NORTH SOUND
MENTAL HEALTH ADMINISTRATION

QUALITY MANAGEMENT OVERSIGHT COMMITTEE

COMMITTEE MEETING PACKET

June 28, 2006

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

Draft June 28, 2006
NORTH SOUND MENTAL HEALTH ADMINISTRATION
QUALITY MANAGEMENT OVERSIGHT COMMITTEE AGENDA

Date: June 28, 2006
Time: 12:30-2:30 PM
Location: NSMHA Conference Room
For Information Contact Meeting Facilitator Greg Long, NSMHA, 360-416-7013

Topic	**Objective**	**ACTION NEEDED**	**Discussion Leader**	**Handout available pre-mtg**	**Handout available at mtg**	**Tab**	**Time**
Introductions	Welcome guests, presenters and new members		Chair				5 min
Review and Approval of Agenda	Ensure agenda is complete and accurate, determine if any adjustments to time estimates are needed. Meeting will start and end on time.	Approve agenda	Chair	Agenda			5 min
Review and Approval of Minutes of Previous Meeting	Ensure minutes are complete and accurate	Approve minutes	Chair	Minutes		1	5 min
Announcements	Inform QMOC of news, events and other important items		All				5 min
Comments from the Chair	Update the committee on recent developments that impact QMOC-	Suggestions to improve meeting -	Chair				5 min
Quality Management Department Report	Standing Agenda Item for Monthly Review	Review accomplishments, data and plans of department-	Greg Long		QM Dept. Report	2	Hand out only
Policy Work group	Report from Work group and update on Board action regarding recommendations		Chair				10 min
Policies to be Approved	Policies 1537, 1538, and 1713 need approval	QMOC approval of policies	GREG LONG	Policies 1537, 1538 1713		3	10 min

Ombuds Report	Report from Ombuds	Review and advise	Chuck Davis		Report	3	15 min
MHD report on NSMHA reported deaths and Critical Incident Program	Inform committee as to MHD report	Review and advise	Debra Jaccard	Summary of meeting and report		4	10 min
EQRO Report	Review report	Review and advise	Greg Long				10 min
High Intensity Treatment Work Group Draft Policy and Recommendations	Recommend draft policy for approval	Deferred until named	Debra Jaccard				
Hospital Inpatient Reduction Workgroup	Review recommendations and determine how to incorporate into QM plan	Approve to move forward	Debra Jaccard	Summary of Workgroup		5	10 min
Exhibit N	Review Semi-annual report on complaints and grivevances		Diana Striplin			6	15
QRT Work Plan	Explanation of plan	Review and advise QRT	Deborah Moskowitz				15 min
Date and Agenda for Next Meeting	Ensure meeting date, time and agenda are planned.		All				5 min
*Review of Meeting	Were objectives accomplished? How could this meeting be improved?		All				5 min

Next meeting July 26, 2006

Potential Agenda Items

Draft Integrated Report

NORTH SOUND MENTAL HEALTH ADMINISTRATION
April 26th 2006
Special QMOC Workgroup Meeting – Review of NSMHA Policies per APN's Request

Convene: The workgroup was convened at 9:04 a.m.

Attending: Gary Williams, QMOC Chair, Board of Directors, Human Services Supervisor, Whatcom County; **Karen Kipling,** Care Crisis Response Director, Volunteers of America; **Janet Lutz-Smith,** Whatcom County Advisory Board; **Chuck Davis,** Skagit County Mediation Services Ombuds; **Deborah Moskowitz,** Skagit County Mediation Services Ombuds; **Mary Good,** NSMHA Advisory Board; **Wendy Klamp,** NSMHA Quality Manager; **Mike Manley,** Administrator of Developmental Disabilities LTC/Aging, Mental Health, Snohomish County Human Services; **Dan Bilson,** NSMHA Advisory Board; **Russ Hardison,** Clinic Manager, Sea Mar; **Chuck Albertson,** NSMHA Advisory Board Chair; **Rochelle Clogston,** Chief Administrative Officer, APN; **Nancy Jones,** Community Mental Health Program Supervisor, Snohomish County Human Services; **Maile Acoba,** Skagit County Coordinator; **Susan Ramaglia,** NAMI Skagit; **Dr. June LaMarr,** Tulalip Tribes, **Shannon Solar,** NSMHA

Timekeeper: Janet Lutz-Smith.

Guests: Chuck Benjamin, NSMHA Executive Director; Stacey Alles, Compass Health Quality Manager; Mike Watson, Clinical Director, Lake Whatcom Center, Dr. Keith Brown, NSMHA Medical Director.

Introduction: Gary thanked all for taking the time out to work on this important issue and noted this session could be an important chance to get a refresher course in policies and procedures and better understand their impact on providers and consumers.

Gary added that the purpose of this workgroup is to address APN's concerns that many of NSMHA's policies are excessive beyond State and Federal requirements and have increased the burden and cost for providers. Today this group will review problematic policies identified by the APN to make recommendations to the NSMHA Board of Directors.

Gary noted policies we will be examining are those indicated as a top priority (1) in the policy tracking list which NSMHA staff have reviewed and disagreed with APN. The other policies, identified as (2) are off the table, as NSMHA staff agree there is room for negotiation and will be discussed and changed later. Policies identified as (3) are those which NSMHA staff have examined and agreed with the APN on.

Gary added that if there is specific WAC language that the policy must exist, we can not dispute it. Interpretations are what need to be discussed, and best practice standards that RSN have established in the past are up for discussion.

Rochelle stated the contract between NSMHA or providers states that "*NSMHA policies should not exceed Federal and State requirements, and shall be limited only to such requirement*s". Chuck Davis added the RFQ would be a State requirement. Chuck Benjamin asked to remember context of language in the contract, which states was if there was a federal or state statute, NSMHA policies would not exceed. However, NSMHA's contract with the State requires them to do *continuous quality management* of providers. Chuck Davis added NSMHA is required to flesh out WAC statutes. Gary suggested in order to prevent any delay in the process, guests from APN and the RSN will leave and return in the afternoon.

Karen clarified that there are other providers here than those part of APN. VOA's contract with NSMHA does not have the same language as APN's and VOA has always negotiated with the RSN in good faith. Rochelle noted she will abstain from including all providers in APN's opinions.

POLICY REVIEW

1002.00 Section A

Rochelle gave a brief statement of APN concern: Concern lies with tracking of complaints. Tracking every complaint, even for issues that can be resolved quickly, such as a waiting room being too cold, is an administrative burden which takes up clinician's time.

Wendy gave a brief statement of RSN response: Diana Striplin expert in this complex intersection of WAC, BBA, RFQ, state model contracts and current contracts, prepared this response. The State requires provider reporting of complaints to NSMHA for Exhibit N. The RSN strongly believes in tracking and reporting complaints as an important part of quality management.

Comments: Gary asked Wendy if this is an interpretation by NSMHA staff of the source or if it is a clear requirement from WAC. Wendy answered she believes this to be a clear requirement. Susan stated the consumer voice is the most important voice and she does not want that voice to be edited. Chuck stated he feels this policy and procedure is working exceedingly well, he knows in talking to other Ombuds this region has the best complaint process in the State, and this is important to clients. Deborah added that Ombuds are committed to resolving complaints at the lowest possible level. If we eliminate this policy/procedure, we will be editing consumer voice, which should be allowed to rise to the surface.
Rochelle stated that issues are resolved right away, agencies would not stop listening to consumers or resolving problems, the concern is with the administrative burden of tracking complaints. While the WAC is laid out very clearly for the grievance, not for complaints. Deborah added the issue is also of having consumer voice being heard broadly, needs to be recorded.
Rochelle noted this is a resource issue. Time is taken away from face to face visits and going to paperwork.
Janet asked if there a difference between levels of complaints, as providers shouldn't have to report miniscule things, while they should report complaints related to service. Process. Karen agreed that some level of judgment is needed on low level complaints, there should be some discretion allowed. Wendy noted the State expresses that any level of complaint be recorded. Chuck noted Ombuds takes the majority of complaints and they need the 30 day requirement to stay.
Russ agreed with Karen, stating that Sea Mar wouldn't track a miniscule issue as a complaint.
Dan added if the complaint was immediately resolved, common sense would be that there is no need to track. Rochelle responded the policy states that even if the complaint is minor it needs to be tracked.
Nancy agreed with Dan. Further clarification is needed on the definition of what defines complaints, we need to set a bar of what constitutes a request vs. complaint.

Action: Gary entertained a motion to support this policy, with the caveat that NSMHA and providers re-examine the definition of what defines a complaint and what does not, to possibly streamline the process. Motion carried, seconded, all in favor.

1002.00 Section B

Rochelle gave a brief statement of APN concern: The requirement to send the additional copy to NSMHA as well as the client when the problem is not resolved is the issue. Rochelle noted if the complaint process is amended, there will likely be less problem with this.

Wendy gave a brief statement of RSN response: RSN feels due to current contract/BBA, it is necessary to send letter to consumer.

Comments: Chuck Davis noted he likes the current process as it informs the client what is going on. Wendy noted this is part of contractual requirements with providers. Nancy asked for clarification on why it is a problem-Rochelle noted it is time consuming. Rochelle added if we get a better definition of what is a complaint, sending letters out will be less of a burden. Chuck noted very few complaints are unresolved, the majority are Ombuds complaints. Gary noted this issue may be mitigated by previous discussion, and made a recommendation to support the policy with a caveat will examine definition.

Action: Gary entertained a motion to support the policy with the caveat there is a potential to bundle with previous policy discussion. Motion made, seconded, all in favor.

1002.00 Section C

Rochelle gave a brief statement of APN concern: The requirement to report narrative for the Exhibit N report every six months is excessive.

Wendy gave a brief statement of RSN response: The RSN is required by the State to submit a report for Exhibit N. The RSN does not ask for a lot of information from providers. A specific template used by the State is used, and the information asked for is required.

Comments: Gary asked for clarification on what amount of information is asked for, Wendy noted it is brief, a summary of each category. Rochelle noted it is the issue of time taken to compile the data. Susan asked wouldn't providers want to do this anyhow? Rochelle noted it is a repetitive process. Karen askedif there is a report that APN QA staff are currently doing that could be sent., Rochelle noted there is, but it is data, not narrative. Deborah noted data without explanation is less useful. Russ added Sea Mar's Exhibit N report has always been brief, but acceptable to NSMHA. He also noted individually these requirements seem small, but they add up to a lot.

Action: Gary –entertained a motion to continue the support the policy with the possible caveat that some other activity similar that APN is doing that could replace this reporting, motion made, seconded. Discussion: Chuck stated that Ombuds makes the same summary, but feels good about collecting the information. Motion was made, seconded, all in favor.

1002.00 Section D

Wendy noted this was a technical requirement, a citation correction has been made.
Action: A motion was made to accept the policy, motion seconded, all in favor.

1007.00 Primary Source Verification

Rochelle gave a brief statement of APN concern: APN does complete a thorough review when new employees are brought into the agency to ensure licenses/degrees are valid. The policy (excessively) requires going back to the agency where the license was issued, instead of using common sense in examining given information.

Wendy gave a brief statement of RSN response: The State has requirement to establish uniform credentialing process, although specifics are not given. There have been high-profile cases where doctors/counselors have given false credentials. The page that comes off WA DOH website would be acceptable source of verification.

Comments: Mike noted Snohomish County has run checks on degrees and come across places never heard of, so how far back do we need to check the diploma comes from a legitimate source? Gary asked if any work is done in the human resource area on this at APN, Rochelle was not sure. Wendy noted the RSN does not do HR review when agency does not, (Sea Mar only) otherwise MHD does. Rochelle suggested a compromise position if see standard WA state degree that looks valid that would be accepted, if degree comes from a questionable institution then validity of the degree must be ensured.
Rochelle added this is going way beyond WAC. Karen noted the VOA agency is moving towards accreditation, we will likely have to do this anyway, but acknowledged VOA has smaller staff than APN.
Nancy added providers sometimes have to pay fees to do verification. There needs to be a policy on the part of agency hiring, as the agency itself does not want unqualified people. Wendy noted we want to provide the most protective policy for consumers and is happy to revisit the policy.

Action: Gary proposed a motion that the policy be referred for discussion between NSMHA and APN. Janet noted all providers should be included. Chuck Davis stated he would like to vote whether or not to support the policy now rather than postpone the process. Gary suggested a new motion to accept the existing NSMHA policy. Motion made, seconded. A motion was made to amend the motion to add a recommendation there be further discussion that there be best practice. All were in favor of main and secondary motions.

1009.00 Critical Incidents
Rochelle gave a brief statement of APN concern: The issue is with the definition of Critical Incidents exceeding the WAC definition, leading to excessive reporting. CI (critical incident) reporting has to be done for any type of death, including natural causes. This is a big increase in administrative burden from what is MHD reportable to what must be reported to NSMHA.

Wendy gave a brief statement of RSN response: The RSN feels this is a foundational part of continuous QM and have exceeded State contract requirement in this regard for many years but have tried to limit the amount of areas which need to be reported.

Comments: Mike noted the State only describes CI's as those media-related, but as a health care provider the RSN would be interested in incidents that may lead to court, or where misconduct occurred. He feels this policy needs more work, more thought should be put into what constitutes a CI. Deborah noted as Ombuds, she feel strongly about this, and sits on the CI committee which looks at incidents through a prevention/QI filter. They often see thread between a CI and a gap in care. If they were only to look at incidents MHD is concerned with, those gathering media attention, a big part of consumer care would be lost. Janet stated we owe clients to know what has happened to them. Rochelle noted APN does not want to lessen quality of services, but time is taken away from serving clients doing reporting on things that are not critical incidents. This is above and beyond WAC requirements and adds another level of burden to APN.

Chuck asked what has resulted from the QM program on the whole. Wendy noted the area of seclusion and restraint at E&T's, a client died in restraints, leading to QI. There were also a cluster of issues with CH, some reportable, some not, QM identified serious problems with the organization and CH submitted a corrective action plan, did major restructuring and since have not seen level of problems. Wendy noted the RSN is concerned with natural deaths (or cases when cause of death is unclear) in people not elderly. RSN feels this does not go beyond WAC as WAC calls for continuous QM. This has been approved by QMOC before, and in all levels of system.

Mike noted he is not recommending that we do away with this process, nor that we approve the policy and step away, clarity is needed in the kind of incidents reported to increase efficiency in the system. Russ stated Sea Mar is JCAHO accredited, and these list of things which should be reported is almost identical to what Sea Mar reports to JCAHO.

Susan asked what APN objecting to reporting to. Rochelle noted not all would raise to level of reportable CI – ex: illness, or natural death of elderly client.

Action: Gary entertained motion to re-confirm NSMHA policy of Critical Incidents with a caveat to review the operational definition of CI and define what is reportable/not reportable. Motion was made, seconded, all in favor.

Policy 1504.00 Assessment for Ongoing Services
Rochelle gave a brief statement of APN concern: Specific concern is with the policy prescribing how to do diagnostic justification: APN wants more flexibility in doing assessments. An ex: there are 5 pts needed for diagnostic justification. APN wants to give clinicians ability to do diagnosis with their own clinical judgment.

Wendy gave a brief statement of RSN response: The RSN previously amended the policy with provider input. NSMHA Medical Director Dr. Brown felt provider diagnostic justification did not meet professional standards, and he requests language from DSM to show how the clinician arrived at diagnoses, what other diagnoses were ruled out, etc.

Comments: Rochelle noted the way diagnoses are done now is very prescribed as clinicians have to check off every item, clinicians should have flexibility in justification. Nancy – does Sea Mar have a problem – Russ no. Karen asked why we would have a medical director and not follow his recommendations? Rochelle – CH has medical director and feels that is unnecessary. Chuck stated this is something we should be doing to treat clients as well as we can. Gary noted this issue seems it should be discussed between RSN/APN medical directors, and the BOD should determine whether they follow recommendations of Medical Director hired but the RSN. Nancy moved to defer this item until guest representatives are present.

Action: A motion was made to defer to this afternoon to discuss. Gary articulated questions that will then be asked: Are the RSN medical directors' requirements to support diagnosis excessive, and what is the basis of the RSN medical directors requirements? Wendy noted the basis is from the DSM, which is standard clinical practice. Susan, Wendy, Chuck and Deborah voted against deferring, the majority were in favor, and the policy was deferred until the afternoon when guests arrive.

B-1 & C-1 also deferred to afternoon.

1505.00 Authorization for Ongoing Outpatient Services
Rochelle gave a brief statement of APN concern: APN has problems with the amount of things that go into developing the initial assessment and the 30-day time limit. It is difficult to make the initial assessment to get treatment plan completed.

Wendy gave a brief statement of RSN response: There needs to be discussion with APN as there may have been a misunderstanding, this policy is taken verbatim from RFQ and is not meant to be the final

treatment plan. The timeline discussion (A-2) will have impact on this (B-1). Wendy noted we can not change main components as this comes from RFQ.

Comments: Janet noted this should be discussed with the state/RFQ in next contracting period, this is impossible situation.

Action: A motion was made to approve policy with discussion for part A & B for further clarification on what definition is needed. Motion was made, seconded, all in favor.

1517.00 Coordination of care with primary care provider and other health care providers

Rochelle gave a brief statement of APN concern: Issue is with the way the policy dictates how to have coordination. APN wants more flexibility in how to work with different PCP's as they are all different and how to work with them differs.

Wendy gave a brief statement of RSN response: This policy was developed by regional medical directors. NSMHA believes we need a policy to ensure consistency among providers. NSMHA saw a cluster of complaints indicating problems in how this was done, therefore framework was instituted, especially in area of medication management, want smooth handoff. Wendy noted frustration that this policy previously went through QMOC, was approved, and is now back here again.

Comments: Rochelle noted this is adding additional requirements than WAC. Susan stated from a consumer viewpoint, there is not a lot going on with PCP's, many consumers do not even have a PCP. Consumers need to know certain dangers, need someone monitoring, they will be better served. Charles noted more and more clients are being served by PCP's than this system, and the transition needs to be smooth. Rochelle noted the concern is with adding extra layer in how this happens. APN wants more flexibility. Susan stated APN should care that the PCP is qualified to do med management. Deborah noted she does not think this "flexibility" is working, as shown by several active cases of hers, complaints with coordination between MH providers and PCP's. We need a better system, people ending up in hospitals is not acceptable. Chuck noted he spoke to a PCP in Mount Vernon who was very unsure about prescribing psychotropic meds, really unsure what he was prescribing to consumer. We should not loosen requirements.

Karen noted these policies have been developed by workgroups and have gone through QMC, QMOC, yet we are here trying to figure them out. This is a frustrating process. Nancy asked if objections were raised previously. Wendy noted they were not; consensus was reached at QMC and QMOC.

Rochelle stated the accumulation of so many excessive requirements adding on to clinicians is leading to APN losing sight of client care. Gary noted this policy was created in 2004.

Susan noted documentation is an important part of service so everyone knows what's going on, including the client.

Wendy noted that Rochelle is representing the viewpoint that there is a fundamental issue of policies exceeding contracts. In previous contract period, there was discussion with APN on who agreed with the concept of a policy driven health plan system. At the time of signing contract, APN Boards raised concerns. Mike noted during contracting period, it was acknowledged that these policies could have a fiscal impact, and if there was a noticeable fiscal impact, it would be discussed. We need to discuss cost on providers.

Action: Gary entertained a motion to support the policy as written. Motion was made, seconded, one against (Rochelle), all else approved

Policy 1518.00 Mental Health Advance Directives

Rochelle gave a brief statement of APN concern: It is difficult to track down someone to sign MH advance directive.

Wendy gave a brief statement of RSN response: MH Advance Directives came into place in 2004. The witness to signature can not be the clinician, but can be receptionist or other clinician. As there are very few MH advance directives completed, the RSN did not feel it would be much of a burden.

Comments: Rochelle noted it was APN's understanding that it was a conflict of interest if other staff signs, Wendy noted it is not a conflict of law. Deborah added witnessing someone signing a document is not a conflict of interest. Wendy noted it is recommended that all clients have an advance directive, but most do not. Deborah suggested having an education for clients on advance directives, have them made and signed at that point. Possibly NAMI or a Church could sponsor this.

Action: Gary entertained a motion to support the current policy, with the sidebar that there may be special events where consumers could be given special opportunity to educate consumers about medical directors. Motion made, seconded, Rochelle against, all else approved.

Policy 1520.00 Second Opinions
Rochelle gave a brief statement of APN concern: This has a financial impact on providers as second opinions often go out of network. The level of second opinions becomes cost prohibitive when they are for higher levels of service.

Wendy gave a brief statement of RSN response: Wendy noted the language on second opinions comes out of BBA and RFQ. NSMHA has never charged providers for second opinions, they have always absorbed costs. The number of second opinions has increased. Clients have a right to request and receive a second opinion. Wendy noted there are two networks – the APN network and the NSMHA network – RSN tries to stay within the NSMHA network. Greg Long tries to get a second opinion from a provider other than where the issue was raised.

Comments: Chuck noted only two or three people in four years went outside of network, as special services were needed. As far as Ombuds this happens very infrequently. Maile asked if the issue is the provider being required to pay. Wendy noted that is in the policy, but has never been exercised. Maile asked if providers will be charged. Wendy noted the RSN has not charged in past as there have not been many, but the number has of late been increasing. Wendy noted that this is something that should be studied and reported back to QMOC on how many occur, how much they cost.

Action: Gary moved to support the existing NSMHA policy, with the addition that second opinions out of the network's financial impact to APN be reviewed at a later date. Motion – made, seconded, Rochelle opposed, all others in favor.
Discussion: Janet noted there is a large gap in what second opinions are on. Dan noted the consumer has the right to get a second opinion from whoever, but the contract will not allow the consumer to go out of network? This is a violation of the consumers civil rights.

1527.00 (in development)
Action: A motion was made to approve the policy, motion made, seconded, all in favor.

1540.00 Criteria for Closing an Episode of Care

Wendy gave a brief statement of RSN response: This specifically has to do with an LR. The State says we can not close someone on an LR.

Rochelle gave a brief statement of APN concern: APN feels they should be able to close an LR when someone dies or moves away.

Comments: Wendy noted agreement with the concept, is willing to make these minor edits. Gary asked how we know if someone has moved from service area? Rochelle stated the client sometimes informs, or get a records request from an agency outside the area.

Action: Gary entertained a motion to continue the existing policy with an added subtitle that the requirement definition of what to do with transferred or deceased clients needs to be clarified. Motion made, seconded, all in favor.

1541.00 Rationale of Use of Seclusion and Restraints and E&T's

Rochelle gave a brief statement of APN concern: APN feels there should be an allowance when doing monitoring that in some instances video monitoring is allowed.

Wendy gave a brief statement of RSN response: This policy came out of a cluster of CI's including a death of a consumer in restraints at an E&T. A collaborative workgroup was formed in reworking policies including this one, attended by CH Medical Director Dr. Stallings, who then agreed with this policy.

Comments: Mike stated video-monitoring at the E&T's could be improved inexpensively to include recording. More creative work needs to be done in this policy, we do not want to tie up a staff person at the E&T. Chuck noted he has been to the E&T's while clients are in restraint, and knows that the TV is not being watched, staff are too busy. Rochelle added E&T's run at high capacity, other clients suffer when staff is occupied servicing one person. Gary stated anyone in restraints needs to be under immediate line of sight of staff.

Susan noted as a NAMI member, NAMI opinion is that anyone in restraint needs face-to-face supervision. Deborah seconded Chuck's concern that video monitoring is ineffective for monitoring people in restraint. Janet asked how many people get put in restraints? Wendy noted the amount has lessened.
Karen stated if Dr. Stallings researched and approved this, it seems inappropriate for this group to contest. Rochelle noted that Dr. Stallings agreed with it but felt that it was potentially excessive.

Action: Motion was made to support the policy as written, motion as seconded, all in favor.

1550.00 EPSDT (early periodic screening, diagnosis, and treatment)

Rochelle gave a brief statement of APN concern: A better summary is needed.

Wendy gave a brief statement of RSN response: APN did not see the requirements in the RFQ or model contract, as they are the areas that are disputed. We must abide the MHD contract. This is word for word.

Comments: Rochelle noted we are getting ahead of ourselves as this is from the RFQ. Having a child MH specialist just to do assessments will be a heavy staffing burden. Wendy noted we agreed in QMC that we would not operationalize until September when the final contract is received.

Chuck noted the RFQ is a formal document, entailing formal federal requirements. We can not dance around them.

Gary noted this policy was developed for the RFQ process. The region does not intend to operationalize it until next contract is received and will change the policy if allowable.

Action: Motion made, seconded. All were in favor.
Discussion: Dan asked if there was discussion on whether there was Child MH specialist available as they can be scarce. Wendy noted there is one at every child-serving agency. Rochelle noted she wants to be clear in NSMHA auditing processes this is not audited on. Wendy agreed it has not been and will not be.

1538.00 – 30-day Letter
Rochelle gave a brief statement of APN concern: This process creates a huge administrative burden. Letters are sent out to every client that wants to terminate service, it does not always make sense to do so.

Wendy gave a brief statement of RSN response: This policy did not receive consensus at QMC, it was taken to RMC, RMC made compromise, revised, policy taken back to QMC, then the RSN had to do the RFQ. The policy has not yet been implemented, waiting to finalize. Concern is that clients were not always notified of termination of treatment in a consistent manner.

Comments: Deborah noted the letter triggers to clients that they have a choice to change case managers or providers, consumers may not understand that without the letter and may disrupt continuity of care. Rochelle noted some clients are insulted by the letter. It is also not CH process to close people's service "in the heat of the moment". Russ noted this issue has not presented a problem at Sea Mar's level. Rochelle stated this requirement is adding another administrative layer that doesn't need to be there.
Gary noted it is typical to get a letter from healthcare plan that coverage ends and sees the procedure as an opportunity to tell client if they need urgent care to call VOA crisis line, or if they need services again to go through access.
Wendy noted the State now requires a letter be sent in 15-days.
Susan asked why in a consumer driven system, other people decide when treatment ends.

Action: A motion was made to support policy as written, motion made, seconded, Rochelle objected, all else in favor.

At this point Dr. Keith Brown, via conference phone, Chuck Benjamin, Stacey Alles, and Mike Watson all joined the discussion.

Revisit of 1504.00
Stacey Alles voiced APN's concerns with the detailed 5-items NSMHA is asking for in diagnostic justification. There is no known source document for those levels of diagnosis and they exceeds a known source requirement. Dr. Brown clarified that in talking about a DSM IV diagnosis, is not the justification DSM IV itself? What else are we asking that is different from DSM IV? Stacey answered requirements to give other multiple diagnosis to show which have been ruled out, as well as to describe justification of GAF score. Dr. Brown stated that interrater liability is needed. Consumer's right to receive services is based on GAF score, so we would want to have integrity in GAF score given. There can be no question of bias, want more rigid, organized type of diagnosis. Stacey noted concern in being held to a rigid standard that may not always be the case. Dr. Brown acknowledged when you feel the diagnosis is clear, it is overkill to go through other diagnoses. How much detail you give in ruling out alternatives depends on situation. In every situation there needs to be a minimum standard.

Mike Watson noted the need for feedback in following the diagnostic tree in DSM IV. A lot of clients come with a lot of history, documentation, then why do need to dispute and give diagnosis again?
Dr. Brown noted it is sufficient to give examples of behavior, then present historical information.
Mike Watson noted clinicians have to spend time writing diagnostic justification whether have historical documentation or not.

Stacey noted this is an example of a policy that exceeds requirements. Dr. Brown stated if clinicians are already doing these assessments, then why are we disputing them? Wendy noted this policy came out of discussions Dr. Brown had with Quality Specialists. Dr. Brown noted that most diagnoses made using DSM IV are made looking at historical behavior.

Stacey noted they are not disagreeing with criteria, they are disagreeing with the way it is enforced.

Dr. Brown noted it is up to the provider how much detail is given. Providers already have discretion whether to rule out one diagnosis or three or writing one sentence or a paragraph, Dr. Brown asked wouldn't providers want more documentation if money was unlimited, there were no RSN requirements? Can providers give a practical example of how this creates more administrative work for providers?
Stacey noted Utilization Reviewers give feedback that they need more narrative than a sentence.
Gary noted there is an application issue when reviewers look at a chart. Dr. Brown stated he wants to enforce this policy in a way that is collaborative for providers, not difficult. Dr. Brown added in terms of auditing records, we need to look at best practice standards. It is unfair to examine the way providers treat clients and not the way they diagnose. Need interrater liability documented to some degree.

Action: Gary entertained a motion to approve staying with the existing policy, motion made, seconded, with the caveat there needs to be discussion on what is required for clarity. This will be operationalized at QMC. All were in favor.

Part C:
Stacey noted that concern is being locked into specific assessments. APN wants flexibility at agency level to have internal processes Rochelle added APN feels this exceeds and is an administrative burden and again stated NSMHA policies should not exceed Federal and State requirements in their contract with APN. Chuck Benjamin handed out portions of the contract that states the WAC requires continuous quality improvement. Dr. Brown noted that the WAC can be extremely vague, perhaps the State/MHD should clarify.
Stacey noted she disagrees with Wendy statement that items have been added over time part of continuous QI. APN developed the policy then RSN added to it, but putting down requirements takes away flexibility. Mike Watson noted this was developed from older WAC's.
Wendy stated the issue is not elements of the policy, but that APN wants to be able to define parts of the intake rather than be told by the RSN what constitutes components of an intake, we don't want to have a policy, even though this used to be APN's policy.
Susan noted recently a consumer into CH, was diagnosed with schizo-affective disorder, person at CH incorrectly diagnosed her in 20 min with depression, leading to crisis. If the clinician had followed the rules laid out in the policy, would that have happened?
Mike Watson noted diagnosis components don't correspond with how long assessment takes.
Wendy asked Dr. Brown is it ok to leave this flexible for providers discretion? Providers do their own training, QI, the RSN merely do auditing on that.

Deborah asked if the providers submitted criteria for assessment, and if using a best practice perspective would providers want to cross anything off the list? Rochelle gave an example of GAF score (not on list). Deborah asked outside of requirements, is there any piece of information that providers would not want to know? Wendy noted the issue APN is bringing up is should each provider have their own flexibility to develop an intake that best meets the needs of their clients. Janet voiced concern that enough time be given at intake. A misdiagnosis is a serious problem.

Action: Gary asked if there was consensus to move Part C to a priority 2 status to discuss further.
Motion was made, moved, seconded, all in favor.

1553.00 Evidence-Based Practices
Rochelle gave a brief statement of APN concern: There is no requirement to follow this policy right now, APN will go ahead with viewing EBP's as upcoming.

Wendy gave a brief statement of RSN response: This was required by the RFQ.

Comments: Susan noted this is part of caring for the client. Rochelle added it is an administrative burden on APN. Gary stated that there is emphasis on EBP's being pushed, there are some risk in EBP's in applying to our system, providers need to give feedback. EBP's need intensive retraining when there is no funding for it.
Action: A motion was made to continue to support the policy as written, motion seconded, all in favor.

1704.00 Crisis Services General Policy (required documentation on ES)
Rochelle gave a brief statement of APN concern: APN believes there is no source document and it adds administrative burden to the provider in having additional requirements beyond the WAC.

Wendy gave a brief statement of RSN response: This came up when RSN was put into corrective action on Crisis Services and MHD did not have a tool so the RSN created their own. When requirements are not written down, there are bad outcomes.

Comments: Karen noted as a Crisis Provider, she has concern that, if there are changes to the data collection process at APN, the Raintree intake screens may have to be changed , and there will be fiscal implications for VOA. ~~Changing this process would result in costs to change processes.~~ Deborah noted when there is no documentation it is difficult to get consumer background. Rochelle noted the broader concern is that corrective action plans will live on forever. Karen acknowledged this concern. Wendy noted the RSN is supposed to review policies annually. Because of RFQ and EQRO, the RSN went from 5 to 200 policies. Gary noted he would rather do a thoughtful review of policy than to modify. This is something we promised the State we would do.

Action: Gary entertained a motion to continue this policy but to keep on the radar screen to review and reflect the work that has been done. Motion made, seconded, Rochelle abstained, all else in favor.

4505.00 – Enrollee Rights A
Action: Motion was made to amend policy as written, motion seconded, all in favor.

4505.00 – Enrollee Rights B
Rochelle noted the policy should read to submit amendments or corrections instead of make amendments or corrections.

Wendy noted the need to cite the HIPAA requirements. HIPAA language states ASK FOR amendments or corrections not MAKE. Need to make in accordance to that in policy, MAKE to ASK FOR.
Action: Motion made to change wording in policy to reflect HIPAA language, seconded, all in favor.

5501.00 Concurrent UR of Outpatient Services
Rochelle gave a brief statement of APN concern: Currently UR's are excessive (5%), there are other opportunities for NSMHA to look at charts.

Wendy gave a brief statement of RSN response: BBA requires UM program that ensures that we do not over or under-utilize services. There is no sample size, it is up to discretion of health plan. RSN feels the amount of UR's done are minimal and probably need to do more. This is the most effective way to bring treatment into clinical guidelines. Don't see how RSN can get away from this as it is required.

Comments: Janet noted the UM subcommittee refers to some inconsistencies in how information is reported back to them. It is important to have a system to do this well. Wendy acknowledged a difficult situation where the RSN is policing providers but also needs to have a collaborative relationship with them. The RSN will commit to having a collaborative ongoing discussion at UM subcommittee. We don't want to change the policy, we want to discuss operationalization.

Action: Gary entertained a motion to continue this policy with the suggestion that identified needs be worked on. Motion made, seconded. All in favor.
Regional Training Plan (B Section)
Rochelle gave a brief statement of APN concern: APN wants to have the flexibility to determine what training is required, they do not want that to be mandated for them.

Wendy gave a brief statement of RSN response: There is a Regional Training Committee that meets every 1-2 months, which agreed to continue the Regional Training Plan. NSMHA also has an internal, extensive training plan.

Comments: Deborah noted she sits on RTC and there was consensus that the regional training plan be continued. Providers have requested more trainings, but there is little funding.
Gary noted concern from providers that there were different training requirements but little funding. Therefore a region wide dialogue was created, leading to the Regional Training Plan.
Deborah noted the big issue is looking at staff in each agency and determining which staff needs to take each training. Rochelle noted there is no source document for this, it requires all providers to do certain training. Deborah noted that APN is represented on the RTC and was given opportunity to do away with the RTP and they approved continuing its usage.
Dan noted that prior to coming to the RSN, he spent several months meeting with APN with reps from all organizations and case managers and consumers and they came up with a Training Plan. This went to APN BOD who did not approve the plan.

Deborah noted that if providers want to be heard, attend the Regional Training Committee and vote.

Karen noted that there is a system of committees and groups that are extremely effective, and her staff spend a lot of time at these meetings. Karen asked if there are necessary people from APN attending all of these committees and groups? Rochelle stated that APN is looking at the whole amount of requirements

being asked of them. Janet acknowledged there must be some feeling of oppression that builds up with a large organization such as NSMHA and its requirements for providers.

Action: Gary entertained a motion to keep the Regional Training Plan as a (2) priority.
Motion made, seconded. All in favor.

1547.00 Customer Service
Rochelle gave a brief statement of APN concern: Although customer service is good, her concern is with the process. Based on the RFQ there were new implementations without opportunity for APN to have discussion.

Wendy gave a brief statement of RSN response: Wendy noted this came out of the RFQ, which has very specific requirements. Customer service needs to be provided according to these requirements. Part of these requirements was that Ombuds could no longer stay at RSN. Now RSN has developed their own Customer Service standards.

Comments: Janet asked how many customer service calls does the RSN get? Wendy noted the RSN is working on a system to track this, it is now about 20 calls a day. Deborah gets feedback that consumers hate having to make extra phone calls. Delegating customer service to another agency from RSN would likely increase that frustration. Susan noted she also gets calls from people on customer service, she refers them to Wendy. Chuck noted the more we move into managed care, the more is required of providers, and the more complaints are received. Gary noted that as this is embodied in the RFQ, in the implementation phase, and will likely be in the new contract, there is not much we can do.

Action: Gary entertained a motion to accept this policy with the caveat that we will examine how this stated in the new contract, as it is required by the RFQ. Motion made, seconded, Rochelle objected, all others approved.

Conclusion
Gary noted that several times today the need for clarity in operationalizing policies was brought up. He added that APN's concern with NSMHA policies & procedures affecting clinician time is an important consideration. Also, all provider agencies need to attend committees and give feedback at every level because considerable time and energy goes into developing these policies and procedures. The region's quality improvement process has always been to look at Federal and State standards, and these will be expanded on, taking into consideration the fiscal impact. In the contract process there needs to be an opportunity for contractors to present substantial negative fiscal impact on their agencies.

Wendy stated she will finalize the policy tracking list and will e-mail out the committee. If there are errors, let her know. From there, the committee's comments will go to the Board of Directors. Gary stated he will be unable to attend so Dr. June LaMarr will present comments in his stead.

Janet asked Rochelle if she felt it was worth all this time to go through all the policies, Rochelle stated she felt it was. Wendy thanked Rochelle for being such a gracious messenger. Deborah thanked Gary for running an efficient meeting and thanked Rochelle and Wendy for succinctly expressing their opinions.

Adjourn: The special meeting was concluded at 3:35 p.m. The regular QMOC meeting originally scheduled for today was cancelled.

Effective Date:
Revised Date:
Review Date:

North Sound Mental Health Administration

Section 1500 – Clinical: Medical Clearance Criteria for Crisis and ITA Assessment

Authorizing Source:
Cancels:
See Also: Approved by: Date:

POLICY #1537.00

SUBJECT: MEDICAL CLEARANCE CRITERIA FOR CRISIS AND ITA ASSESSMENT

PURPOSE

To provide a consistent and basic medical status prior to screening for crisis and involuntary assessment at emergency departments or community hospitals. Such criteria are essential to assure medical stability of the client for the assessment process.

POLICY

Individuals must be medically stable to assure accurate psychological and chemical dependency assessments. Exceptions to basic medical clearance can be made on a case by case basis, when in the professional judgment of the ED physician, ARNP, or PAC, specific diagnostic/medical clearance procedures are not warranted or are not in the best interest of the individual's assessment and treatment. Exceptions and rationale should be communicated to the Care Crisis worker.

PROCEDURES

1. Patients will be seen by a physician, ARNP, or PAC prior to contacting triage at the Care Crisis Line. The patient's presenting problem for going to the ER has been addressed by the ED professional.
2. All potential referrals to the crisis and ITA services must have had a full documented body systems examination by an MD, ARNP, or PAC, to include wounds or trauma, cardiac and respiratory status, evidence of acute nutritional/hydration issues and acute etiologies ruled out for, and complaints of pain.
3. The following vitals parameters must be met prior to evaluation for Crisis and ITA services.

    a. Pulse no greater than 120
    b. Systolic BP no greater than 200
    c. Diastolic BP no less than 50, no greater than 110
    d. Temp no greater than 100.5 degrees F.

4. The following foundational lab work on all referrals for potential evaluation, unless clinically not warranted:

    a. Chem 7
    b. CBC with differential, if febrile.
    c. Urine sample to screen for tox and UA.

5. The following labs and levels are required for the following individuals with the following specific conditions:

a. Known diabetics:
    i. Blood glucose less than 200

b. ETOH intoxication

    i. Blood alcohol less than .08%.
    ii. If the request is for investigation under 70.96 B
        1) For those individual's with presentations with alcohol and a blood alcohol level of .08% or greater.
        2) If other procedures have been addressed for medical clearance, and if the individual has a known pattern of qualifying behaviors that suggest chronic alcoholism, the individual can be seen by Crisis Worker or DMHP/DCR (policy 5763).

c. Known to be taking Lithium.

    i. Lithium level, prior to admit.

6. Chest x-ray:
   If cough in a homeless individual or person with obvious poor health care
7. Neuro-screen in individuals presenting with psychosis and no mental health or drug use history.
8. A constellation of confusion, agitation, incoherence, and elevated VS should be assumed to be delirium until proved otherwise. This would include delirium secondary to substance withdrawal.
9. Brief Mental status exam

10.

Policy and Procedure Tracking Sheet

Name of Policy: Notification of Service Termination by Provider

Author: Wendy Klamp New ☒ Revision ☐

Policy Development Step	Person Responsible	Completion Date	Notes
Initial draft 1. Include this tracking sheet at top of policy file. 2. Save the combined tracking sheet/policy in shared/policies and procedures/policy processing/draft policies folder. 3. List all attachments at the end of the policy by file name and location. 4. For new policy, specify in which policy section to assign the policy. 5. Rebecca Pate notified via e-mail.	Policy author: WK	8/22/05	
Do general formatting according to NSMHA specifications. Spell and grammar check. Provide a sequential policy number in the section indicated by the author.	Rebecca Pate	8/23/05	
Save a copy of any attachments in the draft policy folder and assign numbers.	Rebecca Pate	N/A	
Turn on track changes. Save the document in the current directory. List policy draft in log.	Rebecca Pate	8/23/05	
Email the author that the policy is ready for his/her review. Also provide hard copy.	Rebecca Pate	8/23/05	
Author to review and make any needed corrections or changes to electronic document using tracked changes. Policies that require group review will also be edited in electronic format using tracked changes.	Policy author:		
Author to make policy matrix assignment here: 1. Provider Must have Policy consistent with NSMHA 2. Provider Must Comply with but need not have policy consistent with NSMHA 3. NA For provider 4. APN Must Have Policy Consistent with NSMHA	Policy author:		
Indicate committees to be sent to (in order) in the Notes column at right. Return to Rebecca Pate. 1. Sub-committees	Policy author: WK		Approved by QMC 7 2005

2. Committees (QMC, Planning, QMOC, etc.) Also indicate final approval by Executive Director or Board of Directors			Approval by ED
Policy Development Step	**Person Responsible**	**Completion Date**	**Notes**
When approved by all Sub-committees and Committees, notify Rebecca Pate by email.	Policy author:		
Move (DON'T SAVE) the policy to Dept/ss/p&p/final dfts w/trkg sht. Also save the tracking sheet as a separate document. Prepare for final approval: format policy and attachments, accept changes, update log, and remove tracking sheet. Save to dept/ss/p&p/formatted	Rebecca Pate		
Email Deirdre that final copy is ready and who approves.	Rebecca Pate		
Email Rebecca and author when policy is approved and if any changes are required	Deirdre Ridgway		
Following approval, add and accept any other changes, add the date signed and who approved, and any needed Motion number. Move (DON'T SAVE) the policy to dept/ss/p&p/final for MW	Rebecca Pate		
Add to table of contents and amend index	Rebecca Pate		
Email Michael that Policy # (title) is ready to be incorporated in Collateral Documents and the web site. Notify MW of policy matrix assignment above.	Rebecca Pate		
File a hard copy in the Manual.	Rebecca Pate		
Update tracking sheet and notify author of approval	Rebecca Pate		
Michael to Collateral, web and update web-posted policy matrix (provider p&p grid)	Michael White		
Deirdre Ridgway to be notified by email if policy is relevant to providers and requires a numbered memorandum to be issued.	Author:		
Numbered memorandum issued	Deirdre Ridgway		
Train staff as needed on policy.	Author:		
Train providers as needed on policy.	Author/designee:		
Finalize tracking sheet and complete log	Rebecca Pate		

Effective Date:
Revised Date:
Review Date:

North Sound Mental Health Administration

Section 1500 – Clinical: Notification of Service Termination by Provider

Authorizing Source:
Cancels: Approved by: Executive Director Date:
See Also: Motion #:
Responsible Staff: Quality Manager

POLICY #1538.00

SUBJECT: NOTIFICATION OF SERVICE TERMINATION BY PROVIDER

POLICY

The North Sound Mental Health Administration requires that all its providers give consumers written notice of provider initiated service changes or terminations in order that consumers have adequate time and information to exercise their rights. The written notice will include consumer rights information regarding the NSMHA Grievance process and how to access Ombuds assistance should the consumer not be agreeable to the proposed change or termination of services.

PROCEDURE

Consumers will receive written notice from the provider in person or by mail of changes in service, or termination in services at least 30 days prior to the effective date whenever possible. This notice will be made in language easily understood by the consumer.

1. Exceptions may be allowed in the following circumstances:

    a. NSMHA or a network provider has confirmation of the person's death.
    b. The person receiving services has agreed to planned discharge and termination of services. In this case, the consumer will sign a treatment plan that includes planning around the transition to discharge that outlines the mutually agreed goals, objectives and intervention necessary to terminate services over a minimum of thirty day and maximum of 90 day period This plan will be signed by the consumer and will serve in place of the thirty day letter.
    c. NSMHA or a network provider has learned that the person has been admitted to a public institution precluding the eligibility for the service.
    d. NSMHA or a network provider has no knowledge of the person's whereabouts and returned mail has no forwarding address.
    e. NSMHA or a network provider has knowledge the person is currently enrolled in another region or state's Medicaid program.

A copy of the notice will be retained in the consumer's medical record.

Effective Date:
Revised Date:
Review Date:

North Sound Mental Health Administration

Section 1700 – Crisis Services: ICRS System Shift Change Protocol

Authorizing Source:
Cancels:
See Also:
Responsible Staff: Deputy Director

Approved by: Executive Director Date:
Motion #

POLICY #1713.00

SUBJECT: ICRS SYSTEM SHIFT CHANGE PROTOCOL

PURPOSE
To assure continuity of care for crisis services during shift changes.

POLICY
ICRS staff will coordinate transitions in service responsibility during shift changes.

PROCEDURE

1. If the VOA triage clinician dispatches an emergency outreach more than one hour prior to the end of the outreach clinician's shift, then the receiving clinician will be expected to begin the outreach.
2. If an emergency outreach is dispatched by the VOA triage clinician within the last hour prior to the end of the outreach clinician's shift, then the outreach clinician will:

    a) Take all available information from the triage clinician;
    b) Make any necessary and/or appropriate phone calls to the client(s) and/or referring party(ies); and
    c) Complete the outreach, if clinically required.

    OR

    d) Pass all the information **directly** to the new outreach worker at the beginning of the new shift.

3. The new outreach worker will begin face-to-face services within 2 hours of the initial dispatch by VOA.

<u>For the Snohomish County Children's Crisis Team</u>

Weeknights – Both the Children's and Adult's Crisis shifts end at midnight. Adult graveyard shift begins at this time. Clinicians from the Children's Crisis Team will take information coming in after 11:00 PM, process as much as possible with the family and pass it on at midnight directly to the Adult Team if outreach is necessary.

<u>Skagit Children's Crisis Team Schedule</u>

The Skagit Children's Crisis Team covers the hours of Monday through Friday from 10:30 to 19:00 (7:00 pm). There are no hours available during the weekends or during any nationally observed holiday. When cases are received by the CCT after 20:30, and an outreach is necessary, the CCT will request VOA to contact a DMHP/DCR since the CCT has no list of which ES Outreach Workers are on-call for any given week.

2/22/2006

Summary of Meeting and Report from MHD Regarding North Sound Death Rates

- MHD noticed that NSMHA reports significantly more reportable deaths than other RSN's (see MHD's table for total reported deaths from RSN's)

- This generated questions regarding our reporting and critical incident program

- NSMHA demonstrated quarterly data showing an actual decrease in reported deaths from past years (See bar chart of Reported Critical Incident Death Sub-types)

- MHD acknowledged that an appearance of an increase in deaths is likely due to NSMHA reporting more events as a result of changes in contract language

- MHD also acknowledged that reporting systems from RSN to RSN vary with little consistency as to definitions of types of incidents being reported

- MHD made recommendation that due to inconsistencies in reporting negative media events, that State Mental Health and PIHP contracts contain draft language that changes the requirement from "potential media event" to "sentinel event"

- Replacing "potential for negative media coverage with "sentinel events" would clarify the types of events that would need to be reported, and broaden the definition beyond only those events that have been or are likely to be reported in the media

- MHD is also recommending that future contract language require reporting via data rather than through telephone and/or fax narrative reports.

- Until reporting requirements are clear and consistent it is impossible to determine where the current death rate in NSMHA lies in comparison to other RSN's

Final Recap/Summary

Hospital Inpatient Utilization Workgroup

December 2005-February 2006

- **A diverse group of stakeholders including outpatient providers, inpatient staff & program managers, social workers, WSH liaison, Emergency Services, VOA and NMSHA staff, met four times (December 12, 2005, January 5, 2006, January 27, 2006 and February 3, 2006) as a focused workgroup to examine issues contributing to hospital inpatient utilization. Member participation did not constitute agreement with or endorsement of recommendations made.**

- **The group looked at data reports generated by NSMHA staff including reports regarding**:
  - Average length of stays by year, patients per hospital & rates of rehospitalization
  - Percentages of Medicaid and State Only Funded Clients Not Receiving Outpatient Services Pre & Post Discharge

- **Discussions were supplemented by issues and challenges offered up by stakeholders and a list of Barriers and Strategies was reformulated each week with new suggestions added**

- **4 Areas Were Identified Using Strategies For Potential Recommendations for Implementation**

I. Communication

a. **Contact point (VOA) be resource bank for eligibility, discharge resource management and limited records management**
b. **Utilize current ICRS automated email notification of inpatient admission for those clients already receiving outpatient services. Develop notification process for those clients not touching ICRS/Inpatient Certification.**
c. **Work with individual hospitals regarding specific inpatient issues/beliefs/inconsistencies in system**
d. **Add outpatient representation to quarterly Hospital Inpatient Meeting schedule with overlapping and individual time for both service areas**
e. **Initiate regional psychiatrist meeting (utilize current Medical Directors Meeting)**
f. **Utilize WBHIA Inpatient Association list serve to get regional information out**

II. Care Coordination

a. **Provider contact/point person(s) to ensure deferral/appointments/follow-up DC plan**
b. **Regional Adult and Child Care Advocates – oversee coordination of client care for clients with highest need**
c. **Appropriate inpatient denial policy for inpt. Certification re: medical necessity**
d. **Medicaid eligible clients that need assistance for enrollment**

III. Outreach to Underserved Populations/Non-enrolled Medicaid Eligibles

a. **Engaging Non-POE pre and post discharge/assist with enrollment**
b. **Kids**
c. **Older Adults**

IV. Basic Resources Needed

a. **Housing**
b. **Medications, especially at discharge**
c. **Non-Medicaid funding**

d. Availability of Prescriber time/More access to triage outside of ES

Barriers Identified

1. **Getting inpatient records in timely manner to outpatient providers to facilitate a) making clinic and medication appointments, get prescribers with vital hospital records, including those from WSH and E&T's**
2. **Providers have little to no contact with client and or social worker/discharge planner**
3. **Difficulty of hospitals in obtaining timely clinical and medication follow-up appointments**
4. **Lack of communication/respect between inpatient and outpatient providers**
5. **No central resource management bank exchange for housing/DC options and/or the perceived barrier of no housing so hospital stays are lengthened due to placement delays and problems**
6. **Difficulty determining client eligibility while hospitalized and getting Medicaid paperwork done prior to DC**
7. **A majority of patients are not getting hooked up with outpatient services post DC**
8. **No clear and consistent way to notify provider of client being hospitalized**
9. **Resources/availability for meds prescribed in inpatient/walking out with prescriptions vs. actual medication**
10. **Lack of availability of CD treatment post DC or other programming to maintain stability (day treatment)**
11. **Difficulty transferring to WSH or CLIP, lengthening stays**
12. **Patient choice to not receive follow-up outpatient services – Won't accept outpatient services**
13. **Large number of hospitals used in our region – causes problems in consistency**
14. **Eighteen-month delay in reimbursement and rate changes makes it difficult to create incentive & fund transitional services**

Strategies Identified

1. **Contact point (VOA) to be resource bank/info point for eligibility, DC resource management and some records management**
2. **ICRS automated E-mail notification of admission to providers. Develop system for non-ICRS contact & impatient certification**
3. **Provider point person(s) identified to ensure deferral/appointments/follow-up DC plan**
4. **NSMHA Regional Adult and Child Care Advocates-oversee coordination of care of clients with high need**
5. **Add outpatient representation to quarterly Hospital Inpatient Meeting schedule with overlapping and**
   individual time for both service areas
6. **Functional interpretation of medical necessity (P&P) as support structure for inpatient cert denials**
7. **Work with individual hospitals regarding specific inpatient issues/beliefs/inconsistencies in system**
8. **Housing options and alternatives to facilitate discharge/to potentially use crisis beds for post-DC, not just to prevent hospitalizations**
9. **Use non-Medicaid dollars to engage consumers who will not accept outpatient treatment or to reach underserved populations (kids and older adults)**
10. **Urgent Care Psychiatric Triage Center in Snohomish County**

11. **When utilizing the need for Home and Community Services call early in stay to set up assessment appointment with the caveat that the appointment might be canceled if necessary**
12. **MD meetings regionally quarterly for (psychiatrists)**
13. **Need to obtain data on kids, possibly a survey to identify if in service at time of hospitalization**
14. **WA Behavioral Health Inpatient Association list serve good way to communicate with inpatient stakeholders**
15. **Discuss with CSO's for expedited discharge/jails**

NORTH SOUND MENTAL HEALTH ADMINISTRATION
COMPLAINT, GRIEVANCE, APPEAL, AND FAIR HEARING REPORT SUMMARY
October 1, 2005 through March 31, 2006

INTRODUCTION and PURPOSE

- The NSMHA continues to report grievance, fair hearing, appeal, and denial data in accordance with the Mental Health Administration reporting templates and requirements.

- The NSMHA continues to provide information about complaint data in a separate format as complaints account for the majority of complaint, grievance, and fair hearing information used for quality management activities.

- Information about complaints, grievances, appeals, denials, and fair hearings remains central to the NSMHA's quality management processes. Complaint data has also become increasingly more central to individual providers' internal quality management processes.

- The NSMHA continues to promote a "no-blame" atmosphere in which to view complaint data--that information about complaints creates opportunities for improvement and that consumers' voicing concerns or ideas for improvement is one form of consumer voice in a recovery based system.

COMPLAINT, GRIEVANCE, DENIAL, APPEAL, and FAIR HEARING DATA

- The overall number of complaint, grievance and fair hearing occurrences reported increased from 288 to 368 since the last reporting period, while the number of cases (people) reported remained relatively stable (There was an increase from 234 to 238 since the last reporting period). The number of complaints reported that involve children decreased from 71 to 65.

- The categories that accounted for the most complaints during the current reporting period are: Consumer Rights 75 (20 %), Physicians and medications 54 (15%), Financial and Administrative Services 41 (11%), Access 37 (10%) and Dignity and Respect 37 (10%). A review of the data shows that Consumer Rights 124 (19%), Physicians and medications 92 (14%).Access 84 (13%), Financial and Administrative Services 62 (9%), and Dignity and Respect 54 (8%) accounted for the most complaints over the past year.

- When combined, Dignity and Respect and Consumer Rights accounted for 112 (30%) occurrences (Dignity and Respect is one of the consumer rights).

- The NSMHA continues to break out the overall complaint, grievance, and fair hearing data by Medicaid and state-funded consumers. The majority of reported complaints, grievances, and fair hearings filed continue to be for Medicaid consumers. Of the 238 reported cases, 211 were for Medicaid consumers and 27 were for state-funded consumers. Of the 368 occurrences reported, 336 were for Medicaid consumers and 32 were for state-funded consumers.

- There was an increase in grievance and fair hearing cases (people) and occurrences (types and levels of concerns) reported since the last reporting period (There were twelve (12) grievance or fair hearing cases and twenty (20) grievance or fair hearing occurrences (as compared to five cases and five occurrences in the last reporting period).

- The overall number of denials for Medicaid consumers has remained relatively stable. There were 122 denials for Medicaid consumers in the current reporting period, as compared to 129 in the previous reporting period. There was a decrease in denials for adults and an increase in denials for children. (Forty seven denials were regarding adults and seventy-five denials were regarding children, as compared with sixty-five denials for adults and sixty-four denials for children during the previous reporting period). On October 1, 2005 inpatient authorization was transitioned from the Associated Provider Network (APN) to the Volunteers of America (VOA). There were no denials for inpatient authorization by the Volunteers of America, as compared with six (6) denials for inpatient service issued by the Associated Provider Network during the previous reporting period.

- There was a decrease in appeals (there were 2 appeals in the current reporting period as compares with 5 in the previous reporting period). For both appeals the original denial decision was overturned during the appeals process. The NSMHA has developed a table to track the number of denials and appeals over time.

BROAD and CONSISTENT REPORTING

- The NSMHA continues to work towards broad and consistent reporting of complaints across multiple reporting sources. Increased reporting of complaints remains a goal of the NSMHA. Part of this goal includes capturing concerns that occur at the provider level when consumers are not involved in Ombuds services.
- The NSMHA continues to track the number and percentages of complaints and cases reported by Ombuds services and providers. The percentage of cases reported by Ombuds services decreased slightly since the last reporting period. (67% of cases were reported by Ombuds services as compared with 69% percent during the previous reporting period). The percentage of complaints, grievance, or fair hearing occurrences reported by Ombuds services increased since the last reporting period (75% of occurrences were reported by Ombuds services as compared with 70% during the previous reporting period).

- Increased reliability in the reporting process is an area identified for continuous quality improvement. Ombuds services completed initial training to the Regional Quality Management (RQMC) on their use of the complaint type categories. The NSMHA and providers will identify next steps in the RQMC.

QUALITY MANAGEMENT PROCESSES

- The NSMHA Internal Quality Management Committee (IQMC) will review the current complaint and grievance data and report, make recommendations for further study and review or quality improvement, and present these recommendations to the Regional Quality Management Committee and Regional Quality Management and Oversight Committee.

- NSMHA providers continue to use complaint and grievance information in their internal quality management processes.

- The NSMHA Ombuds services provide a semi-annual summary of their data and recommendations for quality improvement.

  - Quality Management Recommendations from the last reporting cycle include:

    ✓ Further study and review of medication management services

- ✓ Further study and review of the processes used to gather information and records during the access process (from the initial call to access through the assessment process)

- Complaint, grievance and appeal data has been one factor in quality improvement efforts towards:

  - ✓ Providing trauma based services
  - ✓ Assuring staff is trained on Dignity and Respect and Consumer Rights
  - ✓ Clarifying policies and procedures regarding the outpatient discharge process
  - ✓ The development of a medication management transfer policy to ensure seamless transition to primary care physicians

NORTH SOUND MENTAL HEALTH ADMINISTRATION
COMPLAINT, GRIEVANCE, APPEAL, DENIAL, AND FAIR HEARING REPORT
October 1, 2005 through March 31, 2006

I. INTRODUCTION

The NSMHA reports grievance, fair hearing, appeal, and denial data in accordance with Mental Health Administration reporting templates. In addition, the NSMHA provides information about complaint data in a separate format as complaints account for the majority of complaint, grievance, and fair hearing information used for quality management activities. The NSMHA continues to report and unduplicate this information through multiple reporting sources (Ombuds services, providers, designees, networks, and the NSMHA).

The NSMHA continues to promote a "no-blame" atmosphere in which to view complaint data – that information about complaints creates opportunities for improvement and that consumers' voicing concerns or ideas for improvement is one form of consumer voice in a recovery based system.

In this report we will:

- Provide an overview of complaint, grievance, denial, appeal and fair hearing data
- Provide follow-up from previous Complaint, Grievance, Appeal, and Fair Hearing Reports, Quality Management Activities or Recommendations
- Provide an overview of internal provider quality improvement activities and Ombuds services recommendations
- Outline future plans

II. COMPLAINT, GRIEVANCE, APPEAL, DENIAL, AND FAIR HEARING DATA OCTOBER 2005 THROUGH MARCH 2006

A. Grievance and Fair Hearing Data

There was an increase in grievance and fair hearing cases (people) and occurrences (types and levels of concerns) reported since the last reporting period. There were twelve (12) grievance or fair hearing cases and twenty (20) grievance and/or fair hearing occurrences (as compared to five cases and five occurrences in the last reporting period). *(See Attachments A – Exhibit N 05-07 Report-PIHP-Medicaid Services Only and Exhibit N- 05-07 Report-RSN State Funded Services Only).*

Eleven (11) grievance occurrences were at the provider level and six (6) were at the PIHP level. There were three (3) fair hearing occurrences. All twenty (20) grievance or fair hearing occurrences were for persons who had Medicaid funding. One grievance occurrence involved a child, the rest involved adults.

B. Complaint, Grievance, and Fair Hearing Data

The overall number of complaint, grievance, and fair hearing occurrences reported also increased from 288 to 368 since the last reporting period. The number of cases (people) reported remained relatively stable (There was an increase from 234 to 238 since the last reporting period). The number of complaints reported that involve children decreased from 71 to 65.

The categories that accounted for the most complaints during the current reporting period are: Consumer Rights 75 (20 %), Physicians and Medications 54 (15%), Financial and Administrative Services 41 (11%), Access 37 (10%) and Dignity and Respect 37 (10%). A review of the data shows that Consumer Rights 124 (19%), Physicians and medications 92 (14%), Access 84 (13%), Financial and Administrative Services 62 (9%), and Dignity and Respect 54 (8%) accounted for the most complaints over the past year.

When combined Dignity and Respect and Consumer Rights accounted for 112 (30%) occurrences (Dignity and Respect is one of the consumer rights).

The NSMHA continues to break out the overall complaint, grievance, and fair hearing data by Medicaid and state-funded consumers. The majority of reported complaints, grievances, and fair hearings filed continue to be for Medicaid consumers. Of the 238 reported cases, 211 were for Medicaid consumers and 27 were for state-funded consumers. Of the 368 occurrences reported, 336 were for Medicaid consumers and 32 were for state-funded consumers.

The NSMHA has developed several tables to assist in identifying trends and provide information about complaints over time. *(See Attachment B – "NSMHA Table 1 – Complaints, Grievances, and Fair Hearings Filed Reporting From 4-1-2000 through 3-31-2006 (with accompanying graphs)" and Attachment C – "NSMHA Table 2 – Complaint, Grievance, and Fair Hearing Data – Past 6 Months, Past Year, since 4-1-2000").*

The data in these tables includes complaints, grievances, and fair hearings for both Medicaid and state-funded consumers. In addition, the category of Access now includes access to inpatient and outpatient.

The NSMHA continues to collapse the new categories of violation of confidentiality and participation in treatment into the category of other. We will separate out these two (2) new categories in future tables so we can track them over time. (For this reporting period there were two (2) complaints reported for violation of confidentiality (Medicaid consumers) and no complaints or grievances reported for participation in treatment.

C. Denial and Appeal Data

1. Denials

The overall number of denials for Medicaid consumers has remained relatively stable. There were 122 denials for Medicaid consumers in the current reporting period, as compared to 129 in the previous reporting period *(See Attachment A – Exhibit N 05-07 Report-PIHP-Medicaid Services Only).* All 122 denials were for access to outpatient services by the NSMHA. For all 122 outpatient denials, the NSMHA determined that the Medicaid individuals did not meet the state defined access to care criteria, which are incorporated into the NSMHA Access to Care Standards.

On October 1, 2005 inpatient authorization was transitioned from the Associated Provider Network (APN) to the Volunteers of America (VOA). There were no denials for inpatient authorization by the

Volunteers of America, as compared with six (6) denials for inpatient service issued by the Associated Provider Network during the previous reporting period.

There was a decrease in denials for adults and an increase in denials for children. (Forty seven denials were regarding adults and seventy-five denials were regarding children, as compared with sixty-five denials for adults and sixty-four denials for children during the previous reporting period). The NSMHA has expressed concerns related to the Access to Care criteria for children to the MHD, as we are concerned that the criteria may be too restrictive.

2. Appeals

There were two (2) appeals initiated with the NSMHA during this reporting period. *(See Attachment D – PIHP Exhibit N Notice of Action Appeals Report 05-06)* as compared with 5 during the previous reporting period. Both appeals were handled through the standard appeals process and decided within 45 days. There were no requests for expedited appeals.

Both appeals regarded the denial of outpatient mental health services for adults. For both appeals the original denial decision was overturned during the appeals process. The NSMHA has developed a table to track the number of denials and appeals over time *(See Attachment E).*

III. FOLLOW UP FROM PREVIOUS COMPLAINT, GRIEVANCE, APPEAL, and FAIR HEARING REPORTS- QUALITY MANAGEMENT RECOMMENDATIONS and ACTIVITIES

As outlined in previous reports, information about complaints, grievances, appeals, denials, and fair hearings remains central to the NSMHA and provider's quality management processes. Complaint, grievance, appeal, denial, and fair hearing data and reports are reviewed in the NSMHA Internal Quality Management Committee (IQMC), Regional Quality Management Committee (RQMC), and Quality Management Oversight Committee (QMOC).

The identification of system implications or trends, areas for further study and review, or areas for quality improvement may be generated at each level of the process. In addition, complaint data has become increasingly more central to individual providers' internal quality management processes.

A brief summary of follow up to recommendations or activities in previous complaint and grievance reports is presented below.

A. <u>Medication Management Services</u>

As outlined in the last report, medication management services, including access and triage to medication management services and discharge from medication management services has been identified as an area for further study and review. (Ombuds services identified concerns about access to prescribers and medication services and the number of complaints in this category has shown an increase over time).

Update: *A review of the data in the current reporting period shows that complaints regarding physicians and medications continue to increase over time. The NSMHA Internal Quality Management Committee (IQMC) is currently evaluating ways to study this area, clarify the issues, and identify existing data sources. The NSMHA will discuss these ideas in QMC and QMOC.*

B. <u>Access Process</u>

As outlined in the last report, the processes used to gather information and records during the access process

(from the initial call to access through the assessment process) has been identified as an area for further study and review. (This recommendation was made in light of the need to establish consumer eligibility for services within a short time frame with the goal of maximizing the potential for complete information when establishing consumer eligibility for services).

Update: *The region wide Access system is undergoing a process of transition from Compass Health to the Volunteers of America. The NSMHA is also restructuring the process for Authorization of Outpatient Services. When these transition processes are complete the NSMHA will review this recommendation to determine how to proceed.*

C. Increased Reliability in the Reporting Process

As outlined in the last report, increased reliability in the reporting process is an area identified for continuous quality improvement. Training by Ombuds services on their use of the complaint type categories was identified as a first step. Ombuds services provided this initial training to the Regional Quality Management Committee.

Update: *The NSMHA continues to have the goal of increased reliability in the reporting process. Providers have also expressed interest in this goal and have requested further discussion, training and clarification of the reporting procedures. The NSMHA will identify next steps with the QMC.*

D. Outpatient Discharge Process

As discussed previously in this report, the NSMHA outlined the need for standardization of the outpatient discharge process (based in part on Ombuds services complaints from consumers and in part on new requirements). The NSMHA and providers began a subcommittee of the Regional Quality Management Committee (RQMC) to clarify discharge policies and procedures.

Policies regarding continued stay/authorization criteria, criteria for closing an episode of care/planned discharge from treatment, and medication management transfers to primary care physicians have been completed.

Update: *The policy regarding 30-day written notice of termination to consumers was approved by QMC and will be presented to QMOC and the NSMHA Board of Directors.*

E. Broad and Consistent Reporting of Complaints

As outlined above and in previous reports, the NSMHA has made it a goal to work towards broad and consistent reporting of complaints across multiple reporting sources. Part of this goal includes capturing concerns that occur at the provider level when consumers are not involved in Ombuds services.

As there have been few emergency services complaints reported by some NSMHA providers, broad and consistent reporting of emergency services complaints was identified as an area for quality improvement and addressed through the NSMHA Integrated Crisis Response System (ICRS) Committee. Broad and consistent reporting of complaints that involve children was also identified as an area for quality improvement

Update: *The NSMHA continues to track the number and percentages of complaints and cases reported by Ombuds services and providers. The percentage of cases reported by Ombuds services decreased slightly since the last reporting period. (67% of cases were reported by Ombuds services as compared with 69% percent during the previous reporting period). The percentage of complaints, grievance, or fair hearing occurrences reported by Ombuds services increased since the last reporting period (75% of occurrences were reported by Ombuds services as compared with 70% during the previous reporting period). (See Attachment F-Table 4).*

The NSMHA also continues to track the number of emergency services complaints reported by each reporting source. Results for the latest reporting period show that emergency services complaints by some provider's remains low. (See Attachment F-Table 5).

Although the number of occurrences and cases reported that involve children showed a slight decrease since the last reporting period, the number of cases and occurrences involving children during the past year has shown an increase as compared with previous years. (See Attachment B for information about complaint reporting for children over time).

F. Trauma Services

In previous reports, we have discussed quality improvement efforts related to complaint and grievance data in the area of treatment for trauma and trauma-based disorders. In previous reports we also reported that the NSMHA and providers established a trauma disorder workgroup and that although the workgroup has ended, the Regional Quality Management Committee (RQMC) will continue to work to increase the access to and quality of services for those with trauma-based disorders.

The NSMHA and providers, through the RQMC, have continued to focus on trauma and work on objectives established by the trauma workgroup. The four recommendations approved by QMC and QMOC outlined in the last report were:

- Adoption of the clinical guideline for Posttraumatic Stress Disorder (PTSD) for adults (pending final revisions)
- Use of the trauma screening tool when trauma is suspected or reported
- Completion of a NSMHA Regional Training Plan module for PTSD
- Invitations by QMOC to the three (3) trauma pilot projects to make presentations at future QMOC meetings under the topic "Quality in Action".

Update: *Since the last report:*

- *WCPC has implemented the regionally approved trauma screening tool when trauma is suspected or reported*
- *WCPC presented the results and current status of their trauma program to QMOC as par of the topic "Quality in Action".*
- *The draft NSMHA Regional Training Plan module for PTSD training has gone to the regional training committee for review. This training module is currently being piloted by providers. It is anticipated that at the next regional training committee meeting the feedback from the pilot will be reviewed for the final draft training module for QMC and QMOC approval.*

The NSMHA will make the final revisions to the clinical guideline for Posttraumatic Stress Disorder (PTSD).

G. Dignity and Respect

As outlined on previous reports, Dignity and Respect has been identified as a training priority on the NSMHA Regional Training Plan.

Update: *The Regional Training Committee is in the process of updating the regional training plan. As Dignity and Respect continue to be a training priority for providers and the NSMHA it is anticipated that this topic will continue on the new Regional Training Plan for 2006-2007.*

H. Region Wide Diagnostic Practice Standards

As outlined in the previous reports the NSMHA has instituted the practice of reviewing appeals that result in the reversal of the original denial decision by the region. Based in part on this review, the NSMHA and providers adopted a set of practice standards for the diagnostic process designed to provide consistent, uniform and complete diagnosis during the assessment process.

Update: The providers have implemented the diagnostic practice standards. The NSMHA has seen an increase in the consistency and quality of the diagnostic formulations used in the assessment process. The NSMHA and providers continue to evaluate the consistency of the diagnostic formulation during the assessment process to ensure consistent regional application of eligibility standards outlined in the statewide Access to Care Standards.

IV. PROVIDER QUALITY IMPROVEMENT ACTIVITIES and OMBUDS RECOMMENDATIONS

As outlined in previous reports, the Providers continue to provide semi-annual information to the NSMHA about how they use complaint and grievance information in their internal quality management processes.

The NSMHA continued to receive positive examples from providers about how they are incorporating complaint data into their quality management processes and how consumer concerns can lead to areas for further study and review or as areas identified for continuous quality improvement. Some examples are:

- Compass Health initiated quality improvement activities regarding Quality/Appropriateness and Dignity and Respect complaints. Part of their process included further categorizing the types of complaints in these areas to help identify clusters of issues within these categories, and clusters of programs in which these complaints arose.
- Compass Health reports that their action taken regarding that data had positive results. They will continue to review and further categorize the complaints from this period in these areas, bring the results of this review to their Quality Committee, and determine further action based on the review.
- Catholic Community Services has identified that complaints from clients about how they are treated (respectfulness, communication style, lack of responsiveness or dependability) indicate an area for further study and possible quality improvement efforts. Their initial plans will focus on discussion about whether supervisors are made aware early on about problems that are brewing, which allows pre-emptive consultation or supervisor intervention. Their Quality Improvement Committee discussion will also focus on whether there is a need for staff in-service, focused discussion in team meetings, or individual supervision to address specific staff improvement needs.
- Compass Health has revised their New Employee Orientation to include more information about Complaints and Grievances and have developed a Tool Box Training on Resolving Complaints for Managers to utilize in training staff.
- Sea Mar experienced an increase in complaints regarding psychiatric services and medications due to a change in psychiatric providers that resulted in some scheduling difficulties and problems for some clients transitioning to a new provider. Sea Mar has identified that it is important to ensure that adequate back-up is in place should a

psychiatric provider decide to leave the agency so that there is no interruption of services and the transition to a new provider can seamlessly occur. Sea Mar has also identified the need for clinicians to work with clients to ensure that issues regarding the loss of a psychiatric provider are processed and the transition to a new provider is eased as much as possible.

The NSMHA Ombuds services also provide a semi-annual summary of their data and recommendations for quality improvement. Ombuds services report that while their number of cases and occurrences usually drop during the winter months, this was not the case during the current reporting period. While the number of cases (people) remained stable, occurrences increased to 256, the highest number reported by Ombuds services.

Ombuds services also report that complaints about consumer rights reached the highest ever at 66, and that there are many consumer rights, and consumers have a sense that they are not receiving their rights as readily as they deserve. Financial occurrences rose to 34. Ombuds services report that Flex funds have essentially disappeared and Ombuds consumers seem to have mounting personal financial problems. Ombuds services also noted that physicians and meds occurrences rose to 31. Access occurrences remained at 27. Housing occurrences also remained at 24 and dignity and respect occurrences rose to an all time high of 21.

Some of Ombuds services recommendations for quality improvement focus include:
(1) Hospitalization and involuntary treatment-Ombuds services reports clients who cannot get into involuntary treatment due to capacity issues, especially on weekends. They also report they have spoken with clients who come out of the hospital or involuntary treatment and are disappointed with the treatment they received.
(2) Ombuds services recommend the NSMHA and providers work jointly on issues that are causing everyone frustration—funding, documentation, time availability, case overload, medication management outsourcing, the RFQ and the Quality Management program.

V. FUTURE PLANS

The NSMHA continues to work towards broad and consistent reporting of complaints across multiple reporting sources and will continue to work towards increased reliability in reporting.

The NSMHA Internal Quality Management Committee (IQMC) will review the current complaint and grievance data and report, make recommendations for further study and review or quality improvement, and present these recommendations to the Regional Quality Management Committee and Regional Quality Management and Oversight Committee.

In addition to reviewing the aggregate data in these reports to identify any trends, individual complaints, grievances, or appeals with system implications, or patterns or clusters of complaints, grievances, or appeals with system implications will be reviewed and used to generate quality improvement activities or identify areas for further study and review. The NSMHA will continue to work closely with Ombuds services to address any emerging patterns or clusters of complaints and incorporate this information into quality management processes.

The NSMHA will also continue the practice of reviewing appeals that result in the reversal of the original denial decision in order to ensure this process is reliable, adheres to standards, and identifies areas for potential quality improvement.

The NSMHA and providers will continue to collaborate to use information about complaints, grievances, appeals, denials, and fair hearings as opportunities for quality improvement.