12
F-12
S-13
F-13
Cases
Occurences


Complaint Breakdown
25
20
15
10
5
0
Consumer Rights
Physicians & Meds
Dignity & Respect
Other
Access
Emergency Services
Financial
Service Intensity
Housing
Unreturned Calls
Quality Approp.
Participation in Tx
Residential
Transportation
Confidentially
Access to Inpatient

Appeals & Administrative Hearings

- Two Appeal Cases: “Other Type”
- No Administrative Hearings

Ethnicity of Non-Caucasian Client



Breakouts

- Physicians & Meds Complaints

Notes and Recommendations

- Case Resolution Outcomes
- Consumer Rights
- Provider Meds Management Policy
- Spenddowns
- Landlord-Tenant Disputes
- Family Member Advocates
- Success Stories

Notes & Recommendations (cont)

- Ombuds Relocation
- Client Exploitation
- PTSD/TBI Studies Worth Tracking
- DBT Classes
- Smoking Cessation, Diet & Exercise
- Changes to Complaint & Grievance System
- Specialized Needs Clients
- Potential Problems

Ombuds and Quality Review Team Report

QUESTIONS or COMMENTS?

FALL 2013 OMBUDS AND QUALITY REVIEW TEAM REPORT

SLIDE 1: We are Chuck Davis & Kim Olander-Mayer from North Sound Regional Ombuds. This is our Ombuds report for April 1st through September 30th, 2013. Two items in your packet accompany it: (1) a report breaking out complaints and grievances by agency; and (2) new grievance and resolution definitions from the Division of Behavioral Health & Recovery. This report presents the client voice on general issues of concern. We estimate the region's satisfaction rate at about 95% or better.

SLIDE 2: This slide shows our work historically and for this period. "F-13," bottom right, stands for fall 2013 and covers April 1st through September 30th, 2013. The S's stand for spring reports. A "Case" is a person while an "Occurrence" is a type of complaint or grievance. We assisted **59** people (cases) this period with **76** complaint occurrences, **4** provider-level grievance occurrences, **4** RSN-level grievance occurrences, **2** appeal occurrences, and **no** administrative hearing occurrences. Two **2** of these 59 people were in hospital psychiatric wards and had complaints specifically against the hospitals. We also provided information and referral services to an estimated **300** people--not included here. Our clients numbered **26** women and **33** men. We assisted **4** children.

SLIDE 3: This slide shows cases and occurrences of complaints only. We show it to clarify our primary numbers. Grievances essentially just repeat complaint issues at higher levels. We had **75** complaint occurrences from **53** people. We will discuss the continuing downward trend in complaints momentarily.

SLIDE 4: Provider-level grievance: **2** people had **4** provider-level grievance occurrences: **2** in Consumer Rights, **1** in Dignity & Respect, and **1** in Physicians & Meds. Upon receiving a response to a complaint we advise clients of their right to elevate the issue higher if they aren't satisfied. The client decides whether to initiate a provider-level grievance or not.

SLIDE 5: RSN-level grievances: **2** people had **4** RSN-level grievance occurrences: **2** in Consumer Rights; **1** in Financial Services and **1** in Housing.

SLIDE 6: We've opened complaints, on **53** people. There were **75** complaint occurrences: **22** in Consumer Rights; **18** in Physicians & Meds; **8** in Services Coordination/Intensity; **7** in Dignity & Respect; **5** in Access; **5** in Emergency Services; **4** in Housing; **2** in Participation-in-Treatment; **2** in Quality Appropriateness; **1** in Other Type; and **1** in Financial Services.

Our 3½ year steady downward trend in clients and client issues continued this period. Although we still deal with many callers, we opened cases on 26 fewer people this period than last. Complaint occurrences were down by a total of 64 from last period and grievance occurrences were down by 6. Some of this stems from the fact that we tend to refer hospital issues to hospital patient advocates and we no longer directly assist in issues involving jails, clinics and doctors not funded by NSMHA, or landlord-tenant housing complaints, all per NSMHA guidance. Yet, as we noted in our last report, we continue to attribute the drop in complaints and grievances primarily to effective treatment programs, especially those that are evidenced-based. In addition to those programs, we see more good things coming. (1) A legislative bill, *Improving Behavioral Health Services Provided to Adults in Washington State,* establishes outcome measures for behavioral health services and establishes a stakeholder committee to do a system-wide review of the public mental health system. It will expand evidence based practices and will develop a Tribal Centric Behavioral Health System. (2) NSMHA has sponsored a number of "*Have Your Say*" Children's Behavioral Health Forums and has obtained stakeholder input for children's services. (3) In its hiring and contracting process, NSMHA is encouraging providers to use peer counselors in more agency roles and is sponsoring more peer counselor training. (4) Under a bill entitled "*Uniform Transfer Agreement*" RSNs must jointly develop agreements for transferring clients between RSNs when the

clients wish to move. And (5) under the *Care Transitions Program* NSMHA hopes to promptly establish outpatient services for people discharging from inpatient services--to prevent re-hospitalization.

SLIDES 7: We had **2** Appeal cases, both "Other Type." There were no administrative hearings.

SLIDE 8: There were: **46** Caucasians; **6** Latinos; **5** African Americans; and **2** American Indian/Alaskan Natives. We made some good contacts at the Tulalip Clinic, and served one child from local tribes by information & referral. Ombuds clients were 78% Caucasian and 22% non-Caucasian. Although our non-Caucasian percentages rose a tiny amount, we still have a ways to go to reach the 34.9% of NSMHA clients in services that are non-Caucasian. Ombuds and several providers have a meeting in October with the Latina/Latino Advisory Council of Skagit County to discuss how to reach Latina/o clients.

SLIDE 9: We broke out this period's Physicians & Meds complaints. They are as follows:
Two prescribers ceased prescribing two clients' meds after the clients stopped taking some of their meds.
A prescriber ceased prescribing a psycho-stimulant after a client allegedly tested positive for street drugs.
A person claims they are receiving meds that are wrong for them and have severe side effects.
A client alleges that his clinician is holding up delivery of his meds.
A client was refused service by a prescriber and wished to transfer services.
A client has a longstanding disagreement with a clinic about diagnoses and meds.
Two clients were denied meds management services until they show they can attend all appointments.
A client considered his meds too heavily prescribed; and also wanted a second opinion.
A client had a prescription fill mix up between the provider agency and pharmacy.
A client with an on-going meds management dispute with a provider agency sought a PCP to prescribe.
A client felt his meds issues weren't resolved at the Evaluation & Treatment facility before release.
A client didn't receive all prescribed meds in a timely manner from her treatment provider.
Two clients had significant disagreement with meds they were prescribed while at the E&T facility.
A client wishes to be issued a weekly mediset rather than have daily monitoring meds taking.

SLIDES 10 & 11: Here are our notes and recommendations.

Outcomes: We closely monitored the outcomes of our cases this period.
- **14** or our 59 clients are still **open** and being worked.
- **32** were favorably closed through **conciliation and mediation**.
- **2** clients' issues were **arbitrated** by NSMHA through RSN-level grievances.
- DBHR dropped Information & Referral as a resolution but most of our 300 callers received both.
- **11** clients didn't pursue their issues. Here is a breakout of these **non-pursued** cases:

-- Reason for "Non-Pursued":	Our follow up:
Client left hospital and didn't return release form.	Client didn't wish to pursue the issue.
Client was released from Hospital	Client didn't wish to pursue the issue.
Client recovered from crisis; doesn't wish to pursue.	Sent 2 release forms.
Friend had client call. Client didn't return release form.	Client doesn't wish to pursue.
Issue was resolved; client is satisfied. No release form.	Client doesn't wish to pursue.
Client got busy with other things.	Client doesn't wish to pursue.
Caller for 2 clients was the grandmother.	Guardian (Mother) chose not to pursue
A PCP wanted Ombuds to initiate a complaint.	Client doesn't want the complaint initiated.
Client decided not to show for 2nd opinion consult	Client no longer wants a 2nd opinion consult.
Client was afraid of retaliation from hospital.	Discussed how retaliation is strictly forbidden and sent 2 release forms; one to clinician.

Consumer rights: All consumers need to be aware that consumer rights are now found in two sources: the Division of Behavioral Health & Recovery (DBHR) Medicaid Benefits Booklet and the new Behavioral Health Services Administrative Requirements, WAC: WAC 388-877-0600. We compared the new consumer rights to those formerly found in WAC 388.865.0410. Many of the old rights were omitted in the new WAC, but more or less, most of the omitted rights are still found in the Medicaid Benefits Booklet. We noted that the right to "*develop a plan of care and services which meets your unique needs,*" is now "*help your provider develop a plan of care with services to meet your needs*" in the DBHR Benefits Booklet. And the right to "*appeal any denial, termination, suspension or reduction of services and to continue to receive services at least until your appeal is heard by a fair hearing judge,*" is gone.

Provider meds management policy: Ombuds is skeptical of provider policies of establishing no meds management appointments until clients regularly keep their case management appointments. The idea is to ensure a client will attend meds management appointments. The clients are sent to local community health centers for meds, yet, we question the amount of time clients get to spend in effective meds management there and we speculate that without necessary medications being prescribed there is more likelihood that symptoms will appear and lead to missed appointments, trespasses from facilities and so forth. We understand the cost of a psychiatrist's time but we aren't sure this is the wisest possible policy. This policy is now being discussed.

Spenddowns: We had a difficult situation wrapped around a spenddown. We appreciate NSMHA's request to DSHS for clarification on this issue. We recommend NSMHA research current providers' policies on charging/collecting for spenddowns and decide how to proceed. With State funding budget cuts, we are concerned about funding for continuing treatment services while people are in spenddown periods. When NSMHA receives its new contract and determines the extent of the state funds cut, this will be an important issue to deal with.

Landlord-tenant complaints: Consumers need to be aware that Ombuds is unable to initiate complaints or grievances on landlord-tenant complaints. We are "community mental health program" Ombuds and landlord-tenant complaints are not community mental health program complaints. Even if a provider agency is the landlord, there are no "landlord-tenant" contracts between NSMHA and provider agency housing agencies. We realize it's difficult for clients to understand why Ombuds can't help them with landlord-tenant disputes specifically involving provider agencies. If there are mental health components to the complaint we help people with those components only. We speculate that with the improved economy, landlords, both provider and non-provider, are tightening up on rental policies and monitoring restrictions more closely. We heartily support DBHR housing webinars on developing & maintaining landlord relationships and other efforts to help tenants and landlords get along. Consumers need to be advised by clinicians and providers that if there is a legitimate landlord-tenant dispute, they can call the Northwest Justice Project's CLEAR line at 1.888.201.1014 to seek free legal assistance.

Family member advocates: Family members who frequently don't appreciate the way the community mental health program operates, need to be aware that making unrealistic demands and violating boundaries often hurts more than it helps. Ombuds will work within the system to advocate for people and present grievances, even to the point of administrative hearings, but we can't exceed our guidelines.

Success stories: (1) We in Ombuds do our best to develop a professional relationship with a client where the client appreciates Ombuds support and encouragement and strives to do well in their recovery to fulfill Ombuds' high expectations. This seems to be working rather effectively with one of our more challenging clients. We hope everyone providing treatment does the same. (2) When Ombuds finds a person who has been denied access by one of the community mental health program providers and we are

fairly certain the person meets standards for access, we usually have that person schedule an access appointment at another agency as a "second opinion" before we have to go through the appeal process. Sometimes we even attend the appointment. That happened recently. The client was accepted for access. Family members attended the appointment and noted that the agency had a very polite, concerned and fair intake evaluation process.

Ombuds relocation: Ombuds has relocated to Suite 42 upstairs in the Carnation Building. Come visit!

Client exploitation: Ombuds found two consumers who were exceedingly vulnerable adults. They lived together independently but were being exploited by a young family member. The family member stole their possessions, money and meds. We were greatly disappointed to learn from Adult Protective Services that they cannot help the couple unless the couple "receive services from a DSHS contracted individual provider"… meaning COPES, hospice or the like. Police and other outside agencies seemed reluctant to help. Fortunately this story had a happy ending. The clinic was able to work with the runaway's family in another state and the runaway was taken back home by a family member. We ask clinicians to be aware of clients living in potentially exploitive environments and do what they can to ameliorate the situation. If needed, Ombuds will help initiate formal complaints with Adult Protective Services and NSMHA will back us up.

PTSD/TBI studies worth tracking: The Departments of Defense and Veterans Affairs have established two joint research consortia at a combined investment of $107 million to research the diagnosis and treatment of post-traumatic stress disorder (PTSD) and mild traumatic brain injury (TBI) over a five-year period. The Consortium to Alleviate PTSD will attempt to develop the most effective diagnostic, prognostic, novel treatment, and rehabilitative strategies to treat acute PTSD and prevent chronic PTSD. Also, the Chronic Effects of Neurotrauma Consortium will examine the factors which influence the chronic effects of mild TBI and common comorbidities in order to improve diagnostic and treatment options. For more information on TBI, visit DoD's Traumatic Brain Injury Special Report webpage. For more resources on PTSD, visit the Military.com PTSD section. (Source: Military.com Veterans Report)

DBT Classes: Several clients have recently initiated complaints that it's difficult to find a Dialectical Behavioral Therapy (DBT) class. We urge providers to have on-going training of sufficient staff to keep the valuable DBT courses going during staff turnover.

Smoking cessation, diet and exercise: We spoke to several doctors this period who provided the same advice. We promised them we would include an entry in our semiannual report. The doctors we spoke to said our clients' lives would be better and longer if the community mental health program stressed smoking cessation, diet and exercise more emphatically than it does.

Changes to the complaint & grievance system: the Division of Behavioral Health and Recovery seems to have worked out the general details of the new grievance, appeal, administrative hearing and notice of action process which is to begin October 1st 2013. We will closely coordinate with NSMHA as it begins writing new local procedures to ensure our clients receive the latest and most up-to-date assistance.

Specialized needs clients: This period we helped two clients with Autism spectrum disorders (one child and one young adult), gain access to behavioral health treatment. However, we are concerned that treatment will be ineffective if the Autism spectrum disorders aren't treated along with the covered mental health disorders. These clients have been turned away by the Developmental Disabilities Administration as being too high functioning. We referred them to the Health Care Authority's Autism assessment programs and Apple Health but neither client has found treatment for the Autism spectrum disorders yet. We will continue to advocate for these clients and their families.

Potential problems: Expecting Medicaid expansion to bring in more federal funds, the legislature has cut state funding for behavioral health services…for NSMHA this comes to around $3 to $4 million potentially to be cut from its approximate $17 million State funding—an 18 to 25% cut. Unfortunately, a number of critical services depend heavily on state funding because Medicaid doesn't cover them sufficiently. These include crisis services, (including all involuntary treatment court costs), housing support services and residential treatment services (residential room and board), flex funds, Medicaid Personal Care, and services for folks just out of Western State Hospital and Children's Long-term Inpatient Program who aren't on Medicaid. The same applies to covering non-Medicaid people court-ordered into outpatient services on lesser restrictive orders and conditional restrictive orders; on-going treatment for people who enter spenddown; and keeping non-Medicaid people in services for longer periods when necessary. Many of these costs were already rising. In addition, chemical dependency treatment will see no increase in funding even though a number of the new Medicaid expansion people will likely have chemical dependency issues; and it's difficult to make headway on mental health treatment in that situation. The legislature also approved loosening the rules to involuntarily commit people beginning July 2014 so numbers of involuntarily committed people will likely rise. But, as noted, Medicaid doesn't cover all involuntary commitment costs. These are problems facing NSMHA. We recommend all stakeholders participate when surveys are conducted and information-gathering forums are held.

SLIDE 12: Are there questions or comments?

AGENCY COMPLAINT/GRIEVANCE OCCURRENCE COUNTS

Approximate numbers of clients served by individual provider agencies (based on latest statistics); and approximate complaint rate overall:

Catholic Community Services: 1276 clients; 0 occurrences = .0% complaint/grievance rate
Compass Health Residences: 46 clients; 0 occurrences = 0% complaint/grievance rate
Compass Health South: 5570 clients; 39 occurrences = .07% complaint/grievance rate
Compass Health North: 1908 clients: 8 occurrences = .04% complaint/grievance rate
Interfaith Family Health Center: 283 clients; 3 occurrences = .1% complaint/grievance rate
Lake Whatcom Center & PACT: 453 clients; 11 occurrences = .2% complaint/grievance rate
SeaMar: 1158 clients; 1 occurrence = .08% complaint/grievance rate
Sunrise Services: 1097 clients; 12 occurrences = .1% complaint/grievance rate
Whatcom Counseling/Psychiatric Clinic: 1365 clients; 5 occurrences = .03% complaint/grievance rate
Volunteers of America: 7934 clients; 1 occurrence = .001% complaint/grievance rate
Pioneer Human Services: 157 clients; 0 occurrences = .0% complaint/grievance rate

PROVIDER AGENCY: **OCCURRENCES:**

Catholic Community Services Mount Vernon: 0 Occurrences **Last period 0 Occurrences**

Catholic Community Services Bellingham: 0 Occurrences **Last period 1 Occurrence**

Catholic Community Services Everett: 0 Occurrences **Last period 0 Occurrences**

Compass Health Residences: 0 Occurrences **Last period 0 Occurrences**

Compass Health, Everett: 14 Occurrences **Last period 17 Occurrences**
Access: **1**
Consumer Rights: **3**
Financial & Admin Services: **1**
Physicians & Meds: **2**
Quality Appropriateness: **1**
Services Coordination/Intensity: **2**

RSN-level grievances:
Consumer Rights: **2**
Financial & Admin Services: **1**
Housing: **1**

Compass Health Snohomish Triage Facility: 0 Occurrences **Last period 4 Occurrences**

Compass Health, Lynnwood (children's & adults): 7 Occurrences **Last period 7 Occurrences**
Access: **1**
Consumer Rights: **2**
Other Type: **1**
Dignity & Respect: **1**
Quality Appropriateness: **1**
Services Coordination/Intensity: **1**

Compass Health, Marysville: 3 Occurrences **Last period 5 Occurrences**
Housing: **1**
Physicians & Meds: **1**
Services Coordination/Intensity: **1**

Compass Health, Mount Vernon: 6 Occurrences — **Last period 4 Occurrences**
Access: **1**
Consumer Rights: **2**
Physicians & Meds: **2**
Services Coordination/Intensity: **1**

Compass Health, Payee Office: 0 Occurrences — **Last period 0 Occurrences**

Compass Health, San Juan: 0 Occurrence — **Last period 1 Occurrence**

Compass Health, Smokey Point: 0 Occurrences — **Last period 2 Occurrences**

Compass Health, Snohomish: 0 Occurrences — **Last period 3 Occurrences**

Compass Health, Whidbey: 0 Occurrences — **Last period 3 Occurrences**

Interfaith: 3 Occurrences — **Last period 3 Occurrences**
Dignity & Respect: **1**
Physicians & Meds: **1**
Services Coordination/Intensity: **1**

Lake Whatcom Center: 10 Occurrences — **Last period 15 Occurrences**
Consumer Rights: **3**
Housing: **2**
Physicians & Meds: **5**

Lake Whatcom Residential & Treatment Center: 0 Occurrences — **Last period 0 Occurrences**

Whatcom PACT: 1 Occurrence — **Last period 10 Occurrences**
Consumer Rights: **1**

Skagit PACT: 1 Occurrence — **Last period 0 Occurrences**
Access: **1**

Snohomish PACT: 0 Occurrences — **Last period 0 Occurrences**

Mukilteo Evaluation & Treatment Center: 15 Occurrences — **Last period 10 Occurrences**
Consumer Rights: **4**
Emergency Services: **3**
Dignity & Respect: **2**
Physicians & Meds: **3**

Provider level grievance occurrences:
Consumer Rights: **1**
Dignity & Respect: **1**
Physicians & Meds: **1**

PeaceHealth Medical Center: 1 Occurrence — **Last period 2 Occurrences**
Consumer Rights: **1**

Skagit Valley Hospital: 0 Occurrences — **Last period 4 Occurrences**

Providence Hospital: 0 Occurrences — **Last period 3 Occurrences**

Swedish Edmonds Hospital: 2 Occurrences — **Last period 3 Occurrences**
Emergency Services: **1**
Participation in Treatment: **1**

Sea Mar, Bellingham: 0 Occurrences **Last period 0 Occurrences**

Sea Mar, Everett: 1 Occurrence **Last period 1 Occurrence**
Dignity & Respect: **1**

SeaMar Lynnwood: 0 Occurrences **Last period 0 Occurrences**

Sea Mar Monroe: 0 Occurrences **Last period 0 Occurrences**

Sea Mar, Mount Vernon: 0 Occurrences **Last period 0 Occurrences**

Skagit Triage Facility: 0 Occurrences **Last period 1 Occurrence**

Snohomish County Involuntary Treatment Services: 0 Occurrences **Last period 1 Occurrence**

Skagit County Involuntary Treatment Services: 1 Occurrence **Last period 0 Occurrences**
Emergency Services: **1**

Whatcom County Involuntary Treatment Services: 0 Occurrences **Last period 1 Occurrence**

Sunrise Services, Everett: 8 Occurrences **Last period 18 Occurrences**
Access: **1**
Consumer Rights: **3**,
Dignity & Respect: **1**
Physicians & Meds: **1**
Participation in Treatment: **1**

Provider-level grievances:
Consumer Rights: **1**

Sunrise Services, Mount Vernon: 4 Occurrences **Last period 1 Occurrence**
Housing: **1**
Consumer Rights: **1**
Dignity & Respect: **1**
Physicians & Meds: **1**

Whatcom Counseling & Psychiatric Clinic: 5 Occurrences **Last period 16 Occurrences**
Emergency Services: **1**
Physicians & Meds: **2**
Services Coordination/Intensity: **2**

VoA (Access Line & Care Crisis Line): **1 Occurrence** **Last period 2 Occurrences**
Consumer Rights: **1**

Hopelink (Medicaid Transportation) **0 Occurrences** **Last period 0 Occurrences**

NSMHA: 2 Occurrences (appeals) **Last period 7 Occurrences**
Other Type: **2**

New definitions of grievances and resolutions:

The Division of Behavioral Health & Recovery and the RSNs are finally working out the details of the new grievance, appeal and formal written notice process and NSMHA will be writing new operating instructions for them soon. We will brief you on the new instructions when they are complete. In this snapshot we have already changed "complaints" and "provider-level grievances" to "Level 1 Grievances" and "RSN-Level grievances" to "Level 2 Grievances." Under the new grievance rules, the timeline for grievances is 45 days, although RSNs can shorten it. Clients still have the right to skip Level 1 grievances and go straight to Level 2 although hopefully that won't happen often.

These are the new, state-wide grievance definitions and resolutions:

Access: Concerns about ability to receive intake appointments, timeliness of referrals/appointments, or other issues with the intake or referral process. Inability to access services due to language barriers. Denials, terminations, suspensions or reductions of services for Non-Medicaid clients. (A denial or termination of services for a Medicaid client is not a grievance, it is an Action and the RSN must provide a Notice of Action. Notices of Actions may then be appealed)

Dignity and Respect: Issues regarding courtesy, tone of voice, language or other treatment seen as disrespectful.

Quality/Appropriateness: Issues regarding poor quality treatment or treatment errors.

Phone Calls Not Returned: May involve calls made to multiple clinicians or supervisors.

Service Intensity, Not available, or Coordination of Services: Generally issues in this category would be Actions, (e.g. disagreement with treatment plan) except for Non-Medicaid clients. It may include problems with coordination between providers, peer support services, health care providers or others involved in treatment planning.

Participation in Treatment: A grievance might be an individual's voice and viewpoint is not being included in treatment planning, or a parent is dissatisfied with their level of participation or requested other supports are not involved in treatment planning.

Physicians, ARNPs, and Medications: Problems with communication or scheduling issues. Disagreement with medications is an Action for Medicaid clients and requires providing a Notice of Action. A person may also request a 2nd opinion.

Financial and Administrative Services: Generally deals with payees employed by the provider and funded by the RSN, or incorrect paperwork or billing issues. An individual may not file a grievance regarding eligibility for SSI or regarding private payees.

Residential: Issues with RSN-related services. These should primarily concern mental health treatment activities, noise or privacy. An individual may, however, file a grievance on other issues including food, health or safety. These issues should be investigated by the RSN as well as be referred to the Department of Health.

Housing*:* Issues related to effectiveness in assisting clients obtain and maintain housing. This does not include landlord/tenant issues.

Transportation: Issues relating to transportation that are RSN-related.

Emergency Services: These grievances would always involve an additional category, to clarify the nature of the problem. Grievances generally relate to services the RSN provides, including crisis lines, E&T centers, hospital alternative programs or detainments.

A person may file an RSN grievance about a DMHP or detention services. The result of the detention process is under the jurisdiction of a Superior Court and is not grievable. RSNs should note any trends in detentions. Examples of grievances might be dignity and respect issues, privacy, lack of timeliness or lack of due process.

Grievances from RSN-enrolled clients regarding an authorized stay in a community hospital are also accepted, as well as encouraging clients to use hospital-specific complaint processes. The intention is to maintain dialogue with hospitals to ensure quality service for RSN clients

Violation of Confidentiality: Any information regarding a client that is inappropriately disclosed, including name, diagnosis, treatment or providers.

Other Rights Violations: Violation of any consumer rights that are not covered in other categories (such as dignity and respect and confidentiality). These could include issues involving interpreters, cultural differences, or Advance Directives.

Other: A rarely used category for hard to categorize issues.

Resolution Types

Information or Referral: A grievance is resolved mutually through providing additional information or referral to other services. An example would be a person believing their rights had been violated but was satisfied by being directed to WAC.

Conciliation/Mediation: A resolution agreed to mutually.

Not Pursued: Client requested to end grievance, discontinued participation in grievance process, moved away, was hospitalized, died, etc. A letter of resolution should be sent whenever possible, using discretion and sensitivity.

Other: An RSN resolution decision without mutual agreement. Other hard to categorize resolutions.

(A Fair Hearing is not a resolution. The grievance resolution letter is sent with its explanation—that is the resolution. The filing of a Fair Hearing is a separate decision.)

NSMHA COMMITTEE DISCUSSION FORM

AGENDA ITEM: Contract Deliverable - Grievance report to DBHR

PRESENTER: Diana Striplin

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

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:

This is the May 15, 2013 Grievance System report sent to DBHR. It covers the period of October 2012 through March 2013.

Grievance System Processes

DBHR has been changing the Grievance System and Grievance System reporting requirements. NSMHA is in the process of reviewing our policies and will be revising our policies and reporting systems to be in line with changing DBHR expectations.

For this reporting period we used the interim reporting system developed by DBHR. For this interim period we reported Grievance data and enrollee appeal data.

We anticipate that some items considered complaints will be reported as grievances in the future. In addition Notices of Action will again be incorporated back into grievance system reporting to DBHR.

Ombuds and providers also continued to collect complaint data and provide semiannual reports to NSMHA.

- Providers continue to report complaint and grievance data for continuous quality improvement and report these efforts to NSMHA every 6 months.
- Providers have incorporated complaint and grievance information into their quality management processes.
- Ombuds continue to provide reports and make recommendations every 6 months.

NSMHA also has an Internal Grievance Committee which reviews grievance system information. System recommendations may also be taken through the committee structure to Leadership Team and then QMOC.

Data from latest report--For this latest report there was a decrease in grievances. NSMHA also had 2 individuals request a fair hearing.

CONCLUSIONS/RECOMMENDATIONS:

1. **Review Status of Previous ongoing System Recommendations in the Report.**
2. **Discuss Expertise for Specialty Areas—NSMHA will ask providers for their plan to work with individuals who have eating disorders and DID. NSMHA's medical director is also contacting University of Washington for resources.**

TIMELINES: May 15, 2013 Report (October 2012 through March 2013)

ATTACHMENTS:
May 15, 2013 Grievance System Report

NORTH SOUND MENTAL HEALTH ADMINISTRATION
GRIEVANCE, FAIR HEARING, and APPEAL SUMMARY
October, 2012 through March, 2013

INTRODUCTION

NSMHA has continued to report grievances, fair hearings, and appeals in accordance with DBHR reporting templates and requirements. NSMHA is utilizing the interim reporting forms as instructed by DBHR for this reporting period of October 2012 through March 2013 and will then phase in the newly developed reporting forms and instructions. NSMHA is in the process of reviewing our policies and will be revising our grievance reporting and policies to be in line with changing DBHR expectations.

GRIEVANCE, APPEAL, and FAIR HEARING DATA

As outlined above, NSMHA utilized the interim reporting forms as directed by DBHR. NSMHA continued to collect grievance cases (unduplicated) and category (type) and level of grievance on these interim reporting forms. Type and level of grievance were referred to as occurrence on previous reports. For the resolved and unresolved columns we reported whether a written resolution was provided by the end of the period (resolved) or not yet provided at the end of the period (unresolved).

The Ombuds row under grievance resolutions reflects the number of resolved grievance categories and levels that Ombuds that was involved with. NSMHA Ombuds may assist individuals at both the CMHA and RSN level grievance process as well as fair hearing requests and appeals.

There were seven (7) new grievance cases and twenty four (24) category (type) and level of grievances reported for October 2012 through March 2013. The number of new cases and category and level of grievances shows a decrease since last period. There was one (1) appeal by an enrollee reported. (See Attachments (1) PIHP Grievances (2) SMHC Grievances and (3) Appeals Report).

NSMHA also had two (2) individuals request fair hearing during this period. Fair hearing is only represented as a resolution on these interim reporting forms so we did not report them. We understand this is changing on the newly developed reporting forms.

QUALITY MANAGEMENT PROCESSES and RECOMMENDATIONS

NSMHA continues to fine-tune our quality management processes and has continued to maintain an Internal Grievance Review Committee and a Leadership Team. System recommendations related to the grievance system are reviewed by NSMHA Leadership Team and then taken to NSMHA Quality Management Committee.

NSMHA has also started a monthly meeting with our Ombuds Services. NSMHA continues to discuss integration of Ombuds recommendations with these other grievance system recommendations and continues to review this system.

North Sound Regional Ombuds also continue to provide a semiannual summary of their recommendations for quality improvement or further study and review to Leadership Team. Once approved by leadership team select recommendations may also be taken to QMOC.

We anticipate that some items that were considered complaints will be reported as grievances in the future. For this reporting period NSMHA providers and designees continued to use both complaint and grievance information in their internal quality management processes and provide a semiannual summary of this information to the NSMHA. NSMHA providers and designees also continue to provide a summary about how complaint and grievance information is integrated into provider/designee Quality Management Plans.

NSMHA Leadership Team will review this report, identify any new recommendations, and review status of previous system recommendations identified and reviewed below. The report will then be taken to NSMHA Quality Management Committee.

Previous System Recommendations through the Quality Management Committee Process that are related to grievance system include:

1. **Expertise for Specialty Areas** (Recommendation was made to contract for assessments and/or second opinions in specialty areas (DID, PTSD, Eating Disorders). The recommendation is to look for expertise in these areas within the network but not restrict ourselves to the network). NSMHA has also had broader discussions about trauma informed care.

   Update: *NSMHA is reviewing expertise within our network. Our medical director may also contact resources outside of our network. The original recommendation was revised to exclude the term complex PTSD as this will not be a diagnosis in the DSM V.*

2. **Consultation during Assessment Process** (Recommendation was made for providers to consult with prescribers of psychiatric medication during the assessment process prior to recommending to NSMHA that individual's do not meet access to care standards. Recommendation was also made for providers to send information about medications to NSMHA when recommending that individual's don't meet access to care standards if they are currently being prescribed psychiatric medications which might be reducing symptoms)

   This item was reviewed in QMOC. It was decided that providers would do the following:
   1. Seek information from prescribers if they plan to recommend that individuals do not meet access to care standards, 2. Ask for an extension if needed, and 3. Clearly document the reason if the information was unable to be obtained. It was also decided that 4. Providers would send in information about psychiatric medications to NSMHA when recommending that individuals do not meet access to care standards.

   Update: *There have not been recent grievances to NSMHA regarding consultation with outside prescribers and we recommended that NSMHA consider this item largely completed at this time. NSMHA will review this item in the future if indicated.*

3. **Dignity and Respect** (Recommendation for further study and review of dignity and respect in the region).

   As outlined in previous reports, the NSMHA plan was to develop a system-wide partnership with consumers, advocates, providers and other stakeholders to explore how dignity and respect is experienced and perceived within our system of care. This plan was reviewed and approved by RQMC and QMOC. In part due to concerns raised by consumers, Dignity and Respect was also a topic of required training on the NSMHA Regional Training Plan.

   NSMHA had initiated the dignity and partnership as outlined above and developed the charter**.** The following recommendations were made to the NSMHA Planning Committee.
   1. Develop a Dignity and Respect Campaign 2. Develop a Dignity and Respect Toolkit. The toolkit will include training resources, organizational self assessments, etc.

   EQRO highlighted dignity and respect workgroup as NSMHA strength in 2010 EQRO Annual Report.

   The Dignity and Respect site has been added to the NSMHA website and the dignity and respect pledge, part of the dignity and respect campaign, was initiated. NSMHA and providers had begun to work on the organizational self-assessment tool.

NSMHA had contracted with the University of Pittsburgh Medical Center (UPMC) to assist us with developing and maintaining our dignity and respect campaign. The UPMC Campaign includes 3 toolkits to be implemented over a 3 year period. UPMC launched a national dignity and respect campaign in 2010. Linda Kehoe was hired as a consultant to assist with our Dignity and Respect Initiative. We will also continue work on a Dignity and Respect Organizational Self-Assessment.

Update: *NSMHA continues with the Dignity and Respect initiative and campaign and continues to have Dignity and Respect meetings with a variety of stakeholders. Linda Kehoe, the NSMHA Dignity and Respect Consultant, has been working on the first of the 3 phases of the Dignity and Respect campaign. The first phase involves raising awareness of dignity and respect and accessing the work environment. Linda Kehoe has also met with a variety of stakeholders on this first phase of the campaign.*

Multiple NSMHA providers have also started their own dignity and respect campaigns. NSMHA and providers will also be meeting to develop a human resources training module. NSMHA had postponed development of an organizational self-assessment tool but has plans to develop this in the future.

4. **Medication Management Services** (Recommendation for further study and review of access to medication management services.) As outlined in the previous reports, medication management services, including access and triage to medication management services, medication management capacity, and discharge from medication management services has been identified as an area for further study and review. (Ombuds services concerns and complaint data were one factor leading to further study and review of access to medication management services.)

   NSMHA completed a plan to study medication management services and the NSMHA and providers adopted a modified fee for service model that purchases an increase in medication management services. NSMHA also began the process to study medication management services by requesting copies of provider medication management triage policies and procedures for review.

   NSMHA has developed a Performance Improvement Project (PIP) to decrease the days to medication evaluation appointment after request for service.

   Update: *NSMHA continues to implement the Performance Improvement Project, regarding the days to medication evaluation appointment after request for services.*

5. **Database for Notices, Complaints, Grievances, and Fair Hearings** (Recommendation to develop a regional database for complaints, grievances and fair hearings to track, monitor and analyze data related to complaints, grievances and fair hearings and unduplicate cases.)

   NSMHA had discontinued collecting and unduplicating overall complaint and grievance data. Ombuds continued to collect complaint data. NSMHA continued to report grievance and fair hearing data. NSMHA had decided to begin by developing a centralized method to collect notices of action and notices of adverse determination.

   Update: *NSMHA will develop a database that is aligned with the new DBHR reporting requirements. This recommendation will be adjusted to reflect the revised DBHR reporting requirements regarding the grievance system including grievances and notice of action.*

COMPLETED, INACTIVE, and HISTORICAL QUALITY IMPROVEMENT INITIATIVES

The NSMHA continues to track areas for further study and review or quality improvement related to complaint, grievance, fair hearing, denial, and appeal data. Information about complaints, grievances, fair hearings, or denials has been one factor in further review or quality improvement efforts over time towards:

- ✓ Reviewing the process for provider **risk assessment and management** in QMOC
- ✓ Reviewing the process by providers to provide **written letters of closure** for episodes of care and assuring those with high needs receive advance written notice of closure
- ✓ Historical efforts to provide a series of region-wide trainings about **eating disorders** and adopting APA Guidelines that outline a continuum of care for eating disorders.
- ✓ Developing a clinical practice guideline for **Adult Attention Deficit Hyperactivity Disorder (ADHD)**
- ✓ Increasing **Flex Funds**
- ✓ Reviewing the **region wide access processes** used to gather information and records when consumers are entering services
- ✓ Historical efforts to provide **trauma informed services** including the development of trauma pilot projects in 3 counties, the development of a PTSD training module and review of trauma screening tools
- ✓ Assuring staff is trained on **Dignity and Respect** and **Consumer Rights**
- ✓ Clarifying policies and procedures regarding the **outpatient discharge process**
- ✓ The development of a **medication management transfer policy** to ensure seamless transition to primary care physicians
- ✓ The development of region wide **diagnostic practice standards** utilized in determining eligibility for services
- ✓ Historical efforts to identify the need to address a shortage **of case management services** at a provider during the transition to modified fee for service contracts.
- ✓ Recommending to **statewide peer support trainers** that they consider adding training about employee issues

Division of Behavioral Health and Recovery

Grievance Report

RSN Name: NSMHA

Reporting Period: Oct 2012 through March 2013

Contract Type: ☐ SMHC ☑ PIHP

Contact Name: Diana Striplin

Unduplicated Number of Adult Grievances: 6

Unduplicated Number of Children's Grievances 0

Adult (21 Yrs. and over)				
Category	**CMHA Grievances**	**PIHP & Ombuds Grievances**	**Resolved**	**Unresolved**
Access to Outpatient	0	0	0	0
Dignity and Respect	0	1	0	1
Quality/ Appropriateness	1	0	1	0
Phone calls not returned	0	0	0	0
Service -- Intensity, Not Available, Coordination	1	0	0	1
Consumer Rights	4	3	6	1
Physicians & Medications	2	2	3	1
Financial & Admin Svs	0	0	0	0
Transportation	1	0	0	1
Emergency Services	0	0	0	0
Access to Inpatient	0	0	0	0
Violation of Confidentiality	0	0	0	0
Participation in Treatment	0	0	0	0
Other	1	0	1	0
Total	**10**	**6**	**11**	**5**

Children (under age 21)				
Category	**CMHA Grievances**	**PIHP & Ombuds Grievances**	**Resolved**	**Unresolved**
Access to Outpatient	0	0	0	0
Dignity and Respect	0	0	0	0
Quality/ Appropriateness	0	0	0	0
Phone calls not returned	0	0	0	0
Service -- Intensity, Not Available, Coordination	0	0	0	0
Consumer Rights	0	0	0	0
Physicians & Medications	0	0	0	0
Financial & Admin Svs	0	0	0	0
Transportation	0	0	0	0
Emergency Services	0	0	0	0
Access to Inpatient	0	0	0	0
Violation of Confidentiality	0	0	0	0
Participation in Treatment	0	0	0	0
Other	0	0	0	0
Total	**0**	**0**	**0**	**0**

Resolutions		
Adult (21 Yrs. and over)	**CMHA Grievances**	**PIHP & Ombuds Grievances**
Fair Hearings		
Ombuds	6	4
Total	**6**	**4**

Resolutions		
Children (under age 21)	**CMHA Grievances**	**PIHP & Ombuds Grievances**
Fair Hearings		
Ombuds		
Total	**0**	**0**

Division of Behavioral Health and Recovery

Grievance Report

RSN Name: Diana Striplin

Reporting Period: Oct 2012 through March 2013

Contract Type: ☑ SMHC ☐ PIHP

Contact Name: Diana Striplin

Unduplicated Number of Adult Grievances: 1

Unduplicated Number of Children's Grievances 0

Adult (21 Yrs. and over)				
Category	**CMHA Grievances**	**PIHP & Ombuds Grievances**	**Resolved**	**Unresolved**
Access to Outpatient	0	0	0	0
Dignity and Respect	0	1	1	0
Quality/ Appropriateness	0	2	2	0
Phone calls not returned	0	0	0	0
Service -- Intensity, Not Available, Coordination	0	0	0	0
Consumer Rights	0	3	3	0
Physicians & Medications	0	0	0	0
Financial & Admin Svs	0	1	1	0
Transportation	0	0	0	0
Emergency Services	0	0	0	0
Access to Inpatient	0	0	0	0
Violation of Confidentiality	0	0	0	0
Participation in Treatment	0	0	0	0
Other	0	1	1	0
Total	**0**	**8**	**8**	**0**

Children (under age 21)				
Category	**CMHA Grievances**	**PIHP & Ombuds Grievances**	**Resolved**	**Unresolved**
Access to Outpatient	0	0	0	0
Dignity and Respect	0	0	0	0
Quality/ Appropriateness	0	0	0	0
Phone calls not returned	0	0	0	0
Service -- Intensity, Not Available, Coordination	0	0	0	0
Consumer Rights	0	0	0	0
Physicians & Medications	0	0	0	0
Financial & Admin Svs	0	0	0	0
Transportation	0	0	0	0
Emergency Services	0	0	0	0
Access to Inpatient	0	0	0	0
Violation of Confidentiality	0	0	0	0
Participation in Treatment		0	0	0
Other	0	0	0	0
Total	**0**	**0**	**0**	**0**

Resolutions		
Adult (21 Yrs. and over)	**CMHA Grievances**	**PIHP & Ombuds Grievances**
Fair Hearings		
Ombuds		5
Total	**0**	**5**

Resolutions		
Children (under age 21)	**CMHA Grievances**	**PIHP & Ombuds Grievances**
Fair Hearings		
Ombuds		
Total	**0**	**0**

PIHP Notice of Action Appeals Report

RSN NSMHA

Report Period October 2012 through March 2013

Expedited Appeals

ADULTS	Resolutions		
	Resolution within **3** working days	Wholly in favor of Enrollee	Not Wholly in favor of Enrollee
Referred to Standard Appeals			
Denials			
Reduction			
Suspensions			
Terminations			
Total		0	0
Fair Hearings			
Refered to Ombuds			

Expedited Appeals

CHILDREN	Resolutions		
	Resolution within **3** working days	Wholly in favor of Enrollee	Not Wholly in favor of Enrollee
Referred to Standard Appeals			
Denials			
Reduction			
Suspensions			
Terminations			
Total	0	0	0
Fair Hearings			
Refered to Ombuds			

Standard Appeals

	Resolutions		
	Resolution within **45** days	Wholly in favor of Enrollee	Not Wholly in favor of Enrollee
Denials (access to care)			
Denial (srvs. Not covered	1	1	
Denial (refusal of tx plan)			
Reduction			
Suspensions			
Terminations			
Total	1	1	0
Fair Hearings			
Refered to Ombuds			

	Resolutions		
	Resolution more than **45** days	Wholly in favor of Enrollee	Not Wholly in favor of Enrollee
Denials (access to care)			
Denial (srvs. Not covered			
Denial (refusal of tx plan)			
Reduction			
Suspensions			
Terminations			
Total	0	0	0
Fair Hearings			
Refered to Ombuds			

Standard Appeals

	Resolutions		
	Resolution within **45** days	Wholly in favor of Enrollee	Not Wholly in favor of Enrollee
Denials (access to care)			
Denial (srvs. Not covered			
Denial (refusal of tx plan)			
Reduction			
Suspensions			
Terminations			
Total	0	0	0
Fair Hearings			
Refered to Ombuds			

	Resolutions		
	Resolution more than **45** days	Wholly in favor of Enrollee	Not Wholly in favor of Enrollee
Denials (access to care)			
Denial (srvs. Not covered			
Denial (refusal of tx plan)			
Reduction			
Suspensions			
Terminations			
Total	0	0	0
Fair Hearings			
Refered to Ombuds			

NSMHA COMMITTEE DISCUSSION FORM

AGENDA ITEM:
Clinical Performance Improvement Project (PIP): *Decrease in the Days to Medication Evaluation Appointment after Request for Service*

PRESENTER: Charissa Westergard for Julie de Losada

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

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:

- Acumentra (External Quality Review Organization) reviewed the PIP, Decrease in the Days to Medication Evaluation Appointment after Request for Service, with NSMHA on September 26, 2013 in their in person PIP Audit.
- After 3 interventions, we have seen no statistical improvement in this PIP.
- All statically significant results appear to be tied to the non-PIP related "open access" models that some providers have adopted.
- The need to reduced # of days from RFS to medication evaluation continues.

CONCLUSIONS/RECOMMENDATIONS:

- Acumentra recommends:
  - Discontinuing this study topic as a PIP
  - Continuing focus on topic through other NSMHA CQI process.
- NSMHA supports this recommendation
- We will need to develop a new clinical PIP topic
  - Recommend tying new PIP to needs identified in NSMHA Strategic Plan
- **RECOMMENDED ACTION: Formal QMOC vote to support discontinuing this PIP**

TIMELINES:

- Julie de Losada will start workgroup for the NEW PIP in January

ATTACHMENTS:

- None

NSMHA COMMITTEE DISCUSSION FORM

AGENDA ITEM:
Non-Clinical Performance Improvement Project (PIP): *Improving the Quality of Care Coordination for High-Risk Transition Age Youth (< age 21)*

PRESENTER: Charissa Westergard for Julie de Losada

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

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:

- Acumentra (External Quality Review Organization) reviewed this PIP on Improving the Quality of Care Coordination for High-Risk Transition Age Youth (< age 21) in person with NSMHA on September 26, 2013.
- We received strong support for the study topic and study population.
- We received feedback on how to make the study simpler, including the suggestion to create as a pilot in Snohomish County the 1st year of intervention and then take to scale the 2nd year.
- This PIP will likely help us adhere to T.R. Settlement Agreement as well.

CONCLUSIONS/RECOMMENDATIONS:

- Continue refining PIP design and data plan

TIMELINES:

- Julie de Losada will re-start this workgroup in December 2013

ATTACHMENTS:

- None

North Sound Mental Health Administration
Regional Support Network for Island, San Juan, Skagit, Snohomish, and Whatcom Counties
Improving the mental health and well being of individuals and families in our communities
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North Sound Mental Health Administration Clinical Guidelines

10/16/13

Effective 2004
Revisions Effective 2005, 2006, 2008, 2010 & 2013*

***Note: See APPENDIX I Guideline Adoption/Review Chronology**

Table of Contents

North Sound Mental Health Administration
Statement of Intent

The intent of the North Sound Mental Health Administration's Clinical Guidelines is to provide a foundation to assist our mental health system in the delivery of high quality, consistent clinical services. They promote the delivery of consistent clinical care on a regional basis.

These clinical guidelines are **not** to be construed to limit the individualization of treatment, clinician judgment or the ability of the clinician to provide treatment in the best interests of the client. Provision of treatment may be qualified by limitations of payment sources and funding.

The basis for these guidelines is the Diagnostic and Statistical Manual of Mental Disorders (DSM 5) however we recognize that symptoms and clinical presentation do not always meet clear DSM 5 diagnostic criteria and response to clinical intervention is not uniform.

Any clinical intervention requires the clinician to adapt a treatment program based on medical necessity and individualized for each client. Guidelines are based on evolving scientific research and experience. Consequently, these guidelines will be reviewed and updated periodically.

All should be considered guidelines only, and we realize that adherence to them does not guarantee a successful outcome, nor should they be construed as including all the proper methods of care or excluding other acceptable methods of care aimed at the same results.

Please note that these guidelines are qualified by the limitations of payment sources and funding as designated through current contracts, state WAC and RCW standards and Federal requirements.

This revision of the clinical guidelines includes internet web addresses to the **American Psychiatric Association** (APA) and **American Academy of Child & Adolescent Psychiatry** (AACAP) Clinical Practice Guidelines as they are available for each diagnosis included herein. The Clinical Guidelines Workgroup recommended to Quality Management Oversight Committee (QMOC) to utilize this format as the APA and AACAP websites are self-updating. Therefore, this revision of the Clinical Guidelines Manual reflects this decision approved by QMOC and the NSMHA Board of Directors to identify the internet address where the delineated guidelines can be found. Two of the three non-diagnosis related guidelines, *Person-Centered Recovery and Resiliency*, and *Differential Diagnosis for Childhood & Adolescent Behavioral Disturbances* can be found in this manual in their entirety.

All NSMHA providers shall develop and implement policies and procedures that support these guidelines. The provider's Medical Director must approve the provider policies and procedures. **When the guidelines are not felt to be desirable for a particular consumer, the rationale for not following the guidelines will be documented in the consumer's medical record.**

All services are provided in accordance with the current NSMHA Clinical Eligibility and Care Standards Manual which establish access to care, continued stay and discharge criteria.

DELINEATED CLINICAL GUIDELINES

- The approved clinical guidelines are listed below.
- The bullet points beneath each guideline reflect the core elements associated with the individual guideline. Note: *Core elements have been identified by the NSMHA Medical Director as minimum critical elements that must be present when NSMHA Utilization Reviewers score a consumer record as reflecting that services are being provided in accordance with NSMHA clinical guidelines.*
- To gain access to the full American Psychiatric Association current guidelines for adults, follow these steps:
    a. Copy and paste the web address http://psychiatryonline.org/guidelines.aspx into the address bar on your web browser. This will take you to the APA Practice Guidelines home page.
    b. Select (single left click on) the desired diagnosis from the list found on the left-center (dark blue on light blue)
    c. Select "Quick Reference Guide" (center of page, dark blue on light blue)
- To gain access to the full American Academy of Child & Adolescent Psychiatry current guidelines for children & youth, follow these steps:
    a. Copy and paste the web address http://www.guidelinecentral.com/summary-authoring-organization/american-academy-child-and-adolescent-psychiatry into the address bar on your web browser. This will take you to the AACAP Guideline Summary page.
    b. Select (single left click on) the "Guidelines Library" option from the white on gray bar near the top of the page.
    c. When the dropdown menu appears, select "Guideline Links"
    d. When the "Guideline Links" page appears, under the "Specialty" tab, select "Psychiatry (gray on white, center of page).
    e. Select (single left click on) the desired diagnosis from the list found on the left-center
    f. Note that the reader can choose from a four-page list of guidelines (see page numbers at the bottom of the page).
- As journal guideline watches are periodically published on the American Academy of Child & Adolescent Psychiatry (Child) website, between formal updates, an ongoing survey of the watches will be undertaken by the NSMHA Medical Director, and elements of these watches will be added to the core elements, where indicated, during a routine, clinical guidelines review/revision by a designated NSMHA Quality Specialist, occurring during the summer, every three years.

Adult Anxiety Disorders (http://psychiatryonline.org/guidelines.aspx)

- There is some form of cognitive behavioral therapy to address anxiety.
- There is an attempt at medication management. If the consumer has a history of substance abuse, then non-sedative medications should be tried first.

Adult ADHD (http://psychiatryonline.org/guidelines.aspx)

- Screen for co morbid substance abuse.
- Alternatives to stimulants are tried first such as Strattera, Wellbutrin, and Effexor.
- If Stimulants are used, then there are efforts to monitor for Substance Abuse and diversion of medication to family and peers.

Adult Bipolar Disorder (http://psychiatryonline.org/guidelines.aspx)

- A mood stabilizer was used or there is documentation that it was considered with the rationale for not prescribing
- There is documentation of psycho-education regarding strategies to prevent episodes on mania or depression

Adult Borderline Personality (http://psychiatryonline.org/guidelines.aspx)

- The treatment team has established a method to discourage self-injury.
- Use of DBT informed therapy or documentation that it was considered with rationale for not providing DBT informed therapy.

Adult Co-occurring Disorders (http://psychiatryonline.org/guidelines.aspx)

- The MH provider must coordinate care with substance abuse provider

Adult Dissociative Disorder (http://psychiatryonline.org/guidelines.aspx)

- There is a form of psychotherapy which is focused on integration of personality.

Adult Eating Disorders (http://psychiatryonline.org/guidelines.aspx)

- There is some form of cognitive behavioral therapy to address distorted body image.
- There is coordination with a medical provider who is monitoring weight and nutrition.
- Failure of intensive outpatient treatment is required before considering higher levels of care.

Adult Major Depressive Disorder (http://psychiatryonline.org/guidelines.aspx)

- An antidepressant medication is being used or there is documentation that it was considered with the rationale for not prescribing
- Some form of psychotherapy is being used or there is documentation that it was considered with a rationale for why it is not being offered

Adult Neurocognitive Disorder (Dementia)

(http://psychiatryonline.org/guidelines.aspx)

- *This group demonstrate behaviors that are aggressive, psychotic or depressed.* Care should be coordinated with primary care givers and PCP.
- Efforts should be made to establish a baseline of behaviors, exploring any environmental triggers and medications should be reviewed.

Adult Obsessive Compulsive Disorder

(http://psychiatryonline.org/guidelines.aspx**)**

- There is some form of cognitive behavioral therapy to address intrusive thoughts and compulsive behaviors.
- Trial of medication has been attempted with SSRI or Anfranil or documentation that that it was considered for rationale for not prescribing.

Adult Schizophrenia (http://psychiatryonline.org/guidelines.aspx)

- An anti-psychotic medication is being used or there is documentation that it was considered with the rationale for not prescribing
- The clinician/case manager is monitoring whether or not the consumer is agreeing to take prescribed psychiatric medications

Adult Trauma Disorders (http://psychiatryonline.org/guidelines.aspx)

- The focus of therapy (group or individual) is on resolving the trauma, through use of cognitive behavioral techniques such as uncovering, exposure, and desensitization or there is documentation that it was considered with a rationale for why it is not being offered.

Adult Suicidal Behaviors (http://psychiatryonline.org/guidelines.aspx) *Note: Suicide Behaviors guidelines can be found in the bottom right corner of the screen, subsequent to the diagnosis related guidelines.*

- At intake, risk factors & protective factors are identified & noted in the risk assessment section of the Intake Assessment
- The risk assessment section of the Intake Assessment assesses of risk (provides a clinical opinion), based on the risk & protective factors, and assigns a level of risk
- The RRP reflects a treatment strategy consistent with the level of risk presented
- Progress notes reflect that risk assessment is ongoing

Child & Youth Anxiety Disorders (http://www.guidelinecentral.com/summary-authoring-organization/american-academy-child-and-adolescent-psychiatry)

- There is some form of cognitive behavioral therapy to address anxiety.
- There is an attempt at medication management. If the consumer has a history of substance abuse, then non-sedative medications should be tried first.

Child & Youth ADHD (http://www.guidelinecentral.com/summary-authoring-organization/american-academy-child-and-adolescent-psychiatry)

- Patient management training has occurred with the primary caregivers or there is documentation that it was considered with a rationale why it is not being offered.
- There are documented efforts at school accommodations or there is documentation that it was considered with a rationale why it is not being offered.
- A psycho-stimulant has been tried or there is documentation that it was considered with a rationale for not prescribing.

Child & Youth Bipolar Disorder (http://www.guidelinecentral.com/summary-authoring-organization/american-academy-child-and-adolescent-psychiatry)

- A mood stabilizer was used or there is documentation that it was considered with the rationale for not prescribing
- There is documentation of psycho-education regarding strategies to prevent episodes on mania or depression

Child & Youth Conduct Disorder (http://www.guidelinecentral.com/summary-authoring-organization/american-academy-child-and-adolescent-psychiatry)

- Patient management training has occurred with the primary caregivers or there is documentation that it was considered with a rationale why it is not being offered.
- The treatment providers are not allowing or supporting efforts for the client to avoid consequences (legal or other consequences) for violating the rights of others.

Child & Youth Co-occurring Disorders

(http://www.guidelinecentral.com/summary-authoring-organization/american-academy-child-and-adolescent-psychiatry)

- The MH provider must coordinate care with substance abuse provider

Child & Youth Dissociative Disorder

(http://www.guidelinecentral.com/summary-authoring-organization/american-academy-child-and-adolescent-psychiatry)

- There is a form of psychotherapy which is focused on integration of personality.

Child & Youth Eating Disorders (http://www.guidelinecentral.com/summary-authoring-organization/american-academy-child-and-adolescent-psychiatry)

- There is some form of cognitive behavioral therapy to address distorted body image.
- There is coordination with a medical provider who is monitoring weight and nutrition.
- Failure of intensive outpatient treatment is required before considering higher levels of care.

Child & Youth Major Depressive Disorder

(http://www.guidelinecentral.com/summary-authoring-organization/american-academy-child-and-adolescent-psychiatry)

- An antidepressant medication is being used or there is documentation that it was considered with the rationale for not prescribing
- Some form of psychotherapy is being used or there is documentation that it was considered with a rationale for why it is not being offered

Child & Youth Obsessive Compulsive Disorder

(http://www.guidelinecentral.com/summary-authoring-organization/american-academy-child-and-adolescent-psychiatry)

- There is some form of cognitive behavioral therapy to address intrusive thoughts and compulsive behaviors.
- Trial of medication has been attempted with SSRI or Anfranil or documentation that that it was considered for rationale for not prescribing.

Child & Youth Psychotic Disorders (http://www.guidelinecentral.com/summary-authoring-organization/american-academy-child-and-adolescent-psychiatry)

- An anti-psychotic medication is being used or there is documentation that it was considered with rationale for not prescribing.
- There has been an exhaustive effort to rule out organic causes of the psychosis such as medical disorders, metabolic disorders, infection, brain injury & drug intoxication or withdrawal.
- If the child is 13 or younger, then there is documentation of consideration if psychotic symptoms related to malingering, attention seeking, misperception, suggestion from caregivers or cultural issues such as religion or other family beliefs.

Child & Youth Trauma Disorders (http://www.guidelinecentral.com/summary-authoring-organization/american-academy-child-and-adolescent-psychiatry)

- The focus of therapy (group or individual) is on resolving the trauma, through use of cognitive behavioral techniques such as uncovering, exposure, and desensitization or there is documentation that it was considered with a rationale for why it is not being offered.

Child & Youth Suicidal Behaviors (http://www.guidelinecentral.com/summary-authoring-organization/american-academy-child-and-adolescent-psychiatry) *Note: Suicide Behaviors guidelines can be found in the bottom right corner of the screen, subsequent to the diagnosis related guidelines.*

- At intake, risk factors & protective factors are identified & noted in the risk assessment section of the Intake Assessment
- The risk assessment section of the Intake Assessment assesses of risk (provides a clinical opinion), based on the risk & protective factors, and assigns a level of risk
- The RRP reflects a treatment strategy consistent with the level of risk presented
- Progress notes reflect that risk assessment is ongoing

Note: The following non-diagnosis related guidelines are reflected in their entirety, below.

Person-Centered Recovery and Resiliency

I. Introduction

The Department of Health and Human Services (DHHS) and the Substance Abuse and Mental Health Administration (SAMHSA) cite **recovery as the "single most important goal for the mental health service delivery system".** As such, ten fundamental components to recovery have been identified: Self-Direction, Individualized and Person-Centered Care, Empowerment, Holistic, Non-Linear, Strengths-Based, Peer Support, Respect, Responsibility, and Hope (SAMHSA, 2004). With this guidance in mind, the North Sound Mental Health Administration (NSMHA) supports and encourages **Person-Centered Recovery Planning;** a process that serves as a working and dynamic roadmap to help **individuals achieve personally meaningful goals** and that **assists agencies in quality and risk management practices.**

Since 2007, NSMHA has also supported trainings in Wellness Recovery Action Plans (WRAP) to assist individuals and agencies increase their own and their communities' wellness. WRAP's primary goal is to teach participants recovery, self-management skills, and strategies for dealing with psychiatric symptoms (Mary Ellen Copeland, 2009). Similar in name and in focus, NSMHA also robustly supports the implementation of the Wraparound model when delivering service and supports to children and families. The Wraparound model is fundamentally rooted in System of Care philosophy and provides coordination, planning and service delivery that is family-driven/youth-guided and culturally competent.

On May 20, 2010, Washington State Department of Social and Health Services (DSHS) has adopted new and revised Washington Administrative Codes (WACs) 388-865-0420; 0425; and 0430 related to Intake Evaluation, Individual Service Plan and Clinical Record (Department of Social and Health Services, Health and Recovery, 2010). These revisions allow mental health providers more flexibility in meeting the needs of individuals while still meeting the statutory

requirements for collecting client history data and focusing on the individual's unique needs and recovery plan. It should be noted, that WACs are administrative rules and regulations by which agencies operate to execute the Laws enacted by the Legislature. With this guideline, we endeavor to coordinate the application of WAC and other legislated or contracted requirements with current and nationally accepted and best practices in the field of mental health recovery and resiliency.

II. Person-Centered Treatment & Recovery Planning

Historically, a "treatment plan" is a professionally-driven document that is often considered a time-consuming exercise conducted in a manner to meet requirements of external auditors or mandates. Traditionally, the individual is referred to as the "consumer" who may be requested to provide "input" into the "treatment plan". However, the document itself may not be written in consumer-friendly language. Individuals often report that they know they have a treatment plan, but are unaware of the content and therefore are unaware of both their responsibilities and the professionals' responsibilities to the plan.

In contrast, a **Recovery Plan** is developed **in partnership with the individual receiving mental health services** and/or their caregivers and family. A recovery plan is **not viewed solely as a compliance tool**; rather as an integral and essential part of the overall clinical documentation and service delivery process. The recovery plan further serves as a primary step in the **engagement phase** of treatment and promotes **person-centered treatment**. Recovery plans should demonstrate **shared decision-making** and **consumer-defined outcomes**. Recovery planning and person-centered treatment "promote **client choice, empowerment, resilience, and self-reliance**" (Adams & Grieder, 2005).

A clearly articulated recovery plan provides the following benefits to the individual and the treatment team:

1. A **roadmap for the individual and the treatment team**, providing direction and allowing the team and individual or family to evaluate the individual's progress toward his/her treatment goals and the effectiveness of interventions;
2. Demonstrates individual or family goals towards recovery;
3. Documents both **individual and provider responsibilities** towards recovery;
4. Provides data from which the organization can monitor and evaluate the quality of services provided (**Quality Improvement**);
5. Functions as a "clinical invoice," justifying admission and length of stay, and substantiating the diagnoses (**Utilization Review**);
6. Increases the probability that the provider will be more successful during **regulatory compliance** surveys, as it demonstrates the professional competence of the individual clinicians who collaborate to develop the plans, and shows the treatment team's adherence to provider organization policies and procedures and regulatory standards on which those policies and procedures are generally based;
7. Protects the provider organization and clinicians against litigation (**Risk Management**).

Core Principles

In the book, Treatment Planning for Person-Centered Care: The Road to Mental Health and Addiction Recovery, Neal Adams and Diane Grieder suggest that general health literature points to **five core principles of person-centered recovery planning**:

1. Understanding needs from a broad bio-psychosocial perspective rather than a deficit or symptom driven perspective;
2. The ability to see the "consumer-as-person" and not diminished or dehumanized in any way by his/her help-seeking;
3. The sharing of power and responsibility in decision making;
4. The recognition of a therapeutic alliance and partnership between the provider and the individual;
5. The ability to view the provider-as-person and not cast him/her into a position of power or undue authority.

Key Components

Per WAC 388-865-0425, "The community mental health agency must develop a consumer-driven, strength-based individual service plan (ISP) that meets the individual's unique mental health needs. The individual service plan must be developed in collaboration with the individual, or the individual's parent or other legal representative if applicable." In addition to the 10 elements required in WAC, NSMHA recommends integration of the 10 Fundamental Components of Recovery as found in the National Consensus Statement on Mental Health with the Recovery Plan (aka ISP). We believe these fundamentals greatly assist the philosophical and practice shift from a standard ISP or "treatment plan" development to a more Person-Centered Recovery Plan. These 10 Fundamental Components of Recovery are (SAMHSA, 2004):

1. **Self-Direction:** Consumers lead, control, exercise choice over, and determine their own path of recovery by optimizing autonomy, independence, and control of resources to achieve a self-determined life. By definition, the recovery process must be self-directed by the individual, who defines his/her own life goals and designs a unique path towards those goals.
2. **Individualized and Person-Centered:** There are multiple pathways to recovery based on an individual's unique strengths and resiliencies, as well as, his/her needs, preferences, experiences (including past trauma), and cultural background in all of its diverse representations. Individuals also identify recovery as being an ongoing journey and an end result, as well as, an overall paradigm for achieving wellness and optimal mental health.
3. **Empowerment:** Consumers have the authority to choose from a range of options and to participate in all decisions—including the allocation of resources—that will affect their lives, and are educated and supported in so doing. They have the ability to join with other consumers to collectively and effectively speak for themselves about their needs, wants, desires and aspirations. Through empowerment, an individual gains control of his/her own destiny and influences the organizational and societal structures in his/her life.
4. **Holistic:** Recovery encompasses an individual's whole life, including mind, body, spirit and community. Recovery embraces all aspects of life, including housing, employment, education, mental health and healthcare treatment and services, complementary and naturalistic services, addictions treatment, spirituality, creativity, social networks, community participation, and family supports as determined by the person. Families, providers, organizations, systems, communities and society play crucial roles in creating and maintaining meaningful opportunities for consumer access to these supports.
5. **Non-Linear:** Recovery is not a step-by step process but one based on continual growth, occasional setbacks and learning from experience. Recovery begins with an initial stage of

awareness in which a person recognizes that positive change is possible. This awareness enables the consumer to move on to fully engage in the work of recovery.

6. **Strengths-Based:** Recovery focuses on valuing and building on the multiple capacities, resiliencies, talents, coping abilities and inherent worth of individuals. By building on these strengths, consumers leave stymied life roles behind and engage in new life roles (e.g., partner, caregiver, friend, student and employee). The process of recovery moves forward through interaction with others in supportive, trust-based relationships.
7. **Peer Support:** Mutual support—including the sharing of experiential knowledge and skills and social learning—plays an invaluable role in recovery. Consumers encourage and engage other consumers in recovery and provide each other with a sense of belonging, supportive relationships, valued roles and community.
8. **Respect:** Community, systems, and societal acceptance and appreciation of consumers — including protecting their rights and eliminating discrimination and stigma—are crucial in achieving recovery. Self-acceptance and regaining belief in one's self are particularly vital. Respect ensures the inclusion and full participation of consumers in all aspects of their lives.
9. **Responsibility:** Consumers have a personal responsibility for their own self-care and journeys of recovery. Taking steps towards their goals may require great courage. Consumers must strive to understand and give meaning to their experiences and identify coping strategies and healing processes to promote their own wellness.
10. **Hope:** Recovery provides the essential and motivating message of a better future— that people can and do overcome the barriers and obstacles that confront them. Hope is internalized; but can be fostered by peers, families, friends, providers and others. Hope is the catalyst of the recovery process. Mental health recovery not only benefits individuals with mental health disabilities by focusing on their abilities to live, work, learn and fully participate in our society, but also enriches the texture of American community life. America reaps the benefits of the contributions individuals with mental disabilities can make, ultimately becoming a stronger and healthier Nation.

III. Cultural Competence

The National Center on Cultural Competence suggests that delivery of services and support in a culturally competent manner facilitates better individual outcomes and increases satisfaction with the services received. Critical factors in the provision of culturally competent care include the understanding of (Georgetown University, 2010):

1. Beliefs, values, traditions and practices of a culture;
2. Culturally-defined, health-related needs of individuals, families and communities;
3. Culturally-based belief systems of the etiology of illness and disease and those related to health and healing; and
4. Attitudes toward seeking help from health care providers.

Person-Centered Recovery plans should reflect an understanding of each individual's unique cultural identity. The following elements are presented as a guide for agencies to self-assess culturally competent plans:

1. Is culture reflected including and beyond race and ethnicity? For example:

a. Language
b. Gender
c. Sexual orientation
d. Socioeconomic status
e. Family roles
f. Housing status
g. Regional differences

2. Is the plan written in language understandable by the individual seeking treatment?
3. Is the plan written at a reading level understandable the individual?
4. Is the plan age appropriate to the individual seeking treatment?
5. Does the plan reflect any & all recommendations provided by the consultant in the special population consultation?

IV. Special Considerations for Children, Youth, and Families

The information presented in sections I-III above is applicable when providing services and supports to individuals of any age. However, NSMHA recommends additional specific training and clinical focus in **System of Care philosophy** including **resiliency and recovery** for all staff who work predominantly with children, youth, and families.

System of Care Defined

(Technical Assistance Partnership for Child and Family Mental Health, 2010)

The system of care model is an organizational philosophy and framework that involves collaboration across agencies, families and youth for the purpose of improving services and access and expanding the array of coordinated community-based, culturally and linguistically competent services and supports for children and youth with a serious emotional disturbance and their families. The core values of the system of care philosophy specify that the system of care:

1. Should be child-centered and family-focused, with the needs of the child and family dictating the types and mix of services provided.
2. Should be community-based, with the locus of services, as well as, management and decision-making responsibility resting at the community level.
3. Should be culturally competent, with agencies, programs and services that are responsive to the cultural, racial and ethnic differences of the populations they serve.

System of Care Values

- Family Driven
- Youth Guided
- Culturally and Linguistically Competent
- Individualized and Community-Based
- Evidence-Based

System of Care Guiding Principles

The following represent the **10 Foundational Principles of the System of Care** philosophy:

1. Children with emotional disturbances should have access to a comprehensive array of services that address their physical, emotional, social and educational needs.
2. Children with emotional disturbances should receive individualized services in accordance with the unique needs and potential of each child and guided by an ISP.
3. Children with emotional disturbances should receive services within the least restrictive, most normative environment that is clinically appropriate.
4. The families and surrogate families of children with emotional disturbances should be full participants in all aspects of the planning and delivery of services.
5. Children with emotional disturbances should receive services that are integrated, with linkages between child-serving agencies and programs and mechanisms for planning, developing and coordinating services.
6. Children with emotional disturbances should be provided with case management or similar mechanisms to ensure that multiple services are delivered in a coordinated and therapeutic manner and that they can move through the system of services in accordance with their changing needs.
7. Early identification and intervention for children with emotional disturbances should be promoted by the system of care in order to enhance the likelihood of positive outcomes.
8. Children with emotional disturbances should be ensured smooth transitions to the adult services system as they reach maturity.
9. The rights of children with emotional disturbances should be protected and effective advocacy efforts for children and adolescents with emotional disturbances should be promoted.
10. Children with emotional disturbances should receive services without regard to race, religion, national origin, sex, physical disability, or other characteristics and services should be sensitive and responsive to cultural differences and special needs.

Family Driven Defined

Family-driven means families have a primary decision-making role in the care of their own children, as well as, the policies and procedures governing care for all children in their community, state, tribe, territory and nation. This includes:

1. Choosing supports, services, and providers;
2. Setting goals;
3. Designing and implementing programs;
4. Monitoring outcomes;
5. Partnering in funding decisions; and
6. Determining the effectiveness of all efforts to promote the mental health and well being of children and youth.

Guiding Principles of Family-Driven Care

1. Families and youth are given accurate, understandable and complete information necessary to set goals and to make choices for improved planning for individual children and their families.
2. Families and youth, providers and administrators embrace the concept of sharing decision-making and responsibility for outcomes with providers.
3. Families and youth are organized to collectively use their knowledge and skills as a force for systems transformation.

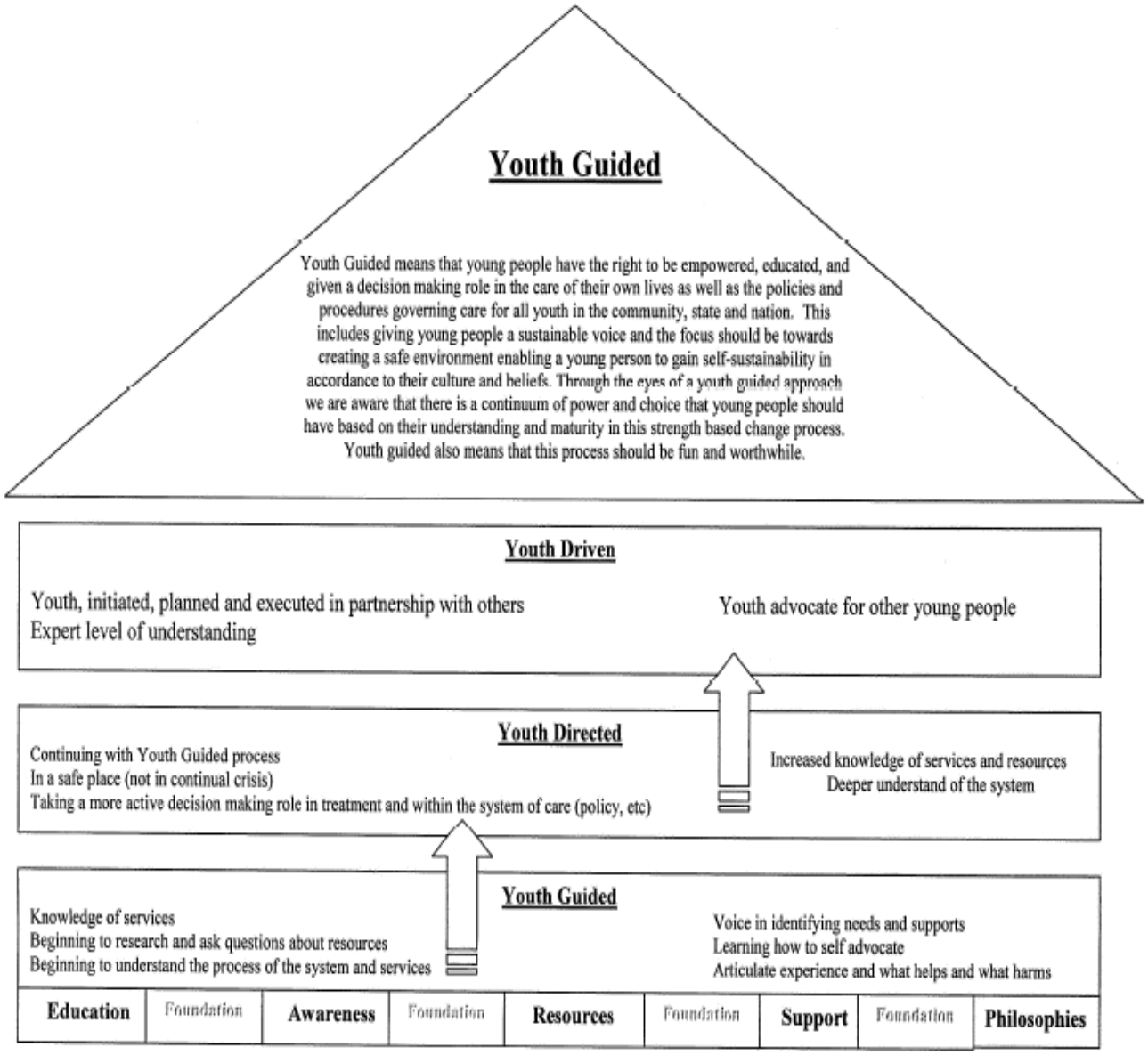
4. Families and family-run organizations engage in peer support activities to reduce isolation, gather and disseminate accurate information and strengthen the family voice.
5. Families and family-run organizations provide direction for decisions that impact funding for services, treatments and supports.
6. Providers take the initiative to change practice from provider-driven to family-driven.
7. Administrators allocate staff, training, support and resources to make family-driven practice work at the point where services and supports are delivered to children, youth and families.
8. Community attitude change efforts focus on removing barriers and discrimination created by stigma.
9. Communities embrace, value, and celebrate the diverse cultures of their children, youth and families.
10. Everyone who connects with children, youth and families continually advances their own cultural and linguistic responsiveness as the population served changes.

Characteristics of Family-Driven Care

1. Family and youth experiences, their visions and goals, their perceptions of strengths and needs and their guidance about what will make them comfortable steer decision-making about all aspects of service and system design, operation and evaluation.
2. Family-run organizations receive resources and funds to support and sustain the infrastructure that is essential to insure an independent family voice in their communities, states, tribes, territories and the nation.
3. Meetings and service provision happen in culturally and linguistically competent environments where family and youth voices are heard and valued, everyone is respected and trusted and it is safe for everyone to speak honestly.
4. Administrators and staff actively demonstrate their partnerships with all families and youth by sharing power, resources, authority, responsibility and control with them.
5. Families and youth have access to useful, usable, and understandable information and data, as well as, sound professional expertise so they have good information to make decisions.
6. Funding mechanisms allow families and youth to have choices.
7. All children, youth and families have a biological, adoptive, foster, or surrogate family voice advocating on their behalf.

Youth-Guided Defined

The systems of care philosophy places high priority on the youth-guided core value. Youth are viewed as true experts and primary consumer services. SAMHSA proposes that the youth-focused movement is defined in three phases: Youth Guided, Youth Directed and Youth Driven. Further, within each phase there are indicators for individual, community and policy. SAMHSA offers the Youth-Guided Pyramid below. For information on Youth Directed and Youth Driven, we refer to the entire document.


Youth Guided
Youth Guided means that young people have the right to be empowered, educated, and given a decision making role in the care of their own lives as well as the policies and procedures governing care for all youth in the community, state and nation. This includes giving young people a sustainable voice and the focus should be towards creating a safe environment enabling a young person to gain self-sustainability in accordance to their culture and beliefs. Through the eyes of a youth guided approach we are aware that there is a continuum of power and choice that young people should have based on their understanding and maturity in this strength based change process. Youth guided also means that this process should be fun and worthwhile.
Youth Driven
Youth, initiated, planned and executed in partnership with others
Expert level of understanding
Youth advocate for other young people
Youth Directed
Continuing with Youth Guided process
In a safe place (not in continual crisis)
Taking a more active decision making role in treatment and within the system of care (policy, etc)
Increased knowledge of services and resources
Deeper understand of the system
Youth Guided
Knowledge of services
Beginning to research and ask questions about resources
Beginning to understand the process of the system and services
Voice in identifying needs and supports
Learning how to self advocate
Articulate experience and what helps and what harms
Education
Foundation
Awareness
Foundation
Resources
Foundation
Support
Foundation
Philosophies

Resiliency and Recovery

Much research has been conducted to explore and identify the meaning of both resiliency and recovery in children's mental health. Through the leadership of Portland State University Research and Training Center (RTC) on Family Support and Children's Mental Health – RTC (http://www.rtc.pdx.edu/). Barbara Friesen and Janet Walker of the RTC and Dr. Charlie Huffine, King County RSN Medical Director for Child & Adolescent Programs, have been specifically credited with promoting the transformation of children's mental health care by increasing knowledge of supports, services and policies that:

- Build on family strengths;
- Are community-based, family-driven, and youth-guided;
- Promote cultural competence; and
- Are based on evidence of effectiveness.

In her 2007 article, *Recovery and Resilience in Children's Mental Health: Views from the Field*, Barbara Friesen states that "recovery elements are entirely compatible with the System of Care philosophy and reliance framework". That is to say that the 10 Fundamental Components of Recovery generally support philosophical practice when working with children and families. However other "**resilience concepts bring added value"** to System of Care Principles such as: **Focus on hope and future planning and the importance of addressing trauma.** Other recovery oriented terms such as "personal responsibility" and "personal determination" are confusing and not easily applied when working with children. For these reasons, it is preferred in the field of children's mental health to use the term "**resilience and recovery".**

It is important that all staff working predominantly with children, youth and families understand comparison core concepts in resiliency, recovery and system of care framework. See Table 1 below for a comparison of key concepts (Friesen, 2007).

NSMHA has assembled a **System of Care Primer and Toolkit** to assist in understanding this philosophy. This document provides **valuable information** and greatly expands this section including the provision of the definitions for **Family-Driven** and **Youth-Guided**. This document is referenced below and available on the NSMHA website.

Additionally, NSMHA recommends that all staff working predominantly with children, youth and families read and refer to the **summer 2005 issue of Focal Point: Resiliency and Recovery**. This issue is dedicated to examining the concepts of resiliency and recovery in children's mental health. All articles therein are available **free of charge** on the web at http://www.rtc.pdx.edu/pgFPS05TOC.php.

Table 1—Comparison of Key Ideas: System of Care, Resilience, and Recovery

Resilience Core Concepts	System of Care Principles	Recovery Elements*
	1. Comprehensive services	1. Holistic (C)
Specification of Elements: (V) Reducing Risk Enhancing Protective Factors	2. Individualized services	2. Individualized & person centered (C) 3. Strengths Based (C)
	3. Community based	(Assumed)
Racial Socialization Healing Historical Trauma (V)	4. Culturally & linguistically competent	Healing historical trauma (V)
Solid Basic and Applied Research Base for Prevention and Early Intervention (V)	5. Early intervention	
	6. Family & youth participation family-driven youth-guided	4. Empowerment (C) 5. Self-direction (C)
	7. Service coordination	
	8. Interagency coordination	
	9. Protective of rights	6. Respect, stigma reduction (V)
	10. Transition	(Life planning) (C)
Future Orientation, Optimism (V)		7. Hope, optimism (V)
		8. Non-linear (acceptance of setbacks)
		9. Personal responsibility
		10. Peer support

*Note. These "Recovery Elements" are the "10 Fundamental Components of Recovery" identified in the National Consensus Statement on Mental Health Recovery at the National Consensus Conference on Mental Health Recovery and Mental Health Systems Transformation on December 16–17, 2004. The conference was convened by the Substance Abuse and Mental Health Services Administration within the U.S. Department of Health and Human Services and the Interagency Committee on Disability Research in partnership with six other Federal agencies.

To read the complete the full statement, see: www.mentalhealth.samhsa.gov/publications/allpubs/sma05-4129/.

Works Cited

Adams, N., & Grieder, D. (2005). *Treatment Planning for Person-Centered Care: The Road to Mental Health and Addiction Recovery.* Arlington, VA: American Psychiatric Association.

Department of Social and Health Services, Health and Recovery. (2010, April 19). *Rule Making Order.* Retrieved May 2010, from http://www.dshs.wa.gov/pdf/ms/rpau/103P-10-09-061.pdf

Friesen, B. (2007). Recovery and Resilience in Children's Mental Health: Views from the Field. *Psychiatric Rehabilitation Journal* , 38-48.

Georgetown University. (2010, May). *Foundations of Cultural & Linguistic Competence.* Retrieved May 2010, from National Center for Cultural Competence: http://nccc.georgetown.edu/foundations/need.html

Mary Ellen Copeland, P. (2009). *Personal Mental Health Recovery Values and Ethics.* Retrieved April 2010, from Mental Health Recovery and WRAP: http://www.mentalhealthrecovery.com/

SAMHSA. (2004, December). *National Concensus Statement on Mental Health Recovery.* Retrieved March 2010, from SAMHSA's National Mental Health Information Center: http://mentalhealth.samhsa.gov/publications/allpubs/sma05-4129/

Technical Assistance Partnership for Child and Family Mental Health. (2010, June). *System of Care Values and Principles* . Retrieved June 4, 2010, from Technical Assistance Partnership: http://www.tapartnership.org/SOC/SOCvalues.php

Other Resources

Implementing Person Centered Care, Practices and Planning:
http://www.personcenteredtreatmentplanning.com/

National Alliance on Mental Illness:
http://www.nami.org/

National Wraparound Initiative:
http://www.nwi.pdx.edu/
http://wrapinfo.org/

National Center for Cultural Competence:
http://www.clcpa.info/
http://nccc.georgetown.edu/foundations/policies.html

Substance Abuse and Mental Health Administration (SAMHSA)
http://www.samhsa.gov/

Systems of Care
http://systemsofcare.samhsa.gov/
http://systemsofcare.samhsa.gov/headermenus/deffamilydriven.aspx

Resiliency and Recovery http://www.rtc.pdx.edu/pgFPS05TOC.php.

Differential Diagnosis Guideline for Childhood and Adolescent Behavioral Disturbances

Introduction

Children and adolescents are often referred into mental health services for behavioral issues. Diagnostic clarification can be challenging, many behavioral problems in children or adolescents are not due to a mental disorders and must be differentiated from developmental issues and family/situational conflicts. A thorough diagnostic assessment is needed to translate those behaviors into symptoms**.**

An adequate diagnostic justification, done through the assessment, is also needed to determine current access into statewide mental health services. Assessors need to gather enough supportive information to consider authorization for ongoing Medicaid services. Components of an intake assessment should

- Be culturally and age relevant
- Document sufficient information to demonstrate medical necessity, as defined in the state plan
- Include presenting problem(s) as described by the individual and those who provide active support to the individual
- Include current physical health status, including any medications
- Include current substance use and abuse and treatment status
- Provide sufficient clinical information to **justify the provisional diagnosis** using diagnostic and statistical manual (DSM IV TR) criteria, or its successor
- Include and identify risk to self or others, including suicide/homicide. A referral for provision of emergency/crisis services, consistent with WAC 388-865-0452, (which assures that community support service providers have the availability of staff to handle the crisis, or refer to staff who will handle the crisis) must be made if indicated in the risk assessment
- A recommendation of a course of treatment

Differential diagnosis

A critical evaluation tool in the diagnostic assessment is the use of a differential diagnosis, defined as a "systematic approach to evaluating an individual's medical, psychiatric, psychological history and the presenting symptoms to identify the underlying causes. A differential diagnosis helps sort out any and all contributing factors."

Diagnostic Assessment

In addition to the components required in the WAC, the assessment should clearly address the differential diagnosis(es) the assessor considered or is considering in the formulation of the clinical impression. Two tools utilized in the Diagnostic and Statistical Manual of Mental Disorders, Handbook of Differential Diagnosis to document consideration for differential diagnoses are decision trees or decision tables. These tools assist the clinician in "establishing boundaries between disorders".

These tools, or similar diagnostic tools, are helpful suggestions in assisting the clinician with ruling out differential diagnoses.

Use of decision trees

Decision trees, noted from the start with a symptom and provide decision points for diagnostic determination, and can assist the clinician in making a diagnostic determination.

- The first step is to determine which trees apply to the clinical presentation
- The second step is to cover the primary mental disorders that may account for the symptom

Use of decision tables

Decision tables, noted in the handbook "help the clinician ensure that they are evaluating the symptoms in a systematic and comprehensive manner".

- Assist in listing the differential diagnoses that must be ruled out
- Offer distinguishing features that help in ruling out the differential diagnoses

The clinical evaluation, to include any differential diagnosis, should be documented in the multi-axial assessment. If current information only supports a provisional diagnosis, the assessment should include a plan to continue to evaluate the provisional diagnosis, to include referrals to other programs to assist with the evaluations needed to complete the assessment.

Differential diagnoses to consider when there are behavioral symptoms

Other diagnoses and/or conditions to be considered when a child presents with behavioral symptoms include: substance usage, general medical conditions, low IQ and impairments, antisocial behavior, defiant behavior, inattentive and hyperactive behaviors, mood changes, psychotic symptoms in absence of mood changes, stereotyped movements, maladaptive responses to stressors, illegal behavior, and what is age appropriate behavior.

Differential diagnoses with disruptive behaviors

Three disruptive behavioral disorders commonly diagnosed in children and adolescents are:

- Attention Deficit Hyperactivity Disorder (ADHD)
- Oppositional Defiant Disorder (ODD)
- Conduct Disorder

When considering **ADHD** as a diagnosis, these other diagnoses should be given consideration and ruled out as a differential diagnosis:

- age appropriate behaviors
- under-stimulating environments
- in-attention in Oppositional Defiant Disorder
- impulsivity in conduct disorder
- inattention or hyperactivity associated with pervasive developmental disorders
- inattention or hyperactivity caused by drugs or medications
- symptoms of inattention due to other mental disorders
- inattention occurring during the course of pervasive developmental disorders, schizophrenia, or other psychotic disorder, or if better accounted by another mental disorder

When considering **ODD** as a diagnosis, these other diagnoses should be given consideration and ruled out as a differential diagnosis:

- non-pathological oppositional behavior
- adjustment disorder with disturbance of conduct
- conduct disorder
- oppositional behavior related to mood or psychotic disorders
- oppositional behavior related to ADHD
- oppositional behavior in mental retardation
- failure to follow directions due to impairment in language comprehension
- antisocial personality disorder which can be diagnosed only in individuals over 18 years of age

When considering C**onduct Disorder** as a diagnosis, these other diagnoses should be given consideration and ruled out as a differential diagnosis:

- disruptive behavior in ODD
- disruptive behavior in ADHD
- anti-social behavior occurring during a manic episode
- anti-social behavior related to psychotic disorder
- adjustment disorder
- adolescent antisocial behavior
- antisocial personality disorder, which can be diagnosed only over 18

When making a differential or provisional diagnosis, consideration should always be given to other co-existing diagnoses, as described in the Diagnostic and Statistical Manual of Mental Disorders.

Reviewing provisional and differential diagnoses

Clinicians should consider the assessment as only the beginning of an evaluation process. Caution should be used in the formulation of a diagnosis too early in the assessment. Provisional diagnoses are a valuable tool in the evaluation "when there is a strong presumption that the full criteria will ultimately be met for the disorder, but not enough information is available to make a firm diagnosis". With any initial diagnostic impression, a review of the provisional diagnosis, to include differential diagnoses, should be done when time and/or further information clarifies symptoms and/or re-evaluated at six month intervals.

The updated diagnosis, to include the justification, should be reflected in an updated assessment, as well as, treatment plans and other documentation. If a provisional or differential diagnosis remains unclear, a consultation with a prescriber should be considered to assist with the clarification of the diagnosis. This should be considered when there is further information and/or at six month intervals, or there should be documentation why that has not occurred.

If further assessment clarifies that a provisional or differential diagnosis does not meet statewide access standards, appropriate referrals to other services should be made and the individual should be discharged from services. Documentation to support that assessment decision should be provided in the chart.

REFERENCES:

1. DSHS Washington State Access to Care Standards 1/1/2006 Authorization of Services for Medicaid Children and Youth
2. 2010 Washington State Code 865- 0420 Intake evaluation
3. Yikshak Shnaps, Princeton, N.J. American board of Psychiatry and Neurology, web publication
4. Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, text revision, Handbook of Differential Diagnosis, American Psychiatric Publishing, 2000, authors Michael B First, MD, Allen Frances, MD, Harold Alan Pincus, MD
5. Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, text revision, Washington, D.C. American Psychiatric Association, 2000

APPENDIX I: Guideline Adoption/Review Chronology

(Numbers correspond with diagnoses listed in the Table of Contents)

YEAR	GUIDELINES REVIEWED/REVISED
2004	1,3,8,11,12,14,16,21,23, & 24
2005	9
2006	2 &15
2008	5 &18
2010	26 & 27
2013	4,6,7,10,13,17,19,20,22 & 25

NORTH SOUND MENTAL HEALTH ADMINISTRATION

QUALITY MANAGEMENT OVERSIGHT COMMITTEE (QMOC)

October 23, 2013

AGENDA ITEM: NSMHA Quality Management Plan

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

PRESENTER: Charissa Westergard prepared by Greg Long

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

OBJECTIVE:

To meet contract requirement and EQRO recommendation that NSMHA have a specific Quality Management Plan

BACKGROUND:

For many years, NSMHA developed an annual quality management plan. When NSMHA developed the highly detailed NSMHA Work Plan and the NSMHA Strategic Plan it was felt that this covered the Quality Management Plan. In the 2012 EQRO Review, it was recommended that NSMHA develop a separate Quality Management Plan.

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:

This version of the NSMHA Quality Management Plan is much briefer than previous plans and incorporates the NSMHA yearly work plan. The work plan gives the many specific tasks and timelines for their completion. The QM Plan is a formal document that must address some specific items such as:

- Structure of the NSMHA Quality Management Program
- Scope of Services
- NSMHA Quality Management Processes
- Consumer/Advocate Involvement in Quality Management and Planning of Services
- Delegation and Delegated Functions
- Remedial action and Sanction Processes
- Flow of information through the quality management process

The companion document to this Quality Management Plan is the yearly Quality Management Plan Summary. The 2012 Quality Management Plan Summary was presented to QMOC in August 2013. It summaries the findings and any recommended actions of NSMHA many Quality Management processes and tasks. Our goal is to complete the 2013 Quality Management Plan Summary by April 2014.

CONCLUSIONS/ACTION REQUESTED:

NSMHA is seeking approval of this document as outlining our 2013 and 2014 Quality Management Plan processes.

FISCAL IMPACT:

No additional impact. This is a contractually required document.

ATTACHMENTS:

2012-2014 NSMHA Quality Management Plan

NORTH SOUND MENTAL HEALTH ADMINISTRATION

QUALITY MANAGEMENT OVERSIGHT COMMITTEE (QMOC)

October 23, 2013

AGENDA ITEM: Report on the types of disorders being treated within the North Sound Mental Health System

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

PRESENTER: Charissa Westergard prepared by Dennis Regan and Greg Long

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

OBJECTIVE:

To inform QMOC of the numbers of people and the types of mental disorders for which they are receiving treatment by North Sound Providers.

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:

This report only covers the 2nd quarter of 2013, April 1 to June 30, 2013. Some people may not have received some services that they receive during this specific time period. The report is broken out by children to age 21 and adults. This report covers a large number of people so the average hours of service and the number of people receiving prescriber services may seem low. No single report can fully reflect the complexities of the regional service delivery system. This report probably under reports service intensity in IOP, Wraparound, PACT, and Residential Services.

This report has been modified at the request of QMOC to more clearly delineate the diagnoses for which people are receiving treatment. The report gives general categories and then specific diagnoses and their subtypes. Several types of disorders including depression and anxiety disorder have been broken out into their own categories in this report to give a more accurate understanding than in previous reports.

The most common diagnoses are:

Adults	Percentage of Group	Children/Adolescents	Percentage of Group
Depressive	39.5%	Depressive	30.3%
Bipolar	20.6%	Anxiety/Generalized Anxiety	28.9%
PDST	18.2%	Neurotic/Personality/Misc.	19.8%
Psychotic Delusional	12.1%	PTSD	8.6%
Schizophrenic	6.7%	ADHD	5.3%
Anxiety/Generalized Anxiety	1.2%	Psychotic Delusional	5.0%
Personality/Neurotic/Misc.	1.2%	Bi-polar	1.9%
ADHD	.2%	Schizophrenia	0.3%

CONCLUSIONS/ACTION REQUESTED:

- Depression is the more common diagnoses treated in the North Sound Regional Systems.
- Perhaps, the categories of Psychotic Delusional Disorders and Schizophrenia should be collapsed
- ADHD seems low for both children and adults
- The prevalence of different disorders is significantly different between children and adults.
- Children receive on average a higher number of hours of service than adults.

FISCAL IMPACT:

None

ATTACHMENTS: Report on the types of diagnoses being treated in the North Sound Region

Diagnosis Dashboard - Outpatient Episode EPISO for time period: 2013 Q2

Diagnosis from most recent authorization diagnosis, outpatient episodes without authorization not included

EPISTYPE	EPISO
PeriodName	2013 Q2

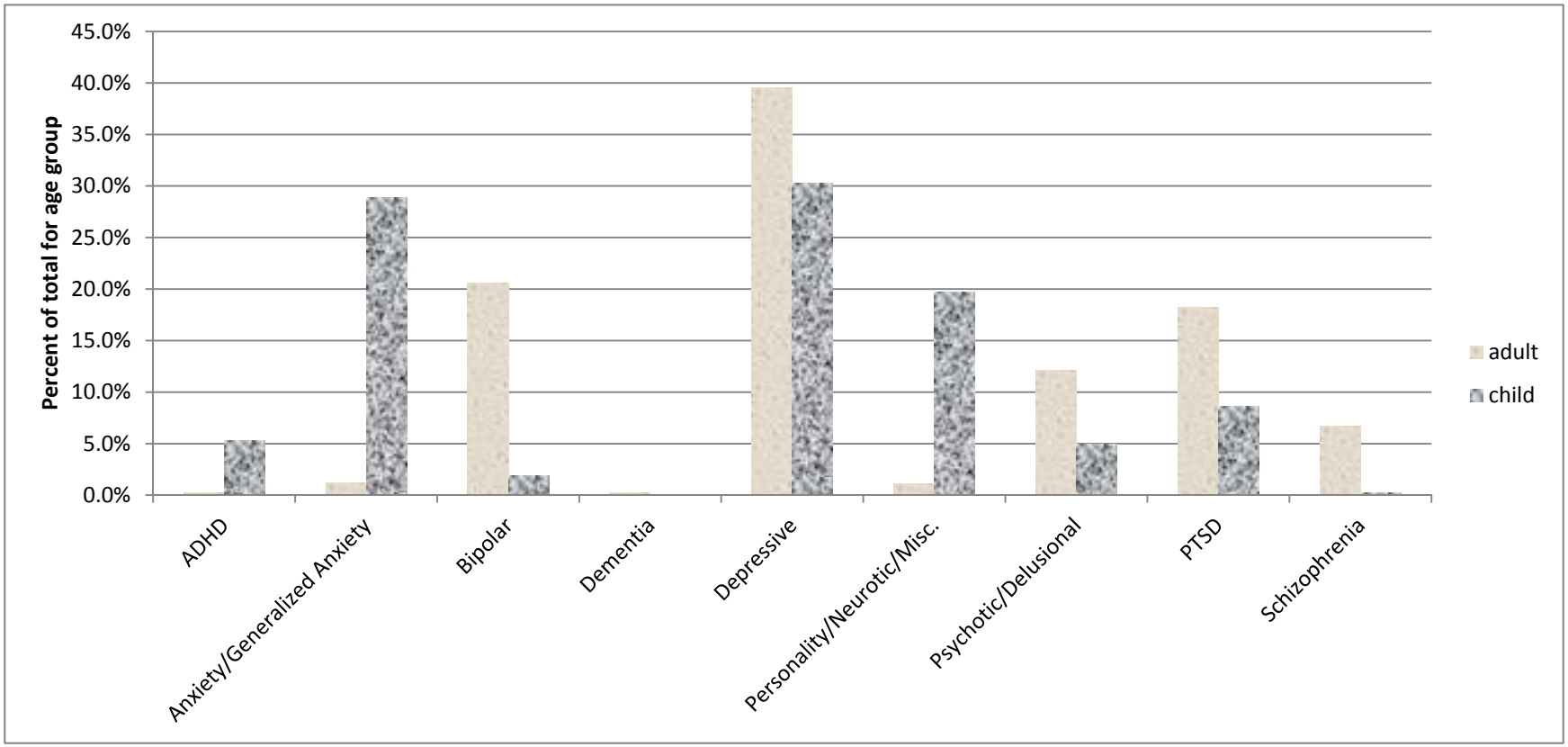
Diagnosis is determined by the most recent authorization to the end of the period

	Values		Percent of people									
Agency and period	# of people	% of total	opened	closed	inpatient during period	received prescriber service	average hours per year	opened	closed	inpatient during period	received prescriber service
adult	7,709	60.4%	975	791	106	2,712	15.0	12.6%	10.3%	1.4%	35.2%
ADHD	19	0.2%	1	1	0	5	3.8	5.3%	5.3%	0.0%	26.3%
Anxiety/Generalized Anxiety	93	1.2%	17	16	1	24	12.0	18.3%	17.2%	1.1%	25.8%
Bipolar	1,588	20.6%	181	165	17	655	15.6	11.4%	10.4%	1.1%	41.2%
Dementia	18	0.2%	4	5	0	7	20.8	22.2%	27.8%	0.0%	38.9%
Depressive	3,047	39.5%	435	312	24	793	15.1	14.3%	10.2%	0.8%	26.0%
Personality/Neurotic/Misc.	84	1.1%	10	7	0	29	14.2	11.9%	8.3%	0.0%	34.5%
Psychotic/Delusional	935	12.1%	95	87	42	461	14.0	10.2%	9.3%	4.5%	49.3%
PTSD	1,406	18.2%	205	162	9	417	14.9	14.6%	11.5%	0.6%	29.7%
Schizophrenia	519	6.7%	27	36	13	321	15.6	5.2%	6.9%	2.5%	61.8%
child	5,060	39.6%	999	760	35	736	17.2	19.7%	15.0%	0.7%	14.5%
ADHD	270	5.3%	32	41	1	82	15.5	11.9%	15.2%	0.4%	30.4%
Anxiety/Generalized Anxiety	1,462	28.9%	307	222	5	145	16.8	21.0%	15.2%	0.3%	9.9%
Bipolar	95	1.9%	13	12	3	31	18.2	13.7%	12.6%	3.2%	32.6%
Depressive	1,533	30.3%	320	208	13	221	16.7	20.9%	13.6%	0.8%	14.4%
Personality/Neurotic/Misc.	1,000	19.8%	193	156	3	116	17.2	19.3%	15.6%	0.3%	11.6%
Psychotic/Delusional	251	5.0%	40	48	5	75	19.1	15.9%	19.1%	2.0%	29.9%
PTSD	435	8.6%	91	69	4	60	20.4	20.9%	15.9%	0.9%	13.8%
Schizophrenia	14	0.3%	3	4	1	6	12.7	21.4%	28.6%	7.1%	42.9%

Adult/Child diagnosis distribution graph page 2

Adult Detailed Diagnosis - Page 3

Child Detailed Diagnosis - Page 8


45.0%
40.0%
35.0%
30.0%
25.0%
20.0%
15.0%
10.0%
5.0%
0.0%
Percent of total for age group
ADHD
Anxiety/Generalized Anxiety
Bipolar
Dementia
Depressive
Personality/Neurotic/Misc.
Psychotic/Delusional
PTSD
Schizophrenia
adult
child

Diagnosis Dashboard - Outpatient Episode adult for time period: 2013 Q2

Diagnosis from most recent authorization diagnosis, outpatient episodes without authorization not included

EPISTYPE	EPISO
StartageGroupChildAdult_0_21	adult
PeriodName	2013 Q2

Diagnosis is determined by the most recent authorization to the end of the period

	Values							Percent of people			
Agency and period	# of people	% of total	opened	closed	inpatient during period	received prescriber service	average hours per year	opened	closed	inpatient during period	received prescriber service
Bipolar	1,588	20.6%	181	165	17	655	15.6	11.4%	10.4%	1.1%	41.2%
Bipolar Disorder NOS	401	25.3%	49	34	3	170	14.3	12.2%	8.5%	0.7%	42.4%
Bipolar I Disorder Most Recent Episode Depressed, In Full Remission	3	0.2%	0	0	0	2	9.6	0.0%	0.0%	0.0%	66.7%
Bipolar I Disorder Most Recent Episode Depressed, In Partial Remission	4	0.3%	1	0	0	1	12.2	25.0%	0.0%	0.0%	25.0%
Bipolar I Disorder Most Recent Episode Depressed, Mild	16	1.0%	2	1	0	9	13.6	12.5%	6.3%	0.0%	56.3%
Bipolar I Disorder Most Recent Episode Depressed, Moderate	148	9.3%	18	13	0	62	20.0	12.2%	8.8%	0.0%	41.9%
Bipolar I Disorder Most Recent Episode Depressed, Severe With Psychotic Features	94	5.9%	7	7	1	34	14.5	7.4%	7.4%	1.1%	36.2%
Bipolar I Disorder Most Recent Episode Depressed, Severe Without Psychotic Features	133	8.4%	20	26	1	41	16.1	15.0%	19.5%	0.8%	30.8%
Bipolar I Disorder Most Recent Episode Depressed, Unspecified	30	1.9%	2	2	0	16	12.8	6.7%	6.7%	0.0%	53.3%
Bipolar I Disorder Most Recent Episode Manic, In Full Remission	2	0.1%	0	0	0	1	1.0	0.0%	0.0%	0.0%	50.0%
Bipolar I Disorder Most Recent Episode Manic, In Partial Remission	5	0.3%	2	0	0	3	29.0	40.0%	0.0%	0.0%	60.0%
Bipolar I Disorder Most Recent Episode Manic, Mild	8	0.5%	0	1	0	4	20.8	0.0%	12.5%	0.0%	50.0%
Bipolar I Disorder Most Recent Episode Manic, Moderate	33	2.1%	3	5	0	8	14.7	9.1%	15.2%	0.0%	24.2%
Bipolar I Disorder Most Recent Episode Manic, Severe With Psychotic Features	72	4.5%	18	9	3	35	22.5	25.0%	12.5%	4.2%	48.6%
Bipolar I Disorder Most Recent Episode Manic, Severe Without Psychotic Features	31	2.0%	5	3	0	10	17.2	16.1%	9.7%	0.0%	32.3%
Bipolar I Disorder Most Recent Episode Manic, Unspecified	72	4.5%	7	9	1	25	9.9	9.7%	12.5%	1.4%	34.7%
Bipolar I Disorder Most Recent Episode Mixed, In Full Remission	2	0.1%	0	0	0	2	27.6	0.0%	0.0%	0.0%	100.0%
Bipolar I Disorder Most Recent Episode Mixed, In Partial Remission	3	0.2%	0	0	0	2	19.6	0.0%	0.0%	0.0%	66.7%
Bipolar I Disorder Most Recent Episode Mixed, Mild	5	0.3%	1	0	0	3	42.8	20.0%	0.0%	0.0%	60.0%
Bipolar I Disorder Most Recent Episode Mixed, Moderate	67	4.2%	11	8	1	22	19.0	16.4%	11.9%	1.5%	32.8%
Bipolar I Disorder Most Recent Episode Mixed, Severe With Psychotic Features	35	2.2%	3	3	0	18	11.1	8.6%	8.6%	0.0%	51.4%
Bipolar I Disorder Most Recent Episode Mixed, Severe Without Psychotic Features	22	1.4%	1	4	0	8	13.9	4.5%	18.2%	0.0%	36.4%
Bipolar I Disorder Most Recent Episode Mixed, Unspecified	21	1.3%	3	3	0	10	24.4	14.3%	14.3%	0.0%	47.6%

Diagnosis Dashboard - Outpatient Episode adult for time period: 2013 Q2

Diagnosis from most recent authorization diagnosis, outpatient episodes without authorization not included

EPISTYPE	EPISO
StartageGroupChildAdult_0_21	adult
PeriodName	2013 Q2

Diagnosis is determined by the most recent authorization to the end of the period

	Values		Percent of people								
Agency and period	# of people	% of total	opened	closed	inpatient during period	received prescriber service	average hours per year	opened	closed	inpatient during period	received prescriber service
Bipolar I Disorder Most Recent Episode Unspecified	91	5.7%	8	9	1	38	13.0	8.8%	9.9%	1.1%	41.8%
Bipolar I Disorder Single Manic Episode, In Partial Remission	2	0.1%	0	0	0	1	14.7	0.0%	0.0%	0.0%	50.0%
Bipolar I Disorder Single Manic Episode, Mild	1	0.1%	0	0	0	0	0.0	0.0%	0.0%	0.0%	0.0%
Bipolar I Disorder Single Manic Episode, Moderate	2	0.1%	0	0	0	1	6.6	0.0%	0.0%	0.0%	50.0%
Bipolar I Disorder Single Manic Episode, Severe With Psychotic Features	2	0.1%	1	0	0	0	14.1	50.0%	0.0%	0.0%	0.0%
Bipolar I Disorder Single Manic Episode, Severe Without Psychotic Features	1	0.1%	0	0	0	0	8.0	0.0%	0.0%	0.0%	0.0%
Bipolar I Disorder Single Manic Episode, Unspecified	6	0.4%	1	0	0	2	10.1	16.7%	0.0%	0.0%	33.3%
Bipolar II Disorder	276	17.4%	18	28	6	127	15.1	6.5%	10.1%	2.2%	46.0%
Dementia	18	0.2%	4	5	0	7	20.8	22.2%	27.8%	0.0%	38.9%
Dementia Due to HIV Disease With Behavioral Disturbance	7	38.9%	1	2	0	1	8.8	14.3%	28.6%	0.0%	14.3%
Dementia Due to Parkinson's Disease Without Behavioral Disturbance	2	11.1%	0	1	0	1	22.9	0.0%	50.0%	0.0%	50.0%
Dementia NOS	8	44.4%	3	1	0	4	32.2	37.5%	12.5%	0.0%	50.0%
Vascular Dementia With Delusions	1	5.6%	0	1	0	1	9.4	0.0%	100.0%	0.0%	100.0%
Depressive	3,047	39.5%	435	312	24	793	15.1	14.3%	10.2%	0.8%	26.0%
Adjustment Disorder With Depressed Mood	4	0.1%	0	1	0	1	3.8	0.0%	25.0%	0.0%	25.0%
Depressive Disorder NOS	53	1.7%	5	7	1	18	18.2	9.4%	13.2%	1.9%	34.0%
Dysthymic Disorder	11	0.4%	2	0	0	3	3.8	18.2%	0.0%	0.0%	27.3%
Major Depressive Disorder Recurrent, In Full Remission	6	0.2%	0	0	0	4	9.4	0.0%	0.0%	0.0%	66.7%
Major Depressive Disorder Recurrent, In Partial Remission	47	1.5%	4	5	0	8	11.9	8.5%	10.6%	0.0%	17.0%
Major Depressive Disorder Recurrent, Mild	244	8.0%	40	31	1	65	15.9	16.4%	12.7%	0.4%	26.6%
Major Depressive Disorder Recurrent, Moderate	1,382	45.4%	189	130	6	380	16.0	13.7%	9.4%	0.4%	27.5%
Major Depressive Disorder Recurrent, Severe With Psychotic Features	174	5.7%	18	18	6	60	12.0	10.3%	10.3%	3.4%	34.5%
Major Depressive Disorder Recurrent, Severe Without Psychotic Features	385	12.6%	68	40	2	112	17.5	17.7%	10.4%	0.5%	29.1%

Diagnosis Dashboard - Outpatient Episode adult for time period: 2013 Q2

Diagnosis from most recent authorization diagnosis, outpatient episodes without authorization not included

EPISTYPE	EPISO
StartageGroupChildAdult_0_21	adult
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	Values							Percent of people			
Agency and period	# of people	% of total	opened	closed	inpatient during period	received prescriber service	average hours per year	opened	closed	inpatient during period	received prescriber service
Major Depressive Disorder Recurrent, Unspecified	234	7.7%	31	10	3	61	11.0	13.2%	4.3%	1.3%	26.1%
Major Depressive Disorder Single Episode, In Full Remission	3	0.1%	0	0	0	1	16.3	0.0%	0.0%	0.0%	33.3%
Major Depressive Disorder Single Episode, In Partial Remission	8	0.3%	1	1	0	2	10.1	12.5%	12.5%	0.0%	25.0%
Major Depressive Disorder Single Episode, Mild	102	3.3%	15	17	2	16	10.9	14.7%	16.7%	2.0%	15.7%
Major Depressive Disorder Single Episode, Moderate	174	5.7%	23	16	1	29	13.8	13.2%	9.2%	0.6%	16.7%
Major Depressive Disorder Single Episode, Severe With Psychotic Features	14	0.5%	0	3	0	4	18.8	0.0%	21.4%	0.0%	28.6%
Major Depressive Disorder Single Episode, Severe Without Psychotic Features	143	4.7%	29	28	2	19	17.0	20.3%	19.6%	1.4%	13.3%
Major Depressive Disorder Single Episode, Unspecified	63	2.1%	10	5	0	10	9.8	15.9%	7.9%	0.0%	15.9%
Psychotic/Delusional	935	12.1%	95	87	42	461	14.0	10.2%	9.3%	4.5%	49.3%
Brief Psychotic Disorder	1	0.1%	0	0	0	0	0.0	0.0%	0.0%	0.0%	0.0%
Cognitive Disorder NOS	4	0.4%	1	1	1	3	19.0	25.0%	25.0%	25.0%	75.0%
Delusional Disorder	11	1.2%	0	1	0	6	8.5	0.0%	9.1%	0.0%	54.5%
Mood Disorder NOS	118	12.6%	13	8	1	34	12.2	11.0%	6.8%	0.8%	28.8%
Psychotic Disorder Due to (Indicate the General Medical Condition) With Delusions	1	0.1%	0	0	0	0	0.0	0.0%	0.0%	0.0%	0.0%
Psychotic Disorder Due to (Indicate the General Medical Condition) With Hallucinat	4	0.4%	0	0	0	1	12.6	0.0%	0.0%	0.0%	25.0%
Psychotic Disorder NOS	304	32.5%	44	34	20	128	13.7	14.5%	11.2%	6.6%	42.1%
Schizoaffective Disorder	488	52.2%	37	43	20	287	14.9	7.6%	8.8%	4.1%	58.8%
Schizophreniform Disorder	4	0.4%	0	0	0	2	5.0	0.0%	0.0%	0.0%	50.0%
PTSD	1,406	18.2%	205	162	9	417	14.9	14.6%	11.5%	0.6%	29.7%
Posttraumatic Stress Disorder	1,406	100.0%	205	162	9	417	14.9	14.6%	11.5%	0.6%	29.7%
Schizophrenia	519	6.7%	27	36	13	321	15.6	5.2%	6.9%	2.5%	61.8%
Schizophrenia Catatonic Type	4	0.8%	1	0	0	3	30.4	25.0%	0.0%	0.0%	75.0%
Schizophrenia Disorganized Type	32	6.2%	2	3	0	18	17.6	6.3%	9.4%	0.0%	56.3%

Diagnosis Dashboard - Outpatient Episode adult for time period: 2013 Q2

Diagnosis from most recent authorization diagnosis, outpatient episodes without authorization not included

EPISTYPE	EPISO
StartageGroupChildAdult_0_21	adult
PeriodName	2013 Q2

Diagnosis is determined by the most recent authorization to the end of the period

	Values							Percent of people			
Agency and period	# of people	% of total	opened	closed	inpatient during period	received prescriber service	average hours per year	opened	closed	inpatient during period	received prescriber service
Schizophrenia Paranoid Type	362	69.7%	18	27	11	230	15.6	5.0%	7.5%	3.0%	63.5%
Schizophrenia Residual Type	15	2.9%	0	0	0	12	8.5	0.0%	0.0%	0.0%	80.0%
Schizophrenia Undifferentiated Type	106	20.4%	6	6	2	58	15.5	5.7%	5.7%	1.9%	54.7%
Personality/Neurotic/Misc.	84	1.1%	10	7	0	29	14.2	11.9%	8.3%	0.0%	34.5%
Acute Stress Disorder	6	7.1%	0	0	0	1	7.3	0.0%	0.0%	0.0%	16.7%
Adjustment Disorder Unspecified	2	2.4%	0	0	0	1	12.3	0.0%	0.0%	0.0%	50.0%
Adjustment Disorder With Mixed Anxiety and Depressed Mood	8	9.5%	2	1	0	2	23.6	25.0%	12.5%	0.0%	25.0%
Adjustment Disorder With Mixed Disturbance of Emotions and Conduct	1	1.2%	0	0	0	0	0.0	0.0%	0.0%	0.0%	0.0%
Agoraphobia Without History of Panic Disorder	1	1.2%	0	0	0	0	20.1	0.0%	0.0%	0.0%	0.0%
Anorexia Nervosa	1	1.2%	0	0	0	0	17.2	0.0%	0.0%	0.0%	0.0%
Conduct Disorder, Childhood-Onset Type	1	1.2%	0	0	0	0	0.0	0.0%	0.0%	0.0%	0.0%
Cyclothymic Disorder	2	2.4%	1	0	0	1	13.2	50.0%	0.0%	0.0%	50.0%
Dissociative Identity Disorder	1	1.2%	0	0	0	1	25.1	0.0%	0.0%	0.0%	100.0%
Obsessive-Compulsive Disorder	17	20.2%	1	2	0	9	12.7	5.9%	11.8%	0.0%	52.9%
Oppositional Defiant Disorder	1	1.2%	0	0	0	0	0.0	0.0%	0.0%	0.0%	0.0%
Panic Disorder With Agoraphobia	26	31.0%	3	3	0	9	12.4	11.5%	11.5%	0.0%	34.6%
Panic Disorder Without Agoraphobia	11	13.1%	3	0	0	4	21.1	27.3%	0.0%	0.0%	36.4%
Social Phobia	5	6.0%	0	1	0	1	16.2	0.0%	20.0%	0.0%	20.0%
Specific Phobia	1	1.2%	0	0	0	0	0.0	0.0%	0.0%	0.0%	0.0%
Anxiety/Generalized Anxiety	93	1.2%	17	16	1	24	12.0	18.3%	17.2%	1.1%	25.8%
Anxiety Disorder NOS	48	51.6%	9	7	0	13	13.7	18.8%	14.6%	0.0%	27.1%
Generalized Anxiety Disorder	45	48.4%	8	9	1	11	10.2	17.8%	20.0%	2.2%	24.4%
ADHD	19	0.2%	1	1	0	5	3.8	5.3%	5.3%	0.0%	26.3%

Diagnosis Dashboard - Outpatient Episode adult for time period: 2013 Q2

Diagnosis from most recent authorization diagnosis, outpatient episodes without authorization not included

EPISTYPE	EPISO
StartageGroupChildAdult_0_21	adult
PeriodName	2013 Q2

Diagnosis is determined by the most recent authorization to the end of the period

	Values							Percent of people			
Agency and period	# of people	% of total	opened	closed	inpatient during period	received prescriber service	average hours per year	opened	closed	inpatient during period	received prescriber service
Attention-Deficit/Hyperactivity Disorder DOS	4	21.1%	0	0	0	2	10.6	0.0%	0.0%	0.0%	50.0%
Attention-Deficit/Hyperactivity Disorder, Combined type	7	36.8%	1	0	0	2	2.9	14.3%	0.0%	0.0%	28.6%
Attention-Deficit/Hyperactivity Disorder, Predominantly Inattentive Type	8	42.1%	0	1	0	1	1.3	0.0%	12.5%	0.0%	12.5%

Diagnosis Dashboard - Outpatient Episode child for time period: 2013 Q2

Diagnosis from most recent authorization diagnosis, outpatient episodes without authorization not included

EPISTYPE	EPISO
StartageGroupChildAdult_0_21	child
PeriodName	2013 Q2

Diagnosis is determined by the most recent authorization to the end of the period

	Values							Percent of people			
Agency and period	# of people	% of total	opened	closed	inpatient during period	received prescriber service	average hours per year	opened	closed	inpatient during period	received prescriber service
Bipolar	95	1.9%	13	12	3	31	18.2	13.7%	12.6%	3.2%	32.6%
Bipolar Disorder NOS	39	41.1%	3	3	1	11	14.0	7.7%	7.7%	2.6%	28.2%
Bipolar I Disorder Most Recent Episode Depressed, In Partial Remission	1	1.1%	1	0	0	0	43.5	100.0%	0.0%	0.0%	0.0%
Bipolar I Disorder Most Recent Episode Depressed, Mild	1	1.1%	0	0	0	1	17.0	0.0%	0.0%	0.0%	100.0%
Bipolar I Disorder Most Recent Episode Depressed, Severe With Psychotic Features	2	2.1%	0	0	0	0	20.9	0.0%	0.0%	0.0%	0.0%
Bipolar I Disorder Most Recent Episode Depressed, Severe Without Psychotic Features	9	9.5%	3	1	0	4	14.6	33.3%	11.1%	0.0%	44.4%
Bipolar I Disorder Most Recent Episode Depressed, Unspecified	4	4.2%	0	0	0	2	4.2	0.0%	0.0%	0.0%	50.0%
Bipolar I Disorder Most Recent Episode Manic, Moderate	1	1.1%	0	1	0	0	0.0	0.0%	100.0%	0.0%	0.0%
Bipolar I Disorder Most Recent Episode Manic, Severe With Psychotic Features	2	2.1%	0	0	1	1	3.7	0.0%	0.0%	50.0%	50.0%
Bipolar I Disorder Most Recent Episode Manic, Severe Without Psychotic Features	1	1.1%	0	0	0	0	0.0	0.0%	0.0%	0.0%	0.0%
Bipolar I Disorder Most Recent Episode Manic, Unspecified	7	7.4%	1	1	1	3	6.2	14.3%	14.3%	14.3%	42.9%
Bipolar I Disorder Most Recent Episode Mixed, Moderate	3	3.2%	1	1	0	1	12.2	33.3%	33.3%	0.0%	33.3%
Bipolar I Disorder Most Recent Episode Mixed, Severe With Psychotic Features	4	4.2%	0	1	0	1	100.9	0.0%	25.0%	0.0%	25.0%
Bipolar I Disorder Most Recent Episode Mixed, Unspecified	1	1.1%	0	0	0	0	12.4	0.0%	0.0%	0.0%	0.0%
Bipolar I Disorder Most Recent Episode Unspecified	9	9.5%	3	2	0	4	28.8	33.3%	22.2%	0.0%	44.4%
Bipolar I Disorder Single Manic Episode, Mild	2	2.1%	0	0	0	0	0.0	0.0%	0.0%	0.0%	0.0%
Bipolar I Disorder Single Manic Episode, Severe With Psychotic Features	1	1.1%	0	1	0	1	6.2	0.0%	100.0%	0.0%	100.0%
Bipolar I Disorder Single Manic Episode, Unspecified	1	1.1%	0	1	0	0	0.0	0.0%	100.0%	0.0%	0.0%
Bipolar II Disorder	7	7.4%	1	0	0	2	22.9	14.3%	0.0%	0.0%	28.6%
Depressive	1,533	30.3%	320	208	13	221	16.7	20.9%	13.6%	0.8%	14.4%
Adjustment Disorder With Depressed Mood	51	3.3%	7	8	0	2	12.6	13.7%	15.7%	0.0%	3.9%
Depressive Disorder NOS	532	34.7%	106	80	6	62	15.0	19.9%	15.0%	1.1%	11.7%
Dysthymic Disorder	146	9.5%	25	24	0	9	17.4	17.1%	16.4%	0.0%	6.2%

Diagnosis Dashboard - Outpatient Episode child for time period: 2013 Q2

Diagnosis from most recent authorization diagnosis, outpatient episodes without authorization not included

EPISTYPE	EPISO
StartageGroupChildAdult_0_21	child
PeriodName	2013 Q2

Diagnosis is determined by the most recent authorization to the end of the period

	Values							Percent of people			
Agency and period	# of people	% of total	opened	closed	inpatient during period	received prescriber service	average hours per year	opened	closed	inpatient during period	received prescriber service
Major Depressive Disorder Recurrent, In Full Remission	1	0.1%	0	0	0	0	22.3	0.0%	0.0%	0.0%	0.0%
Major Depressive Disorder Recurrent, In Partial Remission	6	0.4%	3	1	0	1	35.0	50.0%	16.7%	0.0%	16.7%
Major Depressive Disorder Recurrent, Mild	42	2.7%	10	6	0	3	13.4	23.8%	14.3%	0.0%	7.1%
Major Depressive Disorder Recurrent, Moderate	192	12.5%	37	22	1	36	16.2	19.3%	11.5%	0.5%	18.8%
Major Depressive Disorder Recurrent, Severe With Psychotic Features	7	0.5%	1	0	0	3	24.6	14.3%	0.0%	0.0%	42.9%
Major Depressive Disorder Recurrent, Severe Without Psychotic Features	56	3.7%	14	6	1	14	17.8	25.0%	10.7%	1.8%	25.0%
Major Depressive Disorder Recurrent, Unspecified	25	1.6%	4	2	0	4	13.1	16.0%	8.0%	0.0%	16.0%
Major Depressive Disorder Single Episode, In Full Remission	1	0.1%	0	0	0	1	14.0	0.0%	0.0%	0.0%	100.0%
Major Depressive Disorder Single Episode, In Partial Remission	10	0.7%	0	1	0	5	25.4	0.0%	10.0%	0.0%	50.0%
Major Depressive Disorder Single Episode, Mild	143	9.3%	26	16	0	15	15.7	18.2%	11.2%	0.0%	10.5%
Major Depressive Disorder Single Episode, Moderate	224	14.6%	65	31	5	46	21.8	29.0%	13.8%	2.2%	20.5%
Major Depressive Disorder Single Episode, Severe With Psychotic Features	11	0.7%	3	0	0	4	26.2	27.3%	0.0%	0.0%	36.4%
Major Depressive Disorder Single Episode, Severe Without Psychotic Features	47	3.1%	10	8	0	12	20.0	21.3%	17.0%	0.0%	25.5%
Major Depressive Disorder Single Episode, Unspecified	39	2.5%	9	3	0	4	9.7	23.1%	7.7%	0.0%	10.3%
Psychotic/Delusional	251	5.0%	40	48	5	75	19.1	15.9%	19.1%	2.0%	29.9%
Mood Disorder NOS	206	82.1%	31	41	1	55	19.0	15.0%	19.9%	0.5%	26.7%
Psychotic Disorder NOS	32	12.7%	7	6	3	16	20.5	21.9%	18.8%	9.4%	50.0%
Schizoaffective Disorder	12	4.8%	1	1	1	3	13.8	8.3%	8.3%	8.3%	25.0%
Schizophreniform Disorder	1	0.4%	1	0	0	1	58.0	100.0%	0.0%	0.0%	100.0%
PTSD	435	8.6%	91	69	4	60	20.4	20.9%	15.9%	0.9%	13.8%
Posttraumatic Stress Disorder	435	100.0%	91	69	4	60	20.4	20.9%	15.9%	0.9%	13.8%
Schizophrenia	14	0.3%	3	4	1	6	12.7	21.4%	28.6%	7.1%	42.9%
Schizophrenia Disorganized Type	1	7.1%	1	0	0	1	32.2	100.0%	0.0%	0.0%	100.0%

Diagnosis Dashboard - Outpatient Episode child for time period: 2013 Q2

Diagnosis from most recent authorization diagnosis, outpatient episodes without authorization not included

EPISTYPE	EPISO
StartageGroupChildAdult_0_21	child
PeriodName	2013 Q2

Diagnosis is determined by the most recent authorization to the end of the period

	Values		Percent of people								
Agency and period	# of people	% of total	opened	closed	inpatient during period	received prescriber service	average hours per year	opened	closed	inpatient during period	received prescriber service
Schizophrenia Paranoid Type	9	64.3%	2	4	1	3	9.8	22.2%	44.4%	11.1%	33.3%
Schizophrenia Undifferentiated Type	4	28.6%	0	0	0	2	14.3	0.0%	0.0%	0.0%	50.0%
Personality/Neurotic/Misc.	1,000	19.8%	193	156	3	116	17.2	19.3%	15.6%	0.3%	11.6%
Acute Stress Disorder	5	0.5%	0	0	0	0	13.4	0.0%	0.0%	0.0%	0.0%
Adjustment Disorder Unspecified	60	6.0%	9	6	0	0	11.2	15.0%	10.0%	0.0%	0.0%
Adjustment Disorder With Disturbance of Conduct	52	5.2%	13	9	0	5	17.1	25.0%	17.3%	0.0%	9.6%
Adjustment Disorder With Mixed Anxiety and Depressed Mood	72	7.2%	22	12	1	3	18.5	30.6%	16.7%	1.4%	4.2%
Adjustment Disorder With Mixed Disturbance of Emotions and Conduct	231	23.1%	52	37	0	9	16.6	22.5%	16.0%	0.0%	3.9%
Bulimia Nervosa	1	0.1%	1	0	0	0	31.7	100.0%	0.0%	0.0%	0.0%
Conduct Disorder, Adolescent-Onset Type	7	0.7%	1	2	0	1	5.6	14.3%	28.6%	0.0%	14.3%
Conduct Disorder, Childhood-Onset Type	12	1.2%	3	1	0	2	14.0	25.0%	8.3%	0.0%	16.7%
Conduct Disorder, Unspecified Onset	6	0.6%	1	2	0	0	32.9	16.7%	33.3%	0.0%	0.0%
Disorder of Infancy, Childhood, or Adolescence NOS	2	0.2%	1	0	0	0	16.7	50.0%	0.0%	0.0%	0.0%
Disruptive Behavior Disorder NOS	228	22.8%	42	38	0	34	18.2	18.4%	16.7%	0.0%	14.9%
Eating Disorder NOS	1	0.1%	0	0	0	1	4.4	0.0%	0.0%	0.0%	100.0%
Hypochondriasis	1	0.1%	0	0	0	0	21.4	0.0%	0.0%	0.0%	0.0%
Obsessive-Compulsive Disorder	17	1.7%	2	2	0	10	27.8	11.8%	11.8%	0.0%	58.8%
Oppositional Defiant Disorder	201	20.1%	32	32	2	39	17.9	15.9%	15.9%	1.0%	19.4%
Panic Disorder With Agoraphobia	6	0.6%	0	1	0	1	9.1	0.0%	16.7%	0.0%	16.7%
Panic Disorder Without Agoraphobia	19	1.9%	5	0	0	3	15.8	26.3%	0.0%	0.0%	15.8%
Reactive Attachment Disorder of Infancy or Early Childhood	13	1.3%	3	3	0	2	25.6	23.1%	23.1%	0.0%	15.4%
Selective Mutism	4	0.4%	0	0	0	1	19.1	0.0%	0.0%	0.0%	25.0%
Separation Anxiety Disorder	50	5.0%	5	9	0	3	16.1	10.0%	18.0%	0.0%	6.0%

Diagnosis Dashboard - Outpatient Episode child for time period: 2013 Q2

Diagnosis from most recent authorization diagnosis, outpatient episodes without authorization not included

EPISTYPE	EPISO
StartageGroupChildAdult_0_21	child
PeriodName	2013 Q2

Diagnosis is determined by the most recent authorization to the end of the period

	Values		Percent of people								
Agency and period	# of people	% of total	opened	closed	inpatient during period	received prescriber service	average hours per year	opened	closed	inpatient during period	received prescriber service
Social Phobia	12	1.2%	1	2	0	2	13.2	8.3%	16.7%	0.0%	16.7%
Anxiety/Generalized Anxiety	1,462	28.9%	307	222	5	145	16.8	21.0%	15.2%	0.3%	9.9%
Adjustment Disorder With Anxiety	99	6.8%	25	22	0	0	16.0	25.3%	22.2%	0.0%	0.0%
Anxiety Disorder NOS	1,100	75.2%	247	171	4	105	17.3	22.5%	15.5%	0.4%	9.5%
Generalized Anxiety Disorder	263	18.0%	35	29	1	40	14.9	13.3%	11.0%	0.4%	15.2%
ADHD	270	5.3%	32	41	1	82	15.5	11.9%	15.2%	0.4%	30.4%
Attention-Deficit/Hyperactivity Disorder DOS	11	4.1%	3	3	0	7	18.7	27.3%	27.3%	0.0%	63.6%
Attention-Deficit/Hyperactivity Disorder, Combined type	228	84.4%	25	33	0	68	15.6	11.0%	14.5%	0.0%	29.8%
Attention-Deficit/Hyperactivity Disorder, Predominantly Inattentive Type	31	11.5%	4	5	1	7	14.1	12.9%	16.1%	3.2%	22.6%