



NORTH SOUND REGIONAL SUPPORT NETWORK

QUALITY MANAGEMENT OVERSIGHT COMMITTEE

COMMITTEE MEETING PACKET

OCTOBER 24, 2001

QMOC GUIDING PRINCIPLES

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

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

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

**North Sound Regional Support Network
Quality Management Oversight Committee
NSRSN Conference Room
October 24, 2001
12:30 – 2:30**

AGENDA

			Time	Page #
1.	Open the meeting & comments from the Chair		5 minutes	
2.	Approval of September 2001 Minutes <small>Action Item</small>	Chair Byrne	5 minutes	4
3.	Reports			
A.	Sea Mar Quality Management Plan <small>Informational Item</small>	Ms. D’Allegri	30 minutes	7
B.	APN Strategic Plan <small>Informational Item</small>	Mr. LaFollette	30 minutes	8
C.	APN Workload Quarterly Report <small>Informational Item</small>	Ms. Murray	30 minutes	34
D.	Hospital Utilization Report <small>Informational Item</small>	Mr. Williams	15 minutes	35
4.	Other Business			
	Meeting Evaluation Results/Discussion	Chair Byrne	5 minutes	
5.	Adjourn			

**North Sound Regional Support Network
Quality Management Oversight Committee
NSRSN Conference Room
September 19, 2001
12:30 – 2:30**

MINUTES

Members Present:

Chair Byrne
JoAnn Angevine
Pamala Benjamin
Dan Bilson
Claudia D'Allegri
Melissa DeCino
Sharri Dempsey

Marcia Gunning
Dolores Holtcamp
Rosemary Lea
Joan Lubbe
Terry McDonough
Francene Thompson
Linda Vaughan
Michael White

Members Not Present:

Charles Albertson
Lorelei Coy
Dave Gossett
Karen Kipling

Staff Present:

Annette Calder
Gary Williams

Guests:

Julia Ortiz

1. Open the meeting & comments from the Chair

Chair Byrne opened the meeting at 12:30 and welcomed everyone, introductions were made. Chair Byrne announced that Agenda Item 3C, APN Workload Quarterly Report, will be postponed until the October meeting. Due to conflicts with conferences being held, the next meeting of this committee scheduled for October 17, 2001, will be now be held on October 24, 2001.

Jere LaFollette announced that the Gibson House for high need children, a new 6 bed residential facility in contract with DCFS and APN is having an open house on October 11, 2001, from 4:00 – 8:00 p.m. at 11919 E. Gibson Road, Everett, WA.

Linda Vaughan announced an upcoming training on Children and Sexual Behavior, "Separating Myth from Fact", being held on Friday, October 12, 2001, 8:30 – 12:30 at the Snohomish County PUD.

Sharri Dempsey announced the upcoming Grief and Loss Conference and the treatment of intergenerational disorders afflicting many Native Americans being held on September 27, 2001, from 9:00 – 3:00 at the Skagit Valley Hotel Resort.

Sharri also informed the committee of the Recovery Vision of Hope Conference being held on November 1, also at the Skagit Valley Hotel Resort.

2. Approval of August 2001 Minutes

It was moved and seconded to approve the minutes as written.

3. Reports

A. NSRSN Quality Management Plan 2001, 2nd Quarter Report

Francene Thompson made a presentation to the committee on the 2nd quarter report of the NSRSN Quality Management Plan 2001 and distributed handouts. A lengthy and lively discussion took place. The following recommendations were presented:

1. Access to Services

A motion was made to perform a review studying access to services, seconded for discussion; a friendly amendment was made that the review be conducted in a collaborative way with providers and the RSN. Chair Byrne called for the vote; 14 for, 1 against, **motion carried**.

2. Quality & Appropriateness of Services

A motion was made to recommend approval of the following recommendation "The NSRSN develop focused review strategies to assess quality and appropriateness of care as related to other significant factors", a friendly amendment was made to remove "focused review", amendment accepted, and motion seconded. Motion reads, "The NSRSN develop strategies to assess quality and appropriateness of care as related to other significant factors", Chair Byrne called for the vote, all in favor, **motion carried**.

3. Dignity and Respect

A motion was made to have the RSN, providers, Ombuds and QRT to define dignity and respect then develop strategies to address the issues that are uncovered, seconded for discussion. Chair Byrne called for the vote, all in favor, **motion carried**.

4. Continuity of Care

The committee reviewed the recommendations and discussion followed. It was decided by the committee that this was an informational item only as the recommendations are currently being practiced and no change and/or action was necessary.

5. Other Business

Chair Byrne addressed the committee regarding the Quality Management Plan 2002-2003 and listed the names of members who worked on this subcommittee last year and asked if they would participate again. The first meeting of this subcommittee has been scheduled for Tuesday, September 25 at the NSRSN.

6. Meeting Evaluation Results

Chair Byrne asked committee members to complete the committee evaluation and turn in to the secretary prior to leaving.

7. Adjourn

Adjourned at 2:43 p.m. The next meeting will be at 12:30 on Wednesday, September 19, 2001, in the NSRSN Conference Room.

Respectfully submitted,

Annette Calder

Please note: The attachments referenced herein were distributed at the meeting and are attached to the file copy and are part of the official record. Please contact the NSRSN at (800) 684-3555 extension 230 if you have any questions, concerns or requests.

NSRSN COMMITTEE DISCUSSION FORM

AGENDA ITEM: Sea Mar Quality Improvement Plan

PRESENTER: Claudia D'Allegri

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

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:

- To assure clients receive appropriate services when needed.
- Maintain accessibility to services and continuity of care.
- To measure the performance of the organization and initiate improvements and/or changes where needed.
- Minimization of risk to patient.
- Medical records contain accurate information.
- Provide QMOC membership with a yearly update of the Sea Mar Quality Improvement Plan.

CONCLUSIONS/RECOMMENDATIONS:

- Provided at the QMOC meeting.

TIMELINES:

- Review on an annual basis.

ATTACHMENTS:

- Documentation to be provided at meeting and/or upon request.

NSRSN COMMITTEE DISCUSSION FORM

AGENDA ITEM: APN Strategic Plan

PRESENTER: Jere LaFollette

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

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:

- A review of accomplishments from the APN 1999 – 2001 Plan
- Initial direction for the 2001 – 2003 Strategic Plan

CONCLUSIONS/RECOMMENDATIONS:

- Review documentation and bring questions, comments and suggestions to the QMOC meeting.

TIMELINES:

- Ongoing

ATTACHMENTS:

- Memorandum to NSRSN and QMOC
- Draft Strategic Plan
- Practice Guidelines
- DD/Mental Health Oversight Committee Charter

MEMORANDUM

Date: 15 October 2001

To: Andy Byrne, Quality Management Oversight Committee
Chuck Benjamin, NSRSN Executive Director

From: Jere LaFollette, MSW MPH Chief Executive

RE: DRAFT APN Strategic Plan
NSRSN QMOC Presentation 24 October 2001

Please find attached a copy of information related to APN's DRAFT Strategic Plan. This material is divided into two sections:

- Evaluation of APN Strategic Plan 1999 – 2001
- APN Strategic Plan 2001 – 2003 Initial Goal Areas

I am very much looking forward to reviewing this material with you at your October 2001 QMOC meeting. We have provided this material to you in draft form in an effort to seek your ideas and suggestions as part of the Strategic Plan development process.

We will also be devoting the next meeting of the APN/NSRSN/Consumer-Advocate Collaboration Meeting to review of our 2001 – 2003 Strategic Plan. That meeting will be held 6 November 2001, 9:30 – 11:30 a.m. at the NSRSN Conference Room, 117 N. 1st Street, Suite 8, Mount Vernon. We will look forward to meeting with NSRSN representatives, County Coordinators, and consumer/advocates to receive comments on these goals and objectives.

Associated Provider Network Strategic Plan

2001 – 2003

Evaluation of APN
Strategic Plan 1999 – 2001

Goals & Objectives

Evaluation of APN
Strategic Plan 1999 – 2001
Goals & Objectives

GOAL 1: Management of inpatient, outpatient, crisis response, and residential utilization, capacity, quality, and cost.

Objective 1: Initiate comprehensive acute care plan for children with NSRSN and DCFS.

Achieved

APN received funding through a grant from the Office of Rural Health, Washington State Department of Health, to initiate this collaborative project in the fall of 1999. NSRSN and DCFS were participants in all phases of project operation. Accomplishments of this project include:

- Completion of a comprehensive needs assessment and plan for children’s acute care services with in the North Sound Region.
- Initiating a multi system regional approach to addressing children’s’ service needs through the establishment of a Regional Children’s Policy Executive Team.
- Priority recommendations from the Regional Plan that have been or are currently under development include:
 - The Regional Children’s Acute Care Center
 - The CMHS/CCSNW/Discovery School Project
 - The 2nd Chance Residential Program for high need children
 - Expansion of Children’s Acute Care team model to the north part of our Region

Objective 2: Strengthen APN member programs for serving American Indian and Alaskan Native populations.

Achieved /

Several specific action steps were identified in the APN 1999 – 2001 Strategic Plan. These included strengthening recruitment and retention of Native American specialists, development of collaborative relationships between Tribal Human Service Departments and APN members, and providing information regarding employment opportunities to Tribal Human Service Departments.

Human Resource Directors from APN agencies met with the APN Chief Executive and NSRSN Tribal Liaison to review Native American specialist recruitment strategies and ways in which employment

opportunities could be communicated to tribes. APN agencies are currently distributing job announcements to Tribal Human Resource Departments in their respective communities.

Other efforts by APN member agencies to strengthen service for American Indian and Alaska Native populations include:

- The provision of training on the NSRSN/DSHS 7.01 Plan by the NSRSN Tribal Liaison to the APN Management Council and the APN Delivery Systems Operation Committee.
- Survey and identification of mental health specialists currently providing services to American Indians and Alaskan Natives in APN agencies.
- Revision of the APN Consent for Treatment Form to ensure American Indians/Alaska Natives are provided information regarding tribal/cultural treatment opportunities.
- Participation in special trainings sponsored by the NSRSN Tribal Committee and Tribal Liaison, and
- Availability of special treatment services within both tribal communities (CMHS efforts with Swinomish) as well as through referral from tribal communities to APN agencies.

Objective 3: Improve the management of inpatient care.

Achieved /

Efforts identified in this objective include protocol and certification procedure development. Accomplishments include:

- Review criteria and protocol have been developed by the Acute Care Team (ACT) for assessing consumers who have been repeatedly hospitalized. The ACT is actively involved with community hospitals and Evaluation and Treatment facilities to coordinate access to care for APN-eligible consumers.
- Inpatient protocols/criteria have been modified to reflect clarification by the Federal government with respect to the use of Medicaid dollars to support the Medicaid population.
- Processes for inpatient certifications and extension have been reviewed and modifications proposed to the NSRSN. This has been collaborative efforts from APN, NSRSN, data entry staff and direct service providers.

- An Inpatient Steering Committee has been established which includes APN and NSRSN to coordinate inpatient management efforts.
- Extensive data has been collected related to inpatient costs for the period 1993 to 2000. This data was analyzed according to age group, county of residence, cost, and diagnoses (both primary and secondary).

A profile of the factors/issues contributing to the need for inpatient care was conducted for the top 30 utilizers in the child and adult age groups. This information has been used to guide program development and system improvement efforts.

Objective 4: Identify, adopt, and utilize key performance indicators in evaluating APN system effectiveness.

Partially Achieved /

APN continues to work with NSRSN in establishing mutually agreed upon key performance indicators for evaluating system effectiveness.

Examples of the use of key performance indicators in evaluating and improving system performance, include the following:

- On the basis of close monitoring of system performance. APN transferred clinical assessments from an initially established centralize assessment team, to an agency based model. This modification reduced waiting time by approximately 80%. Currently assessments are performed within seven days, well within WAC and contract requirements.
- APN continues to closely monitor access system performance including call abandonment. APN has adopted national standards for access performance measures. The goal of an abandonment rate of less than 5% has been achieved on a consistent basis.

Most recently, in planning for implementation of a new management information system, APN is collaborating with NSRSN and other stakeholders in the assessment and development of consistent performance and outcome measures. The MIS Policy Group has learned that MHD is defining and developing such measures.

MHD has convened a Performance Indicator Work Group to assure consistency with national efforts to standardize indicators across states. The PI Work Group is developing a consumer-level outcome measurement system. These plans comply with the Joint Legislative Audit Review Committee's report to the legislature.

Francene Thompson, QA/Clinical Manager, represents NSRSN on the PI Work Group, and she is working closely with Rosemary Lea, APN Director of QM, in sharing the information and applying it in the North Sound Region. Both Francene and Rosemary participate on the Advisory Committee.

APN designed and implemented Regional wide training (5 Item Training) on the basis of data identified from a review of NSRSN Quality Managers Concurrent Reviews of clinical charts. An APN committee developed an individualized training curricula around these five items (access, assessment, consumer voice, crisis planning, and discharge planning) and conducted Regional training for all APN agencies. This serves as an additional example of utilizing key performance indicators in assessing and approving APN system operation.

Objective 5: Increase correlation between service intensity and clinical need.

Partially Achieved /

On the basis of an analysis of service data (including inpatient utilization) several program modifications have occurred as system improvement efforts. These include:

- Use of the acute care study and hospital utilization data in responding to Second Chance/DCFS request for collaborative approach to serving high need children.
- The implementation and strengthening of intensive case management services within APN agencies.
- Increase use of group services and educational programs for clients requiring services of lesser intensity.

This will be a continuing area for activity. Through efforts such as those conducted within the Inpatient Steering Committee, ongoing efforts are being made to increase correlation of service intensity and clinical need.

GOAL 2: Strengthen client voice and ownership.

The NSRSN has shown great leadership in strengthening consumer voice and ownership during the past two years. As part of this Regional effort, APN established a number of key objectives related to this goal as part of its 1999-2001 Strategic Plan. These efforts include developing opportunities for client employment and creating opportunities for information sharing between consumers/advocates and provider staff.

Objective 1: Provide skill development, employment and educational opportunities for clients related to mental health service provision.

Achieved /

APN agencies have established a number of innovated programs to support employment and training opportunities for clients working within the mental health system. These efforts have included collaboration with the State Client-to-Provider programs the development of peer counseling, supported education, and client-owned business.

- In conjunction with the mental health community in Whatcom County, a peer-counseling program has been established at the Rainbow Center that currently utilized four part-time peer counselors in outreach and advocacy.
- In Skagit County Consumer Oriented Project funds were obtained for a CMHS program that has trained three peer counselors to work under the supervision of case management staff.
- Through a cooperative program with Skagit Valley College, CMHS and NSRSN have established the Supported Education Project which has placed a consumer in the role of instructor, advisor, and resource coordinator for mentally ill adults entering the community college system.
- Cookie Creations and Alchemy Upholstery continue to operate as client-owned businesses in conjunction with Island Mental Health/CMHS. Cookie Creations received national recognition as the Ely Lilly & Co. exemplary employment program through the Ely Lilly Re-integration Awards for 2000.

Objective 2: Provide client voice/ownership and participation through the ongoing APN Committee Structure.

Partially Achieved /

APN is continuing to explore ways to incorporate the consumer perspective within the APN Committee Structure. A consumer advocate has participated as a member of the Delivery Systems Operation Committee (DSOC) during the past contract period. APN is reviewing how consumers can provide greater consumer voice in special projects, such as consumer satisfaction survey and service delivery efforts.

Objective 3: Encourage client voice/ownership and participation through a client involvement work group to provide regular feedback to the APN Management Council.

Achieved / Ongoing

In conjunction with NSRSN, APN continues to host quarterly Collaboration Meetings that include advocates, consumers, county coordinators, NSRSN officials, and APN representatives. These quarterly meetings are designed to provide a forum for communication between all elements of the community mental health system within our Region.

Other opportunities to receive consumer feedback include:

- APN Chief Executive attends pre-QMOC meetings to participate in informal discussion regarding clinical service.
- The APN Clinical Director, Bob LeBeau, is a member of the Peer Counseling Advisory Group in Whatcom County.
- The NSRSN Executive Director and the APN Chief Executive have recently initiated a series of forums where consumers can meet directly with the system administrators. The first of these forums was held in Whatcom County with an attendance of over 50 consumers meeting to share their thoughts, ideas, and suggestions for an improved mental health system.

Objective 4: Ensure administrative staff of APN member and affiliate agencies have opportunities to learn from Regional QRT and Ombuds staff.

Not Achieved /

With the transition in the position of Director of QM, this objective has not been met. However, the new Director of QM supports discussions with QRT and Ombuds staff on issues related to direct client care and will initiate such discussions periodically over the next two years.

Objective 5: Increase collaboration between APN, clients, and advocates around key community education issues.

Achieved / Ongoing

APN supports a coordinated community education effort whereby agencies, consumers, advocates, and government officials work together in community education. APN has established a community education plan which includes publication of articles hosting public education events and working with the Washington State Legislature in advocating for an effective community response to mental health. That plan has included collaborative efforts with a number of other entities.

Objective 6: Establish direct feedback loops to incorporate client and family/guardian feedback and preferences.

Achieved / Ongoing

A consumer satisfaction survey was again conducted in spring 2000 with 1031 responses received.

Each agency utilizes specific information from complaints and grievances to guide system improvement efforts. The APN QM Committee reviews aggregate data on a quarterly basis and these reports are presented to the APN Management Council.

The APN QM Committee is reviewing data pertaining to Critical Incidents and using that information to make improvements in the process for documenting such incidents. Collaborative efforts in this area are underway with the NSRSN.

GOAL 3: Improve systems and procedures to effectively utilize management information system data.

Objective 1: Update and distribute APN MIS Quality Assurance Plan.

Achieved

Plan was completed in September of 1999 and submitted to the NSRSN. Plan was reviewed by IS Tech team in September of 2000 and no changes were made.

Objective 2: The APN Data Dictionary will agree with contract reporting requirements at both RSN and State level.

Achieved

The data dictionary was updated in May of 2000 and is in compliance with the NSRSN and State requirements.

Objective 3: The APN Date Dictionary will include data elements and descriptions required to support the following areas: (a) Clinical, (b) Quality Management, (c) UM, and (d) Fiscal.

Achieved

The data dictionary currently supports the data structure necessary to produce reports and analysis in the four areas listed above.

Objective 4: Assure that policy and procedures support data integrity and reporting requirements.

Achieved

Internal APN data integrity reports were developed, implemented, and distributed to providers to improve the quality and accuracy of data used in reporting.

Objective 5: Data collection forms will assure that core data being collected meets APN Core Data requirements.

Achieved

Representative's from the IS Tech group have participated in DSOC, QM and APN Paperwork committee's to assure that data collection forms are designed and implemented in a manner that assure accurate data collection.

Objective 6: Clarify contractual outcome measures with NSRSN and assure that they are included.

Not Achieved /

Some work was completed on this objective, but it was never completed.

Extensive APN/NSRSN work now underway in this area.

Objective 7: Improve communication with NSRSN on data-related issues.

Achieved

APN participated actively in the NSRSN CIS meetings during the past year. These meeting provided a positive environment for identifying and working on key data integrity issues and developing ways to improve the information.

Objective 8: Evaluate software to assess how it meets current business needs.

Achieved

APN Completed an intensive needs analysis, requirements definition and software search process resulting in the decision to purchase new Clinical Information System.

Objective 9: Increase MIS expertise at the agency level.

Achieved /

APN provided both training and technical support to provider agencies in this area. Additional staff was added at the APN to support report development and data integrity during the past two years. Agencies participated in APN training and several staff attended BDS technical training's. The reduction in error reports and improvement in data accuracy were direct results of training and additional resources at the agency level.

GOAL 4: Assure eligible clients are offered initial appointment with an APN clinician within ten (10) working days of initial contact.

Objective 1: Reduce delays in offering initial assessment appointments to 10 working days.

Achieved

Initially, APN established a centralized Assessment Team to coordinate access to services. This model resulted in extended delays before consumers were able to access services. As a result of these problems, the process for performing assessments was decentralized and performed by clinicians at each agency. This improvement reduced waiting time by approximately 80%. Currently, assessments are performed within 7 days, well within the WAC and Contract requirements of 10 days.

Objective 2: Assure ongoing compliance with 10 working day requirement.

Achieved / Continued

See response to Objective 1, above. Currently, assessments are performed within 7 days, well within the WAC and Contract requirements of 10 days.

GOAL 5: Clarify roles and responsibilities both internal and external to APN.

Objective 1: Key member and affiliate staff must be familiar with NSRSN/APN roles and responsibilities as defined in the NSRSN contract.

Achieved / Ongoing

APN committees provide a key link between APN and its member and affiliate agencies. APN Committees include the Management Council, Delivery Systems Operation, Quality Management, and

Chief Financial Officers. APN staff and Management negotiated the 1999 – 2001 NSRSN/APN Contract provided training to APN committees following contract negotiations in the fall of 1999.

APN committee members reviewed appropriate portions of the NSRSN/APN contract with staff from individual agencies.

The APN Management Council reviews all NSRSN/APN Contract amendments and those documents are distributed as signed by NSRSN and APN.

Objective 2: Provider Agreements define service performance relationships between APN member and affiliate agencies, consistent with NSRSN Contract:

Achieved/On

It is important that APN member and affiliate agencies have clear definitions as to roles and responsibilities of various system components. This is true as to relationships between APN and its members, between members themselves, and between APN and outside organizations including the NSRSN and County governments.

APN Provider Agreements define the relationship between APN and its member and affiliate agencies. Beyond that definition, however, close and positive working relationships must exist between APN and its member and affiliate agencies. We believe the effectiveness of these relationships can be demonstrated through the ongoing participation of members within APN committees. The APN Management Council has recently celebrated its 100th official meeting. The level of collaboration and cooperation as to decision making within this body has been outstanding.

This same high level of participation and active decision making by other APN committees has also been consistent over the life of APN. The APN Management Council, in consultation with its committees, has developed and implemented a decision making process that empowers committees and emphasizes a consensus model of decision making that is practiced throughout APN.

We do not believe that there is any area of the State of Washington where as close a relationship exists among the mental health providers as is the case in the North Sound Region. In addition to working in a positive and collaborative way this same attitude has

been our goal partnering with other mental health providers within the North Sound Region and with other service systems.

APN has continued to strengthen its Management Information System capabilities for measuring performance.

During the past year a set of new reports have been developed for provision to APN member agencies to monitor performance.

APN continues to work with its member and affiliate agencies in addressing issues of contract compliance and performance. An example of this process has been reflected in the collaborative system improvement effort around the children's hospital alternative (CHAP) program. Throughout this process APN has worked closely with both NRSNS and counties in addressing these issues. Part of the solution to address deficiencies has been the reallocation of responsibility from one APN agency to another for CHAP services in one county.

Objective 3: Plan in place for increased communication and collaboration between APN, member and affiliate agencies, and other stakeholders (NAMI, County Boards, NSRSN Advisory Board, NSRSN staff and Board).

Not Achieved

We believe that effective levels of communication exist between APN, its members and affiliates, and other stakeholders (NAMI, County Boards, NSRSN Advisory Board, NSRSN staff and Board). We have not developed a specific plan to address this issue however.

Objective 4: Review and update committee and subcommittee charters, including goals and membership.

Achieved

APN committees operate under currently approved written charters.

Objective 5: Assure representation from direct service staff on appropriate APN committees and work groups.

Achieved

APN consistently calls on direct service staff to sit on APN committees and subcommittees. This is true for standing committees. Sub-committees of standing committees, as well as ad hoc or short term planning groups.

GOAL 6: Standardized clinical services among APN providers to reflect current “best practices”.

Objective 1: Complete/implement standardized clinician training program for adults across APN.

Achieved /

Extensive training opportunities are provided to clinical staff of APN member and affiliate agencies both within agencies and in the larger community. All agencies provide training in line with specified WAC requirements. These trainings are documented in clinical files and are reviewed at the time of NSRSN and MHD licensing audits.

A number of additional clinical training efforts have been conducted by APN. Central to this issue was the comprehensive “Five Item Training” that was conducted throughout APN agencies during the spring of 2000. This material was prepared by the APN Quality Improvement Action Committee consisting of key clinical staff throughout APN organizations. This training focused on NSRSN concurrent review and identified issues including:

- Client Voice,
- Use of Natural Supports,
- Strength Based Approach to Treatment,
- Documentation of Treatment Plans, and
- Crisis Plans.

Universal training coordinated by APN is currently underway as part of our DDD/Mental Health Enhancement Plan.

APN in collaboration with NSRSN and the Eli Lilly company are currently implementing a training enhancement program that will increase agency/Regional collaboration around training and utilize new technologies for improving the effectiveness of training programs throughout the region. A grant from the Eli Lilly Company has been secured to implement this project over the coming year.

APN and agency representatives similarly collaborated with the NSRSN in conducting a Regional Training directed toward improved services for victims of trauma. Additional training in this area will be an ongoing project over the next year to strengthen services for victims of trauma within the North Sound Region.

Objective 2: Develop diagnostically driven clinical pathways/practice guidelines for high-risk/high-need clients.

Partially Achieved /

The APN Delivery System Operation Committee has approved Clinical Pathways and Practice Guidelines for the following disorders:

- Dissociative Disorders (300.14)
- Depressive Disorders (296.2x, 296.3x)
- Schizophrenia, Schizophreniform Disorder (295.xx, 295.40)
- Attention Deficit Hyperactivity Disorder (314.xx)
- Borderline Personality Disorder (301.83)
- Bi-Polar Disorder (296.0x, 296.40, 296.4x, 296.5x, 296.6x, 296.89, 296.80)

Clinical teams have been established to develop Practice Guidelines in a number of additional areas including:

- Co-occurring Disorders
- Post-traumatic Stress Disorder (309.81)
- Oppositional Defiant Disorder (313.81)
- Dementia (290.xx)
- Obsessive Compulsive Disorder (303.3)
- Reactive Attachment Disorder (313.89)
- Suicide Risk Assessment

Objective 3: Provide training to staff of APN agencies on DSHS 7.01 Plan and collaborative relationships with tribes in serving American Indians and Alaskan Natives.

Achieved

The APN Chief Executive and the NSRSN Tribal Liaison met to review components of the DSHS 7.01 Plan adopted within the North Sound Region. The Tribal Liaison was invited to present and review the 7.01 Plan with the APN Management Council. A training was provided for the APN Delivery Systems Operations Committee on the 7.01 Plan, and copies of the Plan were distributed to DSOC and APN agencies. This information has been shared with the staff of APN member agencies through presentations, the explanation of agency responsibilities, and in one case a newsletter article describing key components of the 7.01 Plan and agency responsibilities in serving Alaska Natives and American Indians.

Objective 4: Improve efficiency and effectiveness of service engagement while maintaining a managed care approach.

Partially Achieved /

A number of efforts, noted above are directed toward the accomplishment of this objective. Examples include:

- Improvement to the access and assessment system.
- Development of Clinical Pathways and Practice Guidelines for clinicians.
- Development of expanded group treatment and educational opportunities.

Objective 5: Use feedback from NSRSN concurrent and agency reviews to identify and address system issues.

Achieved /

Feedback from NSRSN concurrent reviews are shared with APN clinical committees and agency staff. This information led to APN “Five Item Training”, as an example of its usefulness in shaping practice. APN anticipates continued efforts with NSRSN staff to develop effective models of using this information in system improvement efforts.

Looking Forward

Strategic Plan 2001 – 2003

Looking Forward 2001 – 2003 Strategic Plan

Listed below are six goal areas established as part of APN's 2001 – 2003 Strategic Plan. Each goal area is accompanied by a brief description of intent as well as specific objectives identified for accomplishment during the coming two-year period.

Goal 1 System Management and Service Integration

Through its contract with the NSRSN, APN operates an integrated mental health system which provides crisis response, outpatient service, residential care, and the management of voluntary inpatient programs. With the assumption of responsibility for the integration of these services, it has become essential to carefully manage available resources. In an integrated system the delivery of service in one area, such as inpatient care, directly affects other program areas, such as outpatient or crisis response services. Thus it is important that we work with other mental health interests to coordinate thoughtful system improvement efforts. This holistic perspective can be seen in the direct patient care as well as the development of improved service delivery programs.

Objectives in this area include:

Objective 1.
Objective 2.

To Be Developed

Goal 2 Clinical Services Development

The heart of an integrated mental health approach is the provision of an appropriate mix of direct treatment services. Thus, this goal is directed toward the design of programs that will address clinical service issues.

Objective 1.
Objective 2.

To Be Developed

Goal 3 Client voice and consumer participation.

APN is committed to working collaboratively with consumers and advocates to strengthen the mental health system of our region.

Objective 1.
Objective 2.

To Be Developed

Goal 4 Strengthen APN Quality Management Programs through collaboration with the North Sound Regional Support Network and Mental Health Division.

APN and its Quality Management Committee (QM) is committed to the increased use of data to improve our understanding of system needs, performance, and outcomes.

Objective 1.
Objective 2.

To Be Developed

Goal 5 Community and professional education

It is important that mental health professionals continue to have access to the latest information regarding direct client care. It is also important to share information regarding mental health services and mental health promotion with members of the public.

Objective 1.
Objective 2.

To Be Developed

Goal 6 Information Systems

Increasingly we rely upon information systems to provide data regarding outcomes, system performance, financial management and administrative review. During the past biennium great strides have been achieved in strengthening the information system perspective among APN agencies. During the coming biennium our focus will be directed toward implementation of a new management information system for APN and its provider network. Other agencies and the NSRSN will be collaborating with us in this effort. Work in this area has been organized around a collaborative IS entity, Sound Data.

Objective 1.
Objective 2.

To Be Developed

The above goals and objectives have been reviewed by a wide range of interests in the mental health community of the North Sound Region.

This plan has been adopted by the APN Management Council as of _____.

APN Practice Guidelines

Major Depressive Disorders (DSM-IV codes 296.2x, 296.3x)

Diagnostic Features (1)	Major Depressive Disorder is characterized by one or more major depressive episodes (e.g. at least 2 weeks of depressed mood or loss of interest or pleasure in nearly all activities). Dysthymia is characterized by fewer, less severe depressive symptoms lasting over a longer time course (e.g. more days than not over at least 2 years).
Assessment components and considerations (1, 2, 3)	<p>A. Major Depression: Characterized by disturbances in affect, interest, neuro-vegetative symptoms, concentration, psycho-motor behavior and self esteem.</p> <p>B. Average age of onset is the mid-twenties.</p> <p>C. Disorder is more common in women.</p> <p>D. Number of past episodes is predictive of likelihood of subsequent episodes (e.g. 50-60% chance of second episode after a first, 70% chance of third episode after a second, and 90% chance of fourth episode after a third.)</p> <p>E. Higher prevalence of the disorder for people with first degree biological relatives with Major Depression.</p> <p>F. Screen for other conditions that are co-morbid or may be confused with Major Depressive disorder (e.g. substance abuse, organic conditions, dementia with older adults, other mood disorders and schizo-affective or other psychotic disorders).</p>
Diagnostic Criteria (1)	<p>Major Depressive Episode:</p> <p>A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure:</p> <ol style="list-style-type: none"> 1. Depressed mood most of the day, nearly every day, as indicated either by subjective report (e.g. feels sad or empty) or observation made by others (e.g., appears tearful). Note: In children and adolescents, can be irritable mood.

	<ol style="list-style-type: none"> 2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others) 3. Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. Note: In children, consider failure to make expected weight gains. 4. Insomnia or hypersomnia nearly every day. 5. Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down) 6. Fatigue or loss of energy nearly every day. 7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick) 8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others) 9. Recurrent thoughts of death (not just fear of dying) recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide. <p>B. The symptoms do not meet criteria for a Mixed Episode.</p> <p>C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.</p> <p>D. The symptoms are not due to the direct physiological effects of a substance (e.g. a drug of abuse, a medication) or a general medical condition (e.g. hypothyroidism).</p> <p>E. The symptoms are not better accounted for by Bereavement, i.e. after the loss of a loved one, the symptoms persist for longer than 2 months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation.</p>
<p>Treatment Planning (2, 3)</p> <p>One or more of the following services:</p>	<ol style="list-style-type: none"> A. <u>Individual Intervention</u>: Individual clinical interventions based on medical necessity for symptom management to build skills and promote stabilization. The use of cognitive behavioral interventions may be beneficial. B. <u>Group Intervention</u>: Combinations of skill building, support and educational groups to promote acquisition of skills and stabilization for example skills to modify negative self-talk. C. <u>Psychiatric Assessment</u>: As appropriate to determine indication for medication for medical stabilization

	<p>D. <u>Employment/Vocational Services</u>: Varied employment strategies including pre-vocational and supported employment to assist clients ready to pursue employment.</p> <p>E. <u>Residential Treatment/Housing/Crisis Beds</u>: For those requiring 24 hour care or access to appropriate community based housing resources as available.</p> <p>F. <u>Co-Occurring Disorder Treatment</u>: Integrated treatment into a standard chemical dependency treatment program or standard chemical dependency treatment plus separate treatment services for Depression.</p> <p>G. <u>Educate</u> the client and significant others as appropriate regarding Major Depressive Disorder, symptoms, treatment and prognosis.</p> <p>H. <u>Crisis Planning</u>: Individualized crisis plan focusing on early symptoms of decompensation, safety and management strategies.</p> <p>I. <u>Inpatient Services</u>: For acute stabilization as necessary.</p> <p>J. <u>Suicide Risk Assessment</u>: See Practice Guideline on suicide risk assessment.</p>
References	<p>(1): <i>Diagnostic and Statistical Manual, Fourth Edition</i></p> <p>(2): <i>American Academy of Family Physicians</i></p> <p>(3): <i>United Behavioral Health Clinical Guidelines</i></p>

North Sound Regional Support Network Developmental Disabilities/Mental Health Oversight Committee Charter

Name: Developmental Disabilities/Mental Health Oversight Committee

Systems represented: Region III Division of Developmental Disabilities, Associated Provider Network, North Sound Regional Support Network, DDD Contracted Providers, County Coordinators involved in mental health and DDD programs.

Guiding Principles:

1. Services should be based on an individual planning process that identifies the strengths and service needs of the individual and that promotes positive outcomes.
2. Services should be planned and provided in a manner that encourages the involvement of family, friends, advocates, community supports and allied systems in the lives of people being served.
3. Services should be provided in the least restrictive and most integrated setting as is reasonably possible.
4. Cross-system collaboration should occur between DDD, Mental Health and other involved allied systems at all levels of service planning and delivery.
5. Services should be provided to individuals in a competent manner and specialized training should be provided to those involved in the delivery of services.
6. Services should be provided consistent with public concerns with public health and safety and protection of society.
7. Services should be evaluated and monitored at both the individual and system level to determine effectiveness and efficiency.

Primary Objectives:

1. Reduce system barriers to service;
2. To provide a venue for cross system education, problem resolution and collaboration in providing services to enrolled DDD adults at risk of requiring inpatient mental health services.
3. Oversee the provision of cross system training efforts so that staff from both systems can increase their knowledge base, skills and comfort levels when working with this population. These training efforts will include families, residential providers (including adult family homes) and community mental health center staff.
4. Oversee enhancements to community-based services available to enrolled DDD adults at risk of requiring inpatient mental health services, including case management and prescriptive services.

5. Improving cross-system collaboration and increasing the effectiveness of interventions from both systems during and following inpatient mental health admissions.
6. Increase public awareness of issues related to developmentally disabled persons with concurrent mental health disorders

Results/Outcomes Expected:

1. Development of a community-based infrastructure of social supports through cross system collaboration and planning.
2. Reduce the number of unplanned changes in consumer's residential setting;
3. Reduce the number of admissions to state and local hospitals/evaluation and treatment centers for adults enrolled in the DDD system; and
4. Reduce lengths of stay for DDD enrolled adults who are admitted to state or local hospitals/evaluation and treatment centers.

Expected Project Completion Date: Ongoing, with meetings at least quarterly

Responsibility for staff support: Region III DD Resource Manager
Associated Provider Network Manager of Special Services

Sub-Committee Meetings: May be established as needed to deal with specific issues.

NSRSN COMMITTEE DISCUSSION FORM

AGENDA ITEM: Clinician Workload (Caseload)

PRESENTER: Paul Vanderveen, Rosemary Lea

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

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:

Clinician Workload is a complicated measure and includes consideration of the following points:

- Total clients, both RSN and non-RSN
- Clinician Full Time Equivalent (FTE's)
- Clients per clinician (Caseload)
- Caseload by service level
- Productivity (% of time spent in client activities)
- Documentation of compliance
- Client outcomes
- Client satisfaction

Paul will provide a 6-month update on the data elements that he presented to QMOC in March 2001.

Rosemary will touch on some the broader issues that provide context for this valuable information.

CONCLUSIONS/RECOMMENDATIONS:

This report is submitted for information only.

TIMELINES:

N/A

ATTACHMENTS:

N/A

NSRSN COMMITTEE DISCUSSION FORM

AGENDA ITEM: NSRSN Inpatient Data Collection

PRESENTER: Gary A. Williams, Quality Manager Whatcom

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

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:

The handout that will be provided at the September QMOC meeting illustrates an overview of the number of inpatient hospitalizations certified by the NSRSN during the period from January 1999 to June 2001. The data reflects two basic data elements, number of admissions and lengths of stay. Additional subsets include voluntary and involuntary admissions, location of admission and by age grouping at admission.

CONCLUSIONS/RECOMMENDATIONS:

This data represents the initial data set for ongoing monitoring by the NSRSN of admission and length of stay trends. It's important to note that data collected before 1999 is considered unreliable and therefore not being used.

No conclusions are being made based on this data at this time. NSRSN staff is continuing to meet with APN staff in an ongoing effort to establish agreed upon review and reporting processes.

In 2002 the NSRSN Quality/Utilization Managers will report to QMOC interpretive conclusions regarding identified trends utilizing this data.

TIMELINES:

Report to QMOC during the first Quarter of 2002

ATTACHMENTS:

None

NSRSN QMOC Discussion Form

AGENDA ITEM: RSN Special Review Process of the Standards of Care

PRESENTER: Greg Long

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

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:

During the contract negotiation process, APN raised a number of issues regarding the Standards of Care Manual. Since QMOC had already approved the Standards of Care, a process separate from the contract negotiations was set up to hear APN's issues with the understanding that any changes would have to be approved by QMOC.

Attached are twenty-eight (28) APN requested issues that the NSRSN Review Group has reviewed and are recommending changes. Originally, there were 44 requested changes. The NSRSN Review Group decided against sixteen (16) requested changes so they are not presented.

Many of these changes are made to conform more directly to the WAC language or to clarify our intent and wording. None of the changes are major changes from our previous operating procedures. However, some individuals have expressed concerns about some of the changes from the proposed Standards of Care.

CONCLUSIONS/RECOMMENDATIONS:

The NSRSN recommends these changes. QMOC approval is needed to make changes to this document that becomes an attachment to the contract with APN. Please review these changes. If you have questions, call Greg Long (800) 684-3555.

ATTACHMENTS:

RSN Special Review Process Table

SPECIAL REVIEW PROCESS ITEM #	Pg	REQUIREMENT	REFERENCE	ISSUE	RSN SPECIAL REVIEW PROCESS RECOMMENDATION
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**NSRSN Standards of Care Manual Revision XXVI
(Eligibility and Clinical Care Standards)
For Publicly-Funded Community Mental Health Services**

September 28, 2001

RSN SPECIAL REVIEW PROCESS

SPECIAL REVIEW PROCESS ITEM #	Pg	REQUIREMENT	REFERENCE	APN's ISSUE	RSN SPECIAL REVIEW PROCESS RECOMMENDATION
2	6	Consumers who will need assistance with accessing state entitlements for funding will be identified at access and offered a first appointment.	WAC 388-865-0425 (4)(h) MHD 1.3.18	<p>This requirement reads as if we are supposed to offer an appointment to every caller who MAY qualify for assistance. I am also confused by the term "consumer". The caller is not technically our consumer until he/she qualifies financially and clinically for services. Actual WAC refers to helping <i>consumers</i> with accessing services. My impression from reading the WAC is that it is referring to individuals who qualify for APN services. Same thing for the MHD contract.</p> <p>Wording seems to open up a very wide door. Perhaps include other criteria that must be met in addition to "who will need assistance with accessing...funding..."</p>	<p>Proposed Access language: Access staff will identify individuals with severe mental illness for whom the severity of their mental illness or other disabilities may prevent them from successfully applying for state or federal entitlement programs and offer them an assessment appointment. Reference: MHD 1.3.18</p> <p>Proposed Assessment language: Assessment staff will assist individuals with severe mental illness for whom the severity of their mental illness or other disabilities may prevent them from successfully applying for state or federal entitlement programs in obtaining benefits for which they are</p>

SPECIAL REVIEW PROCESS ITEM #	Pg	REQUIREMENT	REFERENCE	ISSUE	RSN SPECIAL REVIEW PROCESS RECOMMENDATION
					eligible, including Medicaid. Reference: MHD1.3.18 WAC388-865-425(4)(h)
4	6	<u>Referrals for service levels 2, 3, 4 will be scheduled for an initial face-to-face multi-axial assessment</u> within ten working days of initial request for services.	MHD 2.3.2—"The Contractor shall ensure: a) routine care is offered to occur within 10 working days, but not to exceed 14 calendar days; b)..."	The MHD requirement is to offer , not schedule, an assessment within ten working days. While the section of the MHD contract cited as reference notes the requirement for routine care to occur within a specified time period, it does not include the additional requirements of the SOC manual.	Tentative agreement. Substitute "offered" for "scheduled".
6	6	Access staff will seek information from the consumer requesting services regarding age, culture, language, gender, <u>sexual orientation</u> and physical condition, and/or special requests.	Exceeds WAC 388-865-0415— <i>Access to services</i> . Section 3 was not noted in the reference but was most applicable. "Assure that services are timely, appropriate and sensitive to the age, culture, language, gender and physical condition of the consumer."	The WAC cited does not include a requirement for information about sexual orientation. What is the source of this requirement? It seems inappropriate to ask this question at Access. The caller may wonder: <ul style="list-style-type: none"> ▪ Will I be treated differently? ▪ Are they assuming that my mental health issues are related to my sexual orientation? ▪ Do they consider gay, lesbian and transgendered people to be mentally ill? It is questionable whether the information collected at Access would be accurate.	Recommend moving to Assessment for this two-year period. In the mean time APN is to find a welcoming way to ask appropriate questions at Access. At next contract, requirement will be moved back to Access.
8	9	Paragraph 3 at top of page: "If consumers are unable to get to clinic- based assessment appointments, those appointments can be established at other locations."	No WAC or MHD reference was provided.	The phrase, "unable to get to" is quite vague and could include the client's simple preference. Suggest more precise working, e.g., "If, for reasons related to client's mental illness, disability, or other prohibitive barriers, consumers are unable to..."	Substitute: If consumers are unable to get to a clinic-based assessment due to the client's mental illness, disability, lack of transportation, disability or other barriers...
10	9	Assessments will be conducted <u>by</u>	MHD 4.1.8.16	Neither reference cited contains specific	a) Assessments are done

SPECIAL REVIEW PROCESS ITEM #	Pg	REQUIREMENT	REFERENCE	ISSUE	RSN SPECIAL REVIEW PROCESS RECOMMENDATION
		<p><u>MHPs who also meet minimal competency requirements in chemical dependency screening.</u></p>	<p>“Competence in the workforce (e.g., appropriate training, licensure, supervision, and clinical oversight of staff employed or contracted by providers).”</p> <p>WAC 388-865-0420—<i>Intake evaluation</i>. “The community support service provider must complete an intake evaluation in collaboration with the consumer within fourteen days of admission to service.”</p>	<p>requirements to have the assessment conducted by an MHP who has met minimal competency requirements in CD screening. What is the definition of “minimal competency requirements”?</p> <p>Note the following references:</p> <p>WAC 388-865-0425—<i>Competency requirements for staff</i>, subsection (3): “Mental health services are provided by a mental health professional, or under the clinical supervision of a mental health professional.”</p> <p>WAC 388-865-0425—<i>Individual service plan</i>, subsection (5): “Document review by the person developing the plan and the consumer. If the person developing the plan is not a mental health professional, the plan must also document review by a mental health professional.”</p> <p>There is no requirement that the assessment be conducted by an MHP. “Minimal competency requirements” are unclear.</p>	<p>by MHPs or under supervision and review of MHPs (follow WAC language)</p> <p>b) Minimum competency means that assessors have at least 15 hours of co-occurring disorder training. (Eventually should meet regional training requirements and pass test)</p>
11	9	<p>Formal reassessment (including updated consumer rights, etc.) will be documented at 24-month intervals for “active” consumers.</p>	<p>NSRSN requirement. No WAC or MHD reference was provided.</p>	<p>The client’s history does not change. Reassessments are completed at each 6-month (180-day) review. This requirement is confusing. Is something different expected?</p> <p>The additional layer of requirements and paperwork seems unnecessary.</p>	<p>Drop requirement</p> <p>NSRSN is concerned that 180-day reviews are not thorough enough. NSRSN will conduct a selective review of 180-day reviews to see if appropriate changes, re-strategizing of treatment is occurring.</p>
14	16	<p>Medication information (i.e., whether the consumer is on</p>	<p>No WAC or MHD reference was</p>	<p>We would like to review the appropriateness of crisis plan review for</p>	<p>Medication Information</p>

SPECIAL REVIEW PROCESS ITEM #	Pg	REQUIREMENT	REFERENCE	ISSUE	RSN SPECIAL REVIEW PROCESS RECOMMENDATION
		medication, history of known adverse reactions to medications, etc.)	provided.	nursing home clients.	(List of current medications prescribed by MH medical staff as of specified date) Also include history of known adverse reactions. Greg consulted with Dr. Keith Brown. He concurred. Can put in a disclaimer, on accuracy and should not be used to prescribe medication by itself.
15	16	"Crisis plans are routinely updated every 180 days and prior to discharge from services. "	This requirement is found in the narrative at the bottom of the page.	We want to coordinate this issue with Phase II implementation of the on-line clinical record.	OK in Phase II – get commitment for when Phase II will be. Change language to: Crisis Plans are routinely updated every 180 days and prior to discharge from services. Discharge crisis plan will be aimed at preventing relapse and assuring appropriate and rapid reconnection to services, if needed.
17	18	Service provision in <u>coordination with</u> community-based Juvenile Justice and Department of Corrections facilities	No WAC or MHD reference was provided.	This statement implies that we provide care at the 4 prisons in Monroe and jail. We have gone out to do assessments but NOT routinely—only as clinically indicated. Consider the language revision.	Tentative agreement. Add "coordination with" language.
18	19 21 23	"The Child/Adolescent has received, at a minimum, an initial screening assessment by a child mental health specialist or child mental health specialist with infant/toddler expertise which..."	No WAC or MHD reference was provided.	This language is redundant. Please note this issue is referenced throughout the Standards of Care document.	Use the WAC language – done by or under the supervision of a child mental health specialist.

SPECIAL REVIEW PROCESS ITEM #	Pg	REQUIREMENT	REFERENCE	ISSUE	RSN SPECIAL REVIEW PROCESS RECOMMENDATION
	20 22	Treatment intensity, frequency, interventions and modalities that have highest (research-based) likelihood of positive outcomes and recovery for identified diagnosis.	MHD 4.1.8.1 and 4.1.8.12 MHD 7.1.2	<p>What is the implication of this language? Where does this fit? How would this be measured?</p> <p>The citation is misleading. Nowhere in WAC 388-865-0425—<i>Individual service plan</i>, is there reference to "...interventions and modalities have highest (research-based) likelihood of positive outcomes and recovery for identified diagnosis."</p>	Change to: Treatment intensity, frequency, interventions that are based on the best available scientific knowledge (wording is from Institute of Medicine's "Crossing the Quality Chasm")
				<p>MHD 4.1.8.1: "The clinical appropriateness or fit between what was needed and what was received." This is a very general statement with no reference to "...interventions and modalities have highest (research-based) likelihood of positive outcomes and recovery for identified diagnosis." MHD 4.1.8.12 is closer. "Performance regarding service delivery within current standards of mental health."</p> <p>It is difficult to understand the link between the last reference and the requirement. MHD 7.1.2 requires that the Contractor shall, "Ensure services are provided in the most cost effective and efficient manner possible."</p>	
	23	<u>Admission Criteria</u> The child/adolescent has received a face-to-face multi-axial assessment by a child mental	No WAC or MHD reference was provided.	Should the language not reference an assessment <u>with</u> a consultation by a child mental health specialist?	Agreed to use WAC language (.0425).

SPECIAL REVIEW PROCESS ITEM #	Pg	REQUIREMENT	REFERENCE	ISSUE	RSN SPECIAL REVIEW PROCESS RECOMMENDATION
		health specialist or child mental health specialist with infant/toddler expertise, which...			
23	26 37	Coordination of and consultation with participation on child/family teams meetings with primary care clinician/team members and inclusion of team members at least weekly. These <u>consultations may</u> meetings will include family, primary care clinician/team, prescription staff , crisis services staff, MHP specialists (as required) and other formal and informal supports.	MHD 4.1.4 MHD 2.3.6 and 2.3.7 and 2.3.8 MHD 4.1.8.9	The WACs and MHD citations do reference teaming; however, there is no requirement for weekly team meetings with the prescription staff present. This whole requirement is burdensome.	Coordination of and participation on child/family team meetings with primary care clinician/team members / and inclusion of team members at least weekly. These consultations <u>should</u> include family / primary care clinician / team prescription staff, crisis services staff, MHP specialists (as required) and other formal and informal supports. If a good faith effort is made to obtain participation, reason for absence of key team members will be accepted if in the progress notes for the team meeting.
24	26	<u>If no MHP specialist consultation has occurred within the previous 60 days, and the previous consultation is current, then no MHP specialist consultation is required.</u> MHP specialist consultation within 5 business days of placement in Level 4 services. (Specialist participation on child/family team meets requirement.)	MHD 4.1.4 WAC 388-865-0405 (5) WAC 388-865-0430 (7, 8)	MHD 4.1.4: "Assure mental health specialists are involved at critical treatment junctures." WAC 388-865-0405— <i>Competency requirements for staff.</i> Subsection 5 contains no requirement for MHP specialist consultation within 5 days. WAC 388-865-0430— <i>Clinical record.</i> Subsection 7: "Consultation must occur within thirty days of admission and periodically thereafter as specified by the mental health specialist." Subsection 8: " Periodic documentation of the course of treatment and objective progress toward	This issue is relatively minor for there are virtually no level IV consumers. Suggest this wording: MHP specialist consultation within 5 business days of placement in Level 4 services. (Specialist participation on child/family team meets requirement.) If a MHP specialist consultation has occurred within the previous 60 days, the previous consultation is current, and no major social/cultural/clinical

SPECIAL REVIEW PROCESS ITEM #	Pg	REQUIREMENT	REFERENCE	ISSUE	RSN SPECIAL REVIEW PROCESS RECOMMENDATION
				<p>established goals for rehabilitation, recovery and reintegration into the mainstream of social, employment and educational choices.”</p> <p>Neither citation of WAC 388-865-0430 contains any requirement for MHP specialist consultation within 5 days.</p> <p>It is also unclear to me why this is needed for all groups except older adults. For older adults it is “as needed.”</p>	<p>change has occurred, then no MHP specialist consultation is required within the five days.</p>
25	31	<p>Exclusion Criteria: Any ONE (1) of the following criteria is sufficient for exclusion from this level of care: 1) Concurrent review has determined that the primary causation of the consumer’s impairment is the result of another disabling condition <u>or</u> and the consumer’s mental health care can either be provided at a lower level or not at all.</p>	<p>No WAC or MHD reference was provided.</p>	<p>We wish to confirm that concurrent review can be performed by resource management or agency staff.</p>	<p>Yes, concurrent review can be by provider staff.</p> <p>NO to change of “and” to “or”. We expect both criteria to be met.</p>
26	32	<p>Met DSM-IV criteria for <u>ONE</u> (1) of the following psychiatric diagnoses: 5. Anxiety, Stress, Posttraumatic Stress, Dissociative and all Personality Disorders, except Anti-Social.</p>	<p>No WAC or MHD reference was provided.</p>	<p>Number 5 includes all of #4. It is confusing the way it is written. Suggest deleting #4.</p>	<p>Tentative agreement.</p>
27	37	<p>Coordination of and <u>consultation with participation on</u> Individual Support Teams with primary care clinician/team members and <u>inclusion of full team at least weekly</u>. These teams meetings will include family, primary care teams, prescription staff, crisis services staff, MHP specialists, as required, and other formal and informal</p>	<p>MHD 2.3.6 and 2.3.7.</p>	<p>There is a problem with the language, “...and inclusion of full team at least weekly.”</p>	<p>The important point is to document efforts to convene and use teams. See page 6, #23...same issue, same response</p>

SPECIAL REVIEW PROCESS ITEM #	Pg	REQUIREMENT	REFERENCE	ISSUE	RSN SPECIAL REVIEW PROCESS RECOMMENDATION
		supports.			
28	38	<u>Admission Criteria</u> The older adult has received a face-to-face multi-axial consultation assessment by a geriatric mental health specialist ...		What is the origin of the requirement for an assessment by a “geriatric mental health specialist”? Suggest following the WAC and consultation by a MHP.	Tentative agreement. Use WAC language.
29	38	<u>Clinical Criteria</u> 3) To remain in a community setting, consumer requires short-term intensive Case Management support and assistance with daily living situations (e.g., housing, financial, medical, social and caregivers).		Intensive Case management for a Level One! With a GAF of 70. This does not fit.	Generally Level 1 consumers do not need this type of service. This is a special addition for older adults to maintain them living as independently as possible. Add after setting ”and avoid a more restrictive and high cost living arrangement” ,
30	55	<u>Add-On to Assisted Living</u> 2) Meet NSRSN Adult Level of Care 2 or 3 criteria and is a Medicaid enrolled individual or meet NSRSN Adult Level of Care 2 or 3 criteria and has <u>no insurance or an inability to pay for treatment</u> .		This requirement could be a big number and costly if we have to “add” on for Older Adults Level 2 with no Medicaid eligibility. Should only apply to Level 3.	Delete the second reference to Level 2 and add “under 200% of the Federal poverty level”.
32	61	Educational supports that include, but are not limited to: (a) information and referrals to specialized and general education programming, (b) information regarding funding and scholarships, (c) mentors and coaches, (d) transportation information and assistance.	WAC 388-865-0456 (2) MHD 4.1.8.8 HCPCS Procedure Code—“MH rehab – education”	This requirement seems to be a higher standard than the WACs or MHD. I do not have a copy of the HCPCS Procedure Code. According to this requirement, anyone over the age of 16 who expresses an interest in school is eligible to receive a coach/mentor and information and referrals regarding school programs and funding. Seems excessive compared to the WACs.	Substitute “may” for “that”.
34	65	For “unknown” or consumers who are not enrolled, there will be contact by NSRSN contracted provider staff within 2 working days.	MHD 2.3.8 MHD 2.4.1	Clarify who will make the contact. ICRS? ACT?	OK to add “eligible” to “unknown”. Correct MHD contract reference.
35	65	For enrolled consumers with a	MHD 2.3.8.4	The MHD document does not state this	For enrolled consumers who

SPECIAL REVIEW PROCESS ITEM #	Pg	REQUIREMENT	REFERENCE	ISSUE	RSN SPECIAL REVIEW PROCESS RECOMMENDATION
		length of stay of 7 or more days, there must be a documented (good faith effort) provider-initiated request for consultation, or completed consultation, with inpatient psychiatrist.		at all. 4.1.8.14 reads, "Continuity of care within and across services." This requirement is an unrealistic expectation for both the inpatient psychiatrist and the providers.	have been hospitalized, hospital records must be obtained and provider differences from hospital discharge diagnosis and prescribed medications must be documented. The underlying rationale shall be documented.
36	67	Consumer's work plan must identify how her/his treatment needs will be met.	WAC 388-865-0425	"work plan" should be "treatment plan."	Tentative agreement.
37	72	<u>Facilitated Transfers</u> 4. Transferring primary care clinician shall enter transfer data into the NSRSN information system within seven (7) business days of confirmed transfer date.	No WAC or MHD reference was provided.	The requirement is confusing. Transfers go through Access; therefore, as soon as the demographic information is given to Access regarding the transfer and the appointment is scheduled it is transmitted to the receiving agency. What are the exact data elements to which they are referring?	Change "primary care clinician" to "agency".
38	72	<u>Changes in Consumer's Level of Care</u> 3. A change of status shall be entered into the NSRSN Information System (IS) by the provider within ten (10) business days. Both the provider and the NSRSN shall use this information to assess the provider's case mix and the accuracy of the provider's level of care assessments.	No WAC or MHD reference was provided.	The requirement is confusing. Are they wanting to capture the client's true level following assessment? If they are, then the way we are discussing not giving a client a level at assessment may help.	Change "status" to "Level of Care".
42	67	MHP will review and update the consumer's treatment plan weekly.	MHD 4.1.8.14	The WAC requirement is monthly.	Recommend using the WAC language. .0466
43	67	Med review monthly.	MHD 4.1.8.16 WAC 388-865-0466 (d)(ii)		Use WAC language.
44	73	Assistance with complaints...	MHD 1.5.7.8 MHD 3.14		Change to: Make good faith attempt to give 15 day notice of change in PCP and 30 day notice of changes in

SPECIAL REVIEW PROCESS ITEM #	PG	REQUIREMENT	REFERENCE	ISSUE	RSN SPECIAL REVIEW PROCESS RECOMMENDATION
					benefit package, residential, and or housing capacity that result in decreased access to care.