NORTH SOUND
MENTAL HEALTH ADMINISTRATION

QUALITY MANAGEMENT OVERSIGHT COMMITTEE

MEETING PACKET

March 26, 2014
1:00 – 3:00 pm

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

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QMOC GUIDING PRINCIPLES

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

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

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

NORTH SOUND MENTAL HEALTH ADMINISTRATION
QUALITY MANAGEMENT OVERSIGHT COMMITTEE AGENDA

Date: March 26, 2014 **Time: 1:00-3:00 PM**

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

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

Topic	Objective	ACTION NEEDED	Discussion Leader	Handout available pre-mtg	Handout available at mtg	Tab	Time
Introductions	Welcome guests; presenters and new members		Chair				*5 min*
Review and Approval of Agenda	Ensure agenda is complete and accurate; determine if any adjustments to time estimates are needed. Meeting will start and end on time.	Approve Agenda	Chair	Agenda		**1**	*5 min*
Review and Approval of Summary of Previous Meeting	Ensure meeting summary is complete and accurate.	Approve Meeting Summary	Chair	Summary		**2**	*5 min*
Announcements and Updates	• Dan Bilson's Retirement • DSM V Training • DDA Training April 2 in Whatcom County • Other						*5 min*
Update on Regional Healthcare Alliance	Brief update.	Inform /discuss	Chair/ Greg				*5 min*
Quality Topics							
WISE Data Reporting	Clarify the reporting requirements regarding the new WISe Program	Inform /discuss/ action	Julie de Losada	Yes		**3**	*15 minutes*
WRAP+MAP Clinical Services	Overview of the cloud-based, evidence-based practice guide for children's mental health strategies	Inform /discuss	Julie de Losada	Yes		**4**	*15 min*
EPSDT Policy	Re-review of EPSDT Policy as requested at last month's QMOC Meeting	Action	Angela Fraser-Powell/Greg Long	Yes		**5**	*10 minutes*
Care Coordination Data Base	Overview of NSMHA's new care coordination data base for identifying people possibly needing changes in treatment.	Inform /discuss	Charissa Westergard	Yes		**6**	*10 min*
Policy 1720 Involuntary Treatment Program Policy	Requesting approval of the revised Involuntary Treatment Program Policy	Discussion/ Action	Sandy Whitcutt/ Greg Long	Yes		**7**	*10 min*
Policy 1725 Mobile Outreach Team Policy	Requesting approval of the revised Mobile Outreach Team Policy	Discussion/ Action	Sandy Whitcutt/ Greg Long	Yes		**8**	*10 min*
Training Committee	Discuss Re-instituting the Regional Training Committee	Discussion /Action	Greg Long	Yes		**9**	*15 min*
Other issues							
***Review of Meeting**	Were objectives accomplished? How could this meeting be improved? Eval forms						
Date and Agenda for Next Meeting	Ensure meeting date, time and agenda are planned						

Next meeting: April 23, 2014- 1:00-3:00 PM

Potential Future Agenda Items:

DRAFT NOT YET APPROVED BY COMMITTEE

QMOC
February 26, 2014

Present: Rob Sullivan, Skagit County Crisis Center; Stacey Alles, Compass Health; Katherine Scott, Sea Mar; Mike Manley, Sunrise Services; Chuck Davis, Ombuds; Richard Sprague, Interfaith; Cindy Ferraro, Bridgeways; David Kincheloe, Mark McDonald, Cindy Trautman and Marie Jubie, NSMHA Advisory Board; Eric Chambers, Northwest ESD; Kathy McNaughton, CCS; Rebecca Clark, Skagit County Health & Community Services; Rochelle Moore, Bridgeways

By Phone: Jeff Reynolds, Skagit Valley REACH Center; Pat Morris, VOA; Kay Burbidge, Lake Whatcom Center; Anne Deacon, Whatcom County Human Services; Cammy Hart-Anderson, Snohomish County Human Services; Joe Warner, Skagit County Community Services

Staff: Greg Long; Charissa Westergard; Sandy Whitcutt; Margaret Rojas; Michelle Hensler

Minutes from Past Meeting: ☐ Approved
☐ Approved with changes
☐ Deferred until next meeting

Agenda Item	Discussion	Action
1. Introductions & Review Minutes	Meeting called to order at 1:02pm Motion to approve minutes. Motion carried.	Approved
2. Announcements & updates	Greg: Recovery Conference is next Tuesday all day at Skagit Valley Community College, McIntyre Hall. Request we resume a training committee of QMOC. Developed modules expectations. Training becoming a bigger issue. Talked with the leadership team. They agree and it makes sense, over the next five years. Meeting would start maybe every other month then maybe quarterly. Discussion regarding the meeting with DDA this morning. If child comes in with Autism or any disability get parents to sign a release so that we can talk to DDA. If you have a child who is not receiving services, the parents should apply for it. If they have applied and turned down, they should appeal. Appeal comes from NSMHA not DDA. Autism isn't a covered service under mental health services however, anxiety and depression are. Discussion regarding appeals and testing. Would be interesting to have someone from DDA come to a future meeting.	Informational
3. Update on Regional Healthcare Alliance	Nothing to report at this time. Group is meeting next week to try and find specific strategies to reduce boarding.	Informational
4. Report on the Recovery Innovations' Consultations	Margaret: Sandy, E&T Staff, Triage Staff, and a few others met with Lori Ashcraft from Recovery Opportunity Center, Phoenix. Their programs use peers in the total recovery model. We want to bring together parent partners and adult peers and at some point bring in youth peers. We will be putting together a survey, more specific than a year ago. This will help our system move more toward peer employment and total recovery. There will be a provider survey and peer survey for those employed as peers. We want to see where the needs are. Help the providers with supervision of peers and practices with peers. Possibly send people down to Phoenix or bring them	Informational

	up here to shadow with some of our programs. Sandy on Triage: Met for two part days. Day 1 with triage & E&T. Lori presented a lot of philosophical things, which were critical as we shift more towards recovery. When dealing in crisis, working a lot on controlling behaviors, Lori addressed some shifts in thinking. Sharing vs. controlling. Peer staff, using peers and making the shift that peers are true employees. Lori spoke of this. Healing spaces, language shift, more of quiet spaces or calming spaces not seclusion and restraint. Changes in documentation, training staff is critical to make it work. Discussed enclosed packet of information. Clinically talking about peers not being called peers but employees. This could help them develop with their skills, enable them to move forward and seek employment elsewhere. Day 2 met at E&T in Mukilteo. Talked about strengths, things that could change. The building is an eye sore. Lori said "it's not about the building, it's about the attitude." Focused on terminology, staffing patterns, increased use of peers. What might we look at differently, seclusion and restraint is an issue we are addressing in this region. Next steps will bring teams back together. How do we want to roll this out? What will it look like? What types of things can we move on? What are long/short term goals? Clearly make a better connection with individual. Pierce program has very few walls in their program; we have a lot of walls. Both physically and philosophically. Lori Ashcraft was Assistant Director with California State Mental Health. Then went to Recovery Innovations'.	
5. Delay of Regional Outcomes Measures	Follow up to discussion at last QMOC, DBHR spoke with RSNs regarding outcomes. Legislation requirements for outcomes will come out in the next two to three months. One measure they are thinking of using is the PHQ9. Discussion of the PHQ9 regarding the use and meaning. Reporting of outcome measures is a going to be an expectation. Discussion of the disconnection between CIS and QMOC. Discussion of EHR regarding which outcomes and the design of the EHR to extract the proper data.	Informational
6. Child and Family Teams Coding	Issues in summary: working on WRAPAROUND services and family teams for 5 years. There have been coding issues in the past. Therefore, there are little or no results. Discussion regarding the possible reason for no data. Codes were not passed on to providers, therefore old codes were input. New code summary is available. CIS gets updates. It will be distributed to QMOC from now on.	Informational
7. Policy 1704	SAMHSA principles allowed first section to flow simpler. Philosophic what guide and components with in. Resourced it to the new standards, about what SAMHSA applies and thinks. Discussed modifications to policy. Approved…Motion passes.	Approved
8. Cultural Competency Expectations	New WACs are not as descriptive. Old WACs have not yet been repealed. Have to follow two sets of WACs at this time. Contract from State hasn't arrived as of yet. We will continue with what we have while developing Cultural Competencies. Discussion regarding current and new WACs; providers to continue with the current WACs.	Informational
9. EPSDT Annual Report and revised Policy 1550	Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Greg noted this is an update to the policy to ensure good coordination between medical entities and the mental health system. The policy also needed some updating in response to the changes coming about with the new WISe system of care.	Motion to move forward to next meeting

	Discussion regarding the follow through responsibility of the EPSDT referral and the workload burden; is there specific language from the state or is this from NSMHA? More clarification on the requirements is called for. There is a motion to table this for the next meeting; motion carried.	
10. Implementation of the WA State Children's Mental Health Principles	EQRO: How philosophy underlined children's mental health reform was being implemented. Looked at 43 charts in our region. Of that, 83% contained a reasonable assessment; 97% diagnoses were adequately justified; 97% of the treatment plans contained interventions and goals that were consistent with assessment. Downside: state is interested in team based services. Only 42% of the cases could they really document that they were team based services. Lack of documentation in care coordination in actual progress notes. Discussion regarding the difficulty of clearer documentation. 43 charts were outpatient charts not wraparound charts.	Informational
11. Other Issues		
12. *Review of Meeting		
13. Date and Agenda for Next Meeting	Adjourned at 2:42 pm. Next meeting on March 26, 2014 1:00-3:00, Go To Meeting.	

NSMHA COMMITTEE DISCUSSION FORM

AGENDA ITEM: WISe Coding

PRESENTER: Julie de Losada

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

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:

The WISe program is the new high intensity wrap-around service being implemented on a graduated basis across the State under a court decree. There are multiple issues that are being worked out regarding the design and reporting of this new program.

Providers would like clarifications regarding questions about the new Service Encounter Reporting Instructions manual including a modifier (-U8) that is to be used with WISe services.

Provider questions are:

1. Will WISe services have a new episode type?
2. Will services provided by non-WISe clinicians post in the WISe episode (if there is one) or in the OP episode?
3. The manual refers to "qualified WISe practitioner." Do we know what that means?
4. The manual seems to say that clinicians who are part of the WISe team use the modifier on everything, and clinicians who are not part of the WISe team would not use it, even if serving a client who is enrolled in WISe. Is that correct?

CONCLUSIONS/RECOMMENDATIONS:

- DBHR, NSMHA and the statewide SERI Workgroup are still working this through. While more may be known prior to March QMOC, we will be able to add clarification on some points.

TIMELINES:

- WISe begins July 1, 2014

ATTACHMENTS:

- SERI Effective July 1, 2013
- http://www.dshs.wa.gov/pdf/dbhr/mh/DSHS_DBHR_MH_SERI_%20Dec_2009%20%206th%20Revision%20final.pdf

NSMHA COMMITTEE DISCUSSION FORM

AGENDA ITEM: WRAP + MAP

PRESENTER: Julie de Losada

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

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:

Wraparound + Managing and Adapting Practice (Wrap+MAP)

The Managing and Adapting Practice (MAP) system is designed to improve the quality, efficiency, and outcomes of children's mental health services by giving administrators and practitioners easy access to the most current scientific information and by providing user-friendly monitoring tools and clinical protocols. Using an online database, the system can suggest formal evidence-based programs or, alternatively, can provide detailed recommendations about discrete components of evidence-based treatments relevant to a specific youth's characteristics. Whether services are delivered through existing evidence-based programs or assembled from components, the MAP system adds a unifying evaluation framework to track outcomes and practices.

Wrap+MAP

Wrap+MAP represents a shared effort of the National Wraparound Initiative (NWI), PracticeWise, LLC, and the Institute for Innovation and Implementation at the University of Maryland School of Social Work to coordinate wraparound with evidence-based strategies by strategically applying the resources of the MAP system.

Wrap+MAP aims to enhance outcomes and efficiency of wraparound in the following ways:

- During wraparound planning, team members use MAP tools to generate a broader array of research-based options that fit the youth and family's needs and preferences.
- Wrap-affiliated clinicians are trained and supported to use effective treatment elements that connect to the youth and family's strengths and preferences when therapy is included in a wraparound plan.
- Parent and youth partners, mentors, behavioral specialists, and other helpers are trained and supported to serve as "care extenders" who can enhance evidence based treatment strategies.
- Progress and practices is monitored consistently and information used to revise plans as needed.

CONCLUSIONS/RECOMMENDATIONS:

- Operationalizes Family-Driven/Youth-Guided Care
- Provides Wraparound/WISe staff with a data based decision making and treatment planning platform
- Assists RSNs and providers in meeting the goals of HB2536 (2012) http://depts.washington.edu/ebpi/2536.php

TIMELINES:

- WISe begins July 1, 2014

ATTACHMENTS:

- https://www.practicewise.com/#services

NSMHA COMMITTEE DISCUSSION FORM

AGENDA ITEM: Policy 1550.00 Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services

PRESENTER: Greg Long for Angela Fraser-Powell

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

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:

As part of the upcoming changes to children's services, the EPSDT policy has been updated to help ensure good care coordination between medical entities and mental health for all youth up to age 21, more focus on transitional age youth and to clarify the procedure for considering consumers as an EPSDT referral and to be consistent with language and requirements in the current contract.

1. **The current contract requires follow up within 10 working days of an EPSDT referral.**

1.37. Request for Service means the point in time when services are sought or applied for through a telephone call, walk-in, or written request for services from an enrollee or the person authorized to consent to treatment for that enrollee. For purposes of this Contract, an EPSDT referral is only a Request for Service when the enrollee or the person authorized to consent to treatment for that enrollee has confirmed that they are requesting service.

13.9.3. The Contractor shall contact the enrollee within ten (10) working days of all EPSDT referrals to confirm whether services are being requested by the enrollee or the person authorized to consent to treatment for that enrollee. The Contractor shall maintain documentation of its efforts to confirm whether the enrollee or the person authorized to consent to treatment for that enrollee requests, declines, or does not respond to efforts within ten (10) working days to confirm whether these services are being requested.

2. **Although some medical offices may use a specific form for EPSDT referral, there is no required form a referral has to be on in order to be considered EPSDT per DBHR. The only requirement is the referral has been given by the consumer's medical provider (see updated qualified provider list in draft policy 1550.00) which could be in written or verbal format.**

CONCLUSIONS/RECOMMENDATIONS:
Recommendation for approval

TIMELINES:

ATTACHMENTS: Policy 1550-revised and Policy 1550-Redline

Effective Date: 6/17/2010; 11/29/2005, 7/3/2007
Revised Date: 12/16/2013
Review Date:

North Sound Mental Health Administration

Section 1500 – Clinical: Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services

Authorizing Source: DSHS Contract;
Cancels:
See Also:
Providers must have a policy "consistent with" this policy — Approved by: Executive Director — Date: 10/4/2010
Responsible Staff:: Deputy Director — Signature:

POLICY #1550.00

SUBJECT: EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT) SERVICES

PURPOSE

To ensure that the North Sound Mental Health Administration (NSMHA) providers assess and provide appropriate levels of mental health services to individuals referred through the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program and to ensure ongoing coordination of care.

DEFINITIONS

EPSDT Program is a preventive health care benefit for individuals with Medicaid under 21 years of age. The program is intended to identify, through periodic screening, any existing physical and/or mental health issues and ensure appropriate referrals and treatment for identified issues. In the context of the NSMHA system, individuals are identified as being in the EPSDT Program when they have been referred to a NSMHA Provider by a Primary Care Provider (PCP).).

Primary Care Provider (PCP) is defined as the following providers eligible to perform EPSDT screens:

A. EPSDT clinics;
B. Physicians;
C. Natropathic Physicians;
D. Advanced registered nurse practitioners (ARNPs);
E. Physician Assistants (PAs) working under the guidance and MAA provider number of a physician;
F. Registered nurses working under the guidance of a physician or ARNP may also preform EPSDT screenings. However, only physicians, PA's and ARNP's can diagnose and treat problems found in screenings.

EPSDT Referral – NSMHA considers the following an EPSDT referral:

A. Written referral in any format from the PCP
B. Verbal referral directly from the PCP
C. Verbal referral by the PCP as reported by the consumer

POLICY

NSMHA believes the early screening and detection of mental health issues in individuals and coordination of care with health care providers are core components of quality mental health services. Mental health services will be provided following the requirements of the EPSDT Program.

The individual's PCP performs the EPSDT screening, which includes a full physical examination at an interval prescribed by the treating PCP but not to exceed two years. The examination may result in referral to mental health services.

EPSDT service must be structured in ways that are culturally and age appropriate, involve the family and/or caregiver and include a full assessment of the family's needs.

PROCEDURE

NSMHA Providers are responsible for:

A. Responding to EPSDT referrals that originate from PCPs. The referral may be a written referral in any format or verbal referral from the PCP office or consumer.

   i. When mental health services are requested with an EPSDT referral, a written response must be provided to the Physician, ARNP, Physician Assistant, trained public health nurse or RN who made the EPSDT referral. This notice must include at least the date of intake and the diagnosis.
   ii. Contacting the individual/guardian within 10 working days of all EPSDT referrals to confirm if services are being requested by the individual/guardian. Documentation of this effort shall be maintained for one year after the completion of the contract period, to confirm if the individual/guardian requests, declines or does not respond to efforts within 10 working days.
   iii. In the event an enrollee's referral to mental health services **did not** originate from a PCP, the individual is not considered an EPSDT referral.

B. Assisting individuals/families, who do not have a PCP, in locating and connecting with a PCP. The following information may be used to assist the individual in locating a provider.

   Toll Free Number: 1-800-562-3022
   Web site: http://hrsa.dshs.wa.gov/applehealth

C. Developing, in coordination with the individual/family, other health care providers, and related allied systems, a Recovery and Resiliency Plan (RRP; aka Individual Service Plan) that addresses the individual/family's needs per NSMHA policies on RRPs and coordination of care (NSMHA Policies 1517, 1546, 1551, etc).

   i. The RRP must contain clarification of roles and responsibilities of all health care providers involved in serving the youth.

   ii. In the event the other health care providers and/or allied systems choose not to jointly create a coordination plan, the NSMHA provider must develop a plan

that addresses how they will interact with the other external providers in order to address the individual/family needs.

Through routine review of NSMHA provider records, NSMHA will ensure providers have:

A. Responded to EPSDT referrals.
B. Assisted in locating and connecting to a PCP.
C. Coordinated development of RRPs.

ATTACHMENTS

None

Effective Date: 6/17/2010; 11/29/2005, 7/3/2007
Revised Date: 12/16/2013 ~~Rev D 5/10/2010~~
Review Date:

North Sound Mental Health Administration

Section 1500 – Clinical: Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services

Authorizing Source: DSHS Contract~~BHR, HRSA, PIHP Contract~~;
Cancels:
See Also:
Providers must have a policy "consistent with" this policy | Approved by: Executive Director | Date: 10/4/2010
Responsible Staff:: Deputy Director | Signature:

POLICY #1550.00

SUBJECT: EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT) SERVICES

PURPOSE

To ensure that the North Sound Mental Health Administration (NSMHA) providers assess and provide appropriate levels of mental health services to individuals referred through the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program and to ensure ongoing coordination of care.

DEFINITIONS

EPSDT Program is a preventive health care benefit for individuals with Medicaid under 21 years of age. The program is intended to identify, through periodic screening, any existing physical and/or mental health issues and ensure appropriate referrals and treatment for identified issues. In the context of the NSMHA system, individuals are identified as being in the EPSDT Program when they have been referred to a NSMHA Provider by a Primary Care Provider (PCP).~~**Services** are available to all Medicaid individuals under 21 years of age. EPSDT identified individuals have been referred by a Primary Care Provider (PCP). on the "referral for mental health/substance abuse assessment" (Healthy Kids~~).

Primary Care Provider (PCP) is defined as the following providers eligible to perform EPSDT screens~~ and to bill Medical Assistance Administration (MAA) the enhanced rate for individuals receiving foster care placement services from Department of Social and Health Services (DSHS)~~:

A. EPSDT clinics;
B. Physicians;
~~B.~~C. Natropathic Physicians;
~~C.~~D. Advanced registered nurse practitioners (ARNPs);
~~D.~~E. Physician A~~a~~ssistants (PAs) working under the guidance and MAA provider number of a physician;
~~E. Nurses specially trained through the Department of Health (DOH) to perform EPSDT screens; and~~
F. Registered nurses working under the guidance of a physician or ARNP may also preform EPSDT screenings. However, only physicians, PA's and ARNP's can diagnose and treat problems found in screenings. ~~and MAA provider number of a physician or ARNP.~~

EPSDT Referral – NSMHA considers the following an EPSDT referral:

Comment [CWMM1]: Do we have to include the enhanced rate piece (a bit confusing)? The billing instructions p. A1 have a slightly simplified list that I would recommend using. We could just reference make a brief statement about an enhanced rate and refer them to WAC for further detail if absolutely needed.

A. Written referral in any format from the PCP
B. Verbal referral directly from the PCP
C. Verbal referral by the PCP as reported by the consumer

POLICY

NSMHA believes the early screening and detection of mental health issues in individuals and coordination of care with health care providers are core components of quality mental health services. Mental health services will be provided following the requirements of the EPSDT Program.

The individual's PCP performs the EPSDT screening, which includes a full physical examination at an interval ~~of up to two years, or at an interval~~ prescribed by the treating ~~pediatrician.~~PCP but not to exceed two years. The examination may result in ~~and possible~~ referral to mental health services.

EPSDT service must be structured in ways that are culturally and age appropriate, involve the family and/or caregiver and include a full assessment of the family's needs.

PROCEDURE

NSMHA Providers are responsible for:

A. Responding to EPSDT referrals that originate from PCPs~~from primary health care providers~~. The referral may be a written referral in any format or verbal referral from the PCP office or consumer.

   i. When mental health services are requested with an EPSDT referral, a written response must be provided to the Physician, ARNP, Physician Assistant, trained public health nurse or RN who made the EPSDT referral. This notice must include at least the date of intake and the diagnosis.
   ii. Contacting the individual/guardian within 10 working days of all EPSDT referrals to confirm if services are being requested by the individual/guardian. Documentation of this effort shall be maintained for one year after the completion of the contract period, to confirm if the individual/guardian requests, declines or does not respond to efforts within 10 working days.
   iii. In the event an enrollee's referral to mental health services **did not** originate from a PCP, the individual is not considered an EPSDT referral.

B. Assisting individuals/families, who do not have a PCP, in locating and connecting with a PCP~~In the event an enrollee **does not** have a primary care provider,~~. ~~t~~The following information~~number~~ may~~must~~ be used to assist the individual in locating a provider.

   Toll Free Number: 1-800-562-3022
   Web site: http://hrsa.dshs.wa.gov/applehealth ~~Allied System Coordination~~

~~individual~~

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Comment [CWMM2]: Pediatrician not eligible provider?

Comment [CWMM3]: "and possible referral to mental health services" doesn't make sense to me in its current location in this sentence. I'm not sure what we are trying to say.

Comment [KAM4]: Isn't "that originate from PCP" redundant? See item #iii, below. In essence, aren't all authentic "EPSD" referrals originated by PCP?

Comment [CWMM5]: I have to admit that once I rea B-F, I am unclear if there is a difference between a PCP and a primary health care provider. Can one of the qualifying people above conduct a screening and referral but not be considered the PCP and therefore it isn't considered an EPSDT referral? I think A-F warrants some discussion and further clarification for us folks who know next to nothing about EPSDT.

Comment [CWMM6]: Marked where?

Comment [KAM7]: What does "marked" mean? Would it be better/clearer to use "considered?"

Comment [CWMM8]: Did you intend to include something here or did it sneak in?

C. Developing, in coordination with the individual/family, ~~and~~ other health care providers, and related allied systems, a Recovery and Resiliency Plan (RRP; aka Individual Service Plan) that addresses the individual/family's needs per NSMHA policies on RRPs and coordination of care (NSMHA Policies 1517, 1546, 1551, etc). ~~An Allied System coordination plan must contain clarification of roles and responsibilities of all the allied systems in serving multi-system youth. For EPSDT, the provider will develop a cross-system Individual Service Plan (ISP) that addresses multi-system youth/assessed family needs per WAC 388-865-042~~

~~5.~~

i. The RRP must contain clarification of roles and responsibilities of all health care providers involved in serving the youth.

ii. In the event the other health care providers and/or allied systems ~~allied systems~~ choose not to jointly create a coordination plan, the NSMHA provider must develop a plan that addresses how they ~~provider~~ will interact with the other external providers~~allied systems~~ in order to address the individual~~youth~~/family needs.

Through routine review of NSMHA provider records, NSMHA will ensure providers have:

A. Responded to EPSDT referrals.
B. Assisted in locating and connecting to a PCP.
C. Coordinated development of RRPs.

~~The allied system coordination of care, including the written notice back to the PCP and documentation confirming service request, through regular reviews.~~

ATTACHMENTS

None

Comment [CWMM9]: Does this mean a ISP or is a coordination plan something else?

Comment [CWMM10]: The references to allied systems and multi-system youth seems somewhat out of place in this policy.

NSMHA COMMITTEE DISCUSSION FORM

AGENDA ITEM: Care Coordination

PRESENTER: Charissa Westergard

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

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:
NSMHA is in the process of completing development of a database to assist our Care Coordination staff with proactively identifying individuals who may be in need of care coordination. Identification criteria include psychiatric inpatient utilization, crisis service utilization, outpatient service utilization, involuntary treatment status, co-morbidity per CA/LOCUS, foster care/homelessness for individuals 20 and younger. As we obtain additional resources, we plan to incorporate PRISM (Predictive Risk Intelligence System) and EDIE (Emergency Department Information Exchange).

For those individuals that are in an outpatient episode with one of the Community Mental Health Agencies (CMHAs), we will be contacting the different agencies. In most cases, it will primarily be notification that individuals are coming to our attention and why. In more limited circumstances, we will request records and maybe a phone call with the agency to assess if further care coordination efforts may be beneficial.

We are currently refining identification so that the number of individuals identified is manageable.

CONCLUSIONS/RECOMMENDATIONS:
This is partially an FYI so agencies are not surprised when we begin some of these care coordination efforts. However, we are also interested in feedback from QMOC regarding criteria for identification as well as care coordination follow up.

TIMELINES:

ATTACHMENTS:
None

NSMHA COMMITTEE DISCUSSION FORM

AGENDA ITEM: ICRS Policy 1720.00 Administration of the Involuntary Treatment Program

PRESENTER: Sandy Whitcutt or Greg Long

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

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:
Designated Mental Health Professionals perform the duties of involuntary investigation when an individual is in crisis, and are authorized to detain the individual in accordance with RCW 71.05, RCW 71.34, RCW 10.77. This policy defines the role, and addresses the agreements in place with the regional Counties. The policy was due for resourcing due to the WAC revisions. There were minimal changes to the policy.
ICRS has reviewed the policy and recommends approval.

CONCLUSIONS/RECOMMENDATIONS:
Approve the revised policy.

TIMELINES:
This revised policy will go into effect 60 days after it is posted to the NSMHA website.

ATTACHMENTS: Policy 1720, clean and version with track changes

Effective Date: 7/14/2010; 8/30/2007
Revised Date: 1/6/14
Reviewed Date:

North Sound Mental Health Administration

Section 1700 – ICRS: Administration of the Involuntary Treatment Program

Authorizing Source: NSMHA contract, DMHP protocols, WAC 388-877-02,200 through280, (except 230) ; RCW 71.05, 71.34, 10.77
Cancels:
See Also: Approved by: Executive Director Date:
Provider must have a "policy consistent with NSMHA policies"
Responsible Staff: Deputy Director Signature:

POLICY #1720.00

SUBJECT: ADMINISTRATION OF THE INVOLUNTARY TREATMENT PROGRAM

PURPOSE

The purpose of this policy is to ensure that Involuntary Treatment Services are provided by Designated Mental Health Professionals (DMHP) to evaluate an individual in crisis and determine if involuntary services are required.

POLICY

North Sound Mental Health Administration (NSMHA) or its member counties will designate DMHPs to perform the duties of involuntary investigation and detention in accordance with the requirements of RCW Chapters 71.05, 71.34, current Washington Administrative Codes(WAC), and current DMHP protocols (see website at: www.dshs.wa.gov/dbhr/mhcdmhp.shtml). This will be done in consultation between the Integrated Crisis Response Services (ICRS) Service Providers, the counties and NSMHA.

RCW 71.05 provides for persons suffering from mental disorders to be involuntarily committed for treatment and sets forth that procedures and services be integrated with Chapter 71.24 RCW.

RCW 71.34 establishes mental health services for minors, protects minors against needless hospitalization, enables treatment decisions to be made with sound professional judgment and ensures minors' parents/guardians are given an opportunity to participate in treatment decisions

PROCEDURE

Definitions

DMHP means a mental health professional designated by the county or other authority authorized in rule to perform the duties specified in these chapters.

"**Detention**" or "**Detain**" means the lawful confinement of a person, under the provisions of these chapters.

1. NSMHA will have agreements in place with ICRS Service Providers, Snohomish, Skagit, Island Whatcom and San Juan Counties to provide services in accordance with the designation noted above.
2. Mental Health Professionals designated to perform these duties will have the necessary training to perform these duties.
3. NSMHA will monitor this designation practice through the auditing process.

ATTACHMENTS

None

Effective Date: 8/30/2007
Revised Date: ~~5/6/2010~~1/6/14
Reviewed Date:

North Sound Mental Health Administration

Section 1700 – ICRS: Administration of the Involuntary Treatment Program

Authorizing Source: NSMHA contract, DMHP protocols, WAC 388-~~865~~877-024,200 through~~5~~280, (except 230)~~(1)~~ ; RCW 71.05, 71.34, 10.77 ~~RCW 70.96 B~~
Cancels:
See Also: Approved by: Executive Director Date: 7/14/2010
Provider must have a "policy consistent with NSMHA policies"
Responsible Staff: Deputy Director Signature:

POLICY #1720.00

SUBJECT: ADMINISTRATION OF THE INVOLUNTARY TREATMENT PROGRAM

PURPOSE

The purpose of this policy is to ensure that Involuntary Treatment Services are provided~~administered~~ by Designated Mental Health Professionals (DMHP)~~/ Designated Crisis Responders (DCR)~~ to evaluate an individual in crisis and determine if involuntary services are required.~~in accordance with chapters 71.05, 71.34 RCW, and RCW 70.96 B.~~

POLICY

North Sound Mental Health Administration (NSMHA) or its member counties will designate DMHPs~~/ DCRs~~ to perform the duties of involuntary investigation and detention in accordance with the requirements of RCW Chapters 71.05, 71.34, 10.77,current Washington Administrative Codes, and current DMHP protocols (see web site at: www.dshs.wa.gov/dbhr/mhcdmhp.shtml).~~ 71.05, 71.34, 70.96B.~~ This will be done in consultation between the Integrated Crisis Service Providers (ICRS), the counties and NSMHA.

RCW 71.05 provides for persons suffering from mental disorders to be involuntarily committed for treatment and sets forth that procedures and services be integrated with Chapter 71.24 RCW.

RCW 71.34 establishes mental health services for minors, protects minors against needless hospitalization, enables treatment decisions to be made with sound professional judgment, and ensures minors' parents/guardians are given an opportunity to participate in treatment decisions

~~RCW 70.96 B provides for persons with chemical dependences and/ or mental illnesses to be involuntarily committed for treatment when such secure resources for detention exist under this law~~

PROCEDURE

Definitions

~~**DCR** means a mental health professional appointed by the county or the regional support network to perform the duties specified in these chapters~~.

DMHP means a mental health professional designated by the county or other authority authorized in rule to perform the duties specified in these chapters.

"**Detention**" or "**Detain**" means the lawful confinement of a person, under the provisions of these chapters.

1. NSMHA will have agreements in place with ICRS Service Providers, Snohomish, Skagit, Island Whatcom and San Juan Counties to provide services in accordance with the~~to~~ designation noted~~of the~~ above.
2. Mental ~~h~~Health ~~p~~Professionals designated to perform these duties will have the necessary training to perform these duties.

3. NSMHA will monitor this designation practice through the auditing process.

ATTACHMENTS

None

NSMHA COMMITTEE DISCUSSION FORM

AGENDA ITEM: ICRS Policy 1725.00 Mobile Outreach Team

PRESENTER: Sandy Whitcutt or Greg Long

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

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:
Mobile Outreach Teams were established in Skagit and Whatcom counties to provide earlier intervention to individuals. These teams, comprised of a mental health professional and peer counselor, provide outreach to the community. The role of these teams is to meet with individuals and families before there is a mental health crisis, and divert from hospitalization. The teams work with the individual and families on a stabilization plan, providing resources to assist with stability. This policy defines the role, addresses procedures, and identifies outreach expectations.
The policy was due for resourcing due to the WAC revisions. There were minimal changes to the policy. ICRS has reviewed the policy and recommends approval.

CONCLUSIONS/RECOMMENDATIONS:
Approve the revised policy.

TIMELINES:
This revised policy will go into effect 60 days after posting to the NSMHA website.

ATTACHMENTS:
Policy 1725, clean and version with track changes

Effective Date: 4/23/2012; 11/29/2011
Revised Date: 9/13/11
Review Date: 2/23/14

North Sound Mental Health Administration

Section 1700 – Crisis Services – Mobile Outreach Team

Authorizing Source: NSMHA contract, WACs 388-877A-0200 through270
Cancels:
See Also: Approved by: Executive Director Date:
Providers must "comply with" this policy
Responsible Staff: Deputy Director Signature:

POLICY #1725.00

SUBJECT: MOBILE OUTREACH TEAM

PURPOSE

To define the role of the Mobile Outreach Team (MOT) which is intended to provide more outreach to individuals in the community to prevent mental health crises, as well as, prevent unnecessary emergency department admissions and inpatient psychiatric hospitalizations.

POLICY

The MOT program is part of an integrated, coordinated and seamless crisis response system for the North Sound Mental Health Administration (NSMHA) and its member counties: Island, San Juan, Skagit, Snohomish and Whatcom ("NSMHA Service Area"). These teams are established in Skagit and Whatcom counties.

The program is intended to provide early intervention to assess, engage, provide temporary support and make appropriate referrals to community resources for individuals who are not currently enrolled in the outpatient public mental health system. The MOTs shall respond to non-emergent mental health situations (i.e., the severity and/or acuity of the individual's behavior/situation does not meet criteria for either emergency services or an involuntary treatment investigation). Non-emergent mental health situations are defined as those situations where the level of stress has overwhelmed the individual's ability to cope and earlier support/intervention may alleviate the effects of the stressful situation.

The MOTs are intended to prevent crises so that:

I. People are stable and safe living in the community;
II. People do not have to go to emergency departments to prevent crises;
III. The number of people needing admission into inpatient psychiatric services can be reduced.

These teams shall respond to direct calls from the community and calls dispatched by the Volunteers of America (VOA) Care Crisis Line. These teams will coordinate as necessary with existing Emergency Services and Involuntary Treatment Investigation Services. As indicated above, these teams are not intended to respond to emergent mental health crises.

PROCEDURES

I. MOT Responsibilities:

Each team will:

A. Provide community outreach as defined below;
B. Be comprised of two members, a Mental Health Professional and peer counselor;
C. Be available Monday through Friday between the hours of 1 pm to 9 pm;
D. Be stationed at their assigned place of work when not out in the community;

E. Take referrals from calls to the Care Crisis Line and direct access calls from the community;
F. Respond to pages from VOA Care Crisis within 10 minutes;
G. Respond to calls dispatched by VOA as rapidly as possible, complete a safety screen, when able, with VOA Care Crisis (see ICRS policy 1702.00) and attempt to make phone or face-to-face contact with the individual or concerned caller by the next business day. Attempts to contact the individual or concerned caller should be documented by the MOT;
H. Utilize family, community and other natural supports to support the recovery plan;
I. Provide stabilization services that can last up to 4 hours (average per contact), and provide up to 10 hours (average), per individual, of direct services within a 30 day time period;
J. Integrate services with existing Emergency Services system and involved treatment providers as appropriate; and
K. Report these services into the Mental Health Consumer Information System as Crisis Services.

II. MOT Community Outreach expectations:

At a minimum, 75% of MOT services will be provided in the home and in community settings.

Community outreach is considered to be at the person's home, place of work, school, community centers, or other community setting (e.g., restaurant). It does not include hospitals, Emergency Departments, or Community Mental Health Agency (CMHA) offices. Teams will:

A. Assess the situation.
B. Provide support to the individual and other involved parties.
C. Work to engage the individual and/or stabilize the situation.
D. Develop a recovery-oriented stabilization/disposition plan with the individual and available supports.
E. Make referrals and connect individuals to appropriate resources.

   Transition resources can include crisis triage centers, coordination with existing Community Mental Health providers and other service providers.

F. Provide coordination of care with care providers.
G. Contacting VOA Care Crisis Line to ascertain any available information and/or to request a WATCH. VOA Care Crisis Line will open an episode as a consult to document this activity.
H. Contact VOA Care Crisis with a stabilization/disposition plan upon completion of the initial contact.
I. Provide necessary follow up to the family or other identified caregivers and supports to include phone calls and outreach.
J. Follow-up to facilitate engagement into services.

ATTACHMENTS

None

Effective Date: 11/29/2011
Revised Date: 9/13/11
Review Date: 2/23/14

North Sound Mental Health Administration

Section 1700 – Crisis Services – Mobile Outreach Team

Authorizing Source: NSMHA contract, WACs 388-877A-0200 through270
Cancels:
See Also: Approved by: Executive Director Date: 4/23/2012
Providers must "comply with" this policy_____
Responsible Staff: Deputy Director Signature:

POLICY #1725.00

SUBJECT: MOBILE OUTREACH TEAM

PURPOSE

To define the role of the Mobile Outreach Team (MOT) which is intended to provide more outreach to individuals in the community to prevent mental health crises, as well as, prevent unnecessary emergency department admissions and inpatient psychiatric hospitalizations.

POLICY

The MOT program is part of an integrated, coordinated and seamless crisis response system for the North Sound Mental Health Administration (NSMHA) and its member counties: Island, San Juan, Skagit, Snohomish and Whatcom (the "NSMHA Service Area"). ~~Initially, t~~These teams ~~will be~~are established in Skagit and Whatcom counties.

The program is intended to provide early intervention to assess, engage, provide temporary support and make appropriate referrals to community resources for individuals who are not currently enrolled in the outpatient public mental health system. The MOTs shall respond to non-emergent mental health situations (i.e., the severity and/or acuity of the individual's behavior/situation does not meet criteria for either emergency services or an involuntary treatment investigation). Non-emergent mental health situations are defined as those situations where the level of stress has overwhelmed the individual's ability to cope and earlier support/intervention may alleviate the effects of the stressful situation.

The MOTs are intended to prevent crises so that:

1. People are stable and safe living in the community;
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3. The number of people needing admission into inpatient psychiatric services can be reduced.

These teams shall respond to direct calls from the community and calls dispatched by the Volunteers of America (VOA) Care Crisis Line. These teams will ~~and integrate~~ coordinate as necessary with existing Emergency Services and Involuntary Treatment Investigation Services. As indicated above, these teams are not intended to respond to emergent mental health crises.

PROCEDURES

I. MOT Responsibilities:

Each team will:

A. Provide community outreach as defined below;

B. Be comprised of two members, a ~~mental~~ Mental ~~health~~ Health ~~professional~~ Professional and a peer counselor;
C. Be available Monday through Friday between the hours of 1pm to 9pm;
D. Be stationed at their assigned place of work when not out in the community;
E. Take referrals from calls to the Care Crisis Line and direct access calls from the community;
F. Respond to pages from Volunteers of America Care Crisis within 10 minutes;
G. Respond to calls dispatched by VOA as rapidly as possible, complete a safety screen, when able, with VOA Care Crisis (see ICRS policy 1702.00) and attempt to make phone or face to face contact with the individual or concerned caller ~~within 24 hours~~by the ~~-~~next business day.~~-~~ Attempts to contact the individual or concerned caller should be documented by the MOT;
H. Utilize family, community, and other natural supports to support the recovery plan;
I. Provide stabilization services that can last up to 4 hours (average per contact), and provide up to 10 hours (average), per individual, of direct services within a 30 day time period;
J. Integrate services with existing Emergency Services system and involved treatment providers as appropriate; and
K. Report these services into the Mental Health Consumer Information System as Crisis Services.

II. MOT Community Outreach expectations:

At a minimum, 75% of MOT services will be provided in the home and in community settings.

Community outreach is considered to be at the person's home, place of work, school, community centers, or other community setting (e.g., restaurant). It does not include hospitals, Emergency Departments, or Community Mental Health Agency (CMHA) offices. Teams will:

A. Assess the situation.
B. Provide support to the individual and other involved parties.
C. Work to engage the ~~person~~ individual and/or stabilize the situation.
D. Develop a recovery-oriented stabilization/disposition plan with the individual and available supports.
E. Make referrals and connect ~~people~~ individuals to appropriate resources.

1. ~~Discharge r~~Transition~~s~~ resources can include crisis triage centers, coordination with existing Community Mental Health providers, and other service providers.

F. Provide coordination of care with care providers.
G. Contacting VOA Care Crisis Line to ascertain any available information and/or to request a WATCH. VOA Care Crisis Line will open an episode as a consult to document this activity.
~~G.~~H. Contact VOA Care Crisis with a stabilization/disposition plan upon completion of the initial contact.
~~H.~~I. Provide necessary follow up to the family or other identified caregivers and supports to include phone calls and outreach.
~~I.~~J. Follow-up to ~~ensure~~ facilitate engagement into services.

ATTACHMENTS

None

NSMHA COMMITTEE DISCUSSION FORM

MARCH 27, 2014

AGENDA ITEM: Re-Instituting the Regional Training Committee

PRESENTER: Greg Long

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

OBJECTIVE: To reinstitute the Regional Training Committee to assure better training and more consistent staff development across the Region

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:

Compass Health staff requested that NSMHA consider re-initiating the Regional Training Committee. This makes sense to NSMHA for training needs are increasing with the growing expectations and in some cases requirements for evidence-based practices. Providers and NSMHA are spending increasing amounts of time and money on training. This is also consistent with several NSMHA strategic priorities including:

- Increasing the use of evidence-based practices and improving the quality of services
- The implementation of WISE with its required training on WISE, CANS and Match
- Work force development
- Implementation and use of Online Learning Systems

NSMHA and its provider network have and are investing in significant amounts of money on training each year:

- 40 hours of Motivational Interviewing Training for 260 staff over the last three years.
- Wraparound Training
- Illness Management and Recovery (IMR) training and consultation
- PACT Training
- DSM V Training

The last approved Regional Training Committee Charter from April 2007 is attached. It would need to be significantly modified for major changes have gone on since 2007.

FINANCIAL IMPACT:

Providers and NSMHA are spending significant amounts of money and staff time on developing training. This should be coordinate training efforts which should increase the effectiveness of the training and reduce costs.

CONCLUSIONS/RECOMMENDATIONS:

NSMHA recommends re-initiating a Regional Training Committee. Initially, it would meet bi-monthly with the hope that it could go to quarterly. It is hoped that it could be done for an hour, 15 minutes after the end of QMOC.

TIMELINES:

ATTACHMENTS: 2007 Regional Training Committee Charter

North Sound
Mental Health Administration

Regional Support Network for Island, San Juan, Skagit, Snohomish & Whatcom Counties
117 N. 1st Street, Suite 8 • Mount Vernon, WA 98273-2858
360.416.7013 • 800.684.3555 • Fax 360.416.7017 • TTY 360.419.9008 • http://nsrsn.org

NSMHA Regional Training Sub-Committee Charter

Charge to the Group

To support planning throughout the region for training to ensure high quality and effective treatment within NSMHA's values and mission.

Primary Objectives

A biennial Regional Training Plan will be developed and reviewed annually for any needed revisions or updates. The Regional Training Committee will work on strategies to develop uniform training modules for selected topics to be used by all providers in training new staff. The committee will review areas for quality improvement as they are identified that relate to training issues and the committee will also be involved in the development of training programs as needs are identified either by the committee, other regional committees, consumers, county coordinators, external stakeholders or other sources.

Membership

Membership is open to all NSMHA providers. There will be at least one representative from the NSMHA Mental Health Advisory Board. Membership will also be open to one consumer representative as appointed by the NSMHA Mental Health Advisory Board. There will also be one committee position for a tribal liaison.

Decision-making

All decision-making is according to the consensus model.

Responsibility for Committee Support:

1. NSMHA will chair the meeting.
2. NSMHA support staff will take minutes and provide support to the committee as needed.

Results/Outcomes Expected:

Through the development of consistent and uniform training expectations, cost effective training tools and coordinated planning and promulgation of training opportunities the quality of services in the region will be improved and staff satisfaction regarding their training will increase.

Expected Project Completion Date: Ongoing

Reporting Relationships:
This sub-committee will submit reports to the Regional Quality Management Committee. Reports from the Regional Quality Management Committee will go to the Regional Management Council, Quality Management Oversight Committee and the NSMHA Board of Directors. The Regional Training Committee will present the Regional Training Plan at least annually to QMOC for review and approval.

Workgroups: To be established as needed to deal with specific issues. Workgroups will have a written charge, expected outcomes, and be time limited.

Timelines:
Review of current biennial Regional Training Plan completed by June 30, 2007. New Regional Training Plan due August 1, 2007.

Meeting Schedule
Every other month unless determined otherwise by the group. Time to be determined by the group.