NORTH SOUND
MENTAL HEALTH ADMINISTRATION

QUALITY MANAGEMENT OVERSIGHT COMMITTEE

COMMITTEE MEETING PACKET

April 27, 2005

QMOC GUIDING PRINCIPLES

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

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

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

North Sound Mental Health Administration
Quality Management Oversight Committee
NSMHA Conference Room
April 27, 2005
12:30 – 2:30

AGENDA

				Page #
1.	**Open the meeting & comments from the Chair**			
2.	**Approval of March 2005 Minutes** Action Item	**Chair**	5 min	1
3.	**Reports**			
	A. Quality Management Department Report FYI and Discussion	**Ms. Klamp**	5 min	4
	B. "Quality in Action" Agency Presentation **Catholic Community Services Northwest** FYI and Discussion		15 min	8
	C. Performance Indicators Report 2003 FYI and Discussion	**Ms. Klamp**	20 min	
	D. Utilization Management Dashboard FYI and Discussion	**Mr. McDonough**	5 min	9
	E. Quality Training – Root Cause Analysis Training	**Ms. Jaccard**	10 min	
	F. WCPC and Sea Mar Audit Results FYI and Discussion	**Ms. Ridgway**	15 min	10
	G. Semi-annual Ombuds Report FYI and Discussion	**Mr. Davis**	15 min	16
	H. Telesage FYI and Discussion	**Ms. Klamp**	10 min	
	I. Critical Incident Report FYI and Discussion	**Ms. Jaccard**	15 min	41
4.	**Other Business**			
	A. Meeting Results	**Chair**	5 min	
5.	**Adjourn**			

Quality Management Oversight Committee
NSMHA Conference Room
March 23, 2005
12:30 – 2:30
MINUTES

Present:
Gary Williams, QMOC Chair, Board of Directors, Human Services Supervisor, Whatcom County
Mary Good, NSMHA Advisory Board
Dr. June LaMarr, The Tulalip Tribes
Chuck Davis, Ombuds
Russ Hardison, Sea Mar
Heather Fennell, Compass Health, APN
Joan Dudley, Assistant Director, Lake Whatcom Center
Susan Ramaglia, Skagit NAMI
Nancy Jones, Snohomish County
Janet Lutz-Smith, Whatcom County AB
Linda Carlson, Volunteers of America
Dan Bilson, Whatcom Co., AB

Not Present:
Joan Lubbe, NSMHA Advisory Board
Maile Acoba, Skagit County Coordinator
Beckie Bacon, NSMHA QRT
Wendy Klamp, NSMHA Quality Manager
Janelle Sgrignoli, Sno. Co. Human Services
Patricia Little, NSMHA Advisory Board
Karen Kipling, VOA
Preston Hess, Snohomish County Mental Health ITA

Others Present:
Greg Long
Mike Watson, Lake Whatcom
Annette Calder

1. Open the meeting & comments from the Chair
Gary opened the meeting and welcomed everyone. Introductions were made.

2. Approval of February 2005 Minutes
Gary asked if there were any changes to the minutes; there were none. A motion was made to approve the minutes of February 2005 as written, seconded, all in favor, **motion carried.**

3. Reports

A. Quality Management Department
Greg Long distributed the Quality Management Department Report for February 2005. He explained the new reporting format to the group. Greg reported on the NSMHA Quality Management Committee, Utilization Management Subcommittee, Integrated Crisis Response Committee, HCS/RSN Meeting; Mental Health Division, Western State Hospital Liaison, CHAP, staffing, etc. and discussion followed. The report is attached to the file copy as part of the official record. Greg was thanked for his report.

B. "Quality in Action" – Agency Presentation – LWRTC – Michael Watson
Mike Watson, Clinical Director from Lake Whatcom Residential Treatment Center made a presentation to the committee on documentation. He distributed information on Lake Whatcom Residential Treatment Center's treatment philosophy that they have used for many, many years (attached to the official record). He said it is similar to the Recovery Model that many others follow today, and reviewed it with the committee. Mike distributed Lake Whatcom Residential Treatment Center's Intake Assessment packet and reviewed it with the group (attached to official record). A question and answer period followed. Mike was thanked for his report.

C. Utilization Management Dashboard

Terry McDonough distributed copies of the "dashboard" and reviewed it with the group (attached to official record). He discussed the cap at Western State Hospital, percentage of usage of the E&Ts, number of calls to the Access line, average hours of service, hospitalizations, etc. Terry explained that there is a two-month lag in reporting, so not all numbers are accurate or complete. A question and answer period followed. The committee suggested that the "dashboard" be modified and broken out by categories that are complete versus those that are not, or report on the most recent completed quarter. Shading columns that have incomplete number and capture Volunteers of America utilization data, which Linda Carlson said could be easily done. Terry was thanked for his report.

D. Quality Training – "Role of Leadership in Quality Improvement"

Greg Long gave a PowerPoint presentation on the Role of Leadership in Quality Improvement (copy of presentation included in the meeting packet). He discussed ways of making improvements within our system, the importance of teaching, instructing and educating; achieving quality, shared values, creating, managing and reinforcing culture; closing the gap, rewarding quality actions by staff, and the role of leadership in quality improvement. A question and answer period followed. Greg was thanked for his presentation.

E. QMOC Ad hoc Group

Gary Williams addressed the committee regarding the activities of the QMOC ad hoc group. Gary reviewed the ad hoc committee recommendations and asked the group to review the recommendations between now and the next meeting and bring comments and suggestions to the April meeting of the QMOC. The recommendations were included in the meeting packet. Group discussion followed. The committee felt the recommendations would help the committee move forward in a good way.

F. Critical Incident Report

Postponed at this time.

G. Access to Care Criteria for Continual Stay

Terry McDonough addressed the committee regarding developing criteria for consumers who remain in treatment beyond their authorization period (continued stay). A work group will be formed in the next month or so to develop Continued Stay criteria. Terry asked those interested in participating to call Wendy Klamp.

4. Other Business

A. Performance Improvement Projects 2005

Greg distributed the NSMHA clinical performance improvement projects 2005 document and reviewed it with the group (attached to the official record) covering from 2004 to present, along with a proposed clinical performance project. A brief question and answer period followed. Motion by Mr. Bilson to approve the PIP #2 – Mortality Review and recommend to the Board of Directors, seconded, and opened for discussion. Ms. Jones strongly objected to this being presented and approved today without adequate time for review and comment by the committee. Ms. Jones stated she would abstain from voting on this motion due to the process followed. Ms. Lutz-Smith made a friendly amendment that the committee sees the tool for this project, amendment accepted by Mr. Bilson. The motion reads: To have QMOC review the tool for the 2005 performance improvement projects and recommend approval of the PIP #2-Mortality Review to the Board of Directors. Chair Williams called for the vote, 10 for, 1 abstention, motion carried.

B. Meeting Evaluation

Gary asked everyone to complete the meeting evaluation form (included in the meeting packet) and turn them in to Annette before leaving.

5. Adjourn

Chair adjourned the meeting at 2:50 pm. The next QMOC meeting is scheduled for April 27, 2005, 12:30-2:30 pm.

Respectfully submitted,

Annette Calder
Executive Assistant

Please Note:
The attachments referenced herein are part of the official record and attached to the file copy. Please contact the NSMHA at 1-800-684-3555 if you have any questions, comments, or concerns.

NSMHA COMMITTEE DISCUSSION FORM

AGENDA ITEM: **Quality Management Department Report**

PRESENTER: **Wendy Klamp, NSMHA Quality Manager**

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

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:

- Summaries of the month's activities of the Quality Management Department and Quality Specialist staff will be provided at the meeting.

CONCLUSIONS/RECOMMENDATIONS:

- A summary of Quality Management Department activities will be given to the QMOC on a monthly basis

TIMELINES:

- Ongoing

HANDOUTS:

- Quality Management Report

Quality Management

Department Report March 2005

Achievements of Note: Participated in the Whatcom Counseling and Psychiatric Clinic Administrative, Fiscal and Clinical Audit

NMSHA Meetings

Facilitated	Attended
Service Mapping Workgroup 3-11-05	**NSMHA All Staff Meeting**
Service Mapping Workgroup 3-31-05	**NSMHA Advisory Board**
Regional Medical Directors Committee	**NSMHA Board of Directors**
QMOC	
Quality Management Committee	
Internal Quality Management Committee	
Critical Incident Review Committee	
Utilization Management Subcommittee	

Cross-System Collaboration and Community Committees

Facilitated	Attended
	State Access to Care Workgroup-Wendy
	Kids Team Meeting-Wendy
	CLIP/CHAP-4 meetings-Sandy
	State Implementation and Design Group-Debra
	Snohomish County Advisory Board
	Skagit MH/Corrections Planning Meeting
	Skagit MH Advisory Board

Tasks and Functions

- Quality Assurance-# of Clinical Records reviewed 90
  # of Encounter Validation audits 0

- Quality Improvement:
- Met with bridgeways to provide technical assistance in development of their Quality Management Plan
- Met with Compass regarding Critical Incident reporting
- Met with Compass regarding complaint, participated in team meeting for care planning of the case
- Investigation of cluster of negative media events and other Critical Incidents of concern
- Review of current Performance Improvement Project and development of 2nd Clinical PIP for QMC and QMOC review
- Quality Improvement Case Reviews-6

- Utilization Management-3 internal meetings, 1 committee meeting. Development of additional data reports, and review of all UM reports with recommendations from UM to go to QMC in April

- Utilization Review-# of charts reviewed 91 # of denial requests reviewed 27

- Risk Management-# of Critical Incidents reviewed= 25

- # Of Complaints Reviewed-3

- # Of Grievances filed-0

- # Of Appeals filed-0

- Planning: Facilitated two meetings for System Capacity and Network Sufficiency, System Service Mapping

- Resource Management (CLIP)

  Cases screened 4 Clients in CLIP placement

- Resource Management (Medicaid Personal Care)-New authorizations-3 Renewals-20

- Resource Management (WSH)

Monthly ADC 96.69 Cap-95 Bed Days over Cap: 0

A.

B.

C.

D. Training Provided :

Training Planned: Customer Service Training for NSMHA Staff-April 2005

E. Training Attended: Evidence-Based Practices for Children-Greg

Activities Planned/Deliverables due in April: Compass Audit, Critical Incident Six-Month Report

Needs/Issues

We are looking forward to Diana Striplin returning from her assignment at Western State Hospital on April 1 to resume her Quality Specialist duties. This will assist the department in moving forward with several activities that have been postponed due to the shortage of staff resources.

We are also wishing the Snohomish County Mental Health staff well who are preparing for their big move to the new building.

NSMHA COMMITTEE DISCUSSION FORM

AGENDA ITEM: **Quality in Action at Catholic Community Services North West**

PRESENTER: **Unknown at time of distribution**

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

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:

In order for QMOC to monitor the implementation of the NSMHA Quality Management Plan, we have requested that selected providers present to the committee on a regular basis. These presentations will demonstrate their participation in the NSMHA Quality Management system, illustrate the implementation of their Quality Management plans and provide the committee with an opportunity to review specific projects that involve the completion of the Quality circle.

CONCLUSIONS/RECOMMENDATIONS:
N/A

TIMELINES:
N/A

ATTACHMENTS:
Any handouts will be provided at the meeting.

NSMHA COMMITTEE DISCUSSION FORM

AGENDA ITEM: **Utilization Management "Dashboard" Report**

PRESENTER: **Terry McDonough**

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

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:
As part of the NSMHA Utilization Management plan we have developed a "Dashboard" of key utilization indicators that will be presented to QMOC on a monthly basis for review.

CONCLUSIONS/RECOMMENDATIONS:
Determine if any specific action or activity is needed regarding these indicators.

TIMELINES:
Ongoing

ATTACHMENTS:
Utilization Management Dashboard Report will be distributed at the meeting.

NSMHA COMMITTEE DISCUSSION FORM

AGENDA ITEM: **WCPC and Sea Mar Audit Results**

PRESENTER: **Ms. Deirdre Ridgway, NSMHA Contracts Manager**

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

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:

In January 2005, NSMHA conducted a limited assessment, for contract compliance purposes, of Sea Mar's administrative, fiscal, and quality assurance/improvement management systems, processes, policies and procedures of the agency. The period reviewed was 1/1/04 through the date of the review. An outpatient clinical record review was conducted at the same time.

In March 2005 similar reviews were conducted at Whatcom Counseling and Psychiatric Clinic.

CONCLUSIONS/RECOMMENDATIONS:

The results of the Sea Mar contract compliance audit were 8 findings and 4 recommendations, and a corrective action plan was requested. The results of the outpatient record review were: Sea Mar's overall score was 86%, which does not meet the 90% requirement. Following completion of a NSMHA-approved corrective action plan, NSMHA will conduct a re-review.

The WCPC audit report has not been released as of the date of this memo, but is expected to be available for the QMOC meeting.

TIMELINES:

N/A

ATTACHMENTS:

Sea Mar Audit Report
WCPC Audit Report will be available at the meeting.

NORTH SOUND MENTAL HEALTH ADMINISTRATION

ADMINISTRATIVE, FISCAL AND QUALITY ASSURANCE/IMPROVEMENT MANAGEMENT SYSTEM MONITORING REPORT

CONTRACTOR: Sea Mar **DATE: March 22, 2005**

CONTRACT NO(S): NSMHA-APN- 04-05

NSMHA MONITOR(S): Deirdre Ridgway, Wendy Klamp, Debra Jaccard, Sandy Whitcutt, Terry McDonough and Bill Whitlock

CONTRACTOR REPRESENTATIVE(S): Claudia D'Allegri, Russ Hardison, Jose Rodriguez

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SCOPE OF REVIEW

The purpose of this monitoring visit was to conduct a limited assessment, for contract compliance purposes, of the administrative, fiscal, and quality assurance/improvement management systems, processes, policies and procedures of the agency. The period reviewed was 1/1/04 through the date of the review. The review included review of the agency's response to NSMHA Administrative, Fiscal and Quality Assurance/Improvement On-Site Monitoring Questionnaire, interviews with management and staff, and review of relevant personnel files, agency and department specific policies and procedures.

SUMMARY OF REVIEW

The following areas were monitored through a review of the "Administrative, Fiscal and Management System Monitoring Questionnaire;" source documents; and interviews with the agency staff:

Financial Management	Internal Controls	Budgetary Controls
Petty Cash	Compensation Plan	Inventory
Purchasing	Regulatory Compliance	MIS
Personnel System	Travel	Consumer Rights
Access and Assessment	Care Management	Cultural Competence
Quality Management	Resource Management	Crisis Response

The responses to the "Administrative, Fiscal and Quality Assurance/Improvement Monitoring Questionnaire" and on-site review were discussed with the Sea Mar staff during the review. Results of the Review follow.

INTRODUCTION

Sea Mar is a community health center that contracts for the provision of mental health services with the North Sound Mental Health Administration (NSMHA). Sea Mar's role in the North Sound system is to make available and provide medically necessary outpatient and community support mental health services, which eliminate or substantially reduce communication and/or socio-cultural barriers and support the natural community available to Hispanic individuals and families. Consumers will live in the community as normally as possible in the least restrictive environment, with minimal dependence on public safety resources and acute care resources.

On January 4 – 7, 2005 the NSMHA Administrative Audit Team conducted a review of the above referenced direct service programs. The audit was conducted jointly with the NSMHA Quality Management Clinical Record Review. The results of the Administrative On-site Review and Quality Management Clinical Record Review are discussed in this report.

Sea Mar is certified by the DSHS Mental Health Division to provide counseling and psychotherapy, case management, and psychiatric treatment, including medication supervision. It is seeking certification for the Outpatient component of the Evaluation and Treatment Program, allowing it to provide services to consumers on Less Restrictive Alternative court orders.

STRENGTHS

Sea Mar serves an important role in the North Sound network of care, insuring that mental health services are available to the Hispanic population.
Sea Mar has kept on top of the changes to the Medicaid reimbursement system that will restrict the ability to serve the non-Medicaid and has been working hard to find alternatives for that population.
Sea Mar has a strong and comprehensive quality management program that meets the needs of its clients.
Sea Mar does a good job of managing the data needs for the Sound Data MIS system.
Sea Mar has an excellent program and set of client forms for medication education.
Sea Mar has emphasized the integration of mental health and medical services and demonstrates a holistic approach to meeting client's healthcare needs.

FINDINGS AND RECOMMENDATIONS

A finding occurs when an agency fails to comply with Federal or State regulations and contract terms and conditions governing contract awards, and which could subject them to failed State Mental Health Licensing review, audit disallowances, debarment, or contract noncompliance. The NSMHA applies the 90% compliance rule established by the State of Washington Mental Health Division in reporting findings.

A recommendation occurs when an agency fails to follow generally accepted accounting principles, is close to, but does not meet the 90% compliance rule in a particular area and other areas in which the monitoring team feels improvement is needed in order to strengthen the agency's administrative, financial, management or quality management capabilities.

ADMINISTRATIVE

FINDINGS

1. Credentialing – There is a need to check for independent verification of personnel qualifications and have written documentation to this effect. Management and all supervisory staff need to know and understand what the credentialing requirements are. After some initial confusion there remain two clinicians with outstanding credentialing deficits documented, Sandra Hall and Emma Jones. These individuals were performing duties of a Mental Health Professional but do not have adequate documentation of qualifications to meet MHP requirements.

2. Supervision – Clinical supervision is excellent and well documented. Communication to staff of general NSMHA requirements is not well documented.

3. Training – Sea Mar is not following the NSMHA recommended regional training plan or consistently using the modules developed by the region for this purpose. Individual training plans are not related to the performance appraisal and there is no documentation that supervisors are checking to see if the training plans are completed.

4. Policies – Policies need to be completed and updated to conform to NSMHA requirements. NSMHA has created a policy grid which is available on its website to ensure that providers are aware of the policies that are required. Most policies are discussed at NSMHA's QMC before being adopted or modified. The Sea Mar Complaint, Grievance and Fair Hearing Policy does not comply with current NSMHA requirements.

RECOMMENDATIONS

1. Compliance – Sea Mar needs to ensure that its encounter data reporting fits with the new state plan modalities.

2. Implementing Policies and Procedures to Assure that Cultural Assessments Go Beyond Ethnicity – Sea Mar specializes in serving the mental health needs of the region's Hispanic population. Our data shows that a significant number of current clients in service are non-Hispanic. Sea Mar has a clear and strongly stated commitment to cultural competence. During the review, it was noted that several of the policies needed to be updated, which Sea Mar did before the conclusion of the audit. It was noted during the clinical review that implementation of the policies will require updating forms used for intake evaluations and ensuring that the forms are completed for all populations. Because a clinical review will need to be conducted anyway, no additional corrective action is required of Sea Mar.

FISCAL

FINDINGS
NONE

RECOMMENDATIONS
NONE

CLINICAL AND QUALITY MANAGEMENT SECTION

FINDINGS

1. Consumer Involvement/Voice – Direct consumer involvement is lacking in the QM process. NSMHA would like to see consumers at the site level more involved and thus empowered.
2. Access – Screening and intakes are not following authorization policy. Screening on phone OK, but must have a face-to-face per the WAC within 10 days of initial request for services/contact with client. Screening and intake process need to be integrated and in all cases performed by a credentialed MHP.
3. Care Management – Clinical record reviews revealed lack of meeting access to care criteria, diagnosis criteria and GAF scaling requirements. GAF and diagnosis were not consistent with symptomology noted in documentation. This is very important due to our diagnosis driven system. Policies and clinical supervision must ensure that staff consistently reassess client's for medical necessity required to continue in service in order to comply with state Access to Care criteria.
4. Treatment Planning - Thirty-eight clinical records were reviewed and all involved psychotherapy/counseling services with no case management noted. This finding is troubling because our system is case management driven. There was a lack of documentation addressing efforts to meet life domain needs. It was unclear how clients who required mental health services not available through Sea Mar such as Residential or High Intensity Treatment would be served.

RECOMMENDATIONS

1) Uniform Forms - The reviewers noted many different versions of forms that are used at Sea Mar's multiple locations and recommends that Sea Mar adopt a uniform form set and develops procedures to ensure that old forms are removed from use. For example, we noted several versions of the crisis plan form in use. NSMHA also notes that some forms could be revised in order to better ensure that documentation meets standards.
2) Board Reporting - Quality Management information needs to be more regularly reported to the Sea Mar board.

QUALITY REVIEW TEAM SECTION

FINDINGS
NONE

RECOMMENDATIONS
NONE

CLINICAL RECORD REVIEW

A total of 37 files were reviewed from all three locations. The summary score sheet is attached. Sea Mar's overall score was 86%, which does not meet the 90% requirement. Following completion of a NSMHA-approved corrective action plan, NSMHA will conduct a re-review.

CORRECTIVE ACTION PLAN

Please prepare a written response documenting what corrective steps you have taken or a plan with timeline to correct for each Finding documented in this Report. Submit your corrective action plan and related responses to Deirdre Ridgway, Contracts Manager no later than April 25, 2005.

NSMHA COMMITTEE DISCUSSION FORM

AGENDA ITEM: **Semi-annual Ombuds Report**

PRESENTER: **Chuck Davis, NSMHA Ombuds**

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

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:

- Summaries of the past six (6) months Ombuds complaints, grievances and appeals will be provided at the meeting. They will include historical comparisons.

CONCLUSIONS/RECOMMENDATIONS:

- A summary of Ombuds' complaints, grievances and appeals is presented to the QMOC on a semi-annual basis.

TIMELINES:

- Ongoing

ATTACHMENTS:

- Ombuds semi-annual report

COMPLAINT & RESOLUTION DEFINITIONS

COMPLAINTS:

Access: Can be initial or on going. Deals with having trouble getting into services or having on-going services cut back. May deal with eligibility for services, terminations from services, or taking too long to receive services. A complaint about access is not only about access into services, but perhaps how long it took, or desiring a type of service not available to the consumer, or a discontinuation of services.

Dignity & Respect: Actual or perceived such treatment. How the consumer felt treated by the staff.

Quality Appropriateness: Appropriate type of service needed isn't available. Example #1: client has been in counseling, but also has a problem with anger management, and the court ordered anger management treatment. Provider has no anger management groups. Client can't afford outside help. Example #2: Client has PSTD and is put in an anxiety group. Client questions quality of the therapist, isn't satisfied with Anxiety group counseling, and wants one on one for PTSD. Perhaps the consumer wants individual therapy, and only receives group therapy. It also may involve frequency of visits.

Phone Calls Not Returned: Just what it says--usually client to case manager/therapist. This would be when the consumer is already in services.

Service Intensity or Coordination of Services: Has to do with coordination between provider and another agency or possibly between service providers in the same agency. Example is an alcoholic client where there must be coordination between the person's medical doctor and therapist. May need ancillary providers from an outside agency working with therapist. This could have to do with something like personal care in the home while also in therapy. Could have to do with case manager not coordinating appointments with the right providers. It may involve level of care or a type of therapy not available in that agency (for instance, treatment for eating disorders). Also, if care is being coordinated not only within the mental health agency, but with allied providers, such as a primary physician.

Consumer Rights: These are listed in the WAC and in our Ombuds brochure. This doesn't involve dignity and respect, which is its own category. It has a number of sub-categories. Mental health consumers have specific rights as listed in the WACs; this would involve a complaint that one or more had been violated.

Physicians and Medications: When someone wants another type of medication or different dosage. Perhaps they think their psychiatrist isn't listening to what they say about their medications. Perhaps it has to do with someone being separated from the provider. Someone may want or need to see a regular physician. Usually it involves medication. This is referring to psychiatrists and psychiatric meds. Complaints in this area might be around side effects and the doctor not paying attention to the consumer's concerns about them.

Financial and Administrative Services: Having to do with client funds. Generally deals with payees and pay problems. We would generally seek assistance from the case manager and payee. These complaints might be about SSI eligibility, or the consumer having a payee that controls his or her benefits.

Residential: This deals with any agency-provided housing, sometimes even if a client purchases a house and still receives case management help. It may be an issue concerning supported living, boarding alone, agency-owned

housing. Aurora House is an example of agency-owned housing. These complaints would involve supported living situations managed by the agency.

Housing: This deals with regular, independent housing out in the community, or perhaps integrating mental health clients back into the community. It also involves Section 8 applications. A complaint here might be that the agency hasn't done enough to find a consumer independent living.

Transportation: May deal with transportation coupons, bus passes, taxis, obtaining an access bus, or possibly transportation to and from services or places they need to go for normal living. May deal with clients who have agoraphobia and have trouble with public transportation. A complaint here would involve transportation to and from mental health services.

Emergency Services: Has to do with crisis services such as Crisis Clinics, or may involve E & T centers. May involve interaction with CDMHP. This complaint would involve crisis services, either the crisis line, or a CDMHP evaluation, or difficulty in the hospital emergency room during a mental health crisis.

Other: Any other type of complaint.

RESOLUTIONS:

Information or Referral: Simply giving information/names/numbers, or referring to another source.

Referral to QRT: This is done when we see a trend.

Conciliation/Mediation: Working out the issue between Ombuds, the provider and the client. Usually involves meetings, letters, phone calls, etc.

Arbitration: Usually done when turning a complaint into a Grievance.

Fair Hearing: Turning a complaint over to a fair hearing.

Other: Another resolution; perhaps the client moved away or died, is hospitalized, etc.

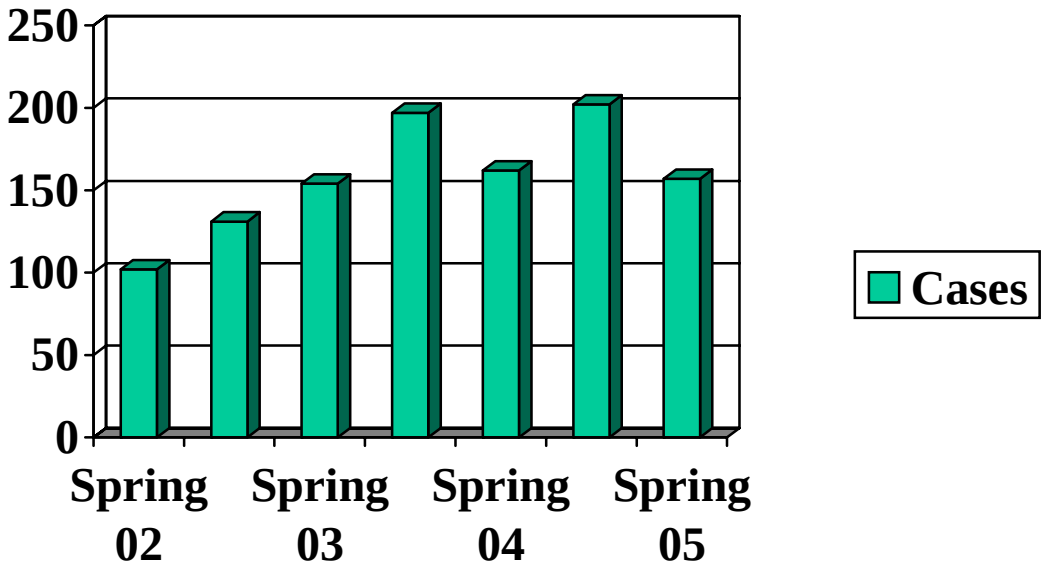
Not pursued: Client dropped the complaint. Perhaps the client didn't understand correct procedures and was OK once they understood the whole situation, or they became satisfied before interaction with the provider, etc.

SEMI-ANNUAL COMPLAINT DATA - PERCENTAGES

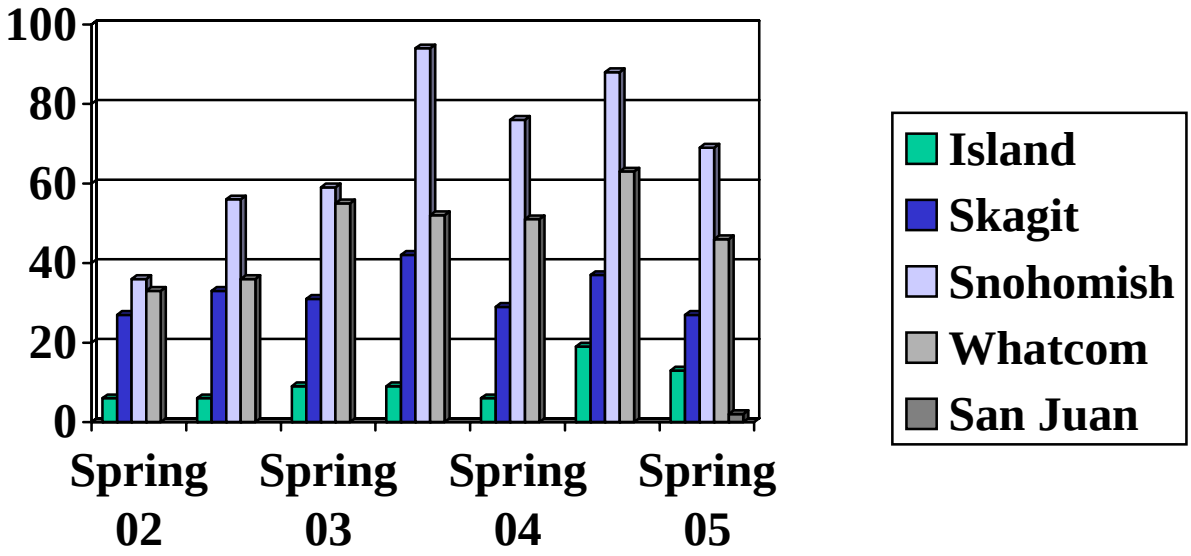
	Oct 01-Mar 02	Apr-Sep 02	Oct 02-Mar 03	Apr-Sept 03	Oct 03-Mar 04	Apr-Sep 04	Oct 04-Mar 05	Total
Number of Cases:	102	131	154	197	162	202	157	1105
Source of Cases:								
Self	85 (83%)	91 (69%)	107 (69%)	129 (84%)	111 (69%)	137 (67%)	103 (65%)	763
Relative	12 (12%)	17 (13%)	16 (10%)	41 (21%)	32 (20%)	40 (19%)	28 (17%)	186
Friend	1 (1%)	16 (12%)	12 (8%)	13 (7%)	6 (4%)	5 (2%)	7 (4%)	60
Other	4 (4%)	7 (5%)	19 (12%)	14 (7%)	13 (8%)	20 (9%)	19 (12%)	96
Demographics:								
Male	40 (39%)	53 (40%)	60 (39%)	85 (43%)	71 (44 %)	83 (41%)	80 (50%)	472
Female	62 (61%)	78 (60%)	94(61%)	112 (57%)	91 (56%)	119 (58%)	77 (49%)	633
Seniors 60+	0	4 (3%)	4 (3%)	6 (3%)	3 (2%)	1 (1%)	10 (6%)	28
Adults 21–59	97 (95%)	127 (97%)	145 (94%)	183 (93%)	151 (93%)	191 (94%)	136 (86%)	1030
Children 0--20	5 (5%)	0	5 (3%)	8 (4%)	8 (5%)	10 (4%)	11 (7%)	47
Cultural/Ethnic:								
African/American	1 (1%)	2 (1%)	3 (2%)	2 (1%)	2 (1%)	2 (02%)	3 (1%)	15
Caucasian	98 (96%)	118 (90%)	138 (90%)	176 (89%)	135 (83%)	174 (86%)	141 (89%)	980
Hispanic	0	5 (4%)	7 (5%)	5 (3%)	8 (5%)	5 (2%)	3 (1%)	33
Native American	2 (2%)	4 (3%)	4 (3%)	12 (6%)	14 (9%)	15 (7%)	7 (4%)	58
Asian/Pacific Islander	1 (1%)	2 (1%)	2 (1%)	2 (1%)	3 (2%)	6 (2%)	3 (1%)	19
Cases by County:								
Island	6 (6%)	6 (5%)	9 (6%)	9 (5%)	6 (4%)	19 (9%)	13 (8%)	68
San Juan	0	0	0	0	0	0	2 (1%)	2
Skagit	27 (26%)	33 (25%)	31 (20%)	42 (21%)	29 (17%)	36 (17%)	27 (17%)	225
Snohomish	36 (35%)	56 (43%)	59 (38%)	94 (48%)	76 (47%)	86 (42%)	69 (43%)	476
Whatcom	33 (32%)	36 (27%)	55 (36%)	52 (26%)	51 (32%)	61 (30%)	46 (29%)	334

	Oct 01-Mar 02	Apr-Sep 02	Oct 02-Mar 03	Apr – Sept 03	Oct 03-Mar 04	Apr-Sep 04	Oct 04-Mar 05	Total
Complaints:	114	137	175	225	181	226	192	1250
Type Complaints:								
Access	7 (6%)	23 (17%)	22 (13%)	29 (13%)	23 (13%)	24 (10%)	13 (1%)	141
Dignity & Respect	15 (13%)	13 (9%)	11 (6%)	12 (5%)	4 (2%)	13 (5%)	12 (6%)	80
Quality Appropriate	23 (20%)	15 (11%)	21 (12%)	19 (8%)	5 (3%)	7 (3%)	6 (3%)	96
Unreturned calls	2 (2%)	2 (1%)	1 (1%)	1 (1%)	1 (1%)	0	0	7
Service Intensity	4 (4%)	15 (11%)	26 (15%)	18 (8%)	33 (18%)	44 (20%)	22 (11%)	162
Consumer Rights	8 (7%)	14 (10%)	18 (10%)	18 (8%)	24 (13%)	29 (12%)	33 (17%)	144
Physicians & Meds	24 (21%)	7 (5%)	11 (6%)	27 (12%)	17 (9%)	19 (8%)	29 (15%)	134
Financial/Admin	5 (4%)	6 (4%)	8 (5%)	19 (8%)	12 (7%)	34 (15%)	25 (13%)	109
Residential	6 (5%)	17 (12%)	10 (6%)	12 (5%)	10 (6%)	1 (1%)	3 (2%)	59
Housing	7 (6%)	5 (4%)	9 (5%)	10 (4%)	13 (7%)	26 (11%)	26 (13%)	96
Transportation	1 (1%)	0	0	0	1 (1%)	0	2 (1%)	4
Emergency Services	8 (7%)	14 (10%)	24 (14%)	31 (14%)	25 (14%)	21 (9%)	12 (6%)	135
Other	4 (4%)	6 (4%)	14 (8%)	29 (13%)	13 (7%)	8 (3%)	9 (5%)	83
Resolutions of Complaints:								
Info/Referral	22 (19%)	10 (7%)	49 (28%)	51 (23%)	65 (36%)	63 (20%)	50 (26%)	310
Refer to QRT	0	0	0	0	0	0	0	0
Conciliation/Mediation	74 (65%)	53 (39%)	94 (54%)	139 (62%)	95 (52%)	130 (47%)	115 (61%)	700
Arbitration	0	1 (1%)	3 (2%)	3 (1%)	3 (2%)	13 (3%)	5 (2%)	28
Fair Hearing	0	0	0	0	0	0	0	0
Not Pursued	12 (11%)	57 (42%)	15 (9%)	17 (8%)	14 (8%)	20 (6%)	6 (3%)	141
Other	6 (5%)	16 (12%)	14 (8%)	15 (7%)	4 (2%)	0	0	55
						Outstanding Cases:	16 (8%)	
Provider Grievances:	0	0	0	0	0	5	7 (1 still open)	12
RSN Grievances:	10	1	3	3	3	6	3	29
Fair Hearings:	0	0	0	0	0	1	0	1

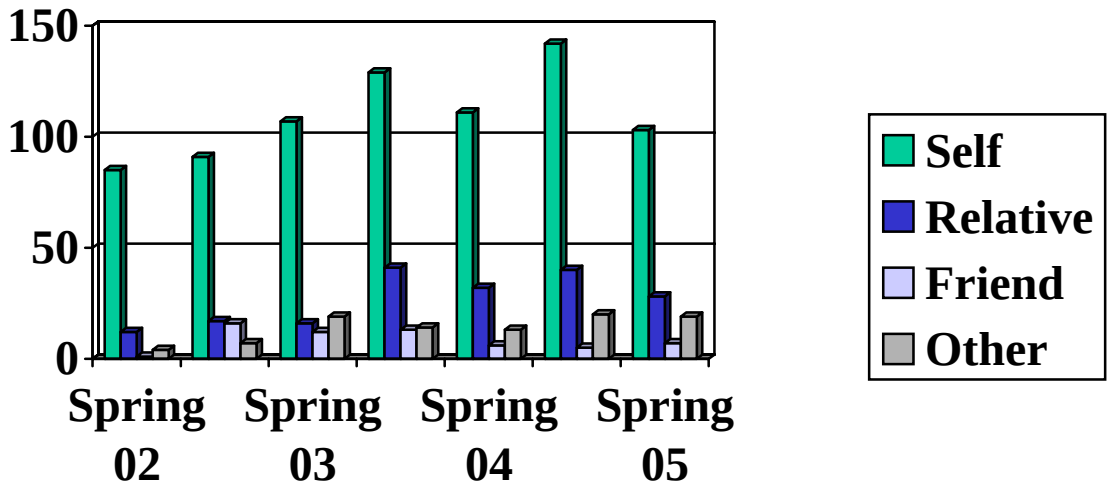
Semi-Annual Cases



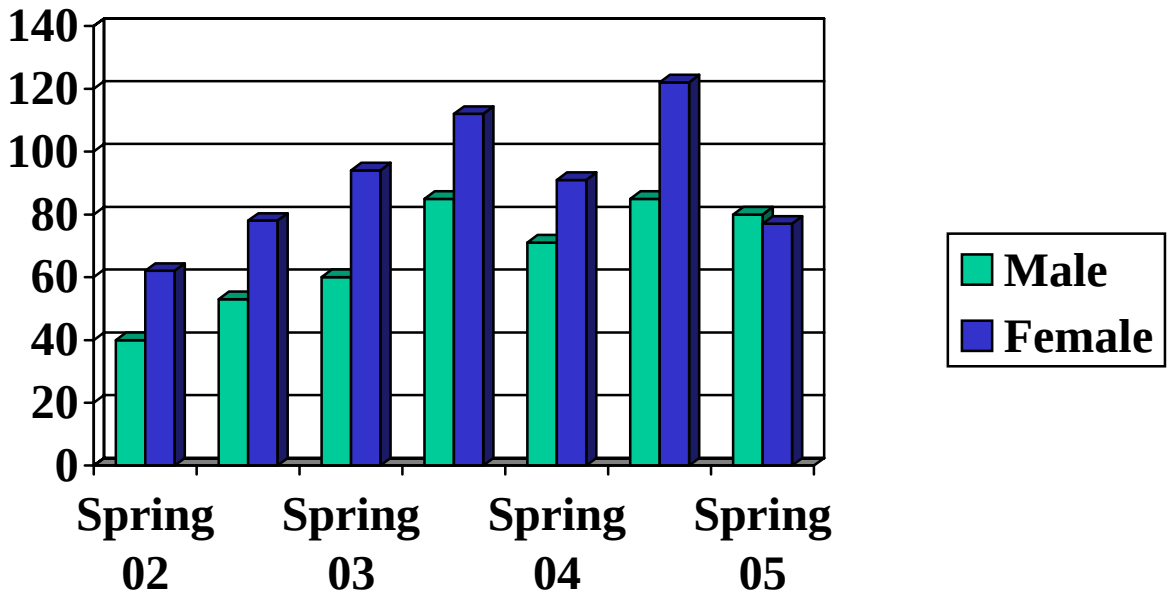
Cases by County



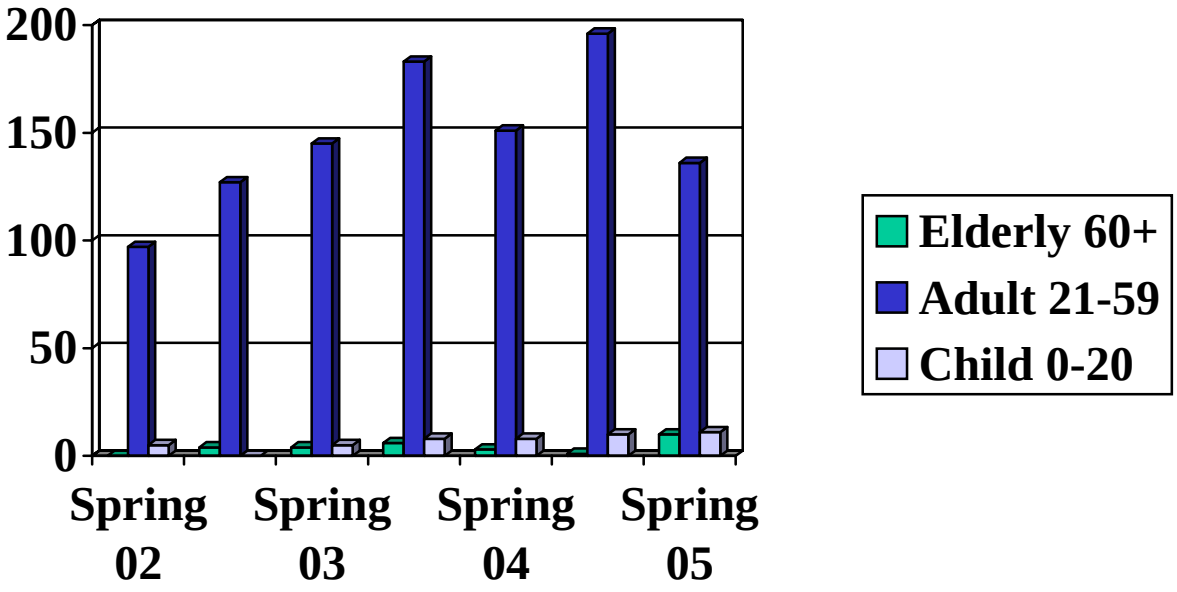
Source of Cases



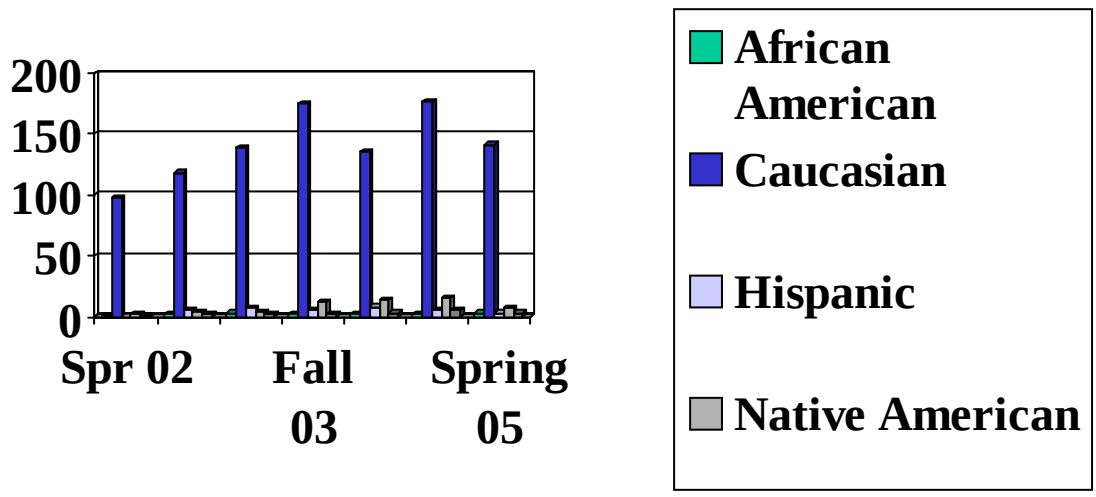
Gender of Client



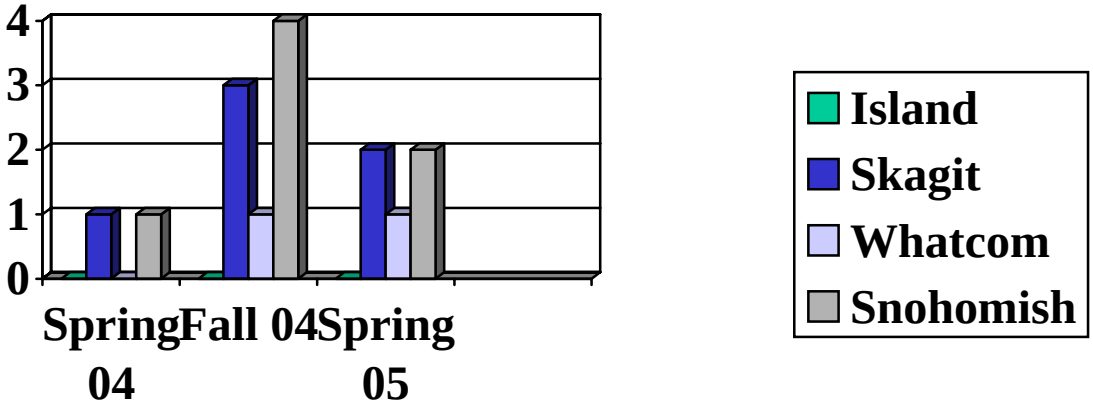
Age of Client



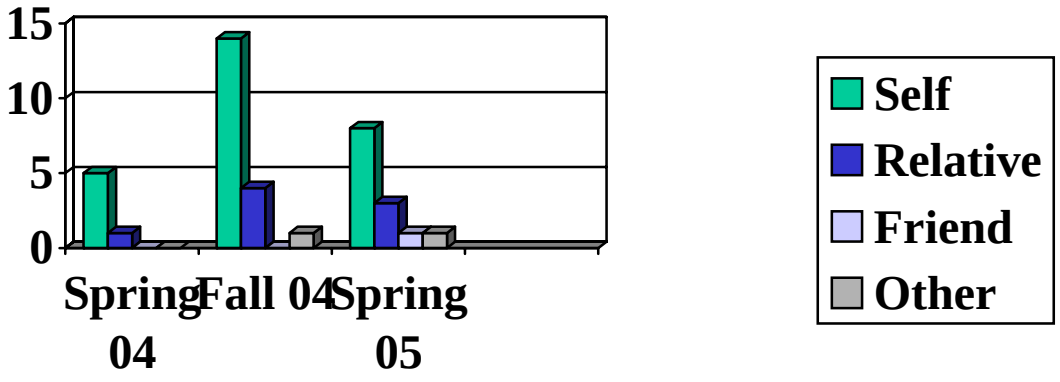
Ethnicity of Client



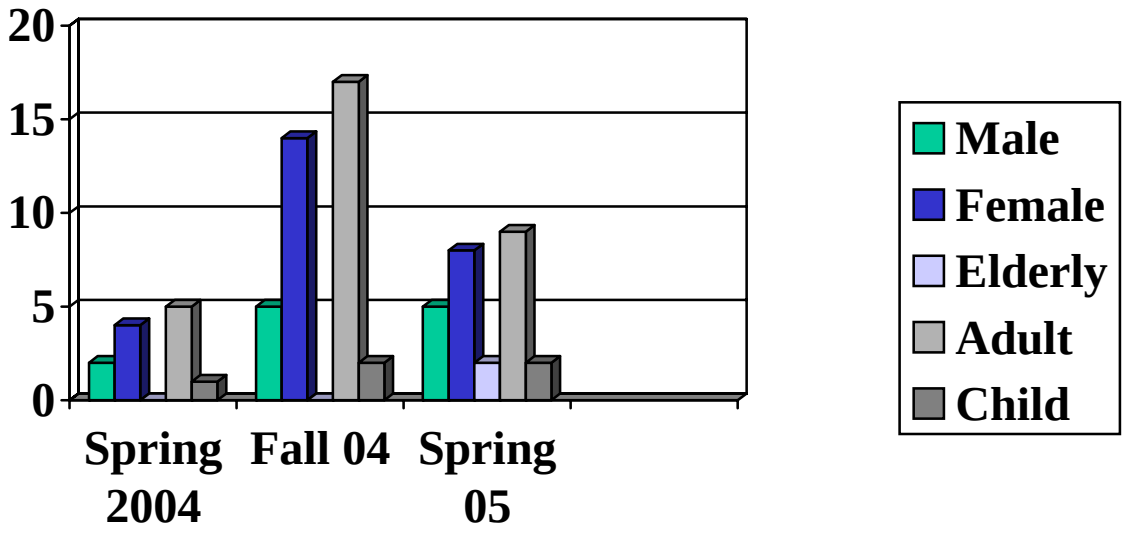
GLBT Clients



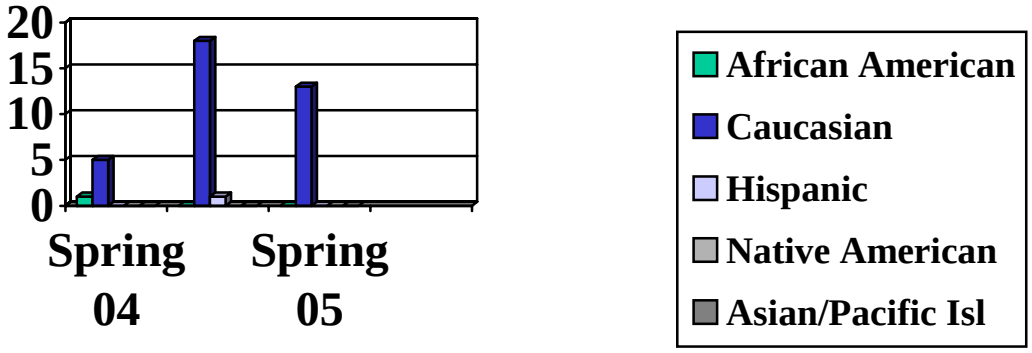
Island County Demographics: Referral Source



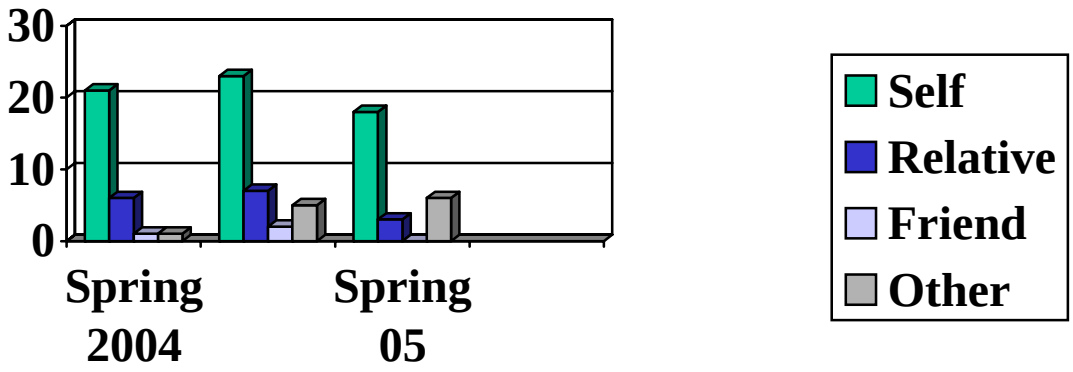
Island County Demographics: Gender and Age



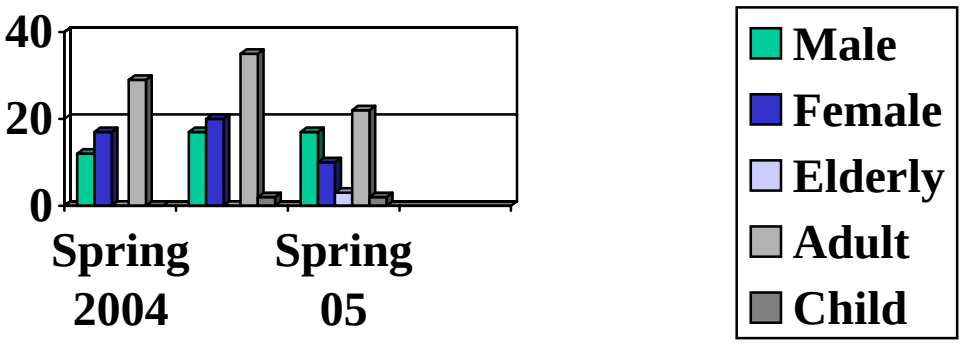
Island County Demographics: Ethnicity



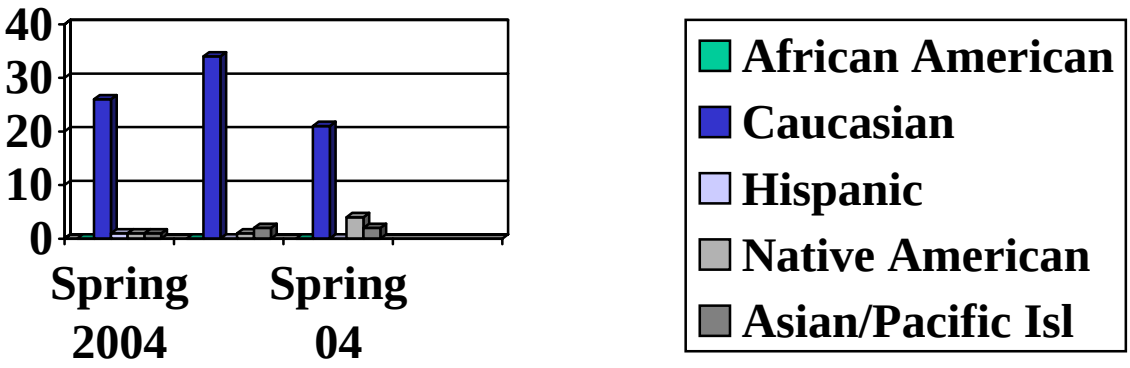
Skagit County Demographics: Referral Source



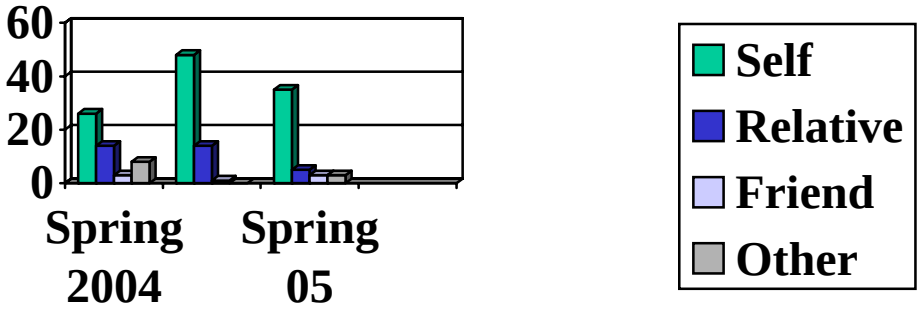
Skagit County Demographics: Gender and Age



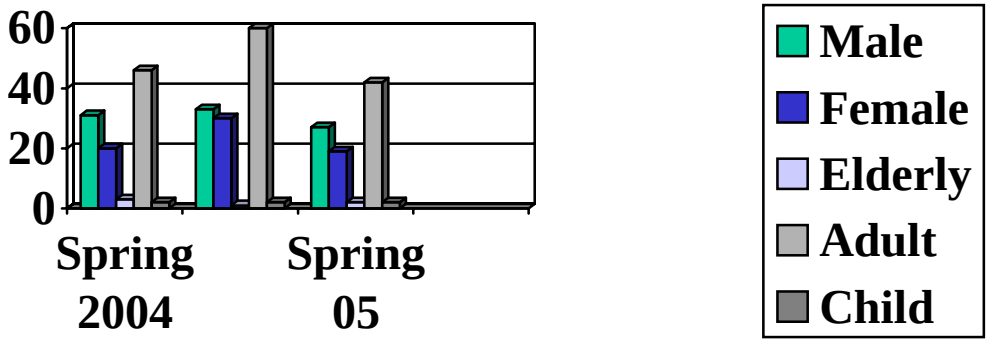
Skagit County Demographics: Ethnicity



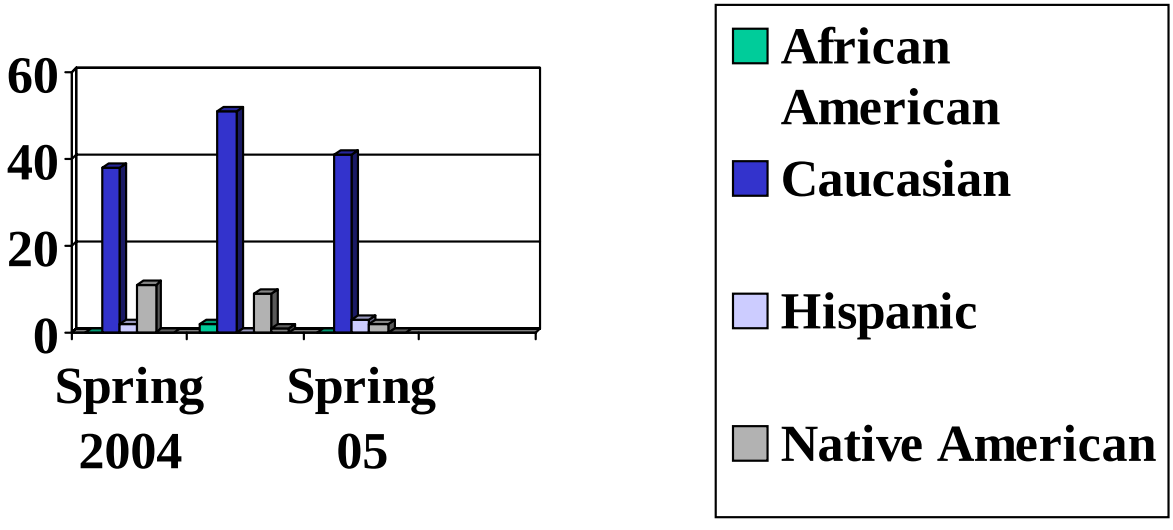
Whatcom County Demographics: Referral Source



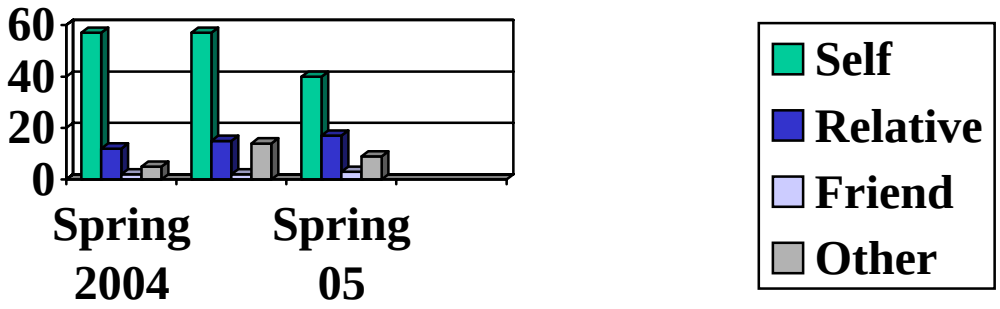
Whatcom County Demographics: Gender and Age



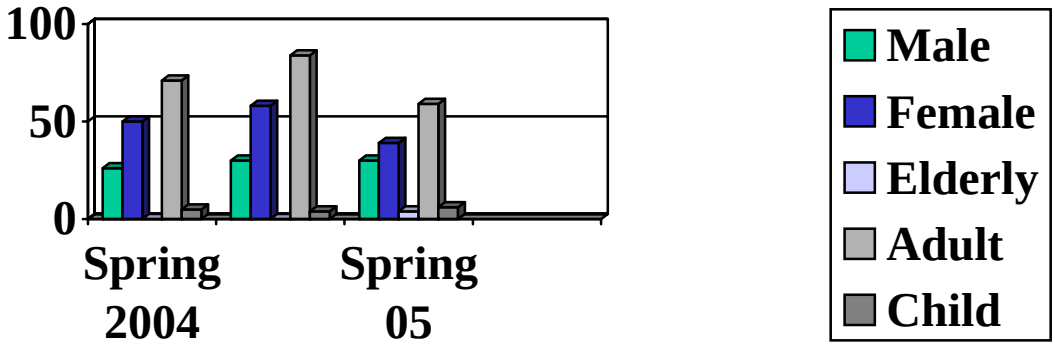
Whatcom County Demographics: Ethnicity



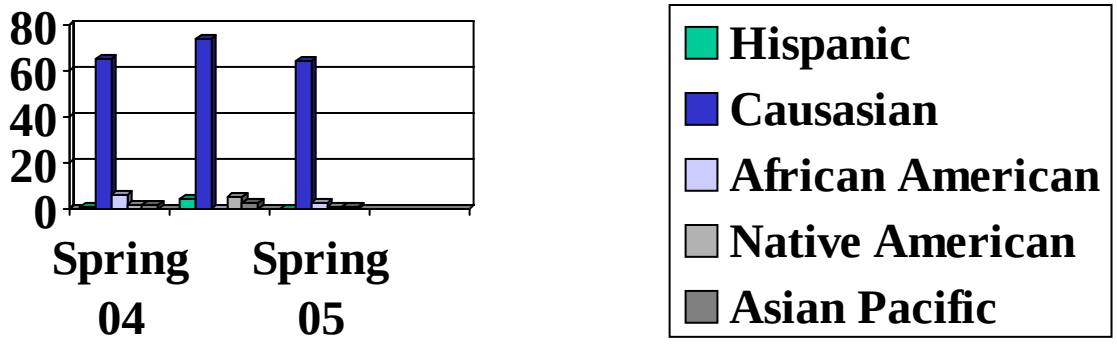
Snohomish County Demographics: Referral Source



Snohomish County Demographics: Gender and Age

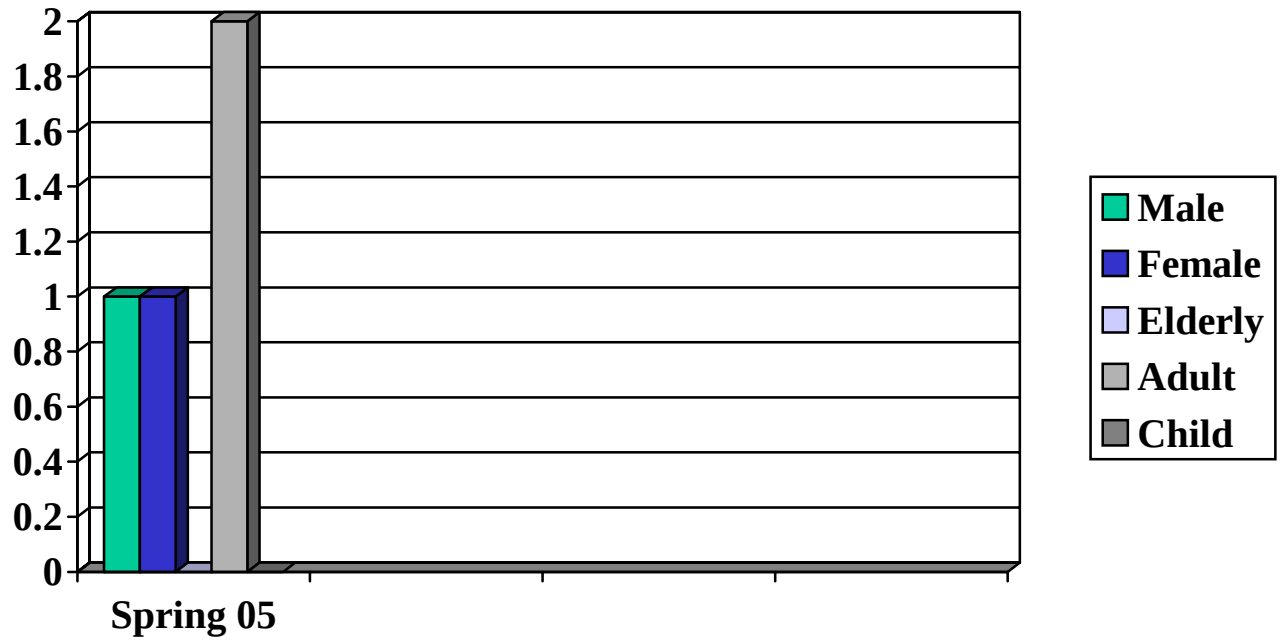


Snohomish County Demographics: Ethnicity

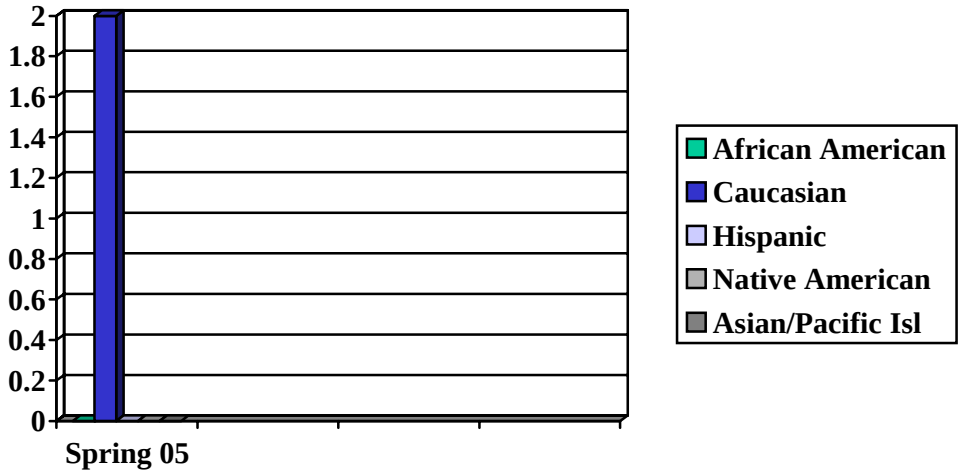


San Juan County Demographics: Referral Source

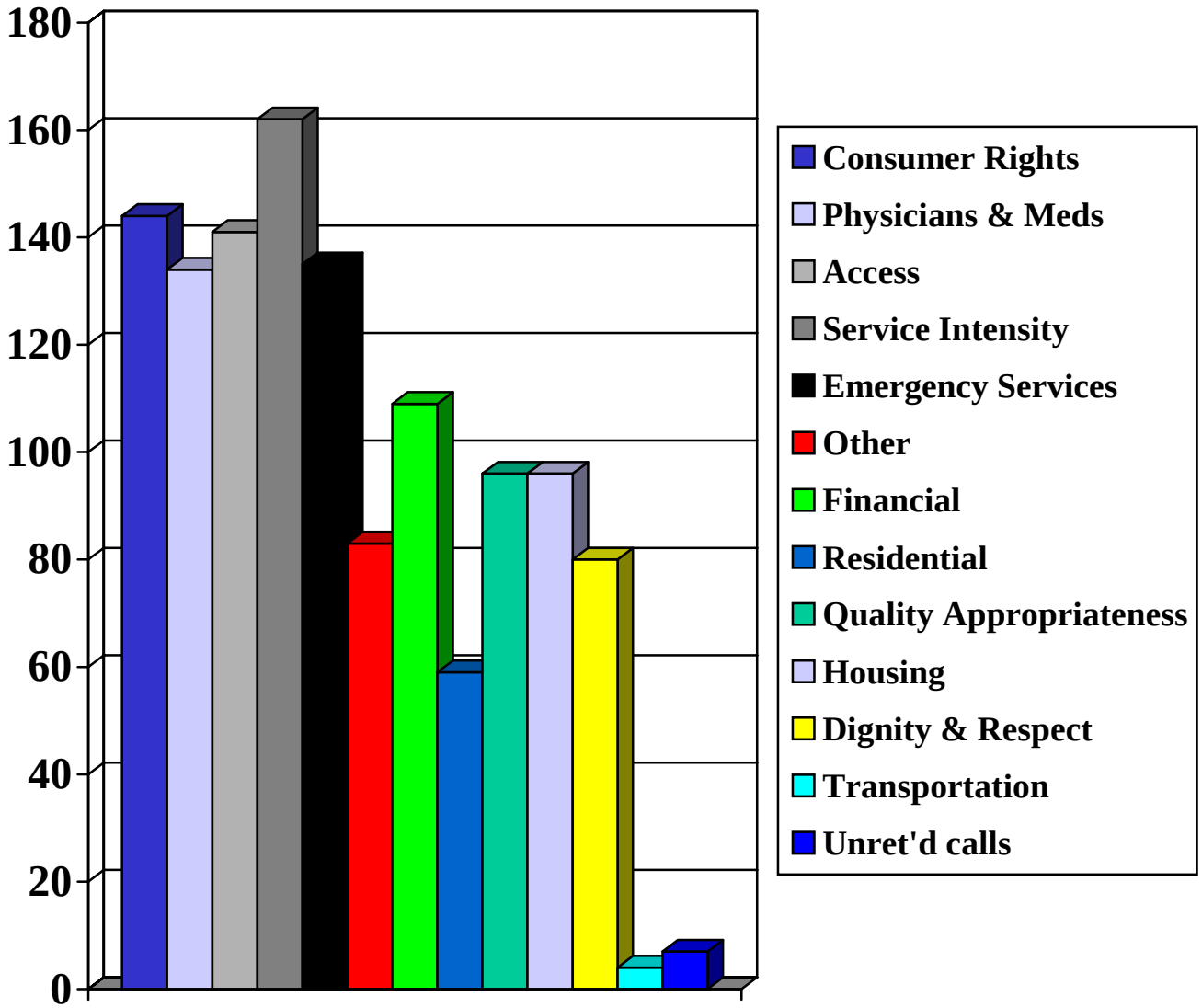
San Juan County Demographics: Gender and Age



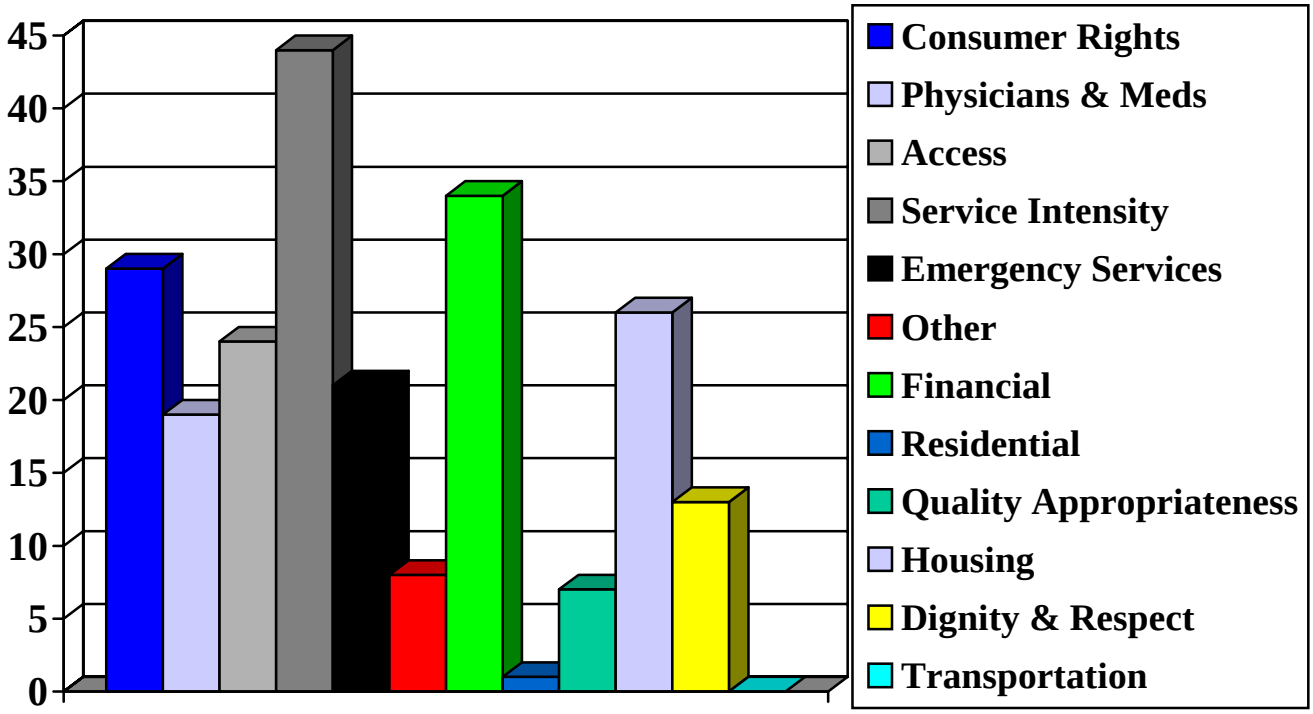
San Juan County Demographics: Ethnicity



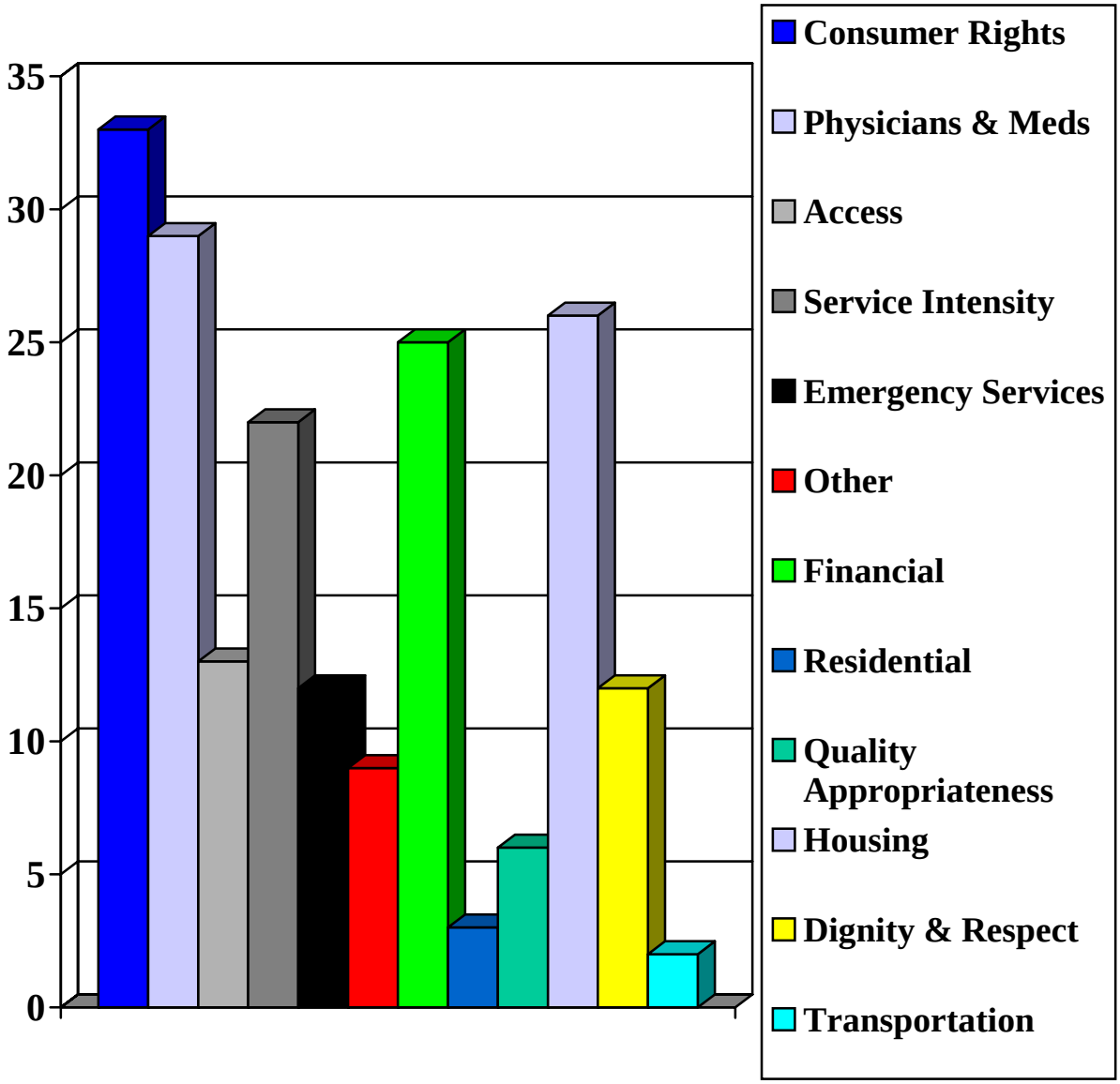
Overall Ombuds Complaints, Spring 2002 to Spring 2005



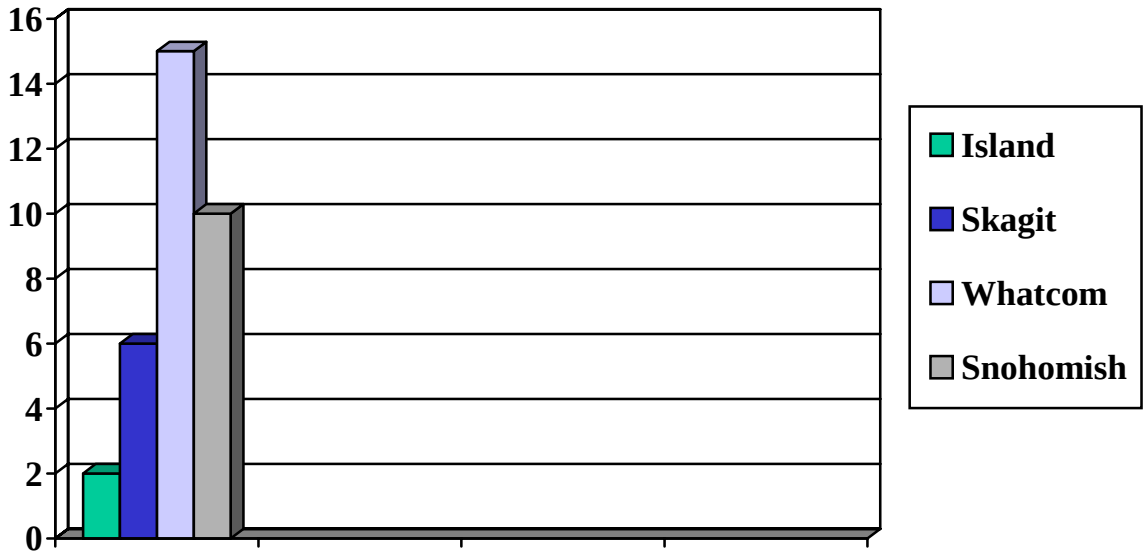
Ombuds Complaints, Fall 2004



Ombuds Complaints, Spring 05



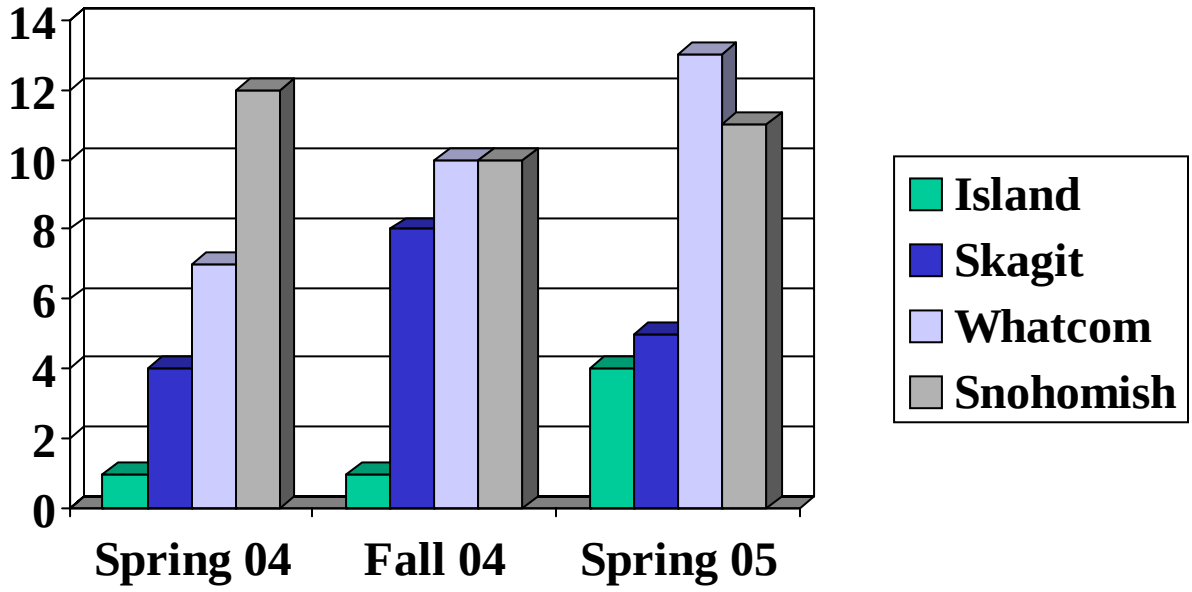
Complaints Not Involving Public Mental Health Provider Agencies



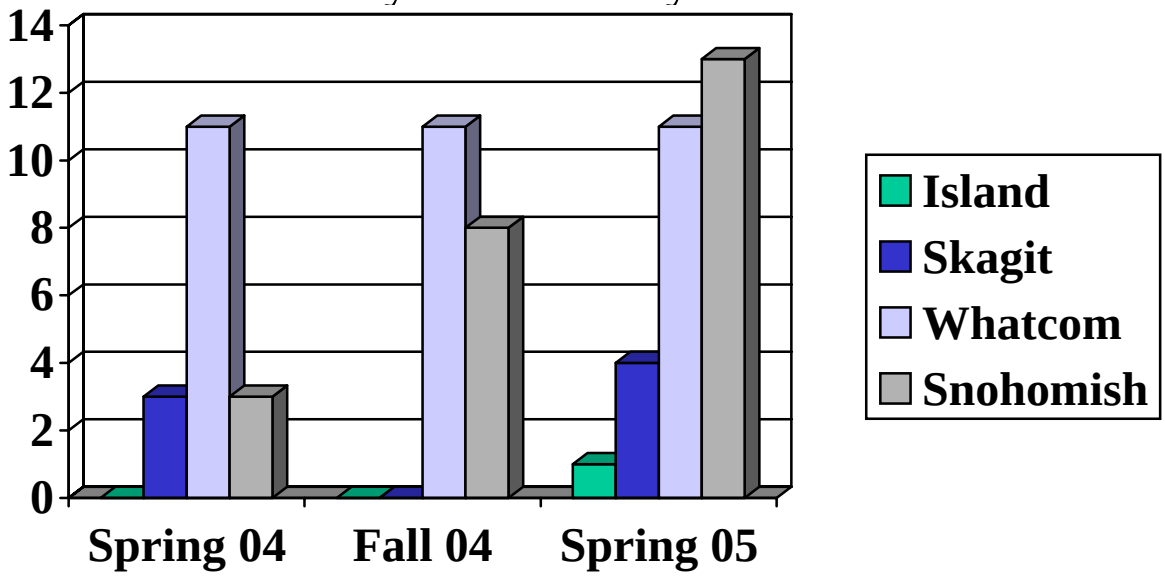
Complaints Not Involving Public Mental Health Providers

- **Island:** Hospital: 1, Jail: 1,
- **Skagit:** SSA: 2, CSO: 2, DDD: 1, PCP: 1,
- **Whatcom:** CSO: 1, Housing Auth: 4, PCP: 2, Hospital: 1, DDD: 1, Payee: 3, Criminal Justice: 2, Medicaid Trans: 1
- **Snohomish:** DDD: 1, Hospital: 4, Jail: 1, CSO: 1, SSA: 1, Housing Auth: 1, Adult Fam Home: 1

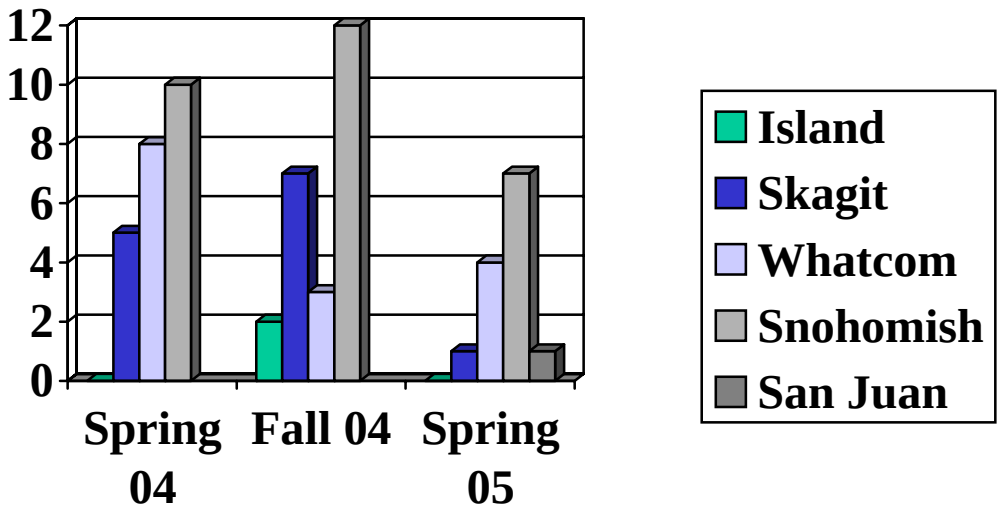
Consumer Rights Complaints by County



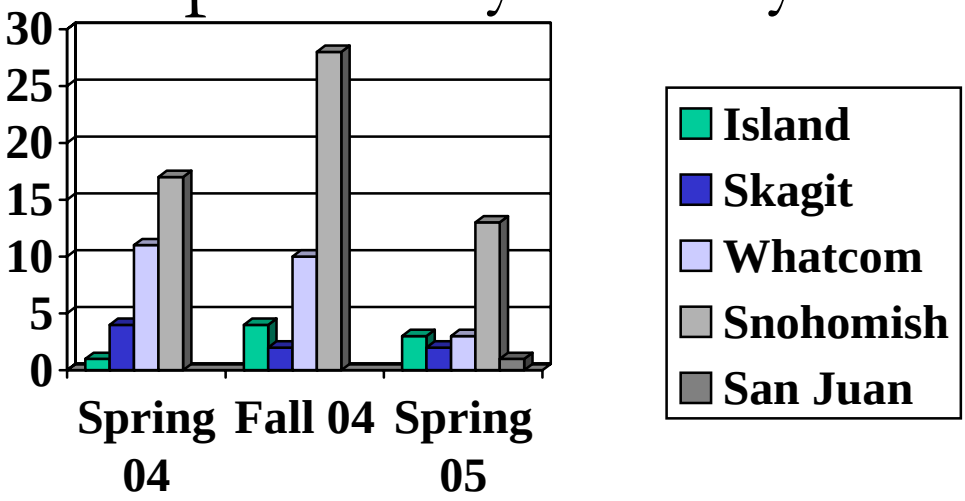
Physicians & Meds Complaints by County



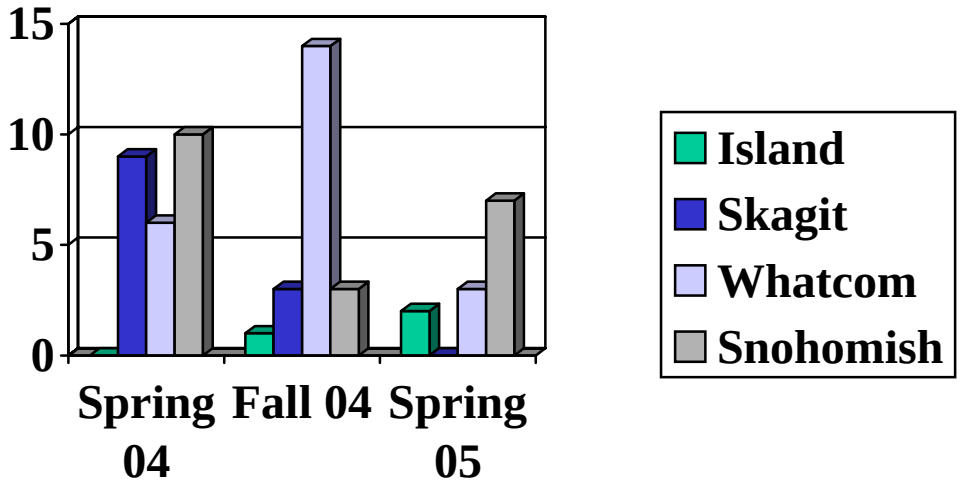
Access Complaints by County



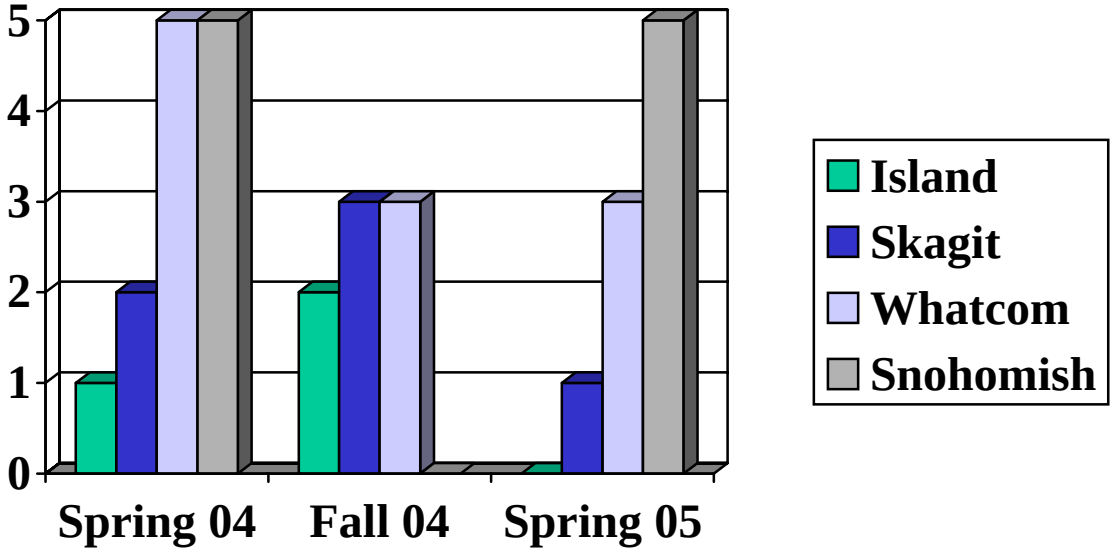
Service Intensity Complaints by County



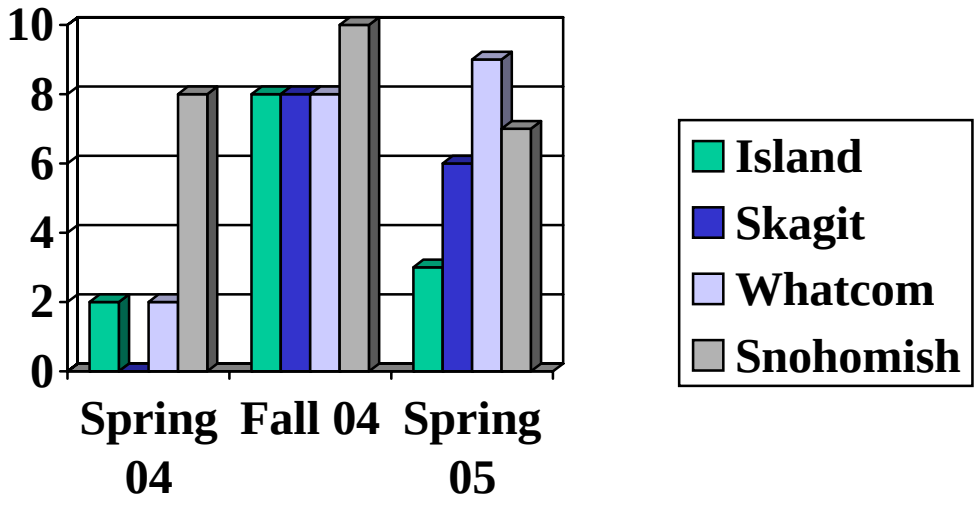
Emergency Services Complaints by County



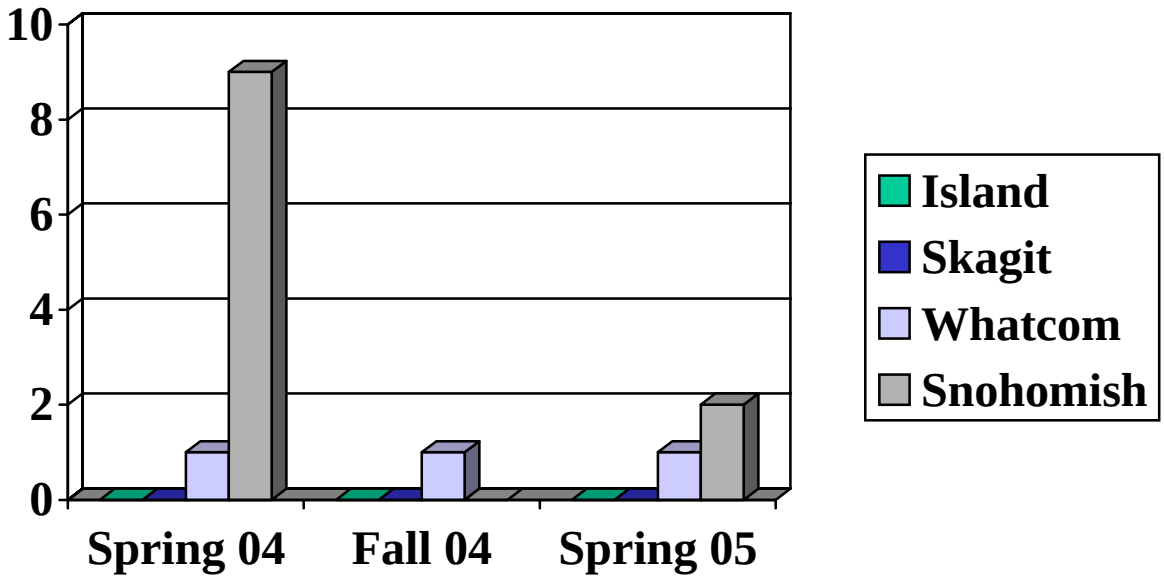
"Other" Complaints by County



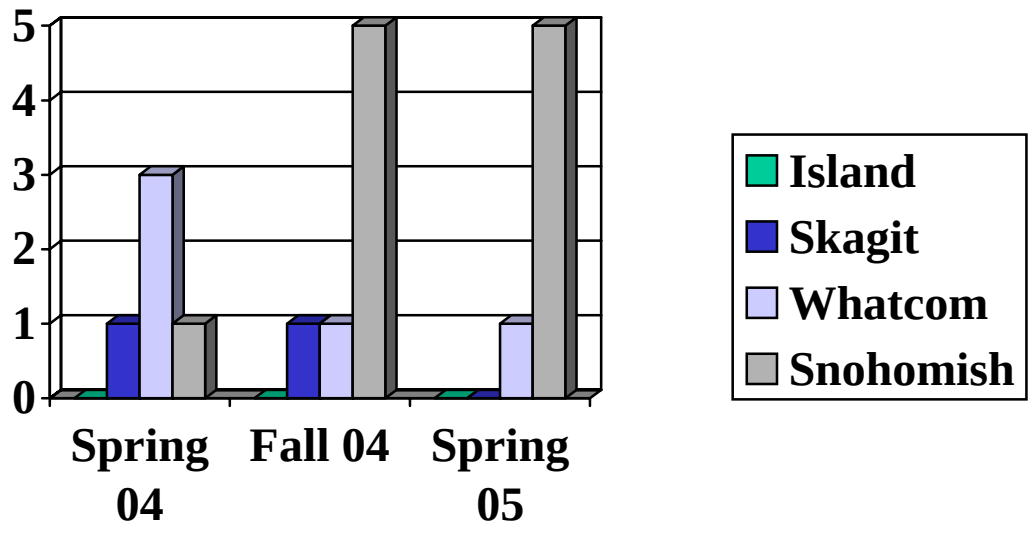
Financial Complaints by County



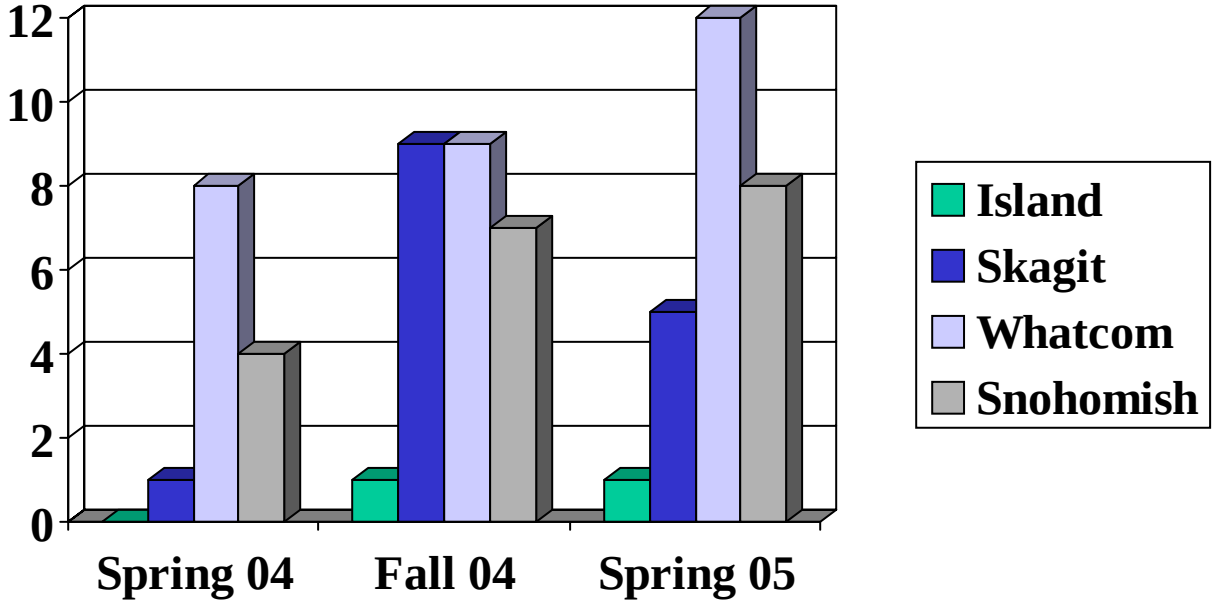
Residential Complaints by County



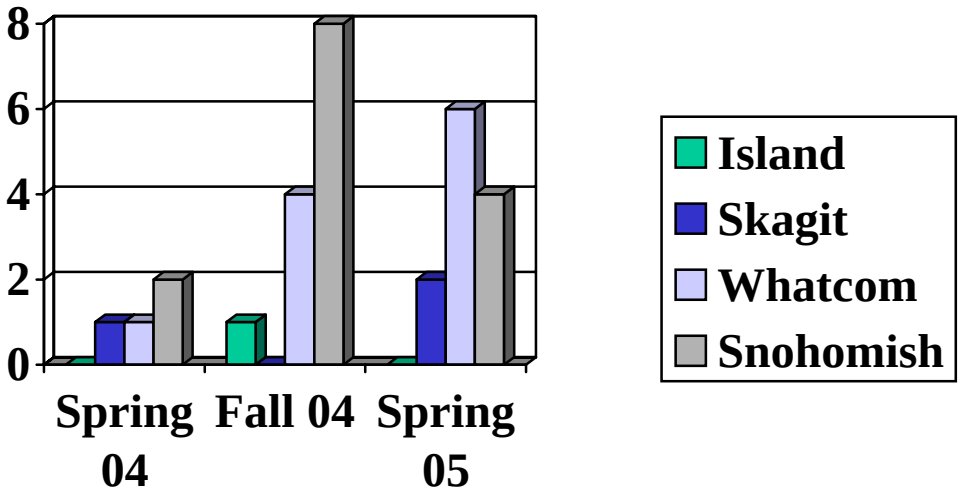
Quality Appropriateness Complaints by County



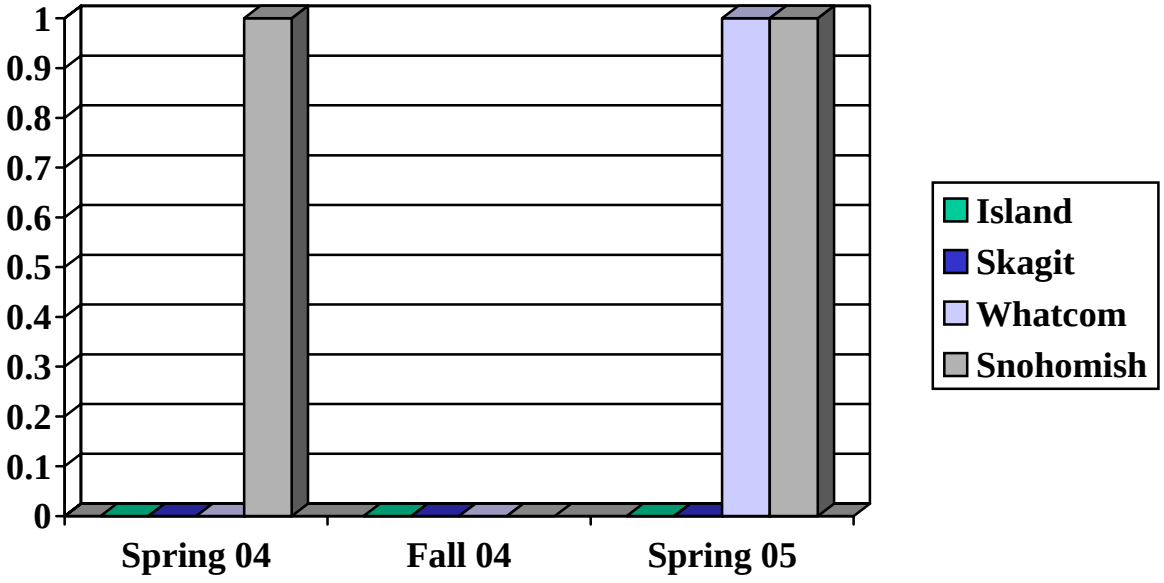
Housing Complaints by County



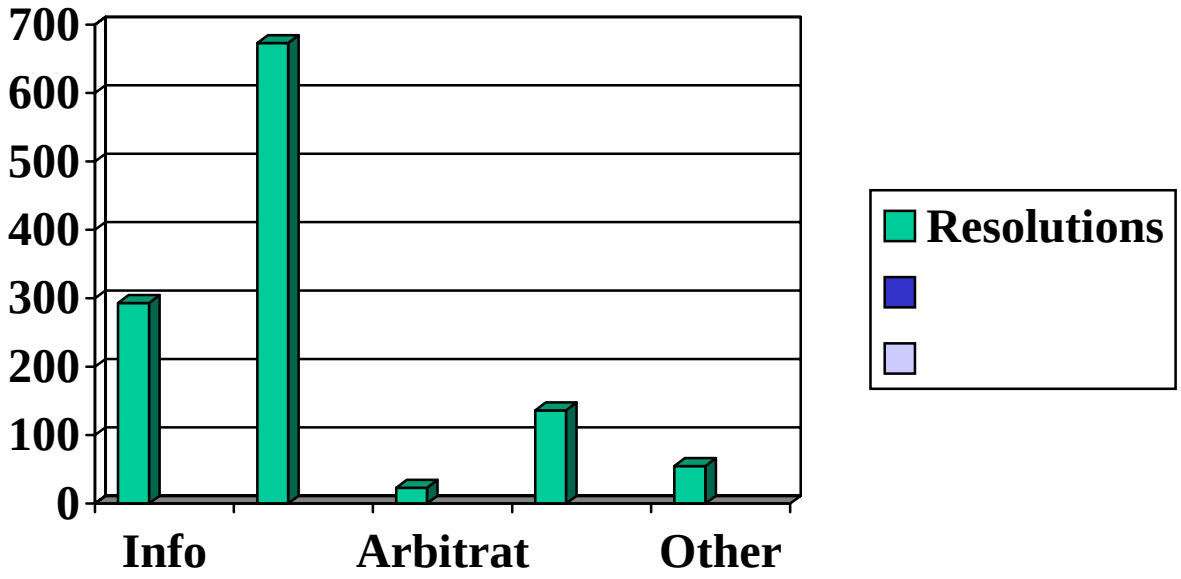
Dignity & Respect Complaints by County



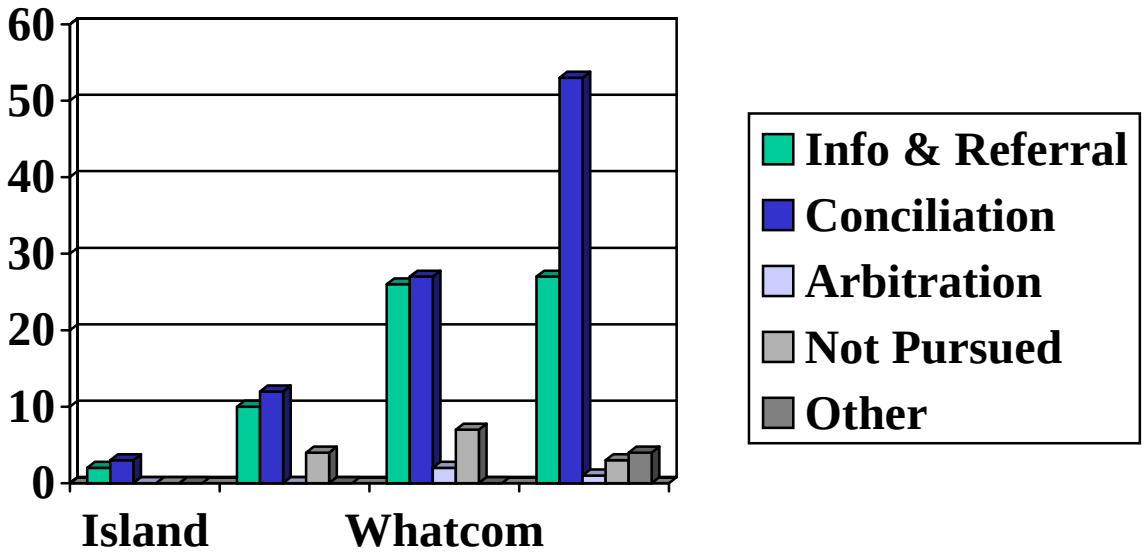
Transportation Complaints by County



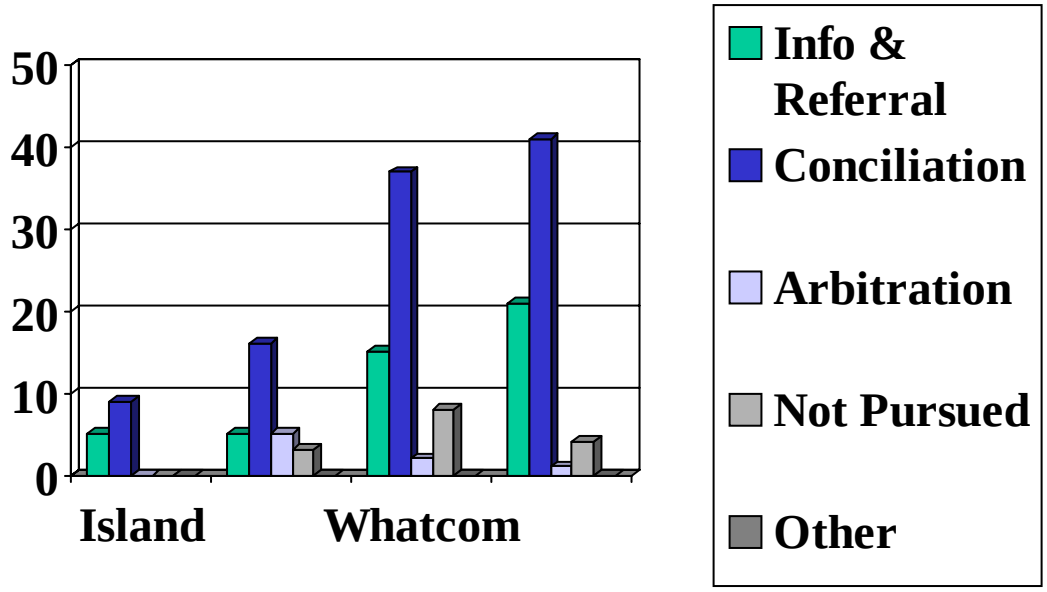
Overall Types of Resolutions Since Spring 2002



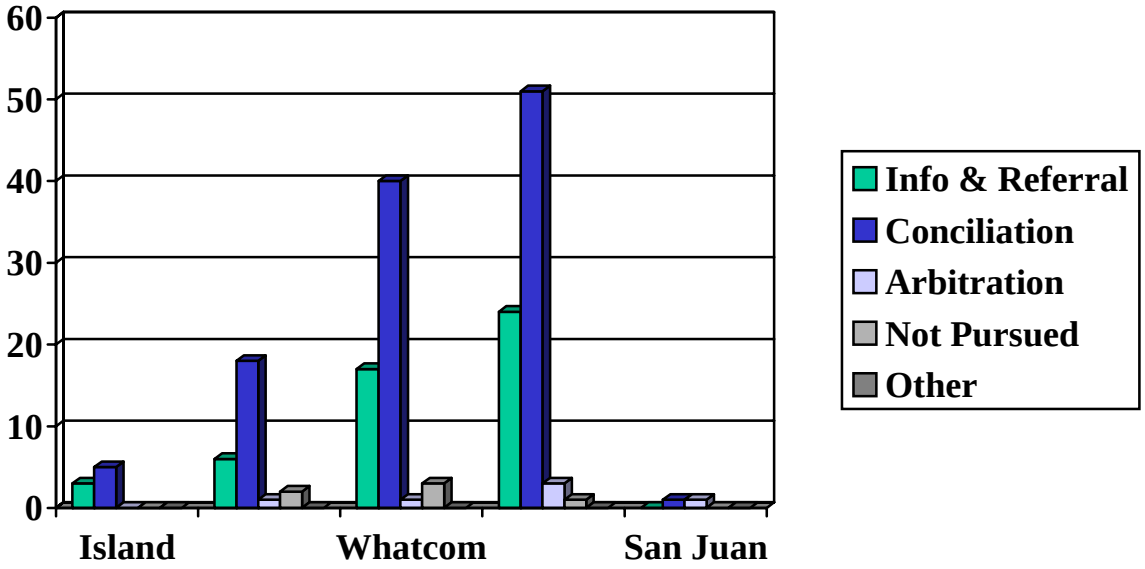
Resolution Types by County, Spring 2004



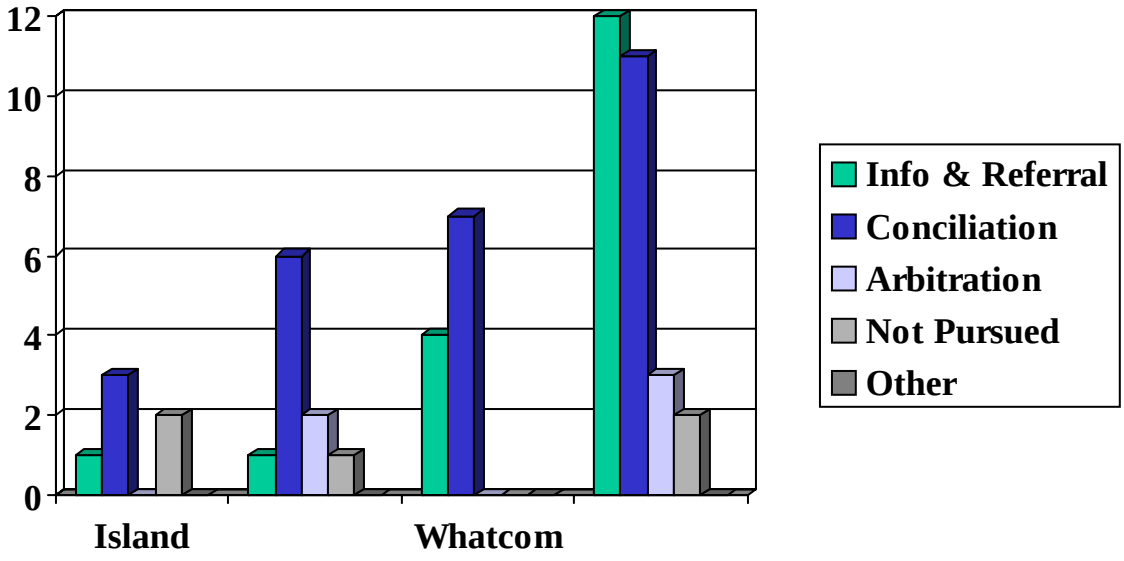
Resolution Types by County, Fall 2004



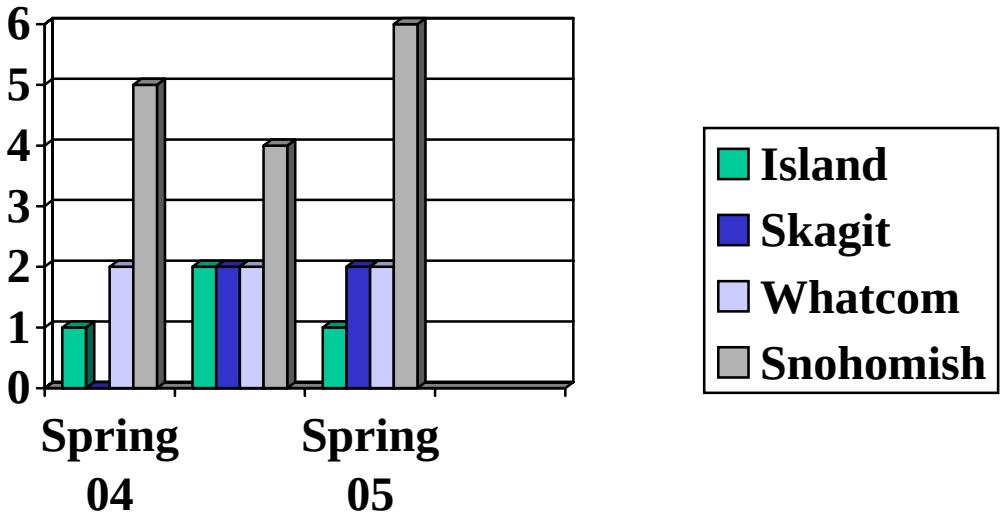
Resolution Types by County, Spring 2005



Resolution of Open Cases from Fall, 2004



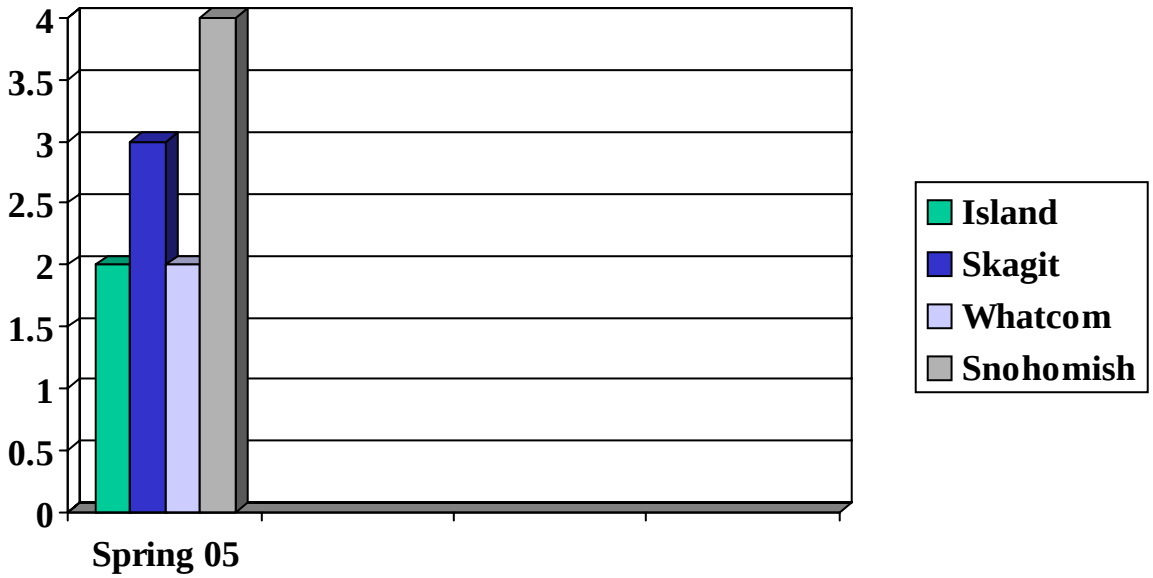
Complaints Involving Children



Complaints Involving Children, Since Spring 2004

- **Island**: Consumer rights: 2, Dignity & respect: 1, Housing: 1
- **Skagit:** Access: 1, Consumer rights: 1, Services Intensity: 1, Consumer Rights: 1
- **Whatcom:** Quality App: 1, Access: 1, Services Intensity: 2, Consumer Rights: 1 Physicians & Meds: 1
- **Snohomish:** Access: 2, Services Intensity: 8, Phys & Meds: 1, Quality appropriateness: 2, Consumer Rights: 1, Residential: 1

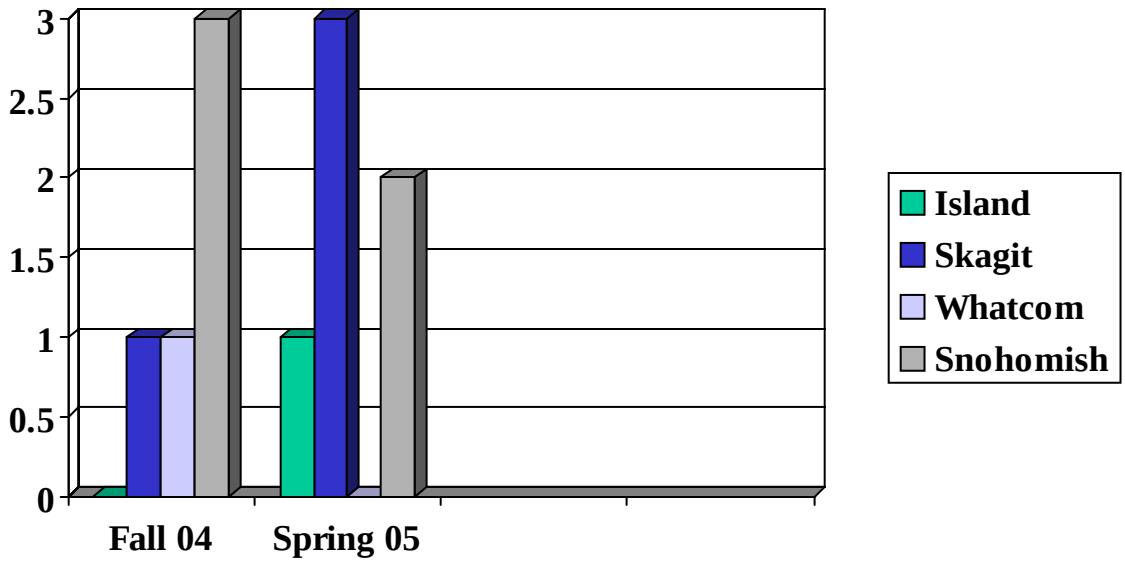
Complaints Involving Seniors



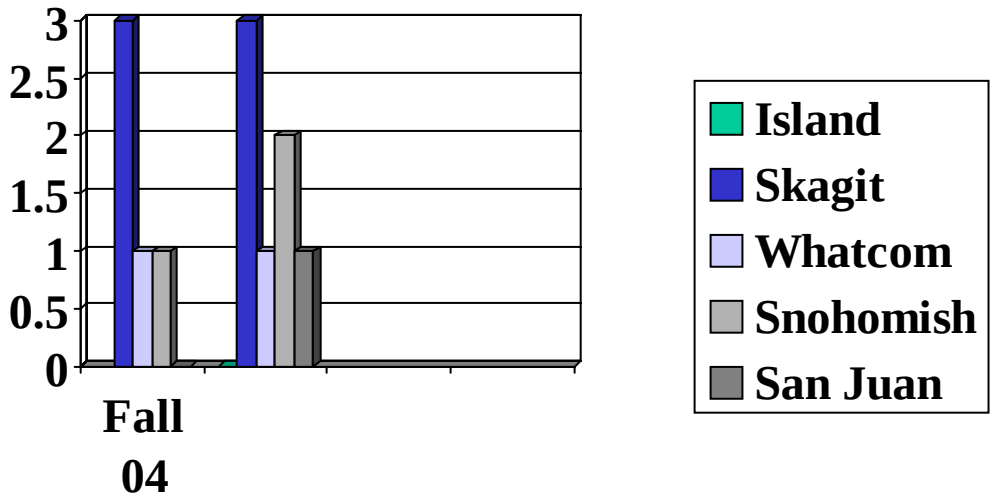
Complaints Involving Seniors

Island: Financial: 1, Emergency Services: 1
Skagit: Financial: 2, Housing: 1
Whatcom: Financial: 1, Housing: 1
Snohomish: Housing: 2, Consumer Rights: 1, Physicians & Meds: 1

APPEALS to denial of Access



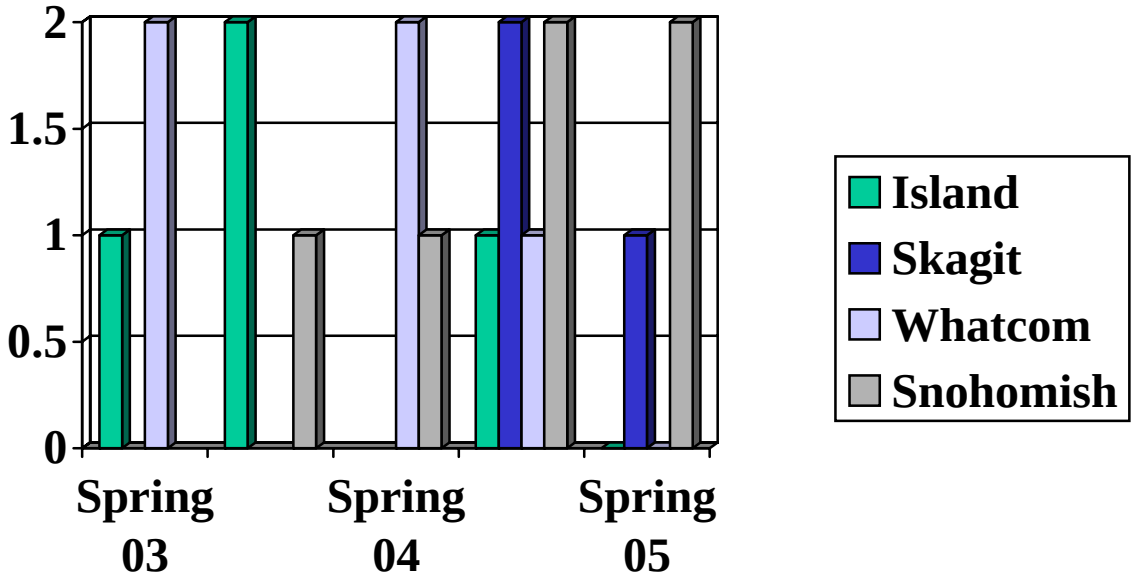
Provider Grievances



Provider Grievances, Since Fall 2004

- **Island:** 0
- **Skagit:** Access: 2, Financial: 2, Consumer Rights: 1, Housing: 1
- **Whatcom:** Dignity/Respect: 1, Housing: 1
- **Snohomish:** Access: 1, Dignity & Respect: 1, Physicians & Meds: 1
- **San Juan:** Services Intensity: 1

RSN Grievances



Overall RSN Grievances

- **Fall 02:** Type Unknown: 1
- **Spring 03:** Quality Appropriateness: 1, Consumer Rights: 1, Physicians & Meds: 1
- **Fall 03:** Dignity & Respect: 1, Other: 1, Housing: 1
- **Spring 04:** Financial: 1, Emerg Svs: 1, Residential: 1
- **Fall 04:** Emerg Svs: 1, Svs Intensity: 3, Qual App: 2
- **Spring 05:** Svs Intensity: 1, Emerg Svs: 1, Access: 1

Fair Hearings

- **Fall 2004:** 1, Type: Emergency Services, County: Snohomish, Status: Judge refused to hear.
- **Spring 2005:** None

Organizations Worked With Since Spring 2004

- CPS & Foster Care: 17 cases
- Chemical Dependency Services: 26 cases
- DSHS Community Service Office: 26 cases
- Criminal Justice: 21 cases
- Developmental Disabilities: 22 cases
- Doctors & Hospitals: 40 cases

Organizations Worked With Since Spring 2004 (cont'd)

- Senior Services: 9 cases
- Social Security Administration: 16 cases
- Housing Authority: 18 cases
- Adult Family Homes: 4 cases
- Lawyers and Courts: 6 cases

Organizations Worked With Since Spring 2005 (cont'd)

- Hospice: 1
- Rehab Centers: 2
- Private Protective Payees: 4
- MAA: 5
- Missions: 5
- Schools: 1

NSMHA COMMITTEE DISCUSSION FORM

AGENDA ITEM: **NSMHA Critical Incident Review Committee Report**

PRESENTER: **Ms. Debra Jaccard, NSMHA Quality Specialist**

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

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:
Presentation of the NSMHA Semi-annual Critical Incident Report for July through December 2004.

The presentation will include an overview of:

- Critical Incident Data
- Review of previous recommendations
- Next steps for using critical incident data for continuous quality improvement

CONCLUSIONS/RECOMMENDATIONS:
N/A

TIMELINES:
July through December 2004

ATTACHMENTS:
Semi-annual Critical Incident Report

NSMHA Semi-annual Critical Incident Report – JULY through DECEMBER, 2004
EXECUTIVE SUMMARY

PURPOSE

- To inform NSMHA Executive Board and Executive Director, county coordinators, CIRC, QMC, QMOC and other interested stakeholders in the region about critical incident data and activities on a semi-annual basis

HIGHLIGHT OF CI DATA FROM JULY THROUGH DECEMBER, 2004

- There were a total of 132 incidents reported for July through December of 2004
- This is down from a total of 156 incidents reported for the same period in 2003
- Comparing quarterly data starting July 2003, there appears to be a seasonal increase in incidents in the first quarter of the year (January-March) in numbers of incidents and number of deaths

CRITICAL INCIDENT REVIEW UPDATES

- The CIRC reviewed all 132 reported incidents and all provider critical incident reviews
- The CIRC also referred critical incidents to NSMHA utilization management staff for further review and requested that NSMHA staff perform quality improvement reviews on selected incidents.
- The CIRC and providers have continued to move towards utilizing data and information about critical incidents as opportunities for quality management at all levels of the system (within a program, within a provider, county wide, or region wide). The CIRC continues to collaborate with providers to create a "no-blame" environment in which all information about critical incidents can be used to identify continuous quality improvement at all levels of the system.
- The NSMHA continues to report critical incidents with the potential for negative media involvement to the NSMHA Board Chair, county coordinators and the WA State Mental Health Division, including a written fax to accompany the required two hour phone in requirement.
- A root cause analysis was conducted on a focused review that had system-wide policy improvements for both the North Sound and Mukilteo E & T's.

UPDATE ON CRITICAL INCIDENT REPORT-QUALITY MANAGEMENT RECOMMENDATIONS AND REVIEW ACTIVITIES

- The review of clinical records that involve the death of those 50 years of age and younger has continued to be postponed due to NSMHA staffing limitations until the 3rd biennial quarter of 2005.
- Due to a review of one particular incident CIRC has made a recommendation to ICRS for the development of a region wide policy to allow for the increased use of collateral contacts in next day appointments and walk-ins to facilitate safety and continuity of care
- Implementation of revised CIRC database at NSMHA effective 1/1/05. The new database will better allow staff to use data to monitor trends in types of incidents, cluster issues and help to assist in following reporting requirements to MHD regarding negative media events.
- The CIRC continues to be active in spearheading new ways utilize Critical Incident data to best facilitate quality improvements activities for the benefit of clients in the NSMHA region.

NORTH SOUND MENTAL HEALTH ADMINISTRATION
SEMI-ANNUAL CRITICAL INCIDENT REPORT
JULY THROUGH DECEMBER 2004

I. INTRODUCTION AND PURPOSE

This is the NSMHA semi-annual Critical Incident Report for the period of July 1, 2004 through December 31, 2004. These reports are provided to county coordinators, the Critical Incident Review Committee (CIRC), QMC, QMOC and other interested stakeholders for the purpose of quality management activities.

This report will:

- Provide and review the critical incident data for July through December 2004
- Provide retrospective data by quarter starting 7/03 to allow for comparison/trends
- Provide an update of CIRC functions and review activities
- Update previous critical incident report recommendations and review activities
- Outline system developments and plans for further development

II. CRITICAL INCIDENT DATA FOR JULY THROUGH DECEMBER, 2004

Critical incident reporting showed a decrease in the last two quarters of 2004. There were 58 incidents reported for October through December of 2004, 74 incidents for July through September, 91 incidents for April through June, and 89 incidents for January through March, for a total of 570 incidents for 2004.

A review of the historical data shows that critical incident reporting for July through December of 2004 is down from critical incident reporting for July through December of 2003. There were 132 incidents reported for July through December of 2004, as compared with 156 incidents for July through December of 2003. (See Attachments A and B-Table 1 Critical Incident Reported to NSMHA by Type & County 7/1/04-12/31/04 and Table 2-Critical Incidents Reported to NSMHA 7/1/03-9/30/04-By Type and County for a break out of incidents by quarter since July 2003).

The number of reported deaths showed a slight increase for July-September 2004 at 21, but 4th quarter deaths came back down into an average range of around 17 for the period of October-December 2004.

Of the 132 reported incidents for July through December of 2004, 38 were death of a consumer, 56 were injury or illness, 15 were assault, 3 were property damage, and 20 were other. Seventy-four reported incidents occurred in Snohomish County, 33 in Whatcom, 14 in Skagit, 7 in Island, 1 in San Juan County, and 3 in counties outside of the North Sound Region. (See Table 1)

III. UPDATE OF CIRC FUNCTIONS AND REVIEW ACTIVITIES

A. Oversight of Critical Incidents and Provider Critical Incident Review Processes

The CIRC continues to review all reported critical incidents and all provider critical incident reviews either submitted to or requested by the committee.

The CIRC continues to request that specific information be provided in some reviews and that additional information or clarification be provided following reviews.

Examples during this period were:

- Requests for treatment plans and crisis plans,
- Requests for fall prevention protocols
- Requests for plans to decrease the likelihood of similar incidents occurring in the future
- Requests for clarification of needs to increase intensity and frequency of care when required to meet individual client needs
- Requests for review of consumer healthcare
- Requests for clarification about whether identified areas for quality improvement have system implications within the provider and how system implications will be addressed.

B. Additional Critical Incident Review and Quality Improvement Activities

The CIRC referred specific incidents to NSMHA quality management staff for more in depth critical incident reviews. Specific corrections requested related to incidents were made regarding diagnosis & treatment planning, increasing intensity and frequency of services to meet expanding client needs, and new or revised provider protocols to ensure client safety and continuity of care.

The CIRC has also continued to make referrals to NSMHA quality management sub-committees for the purpose of policy development and quality management. To this end CIRC has recommended that the Integrated Crisis Response System (ICRS) take steps to reduce inpatient admissions, review the practice to hold a bed at the Evaluation and Treatment Facility in Snohomish County, and develop a regional protocol that outlines procedures when consumers require detention and there is no inpatient capacity within the region or state. The result of another review resulted in a second recommendation to ICRS for the development of a policy to allow for the increased use of collateral contacts in next day appointments and walk-ins to facilitate safety and continuity of care.

The NSMHA continues to seek to collaborate with county coordinators regarding critical incidents. Based on review of a critical incident, the NSMHA requested the assistance of

County Coordinators to review the use of emergency rooms, for consumers who require involuntary detention, across county lines. The NSMHA also has plans to seek the assistance of a county coordinator regarding crisis system training and coordination.

The CIRC committee also referred critical incidents to the NSMHA utilization management staff for utilization review. CIRC will begin to address any areas identified for quality improvement as a result of these reviews with providers.

In addition to overseeing individual incidents and reviewing individual incidents for system implications, the CIRC also looks for patterns or clusters of incidents that may indicate an area for further review or quality improvement. The NSMHA also maintains the critical incident database to monitor and track aggregate critical incident data. CIRC reviews all semi-annual reports to both monitor critical incidents and identify any trends in the data.

C. Quality Improvement Focus in Critical Incident Review Processes

Continued areas of quality improvement receiving focused attention by CIRC include:

- System implications or issues (program specific, provider, county wide, region wide, etc)
- Barriers to quality improvement
- Additional information or data needed to determine the need for quality improvement and/or potential planning
- Potential areas for quality improvement

D. Reporting Critical Incidents

The NSMHA continues to report critical incidents with the potential for negative media involvement to the Washington State Mental Health Division within 2 hours of knowledge of event. The NSMHA Board Chair, county coordinators and the NSMHA Executive Director are also notified at this time.

The NSMHA has implemented the new contract requirements for critical incident reporting and follow-up to the MHD and has also developed and implemented a format to provide written follow up to the Mental Health Division as part of the implementation of these requirements. This includes an initial telephone call to MHD within the required 2 hours period a brief follow-up fax to confirm the telephone call with the basic facts known at the time. Two weeks later after a formal provider review is submitted to NSMHA from providers, a written follow-up report is submitted to MHD with systems recommendations from providers when noted to prevent further similar instances from occurring in the future.

IV. PREVIOUS CRITICAL INCIDENT REPORTS- QUALITY MANGEMENT RECOMMENDATIONS and REVIEW ACTIVITIES

A. Further Study and Review of the Critical Incidents that Involve Death

As outlined in previous reports, a chart review tool has been designed to look at the records of those 50 and younger that die of natural causes, accidents, or where the cause of death is unclear. The purpose of this review is to further study the deaths of these adults in the region to see what we can learn about these deaths. The chart review tool has been piloted. Revisions were made to the tool based on the pilot. Implementation of the review is scheduled for the third biennial quarter, as staffing shortages and temporary reassignments have limited the department's resources.

B. Incorporating Quality Improvement Questions in Both Provider and NSMHA Critical Incident Reviews

As outlined in previous reports, the NSMHA has developed and begun using a quality review tool for internal use that incorporates the quality improvement questions outlined above. Some providers have begun to use this tool and others have incorporated quality improvement questions into their review tools. Although there continues to be variability between and within providers concerning the degree to which quality improvement is incorporated into the review process, there has been increased focus towards incorporating quality improvement questions into provider review processes.

OUTCOMES: Quality improvement questions are currently being used region wide and have resulted in more thorough reviews that address implications for system-wide quality improvement activities for each provider.

C. Incorporating Risk Assessment, Safety Planning, and Triage Into the Regional Crisis Respite Protocols When Consumers Discharge from Crisis Respite Facilities

As outlined in the last report, CIRC reviewed several incidents and provider reviews that highlighted a need for more clear protocols regarding risk assessment, safety planning and triage for consumers who discharge from crisis respite facilities. The NSMHA ICRS committee has reviewed and revised the crisis respite protocols. The crisis respite protocols now outline more clearly how risk assessment, safety planning and triage will occur for consumers who discharge from crisis respite facilities.

OUTCOMES: Fewer incidents regarding client safety regarding post-DC from crisis beds.

D. Critical Incidents at Evaluation and Treatment Facilities

1) The pattern of Critical Incidents at the Evaluation and Treatment Facilities (E&Ts) was identified by CIRC as an area for further study and review. A corrective action plan was instituted and including the use of contracted staff to meet required staffing levels, concerns regarding onsite critical incident occurrences, and reliance on local law enforcement staff to provide security.

OUTCOMES: Reduced incidents regarding restraint and seclusion

2) An additional Root Cause Analysis (RCA) from an incident in October 2004 resulted in system-wide improvements at both E & T's surrounding staff training, improving available medical equipment on sites and staff communication strategies.

OUTCOMES: NSMHA will continue to monitor results of implementation of system-wide improvements, but no similar incidents have been reported to date.

E. Review and Analysis of Washington State Coalition Against Domestic Violence 2002 Fatality Review Findings and Recommendations

As outlined in the last report, the NSMHA performed a sequential Root Cause Analysis (RCA) of a critical incident. As a part of this review, the NSMHA and providers researched the Washington State Coalition Against Domestic Violence 2002 Fatality Review Findings and Recommendations and selected several of the mental health recommendations for further analysis. The NSMHA also referred one of the reports recommendations to the NSMHA Integrated Crisis Response System (ICRS) Committee. Further work on this topic is pending through the ICRS committee.

OUTCOMES: A policy regarding mental health assessment and domestic violence is still being formulated and is forthcoming.

V. SYSTEM DEVELOPMENTS/FUTURE PLANS

The NSMHA continues to work to refine and update the critical incident processes in the NSMHA. At the request of county coordinators, the NSMHA developed a critical incident flow chart that clarifies the current critical incident processes (See Attachment D-NSMHA Critical Incident Flow Chart).

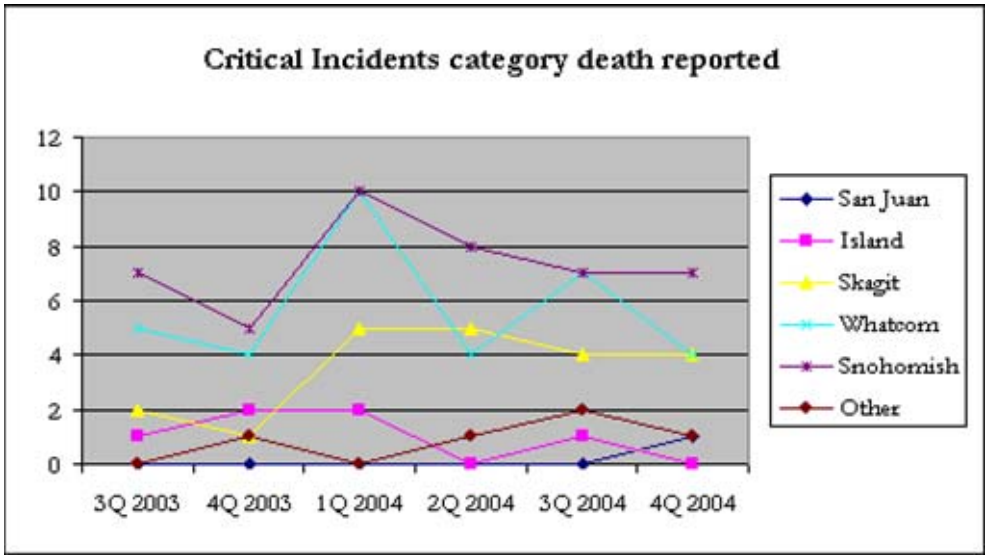
Although there have been many refinements to the critical incident system there are plans for continued development. As outlined in previous reports, areas for continued development include:

- Transitioning to the new critical incident database
- Creating focused semi-annual critical incident reports
- Updating critical incident report forms and refining critical incident definitions
- Developing a process to identify quality improvement questions to be included in both provider and NSMHA reviews
- Increasing discussion and collaboration with county coordinators and addressing the needs identified by county coordinators (including the need for all critical incidents with the potential for negative media to be reported in a timely manner, possible variances in provider reporting styles of critical incidents, and relaying information to county coordinators if trends are identified in their county)
- Collaborating with providers to create a "no-blame" environment in which information about critical incidents can be used to identify continuous quality improvement at all levels of the system
- Enhancing the role of the NSMHA medical director in the critical incident review process

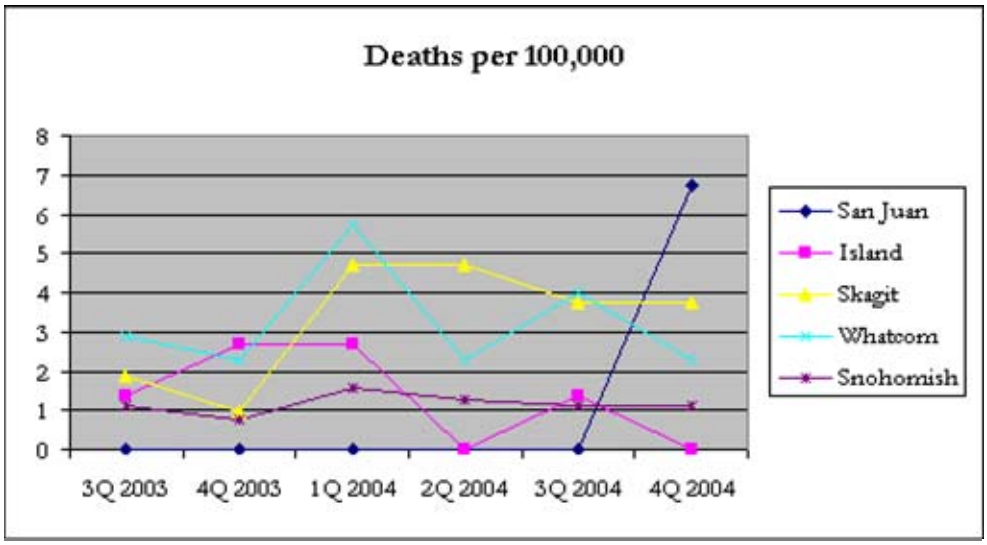
As 2005 progresses the Critical Incident Review Committee will, as part of the NSMHA Quality Improvement program, continue to identify and refine its process to review the critical incident system and the components outlined above.

Deaths per Quarter from July 2003 through December 2004

	3Q 2003	4Q 2003	1Q 2004	2Q 2004	3Q 2004	4Q 2004
San Juan	0	-	0	0	0	1
Island	1	2	2	0	1	0
Skagit	2	1	5	5	4	4
Whatcom	5	4	10	4	7	4
Snohomish	7	5	10	8	7	7
Other	0	1	0	1	2	1

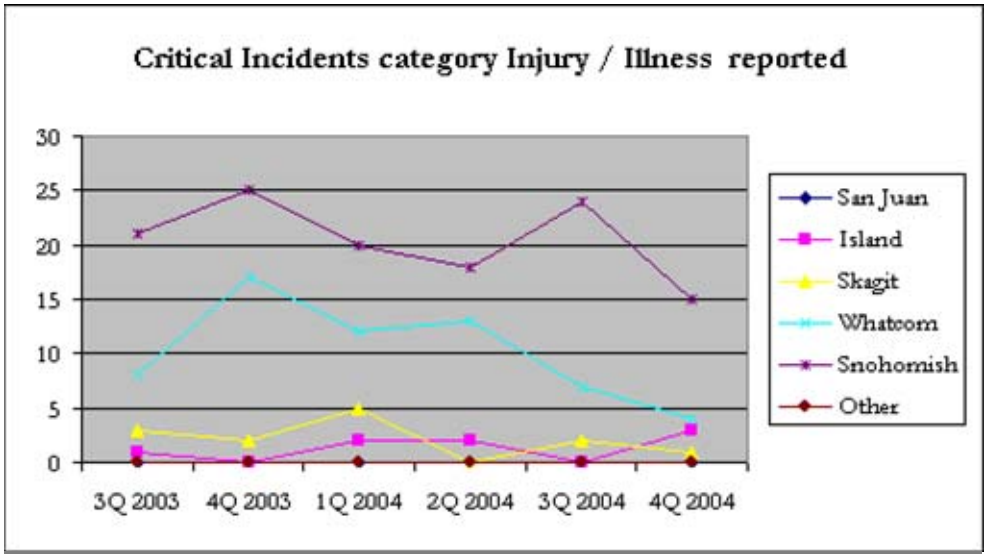


	3Q 2003	4Q 2003	1Q 2004	2Q 2004	3Q 2004	4Q 2004
San Juan	0.00	0.00	0.00	0.00	0.00	6.76
Island	1.35	2.70	2.70	0.00	1.35	0.00
Skagit	1.87	0.94	4.69	4.69	3.75	3.75
Whatcom	2.87	2.29	5.73	2.29	4.01	2.29
Snohomish	1.10	0.78	1.57	1.25	1.10	1.10
Other	0.00	0.00	0.00	0.00	0.00	0.00

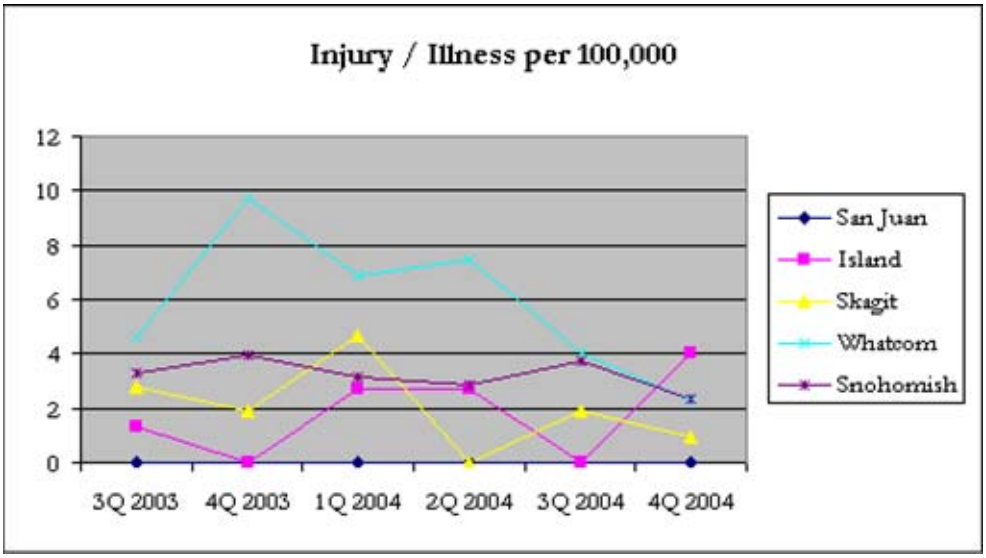


Injury/Illness/Quarter from July 2003 through December 2004

	3Q 2003	4Q 2003	1Q 2004	2Q 2004	3Q 2004	4Q 2004
San Juan	0	-	0	0	0	0
Island	1	-	2	2	0	3
Skagit	3	2	5	0	2	1
Whatcom	8	17	12	13	7	4
Snohomish	21	25	20	18	24	15
Other	0	-	0	0	0	0

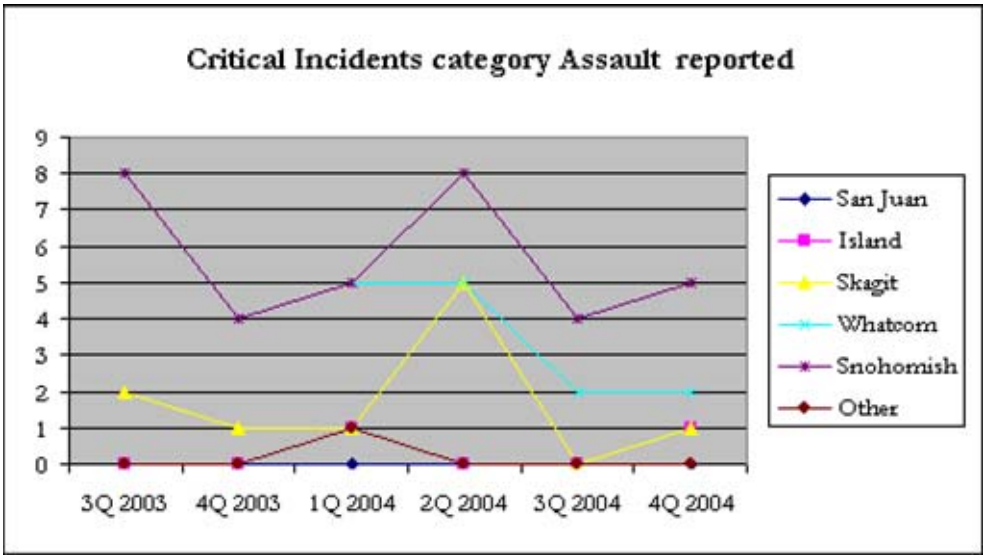


	3Q 2003	4Q 2003	1Q 2004	2Q 2004	3Q 2004	4Q 2004
San Juan	0.00	0.00	0.00	0.00	0.00	0.00
Island	1.35	0.00	2.70	2.70	0.00	4.05
Skagit	2.81	1.87	4.69	0.00	1.87	0.94
Whatcom	4.58	9.74	6.88	7.45	4.01	2.29
Snohomish	3.29	3.92	3.14	2.82	3.76	2.35
Other	0.00	0.00	0.00	0.00	0.00	0.00

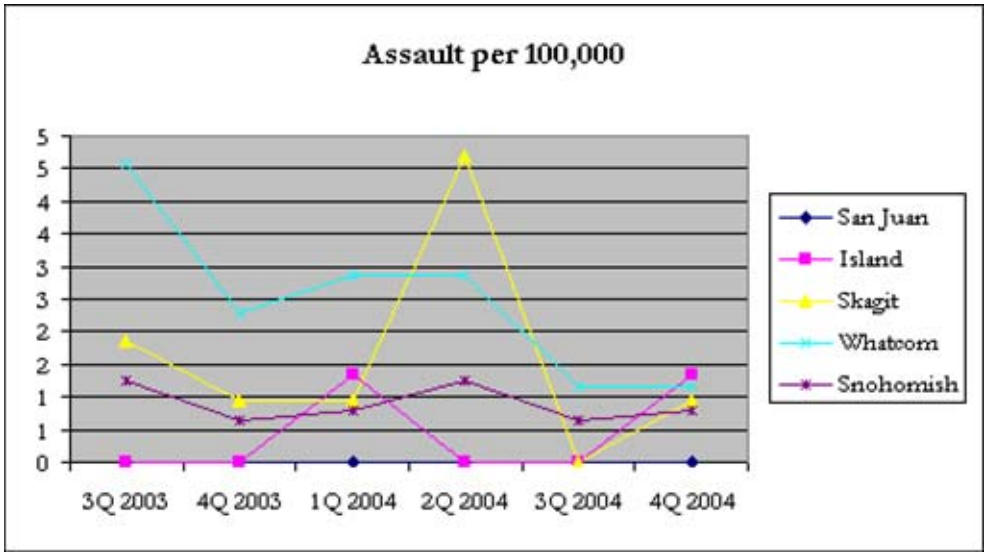


Assaults per Quarter from July 2003 through December 2004

	3Q 2003	4Q 2003	1Q 2004	2Q 2004	3Q 2004	4Q 2004
San Juan	0	-	0	0	0	0
Island	0	-	1	0	0	1
Skagit	2	1	1	5	0	1
Whatcom	8	4	5	5	2	2
Snohomish	8	4	5	8	4	5
Other	0	-	1	0	0	0



	3Q 2003	4Q 2003	1Q 2004	2Q 2004	3Q 2004	4Q 2004
San Juan	0.00	0.00	0.00	0.00	0.00	0.00
Island	0.00	0.00	1.35	0.00	0.00	1.35
Skagit	1.87	0.94	0.94	4.69	0.00	0.94
Whatcom	4.58	2.29	2.87	2.87	1.15	1.15
Snohomish	1.25	0.63	0.78	1.25	0.63	0.78
Other	0.00	0.00	0.00	0.00	0.00	0.00



Property Damage per Quarter – July 2003 – December 2004

	3Q 2003	4Q 2003	1Q 2004	2Q 2004	3Q 2004	4Q 2004
San Juan	0	-	0	0	0	0
Island	0	-	0	1	0	0
Skagit	1	-	1	1	0	1
Whatcom	0	1	1	1	1	0
Snohomish	1	-	1	1	0	1
Other	0	-	0	0	0	0

	3Q 2003	4Q 2003	1Q 2004	2Q 2004	3Q 2004	4Q 2004
San Juan	0.00	0.00	0.00	0.00	0.00	0.00
Island	0.00	0.00	0.00	1.35	0.00	0.00
Skagit	0.94	0.00	0.94	0.94	0.00	0.94
Whatcom	0.00	0.57	0.57	0.57	0.57	0.00
Snohomish	0.16	0.00	0.16	0.16	0.00	0.16
Other	0.00	0.00	0.00	0.00	0.00	0.00