NORTH SOUND
MENTAL HEALTH ADMINISTRATION

QUALITY MANAGEMENT OVERSIGHT COMMITTEE

COMMITTEE MEETING PACKET

March 28, 2007

QMOC GUIDING PRINCIPLES

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

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

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

NORTH SOUND MENTAL HEALTH ADMINISTRATION
QUALITY MANAGEMENT OVERSIGHT COMMITTEE AGENDA

Date: March 28, 2007
Time: 12:30-2:30 PM
Location: NSMHA Conference Room
For Information Contact Meeting Facilitator Greg Long/Debra Jaccard, NSMHA, 360-416-7013

Topic	Objective	ACTION NEEDED	Discussion Leader	Handout available pre-mtg	Handout available at mtg	Pg.	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			5 min
Announcements	Inform QMOC of news, events: • PACT RFP • RFP	Inform/discuss	DEBRA/ALL				10 min
Comments from the Chair	Update the committee on recent developments that impact QMOC- • Board actions	Inform	Chair				5 min
Policy Sub-Committee Report	Review and discuss policies reviewed by QMC	Review and approve	GARY WILLIAMS	Report In			5 min
EQRO Final Report	QMOC to Review	Review and Discuss	GREG/DEBRA/ALL		Available at www.nsmha.org/reports		10 min
Exhibit N	Inform QMOC of April-September 06 Exhibit N Report	Discuss & Review	DIANA STRIPLIN	Packet	Attach		15

Quality in Action: CPET Process and Activities	Inform QMOC of future plans of the Children's Policy Executive Committee	Informational	JULIE DE LOSADA, ANGUS MCCLANE				15
PI Measures	QMOC to Discuss	Discuss & review	DIANA/GREG				10
Crisis Services Policies	QMOC to Review	Review and approve	SANDY WHITCUTT/GREG LONG		Attach		10
Regional Training Committee	Review Charter Regional Training Plan Tribal/PTSD Training Modules/Online Test Answers and Recruitment	Inform & discuss	DEBRA/CHARISSA	Attach	Attach		20
Date and Agenda for Next Meeting	Ensure meeting date, time and agenda are planned.		All				
*Review of Meeting	Were objectives accomplished? How could this meeting be improved?		All				

Next meeting April 25, 2007, 12:30-2:00

Potential Agenda Items: **Policy Sub-Committee Update**
Integrated Report
QM Plan
CI Report

North Sound Mental Health Administration
Quality Management Oversight Committee
NSMHA Conference Room
February 28, 2007
12:30 – 2:30
DRAFT MINUTES

Present:
Gary Williams, Whatcom County
Debra Jaccard, NSMHA
Rochelle Clogston, Compass Health
Russ Hardison, Sea Mar
Dr. June LaMarr, the Tulalip Tribes
Chuck Davis, North Sound Ombuds
Deborah Moskowitz, North Sound Ombuds
Dan Bilson, NSMHA Advisory Board
Mary Good, NSMHA Advisory Board
Shannon Solar, NSMHA

Not Present:
Maile Acoba, Skagit County

Excused:
Janet Lutz-Smith, NSMHA Advisory Board
Mike Manley, Snohomish County Human Services
Susan Ramaglia, Advocate
Karen Kipling, VOA

Others Present:
Marta Pierson, Guest
Greg Long, NSMHA
Charissa Fuller, NSMHA

1. Introductions

The meeting was convened at 12:35 pm.

2. Review and Approval of Agenda

The agenda was reviewed and no additions were made.

3. Review and Approval of January 2007 Minutes

The minutes from the previous meeting were reviewed and Chair Williams noted a workgroup to focus on residential councils was going to be formed. Chuck Davis updated they have formed, reviewed WAC, contacted LWC about forming a council with them; their management council is discussing it. Rochelle asked that Terry Clark's name be removed from the attendee list. A motion was made to approve the minutes with those changes.

4. Announcements

- Debra announced some things going on at the region – the PACT program was awarded to consortium of Bridgeways, Sunrise Services, and Compass Health. The contract is close to being signed. Hiring will start soon.
- System Change Update: Debra noted the RFP process is out for submissions which are due March 14th. There will be a 4-6 decision making process with a review committee. NSMHA received a preliminary EQRO report which was positive. The final report will be brought to next month's QMOC meeting.
- Greg noted the Children's Policy Executive Team has started taking action – NSMHA and Children's Administration are both having a part-time person work on Children's issues. At NSMHA this person will be Julie de Losada. Children's Administration and NSMHA

are developing a FAST program to divert children from being hospitalization and to stabilize them at their placement. Deborah asked if this program will serve region one. Julie de Losada and the Children's Administration rep will attend QMOC next month.

- Gary noted Whatcom County has been funding a program similar to FAST and that he would like to be part of the planning of the FAST program.

5. Comments from the Chair

Chair Williams noted discussion on many levels all the way up to the state on housing and its relationship to our population. Housing has a huge impact on effectiveness of service. Gary noted he is going to Washington D.C. to study a housing program used in England.

6. Policy Sub-committee Report

Chair Williams noted this committee has continued to meet and went over policies 1505 and 1717. Debra noted policy 1505 has been worked over multiple times. A motion was made to approve policy 1505. Motion seconded, carried, all in favor. Debra noted policy 1717 was a re-naming only. No motion was needed to approve.

7. Pre-PIP #3 Summary Mortality Review

Debra noted the Critical Incident Review Committee had concerned with a trend of consumers under 50 passing away with no apparent reason. This is currently a pre-PIP. Charissa added that national literature shows persons with mental illness are dying 20-25 years younger than the general population. There are a variety of reasons this may be happening. 22 charts were studied and included in a pre-investigation mortality review and results reflected national studies. Chair Williams noted concern that there is a challenge for consumers to find primary care. Deborah noted some prescribers feel they can not be responsible for medical care, Rochelle noted we need to be careful to stay in our 'sphere of influence'; we cannot control primary care physicians. Chair Williams noted there is a breakdown as primary care physicians expect MH case managers to get consumers to medical sessions etc. Deborah noted communication with prescribers could make steps to improvements.

Dr. LaMarr noted the effort has to be collaborative, at Tulalip; MH case managers have access to doctors. Russ noted Sea Mar has a medical clinic, behavioral health case managers are there to help client with medical issues/appointments etc. and are monitored on the treatment plan.

Russ noted Sea Mar created a behavioral health technician position, who works closely with doctors in the medical clinic. This has been going on for about three months and is successful.

Chair Williams noted this issue may have to go to policy & procedure in order for providers to spell out what they can do to make sure their clients get the array of services they require. Debra noted there is a health/medical information sheet filled out at assessment. PCP's are frustrated with the responsiveness of MH. There is also an access/availability issue as many PCP's only take a certain amount of Medicaid consumers.

Greg noted NSMHA has hired Tom Yost a part-time employee to work on system collaboration; he is currently working on coordination with health care systems.

Rochelle noted we may be doing things already we are not tracking and suggested looking at what is already in place. Deborah noted we also need to know what is place with PCP's. Gary noted this is a serious area to examine as we are talking about losing lives and asked if we wanted to make this a regional PIP. Charissa felt it could be a PIP.

Rochelle made a recommendation that Tom Yost, NSMHA Planning Specialist, examine what we are doing regionally to work with primary care physicians to ensure we are having good communication with them and building from there. Group agreed.

Chair Williams made an additional recommendation that upon Tom Yost's completion of the system review (by June) we will review the status to see if this will be a PIP.

8. Quality in Action—Trauma Based Training Opportunities
Marta Pierson spoke to the committee to discuss training resources available on trauma, describing classes she teaches and proposing a pilot project to provide training to 125-150 participants on Trauma Recovery. Marta held a trauma workshop primarily for clinicians. Deborah noted there are not sufficient trauma resources to meet the need. Deborah and Chuck Davis attended a one-day training by Marta at CCS and were impressed. Marta noted she held a yearlong group therapy program and feels this is the only way to inflict lasting change. Deborah noted this Proposed Pilot for training would affect many people. Chuck noted every client he has dealt with has had trauma issues and experience things that re-traumatize them, Marta could teach the clients how to deal with this. The group thanked Marta for presenting.

9. Crisis Service Policies
Greg noted the two ICRS policies 1701 and 1703 were brought to the group for approval.

In policy 1701 Greg noted 'DCR' will be added to be included where 'emergency services workers; is mentioned in policy 1703. Gary noted page 2 of 6 in policy 1703, replacing mention of APN enrolled to 'enrolled clients' to make verbiage more generic. Rochelle noted there are a number of APN references in the policy and if they are all going to be pulled out, it should go back to the policy subcommittee for review.

Policy 1703 – A motion was made to approve the policy. Motion seconded, carried, all in favor.

10. Clinical Redesign Implications for Provider Training Needs
Debra passed out copies of the children and adult LOCUS models. Charissa read from her summary of the LOCUS tools. This assessment tool will be used in addition to the assessment done currently. This tool will determine what level of care clients receive and also will help to monitor that clients are receiving the right services.

Dr. LaMarr asked to see the research literature on the tool, Charissa noted she will locate this.
Reps from Parker Dennison, two main trainers of this system will be coming to doing the training. The tentative trainer is Mary Thornton.

11. Date and Agenda for Next Meeting
The next meeting will be held on Wednesday, March 28th, 2007. Chair

Respectfully submitted,

Shannon Solar

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

NORTH SOUND MENTAL HEALTH ADMINISTRATION
COMPLAINT, GRIEVANCE, APPEAL, DENIAL, AND FAIR HEARING REPORT
SUMMARY

April 1, 2006 through September 30, 2006

INTRODUCTION and PURPOSE

- The NSMHA continues to report grievance, fair hearing, appeal, and denial data in accordance with the Mental Health Division reporting templates and requirements. The Mental Health Division now requires reporting in variable increments rather than 6 month periods. For this reporting period the MHD also required reporting for the standard 6 month period. The Mental Health Division no longer requires the reporting of complaint data

- 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. The NSMHA also continues to collect this data by 6 month periods as we have done since 1999.

- Therefore in this report we will include the required Mental Health Division reporting formats as well as the expanded reporting used for additional quality management purposes by the NSMHA.

- 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.*

- Single complaints or grievances with system implications, patterns or clusters of complaints or grievances, and/or overall complaint and grievance data are used to identify areas for further study and review or quality improvement

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

- The overall number of complaint, grievance and fair hearing occurrences reported decreased from 368 to 275 since the last reporting period, and the number of cases (people) reported decreased from 238 to 176 since the last reporting period.

- Several reporting changes may account for some of this reduction in reporting. NSMHA Ombuds services have refined their reporting to reflect only complaints about publicly funded Mental Health Services. The NSMHA and Ombuds services will work to refine this aspect of reporting for future reports. In addition, the NSMHA has operationalized the term "case" to reflect the number of unduplicated people during a reporting period.

- The categories that accounted for the most reported complaints during the current reporting period are: ***Physicians and medications*** 44 (16%), ***Dignity and Respect*** 38 (14%), ***Access*** 34 (12%), ***Emergency Services*** 26 (9%), and ***Consumer Rights*** 22 (8 %),

- A review of the data shows that ***Physicians and medications*** 98 (15%) ***Consumer Rights*** 97 (15%), ***Dignity and Respect*** 75 (12%) ***Access*** 71 (11%), and ***Financial and Administrative Services*** 56 (9%) accounted for the most complaints over the past year.

- **When combined,** *Dignity and Respect* and *Consumer Rights* **accounted for 60 (22%) occurrences as compared to 112 (30%) during the previous reporting period (*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 176 reported cases, 163 were for Medicaid consumers and 13 were for state-funded consumers. Of the 275 occurrences reported, 260 were for Medicaid consumers and 15 were for state-funded consumers.**

- **There was an decrease in grievance and fair hearing cases (people) and occurrences (types and levels of concerns) reported since the last reporting period (There were seven (7) grievance or fair hearing cases and seven (7) grievance or fair hearing occurrences (as compared to twelve (12) cases and twenty (20) occurrences in the last reporting period). The NSMHA and Ombuds services will also meet to review grievance reporting to assure that the multiple occurrences (types) are reported consistently at the grievance and fair hearing level.**

- **The overall number of denials for Medicaid consumers has increased since the last several reporting periods. There were 181 denials for Medicaid consumers in the current reporting period, as compared to 122, 129, and 128 in the previous three (3) reporting periods. Denials for children remain higher than for adults. There were 99 denials for children and 82 for adults. Fifty seven (57) percent of the denials over the past year were for children. Four (4) of the 181 reported denials were for inpatient services.**

- There were four (4) appeals reported for the current period. Two (2) appeals involved services for children and two (2) for adults. For all 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 and occurrences reported by Ombuds services is the lowest since 1993 when we began keeping this data. One factor may be the changes in Ombuds reporting outlined above.

- As outlined in previous reports increased reliability in the reporting process is an area identified for continuous quality improvement. Ombuds services completed initial training to the Regional Quality Management Committee (RQMC) on their use of the complaint type categories. The NSMHA also provided region wide training to Ombuds and providers. The NSMHA anticipates continued training in this area and will continue to 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 (RQMC) and Quality Management and Oversight Committee (QMOC).

- **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 approved during the last reporting cycle include:

  ✓ **Inpatient Capacity** Recommendation for further study and review of inpatient capacity (Ombuds services raised concerns regarding inpatient capacity). After review in RQMC, the recommendation was made to refer inpatient capacity to Management Council and/or the NSMHA Planning Committee. RQMC consensus was that we cannot compartmentalize approaches to this issue and that we need to create capacity and review the systems that are in place regarding inpatient services.

  ✓ **Dignity and Respect and Consumer Rights** Recommendation to Monitor dignity and respect and consumer rights issues over the next 6 months and in future reporting cycles

  ✓ **Trauma** Recommendation to discuss and evaluate the status of the trauma project (There continue to be some complaints concerning the availability of trauma services).

  ✓ **Flex funds** Recommendation to increase flex funds (Ombuds services report that at times flex funds were unavailable when needed to assist consumers)

  ✓ **System Tensions and Frustrations** Ombuds services recommendation that the NSMHA and providers work jointly on issues that are causing systems frustration for example funding, documentation, time availability, case load sizes, and medication management capacity concerns to decrease system tensions from impacting consumers. The recommendation is to refer this to management council so that there is a discussion regarding ways to prevent future system tensions from impacting consumers (per ombuds report).

- Several NSMHA grievances with system implications were discussed in the NSMHA Internal Quality Management Committee and Regional Quality Management Committees:

  ✓ **Adult Attention Deficit Hyperactivity Disorder** The NSMHA received several grievances related to the treatment for Adult Attention Deficit Hyperactivity (ADHD) Disorder over the last several reporting periods. The NSMHA IQMC recommended to RQMC that Clinical Practice Guidelines for Adult Attention Deficit Hyperactivity Disorder be prioritized for development. This recommendation and the guidelines were approved and adopted by RQMC.

  ✓ **Eating Disorders** The NSMHA also received several grievances related to the treatment for eating disorders over the last several reporting periods. The NSMHA IQMC has discussed the need to clarify the continuum of care for eating disorders on a region wide basis. Initially, IQMC recommended to RQMC that Clinical Practice Guidelines for eating disorders be prioritized for

development. At the time, this area was not prioritized for development. The NSMHA will revisit this issue in future IQMC and RQMC meetings.

- Updates on PREVIOUS Quality Management Recommendations:

  ✓ **Medication Management Services** Further study and review to include access and triage to medication management services, medication management capacity, and discharge from medication management services. (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 shows that complaints regarding physicians and medications accounted for the most complaints in the current reporting period and the most complaints over the past year. The NSMHA Internal Quality Management Committee (IQMC) completed a plan to study medication management services and clarify any issues. The plan was reviewed by the NSMHA Medical Directors Committee and RQMC. . In addition to this study process, the NSMHA and providers, for the next contracting period, has adopted a modified fee for service model that will purchase an increase in medication management services.*

  ✓ **Region Wide Access Process** 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 (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: *As discussed in the last report 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.*

  ✓ **Reliability in the Complaint and Grievance Reporting Process** Increased reliability in the reporting process.

  Update: *As outlined in previous reports Ombuds services completed initial training to the Regional Quality Management (RQMC) on their use of the complaint type categories. Since that time the NSMHA provided region wide training to Ombuds and providers. The NSMHA anticipates continued training in this area and will continue to identify next steps in the RQMC. In addition the NSMHA and Ombuds services plan to meet to work on continued standardization of the reporting format.*

- 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
  ✓The development of region wide **diagnostic practice standards**

NORTH SOUND MENTAL HEALTH ADMINISTRATION
COMPLAINT, GRIEVANCE, APPEAL, DENIAL, AND FAIR HEARING REPORT
April 1, 2006 through September 30, 2006

I. INTRODUCTION

The NSMHA continues to report grievance, fair hearing, appeal, and denial data in accordance with the Mental Health Division's reporting templates and requirements. The Mental Health Division now requires reporting in variable increments rather than 6 month periods. For this reporting period the MHD also required reporting for the standard 6 month period. The Mental Health Division no longer requires the reporting of complaint data.

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.

The NSMHA continues to report and unduplicate this information through multiple reporting sources (Ombuds services, providers, designees, networks, and the NSMHA).

The NSMHA will also continue to collect this data by 6 month periods as we have done since 1999, in addition to the variable timelines. Therefore in this report we will include the required Mental Health Division reporting formats as well as the expanded reporting used for additional quality management purposes by 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 a summary of quality management recommendations from the previous reporting period and subsequent quality management cycle
- Provide follow-up from previous complaint, grievance, appeal, denial and fair hearing 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 APRIL 2006 THROUGH SEPTEMBER 2006

The NSMHA reported grievance, appeal, fair hearing and denial data to the Mental Health Division for both April through September 2006 and for the month of September 2006 as required in contracts with the Mental Health Division. The NSMHA also collected data for complaints for April through September 2006.

A. Grievance and Fair Hearing Data

There was a decrease in grievance and fair hearing cases (people) and occurrences (types and levels of concerns) reported for April through September 2006 as compared to the last reporting period. There were seven (7) grievance or fair hearing cases and seven (7) grievance or fair hearing occurrences reported for April through September 2006 as compared to twelve (12) cases and twenty (20) occurrences for October 2005 through March 2006. Five (5) of the grievance cases and occurrences were reported at the NSMHA level and two (2) at the provider level. All cases and occurrences were for adults who had Medicaid funding.

A review of the grievance files and data for the most recent period suggests that multiple occurrences were not reported at the grievance level. The NSMHA and Ombuds services will meet to review grievance reporting to assure that multiple occurrences (types) are reported consistently at the grievance and fair hearing level.

The NSMHA also was required to report the number of grievances and fair hearings for September of 2006. There were no reported grievances or fair hearings for September. *(See Attachments A – PIHP Grievances and Denials 6 months, PIHP Grievances and Denials September, SMHC Grievances 6 months, and SMHC Grievances September).*

B. Complaint, Grievance, and Fair Hearing Data

There was a decrease in overall complaint, grievance and fair hearing cases (people) and occurrences (types and levels of concerns) reported for April through September 2006 as compared to the last reporting period. There were 176 cases (people) and 275 occurrences reported for April through September 2006 as compared to 238 cases (people) and 368 occurrences for October 2005 through March 2006.

Several reporting changes may account for some of this reduction in reporting. NSMHA Ombuds services have refined their reporting to reflect only complaints about publicly funded Mental Health Services. The NSMHA and Ombuds services will work to refine this aspect of reporting for future reports. In addition, the NSMHA has operationalzed the term “case” to reflect the number of unduplicated people during a reporting period.

The categories that accounted for the most reported complaints during the current reporting period are: Physicians and medications 44 (16%), Dignity and Respect 38 (14%), Access 34 (12%), Emergency Services 26 (9%), and Consumer Rights 22 (8 %).

A review of the data shows that Physicians and medications 98 (15%) Consumer Rights 97 (15%), Dignity and Respect 75 (12%) Access 71 (11%), and Financial and Administrative Services 56 (9%) accounted for the most complaints over the past year.

When combined, Dignity and Respect and Consumer Rights accounted for 60 (22%) occurrences as compared to 112 (30%) during the previous reporting period (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 176 reported cases, 163 were for Medicaid consumers and 13 were for state-funded consumers. Of the 275 occurrences reported, 260 were for Medicaid consumers and 15 were for state-funded consumers.

The NSMHA has developed several tables to assist in identifying trends and provide information about complaints over time *(See Attachments C – Table 1, Table 2, and Charts)*. 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 six (6) complaints reported for violation of confidentiality and four (4) complaints reported for participation in treatment (Medicaid consumers).

C. Denial and Appeal Data

1. Denials

The overall number of denials for Medicaid consumers has increased since the last several reporting periods. There were 181 denials for Medicaid consumers for April through September 2006, as compared to 122, 129, and 128 in the previous three (3) reporting periods. Four (4) of the 181 reported denials were for inpatient services.

The NSMHA realized that they did not report denials for September only in the original reporting materials sent to the Mental Health Division and have included them in this report (*See Attachment A – PIHP Grievances and Denials September).*

Denials for children remain higher than for adults. There were 99 denials for children and 82 for adults. Fifty seven (57) percent of the denials over the past year were for children. As outlined in the previous report 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. The NSMHA understands that the MHD is currently reviewing the Access to Standards for Children.

2. Appeals

There were four (4) appeals reported for April through September 2006 and none reported for September only. *(See Attachments B-- Appeals PIHP 6 months and Appeals PIHP September).* Two (2) appeals involved services for children and two (2) for adults. For all appeals the original denial decision was overturned during the appeals process.

All appeals were handled through the standard appeals process and decided within 45 days. There were no requests for expedited appeals. The NSMHA has developed a table to track the number of denials and appeals over time *(See Attachment D--Appeals and Denials Over Time).*

III. QUALITY MANAGEMENT RECOMMENDATIONS and ACTIVITIES from PREVIOUS REPORTING PERIOD AND QUALITY MANAGEMENT CYCLE

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.

Single complaints or grievances with system implications, patterns or clusters of complaints or grievances, and/or overall complaint and grievance data are used to identify areas for further study and review or quality improvement.

The Complaint, Grievance, Appeal, Denial, and Fair Hearing Report for October 2005 through March 2006 was reviewed by IQMC, RQMC, and QMOC. A brief summary of recommendations or activities are presented below.

A. **Inpatient Capacity** Recommendation for further study and review of inpatient capacity (Ombuds services raised concerns regarding inpatient capacity). After review in RQMC, the recommendation was made to refer inpatient capacity to Management Council and/or the NSMHA Planning Committee. RQMC consensus was that we cannot compartmentalize approaches to this issue and that we need to create capacity and review the systems that are in place regarding inpatient services.

B. Dignity and Respect and Consumer Rights Recommendation to monitor dignity and respect and consumer rights issues over the next 6 months and in future reporting cycles

C. Trauma Recommendation to discuss and evaluate the status of the trauma project (There continues to be some complaints concerning the availability of trauma services).

D. Flex Funds Recommendation to increase flex funds (Ombuds services report that at times flex funds were unavailable when needed to assist consumers)

E. **System Tensions and Frustrations** Ombuds services recommendation that the NSMHA and providers work jointly on issues that are causing systems frustration for example funding, documentation, time availability, case load sizes, and medication management capacity concerns to decrease system tensions from impacting consumers. The recommendation is to refer this to management council so that there is a discussion regarding ways to prevent future system tensions from impacting consumers (per ombuds report).

In addition, several NSMHA grievances with system implications were discussed in the NSMHA Internal Quality Management Committee and Regional Quality Management Committees. These discussions are summarized below.

A. Adult Attention Deficit Hyperactivity Disorder

The NSMHA received several grievances related to the treatment for Adult Attention Deficit Hyperactivity Disorder (ADHD) over the last several reporting periods. The NSMHA IQMC recommended to RQMC that Clinical Practice Guidelines for Adult Attention Deficit Hyperactivity Disorder be prioritized for development. This recommendation and the guidelines were approved and adopted by RQMC.

B. Eating Disorders

The NSMHA also received several grievances related to the treatment for eating disorders over the last several reporting periods. The NSMHA IQMC has discussed the need to clarify the continuum of care for eating disorders on a region wide basis. Initially, IQMC recommended to RQMC that Clinical Practice Guidelines for eating disorders be prioritized for development.

At the time, this area was not prioritized for development. The NSMHA will revisit this issue in future IQMC and RQMC meetings.

A. IV. FOLLOW UP FROM PREVIOUS COMPLAINT, GRIEVANCE, APPEAL, and FAIR HEARING QUALITY MANAGEMENT RECOMMENDATIONS and ACTIVITIES

A brief summary of follow up to previous recommendations or activities is presented below.

A. Medication Management Services

As outlined in the previous reports, medication management services, including access and triage to medication management services, medication management capacity, and discharge from medication management services has been identified as an area for further study and review. (Ombuds services 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 shows that complaints regarding physicians and medications accounted for the most complaints in the current reporting period and the most complaints over the past year. The NSMHA Internal Quality Management Committee (IQMC) completed a plan to study medication management services and clarify any issues. The plan was reviewed by the NSMHA Medical Directors Committee and RQMC. In addition to this study process, the NSMHA and providers, for the next contracting period, has adopted a modified fee for service model that will purchase an increase in medication management services.*

B. Region Wide Access Process

As outlined in previous reports, 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: *As discussed in the last report 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, Ombuds Services, and providers continue to have the goal of increased reliability in the reporting process. Providers have requested further discussion, training and clarification of the reporting procedures. Since the last report, the NSMHA also provided region wide training to Ombuds and providers with the goal of increasing the reliability of the reporting process. The NSMHA anticipates continued training in this area and will continue to identify next steps in the RQMC. In addition the NSMHA and Ombuds services plan to meet to work on continued standardization of the reporting format.*

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 RQMC.*

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 and grievances 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 complaint and grievance occurrences and cases reported by Ombuds services and providers. The percentage of cases and occurrences reported by Ombuds services is the lowest since 1993 when we began keeping this data.*

As outlined above, the NSMHA Ombuds services refined their reporting to reflect only complaints about publicly funded Mental Health Services, which may account for some of the reduction in the percentage of cases and occurrences reported through Ombuds service. The NSMHA and Ombuds services will work to refine this aspect of reporting for future reports. In addition, the NSMHA has operationalzed the term "case" to reflect the number of unduplicated people during a reporting period. This may also have impacted reporting (See Attachment E-for additional information about cases and occurrences over time).

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 E--for additional information about emergency services reporting over time).

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 C—Table 1 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. We also reported that RQMC and QMOC approved four recommendations.

Update: *The NSMHA and providers, through the RQMC, have continued to focus on trauma and work on objectives established by the trauma workgroup. Progress on objectives since the last report includes:*

- ***Posttraumatic Stress Disorder (PTSD) Clinical Guidelines:*** *The final revisions to the Posttraumatic Stress Disorder (PTSD) clinical guidelines for adults were completed, and the guidelines were approved by QMC, QMOC, and adopted by the NSMHA Board*
- ***Trauma Screening Tool:*** *There has been continued implementation of the trauma screening tool when trauma is suspected or reported*
- ***Trauma Training:*** *The NSMHA Regional Training Plan module for PTSD was completed and is now part of the regional training plan*
- ***"Quality in Action" Presentations to QMOC by the Three Trauma Pilot Projects:*** *There have been no new presentations since Whatcom Counseling and Psychiatric Clinic's presentation regarding their trauma pilot project.*

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 2006-2007 Regional Training Plan has been approved and Dignity and Respect continues to be a prioritized training topic.*

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 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.***

B. 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 has also begun to collect information about how this information is integrated into provider Quality Management Plans.

A. Provider Quality Improvement Activities

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 is doing further analysis on complaints regarding Physicians and Medications to clarify what sub-categories can be identified, and compare that information with previous reporting periods. They will also be reviewing the data based on program to identify if there are a cluster of complaints about a prescriber or prescribers in a particular program.

- Compass Health has also made efforts to increase the number of complaints tracked that did not come through Ombuds services, as a way of ensuring that a) consumers feel comfortable expressing complaints and b) they are recording and capturing the fact that they receive, address, and resolve complaints on a regular basis.

- Catholic Community Services (CCS) has identified the need for increased attention to vulnerabilities during transition times when clinicians leave their employment to assist clients and their families to connect to their new clinician.

- CCS also identified the continued need for effective strategies for engaging parents in the treatment of their children and teens if parents are fearful or ambivalent about being involved.

- CCS is also working to increase their consistency of complaint reporting across multiple locations and requests continued work region wide to clarify reporting categories.

- Lake Whatcom Center (LWC) has continued to further define and separate the landlord/tenant program and representative payee program from their clinical services, as a result of a NSMHA level grievance.

- LWC also revised their clients' rights training which staff receive within ten days of hire and invited Ombuds services, Chuck Davis, to provide information on respect and dignity at all staff training. .

- Sea Mar has identified the goal of reducing turnover of psychiatric staff and finding a regular, permanent prescriber who can get to know their consumers and establish an ongoing working relationship regarding medications.

- Sea Mar has also addressed Dignity and Respect issues through in-service trainings at their all staff meetings to reaffirm their organization's commitment to treating all clients in a respectful, dignified manner.

B. Ombuds Services Recommendations

The NSMHA Ombuds services also provide a semi-annual summary of their data and recommendations for quality improvement. Some of Ombuds services recommendations for quality improvement focus include:

(1) Physicians & Medications Issues- Ombuds Services recommend that the NSMHA continue its plan for further study and review of medication management services and medication management capacity. Ombuds services also continue to report complaints regarding the transition of medications to primary care physicians.

(2) Dignity & Respect-Ombuds services recommend the NSMHA continue efforts towards addressing dignity and respect.

(3). Eating Disorders- Ombuds services recommend that the NSMHA develop a plan for treating clients with eating disorders, which is currently being considered by quality and management committees..

V. FUTURE PLANS

(1). 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.

(2). 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.

(3). 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.

(4). 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.

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

(6). The NSMHA will also continue to work with the Mental Health Division to clarify changes in the reporting format and changes in the contract regarding the grievance system. The NSMHA will update the Complaint, Grievance, Appeal, and Fair Hearing Polices to reflect these changes.

05-07 Report - PIHP - Medicaid Services Only

PIHP Name North Sound MHA

Contact Name: Diana Striplin

Contact Phone No. 360 416-7013

Reporting Period: (Month and Year) April , 2006 -September 30, 2006

Total Unduplicated Number of Adult Cases 7

Total Unduplicated Children Cases 0

Occurrence Adult (21 Yrs. and over)	CMHA Grievances	PIHP Grievances	Fair Hearings	Outstanding	Denials
Access to Outpatient					78
Dignity and Respect	1	1			
Quality/ Appropriateness		2			
Phone calls not returned					
Service -- Intensity, Not Available, Coordination					
Consumer Rights					
Physicians & Medications	1	1			
Financial & Admin Svs		1			
Transportation					
Emergency Services					
Access to Inpatient					4
Violation of Confidentiality					
Participation in Treatment					
Other					
Total	**2**	**5**	**0**		**82**

Occurrence Children (0-20 Yrs.)	CMHA Grievances	PIHP Grievances	Fair Hearing	Outstanding	Denials
Access to Outpatient					99
Dignity and Respect					
Quality/ Appropriateness					
Phone calls not returned					
Service -- Intensity, Not Available, Coordination					
Consumer Rights					
Physicians & Medications					
Financial & Admin Svs					
Transportation					
Emergency Services					
Access to Inpatient					
Violation of Confidentiality					
Participation in Treatment					
Other					
Total	**0**	**0**	**0**		**99**

Resolutions *Adult (21 Yrs. and over)*	CMHA Grievances	PIHP Grievances	Fair Hearings	Outstanding from Last Period	
Info/Referral					
Referral to QRT					
Conciliation/Mediation	2	4			
Arbitration					
Fair Hearing					
Other					
Not Pursued		1			
Total	**2**	**5**	**0**		**0**

Resolutions *Children (0-20 Yrs.)*	CMHA Grievances	PIHP Grievances	Fair Hearing	Outstanding from Last Period	
Info/Referral					
Referral to QRT					
Conciliation/Mediation					
Arbitration					
Fair Hearing					
Other					
Not Pursued					
Total	**0**	**0**	**0**		**0**

05-07 Report - PIHP - Medicaid Services Only

PIHP Name North Sound MHA

Contact Name: Diana Striplin

Contact Phone No. 360 416-7013

Reporting Period: (Month and Year) September 1 2006-September 30, 2006

Total Unduplicated Number of Adult Cases 0

Total Unduplicated Children Cases 0

Occurrence Adult (21 Yrs. and over)	CMHA Grievances	PIHP Grievances	Fair Hearings	Outstanding	Denials
Access to Outpatient					7
Dignity and Respect					
Quality/ Appropriateness					
Phone calls not returned					
Service -- Intensity, Not Available, Coordination					
Consumer Rights					
Physicians & Medications					
Financial & Admin Svs					
Transportation					
Emergency Services					
Access to Inpatient					
Violation of Confidentiality					
Participation in Treatment					
Other					
Total	**0**	**0**	**0**		**7**

Occurrence Children (0-20 Yrs.)	CMHA Grievances	PIHP Grievances	Fair Hearing	Outstanding	Denials
Access to Outpatient					20
Dignity and Respect					
Quality/ Appropriateness					
Phone calls not returned					
Service -- Intensity, Not Available, Coordination					
Consumer Rights					
Physicians & Medications					
Financial & Admin Svs					
Transportation					
Emergency Services					
Access to Inpatient					
Violation of Confidentiality					
Participation in Treatment					
Other					
Total	**0**	**0**	**0**		**20**

Resolutions *Adult* (21 Yrs. and over)	CMHA Grievances	PIHP Grievances	Fair Hearings	Outstanding from Last Period	
Info/Referral					
Referral to QRT					
Conciliation/Mediation					
Arbitration					
Fair Hearing					
Other					
Not Pursued					
Total	**0**	**0**	**0**		**0**

Resolutions *Children* (0-20 Yrs.)	CMHA Grievances	PIHP Grievances	Fair Hearing	Outstanding from Last Period	
Info/Referral					
Referral to QRT					
Conciliation/Mediation					
Arbitration					
Fair Hearing					
Other					
Not Pursued					
Total	**0**	**0**	**0**		**0**

05-07 Report -- RSN -- State Funded Services Only

RSN Name North Sound MHA

Contact Name: Diana Striplin

Contact Phone #: 360 416-7013

Reporting Period: April 1-September 30, 2006 ***(Month and Year)***

Total Unduplicated Number of Adult Cases 0

Total Unduplicated Number of Children Cases 0

Occurrence ***Adult** (21 Yrs. and over)*	**CMHA Grievances**	**RSN Grievances**	**Fair Hearings**	**Outstanding**
Access				
Dignity and Respect				
Quality/ Appropriateness				
Phone calls not returned				
Service -- Intensity, Not Available, Coordination				
Consumer Rights				
Physicians & Medications				
Financial & Admin Svs				
Residential				
Housing				
Transportation				
Emergency Services				
Violation of Confidentiality				
Participation in Treatment				
Other				
Total	**0**	**0**	**0**	**0**

Occurrence ***Children** (0-20 Yrs.)*	**CMHA Grievances**	**RSN Grievances**	**Fair Hearings**	**Outstanding**
Access				
Dignity and Respect				
Quality/ Appropriateness				
Phone calls not returned				
Service -- Intensity, Not Available, Coordination				
Consumer Rights				
Physicians & Medications				
Financial & Admin Svs				
Residential				
Housing				
Transportation				
Emergency Services				
Violation of Confidentiality				
Participation in Treatment				
Other				
Total	**0**	**0**	**0**	**0**

Resolutions Adult (21 Yrs. and over)	CMHA Grievances	RSN Grievances	Fair Hearings	Outstanding from Last Period
Info/Referral				
Referral to QRT				
Conciliation/Mediation				
Arbitration				
Fair Hearing				
Other				
Not Pursued				
Total	0	0	0	0

Resolutions Children (0-20 Yrs.)	CMHA Grievances	RSN Grievances	Fair Hearing	Outstanding from Last Period
Info/Referral				
Referral to QRT				
Conciliation/Mediation				
Arbitration				
Fair Hearing				
Other				
Not Pursued				
Total	0	0	0	0

05-07 Report -- RSN -- **State Funded** Services Only

RSN Name North Sound MHA

Contact Name: Diana Striplin

Contact Phone #: 360 416-7013

Reporting Period: September 1-September 30, 2006

(Month and Year)

Total Unduplicated Number of Adult Cases 0

Total Unduplicated Number of Children Cases 0

Occurrence ***Adult** (21 Yrs. and over)*	**CMHA Grievances**	**RSN Grievances**	**Fair Hearings**	**Outstanding**
Access				
Dignity and Respect				
Quality/ Appropriateness				
Phone calls not returned				
Service -- Intensity, Not Available, Coordination				
Consumer Rights				
Physicians & Medications				
Financial & Admin Svs				
Residential				
Housing				
Transportation				
Emergency Services				
Violation of Confidentiality				
Participation in Treatment				
Other				
Total	**0**	**0**	**0**	**0**

Occurrence ***Children** (0-20 Yrs.)*	**CMHA Grievances**	**RSN Grievances**	**Fair Hearings**	**Outstanding**
Access				
Dignity and Respect				
Quality/ Appropriateness				
Phone calls not returned				
Service -- Intensity, Not Available, Coordination				
Consumer Rights				
Physicians & Medications				
Financial & Admin Svs				
Residential				
Housing				
Transportation				
Emergency Services				
Violation of Confidentiality				
Participation in Treatment				
Other				
Total	**0**	**0**	**0**	**0**

Resolutions *Adult (21 Yrs. and over)*	CMHA Grievances	RSN Grievances	Fair Hearings	Outstanding from Last Period
Info/Referral				
Referral to QRT				
Conciliation/Mediation				
Arbitration				
Fair Hearing				
Other				
Not Pursued				
Total	**0**	**0**	**0**	**0**

Resolutions *Children (0-20 Yrs.)*	CMHA Grievances	RSN Grievances	Fair Hearing	Outstanding from Last Period
Info/Referral				
Referral to QRT				
Conciliation/Mediation				
Arbitration				
Fair Hearing				
Other				
Not Pursued				
Total	**0**	**0**	**0**	**0**

Standard Appeals

	Resolution within **45** days	Resolutions: Wholly in favor of Enrollee	Resolutions: Partially in favor of Enrollee	Resolutions: Appeal Denied
Denials	2	2		
Reduction				
Suspensions				
Terminations				
Total	2	2		

	Resolution within **59** days	Resolutions: Wholly in favor of Enrollee	Resolutions: Partially in favor of Enrollee	Resolutions: Appeal Denied
Denials				
Reduction				
Suspensions				
Terminations				
Total	0			

Standard Appeals

	Resolution within **45** days	Resolutions: Wholly in favor of Enrollee	Resolutions: Partially in favor of Enrollee	Resolutions: Appeal Denied
Denials	2	2		
Reduction				
Suspensions				
Terminations				
Total	2	2		

	Resolution within **59** days	Resolutions: Wholly in favor of Enrollee	Resolutions: Partially in favor of Enrollee	Resolutions: Appeal Denied
Denials				
Reduction				
Suspensions				
Terminations				
Total	0			

PIHP Notice of Action Appeals Report 05-07

PIHP North Sound MHA

Report Period September 1-September30 2006

Expedited Appeals

ADULTS	Resolution within **3** working days	Resolutions: Wholly in favor of Enrollee	Resolutions: Partially in favor of Enrollee	Resolutions: Appeal Denied
Referred to Standard Appeals				
Denials				
Reduction				
Suspensions				
Terminations				
Total	0			

CHILDREN	Resolution within **3** working days	Resolutions: Wholly in favor of Enrollee	Resolutions: Partially in favor of Enrollee	Resolutions: Appeal Denied
Referred to Standard Appeals				
Denials				
Reduction				
Suspensions				
Terminations				
Total	0			

Standard Appeals

ADULTS	Resolution within **45** days	Resolutions: Wholly in favor of Enrollee	Resolutions: Partially in favor of Enrollee	Resolutions: Appeal Denied
Denials				
Reduction				
Suspensions				
Terminations				
Total	0			

CHILDREN	Resolution within **45** days	Resolutions: Wholly in favor of Enrollee	Resolutions: Partially in favor of Enrollee	Resolutions: Appeal Denied
Denials				
Reduction				
Suspensions				
Terminations				
Total	0			

Resolutions

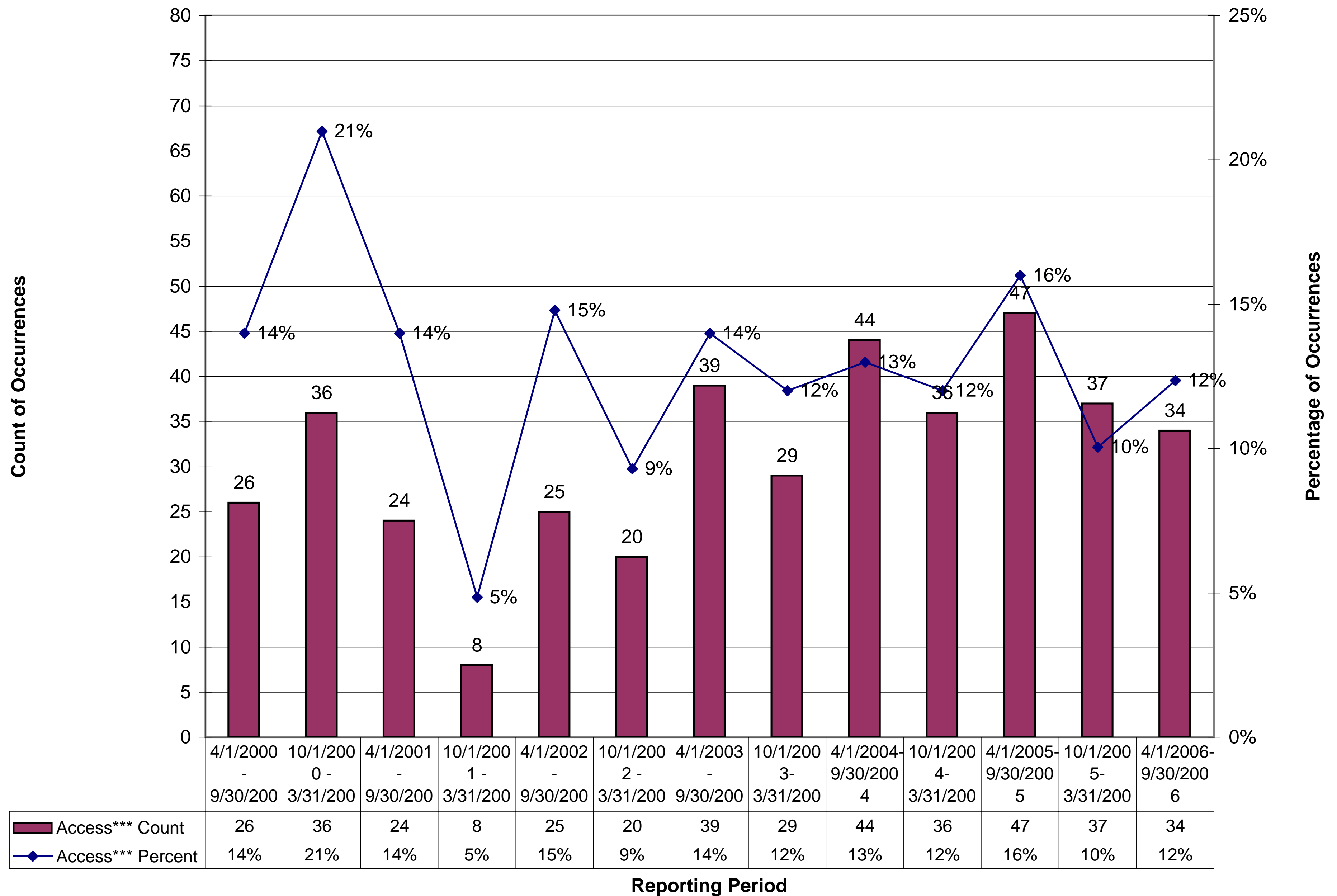
Resolutions

	Resolution within **59** days	Wholly in favor of Enrollee	Partially in favor of Enrollee	Appeal Denied
Denials				
Reduction				
Suspensions				
Terminations				
Total	0			

	Resolution within **59** days	Wholly in favor of Enrollee	Partially in favor of Enrollee	Appeal Denied
Denials				
Reduction				
Suspensions				
Terminations				
Total	0			

Attachment C
Complaints, Grievances,
and Fair Hearings Filed

Chart 1 -
Access

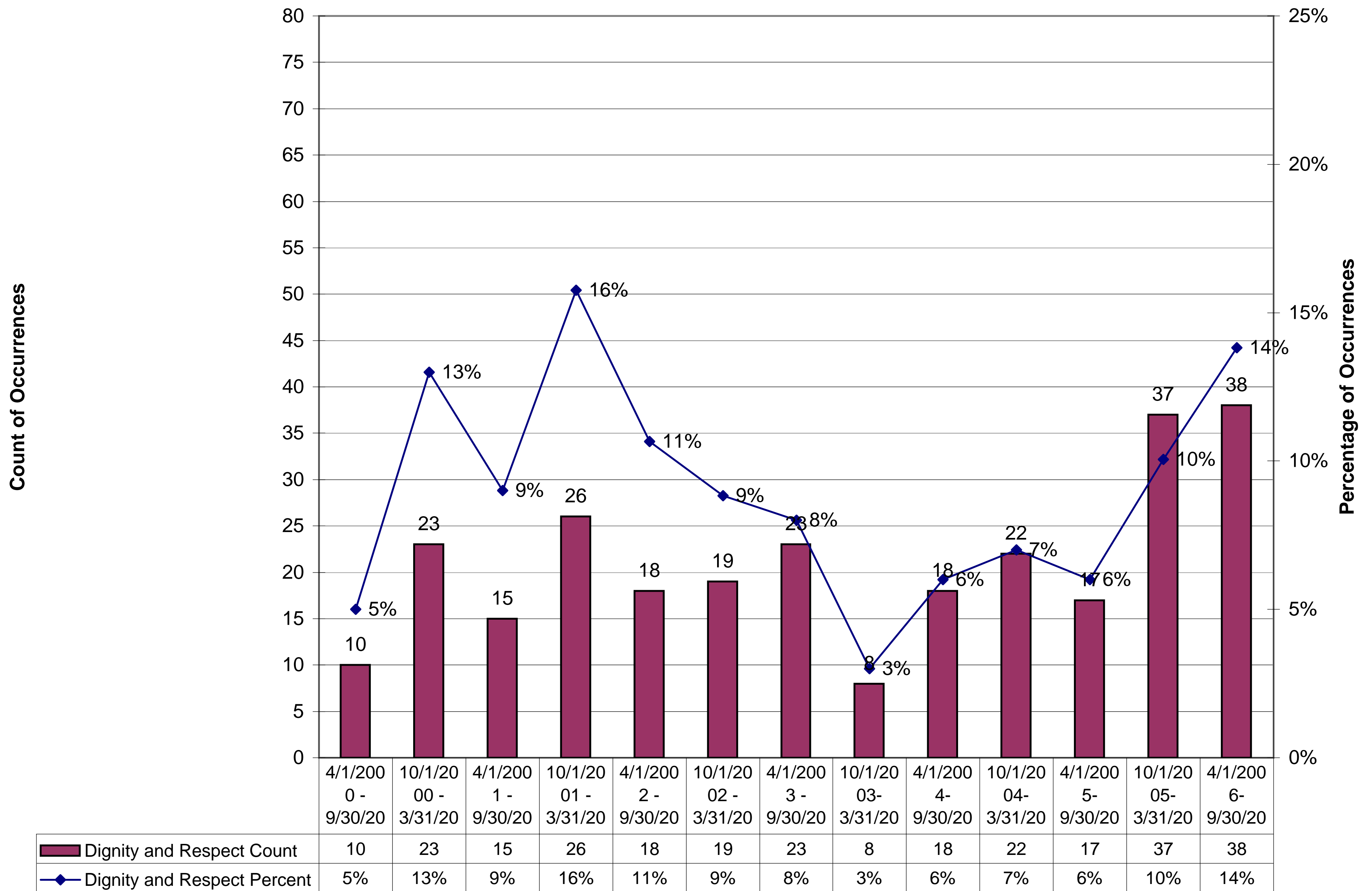


Reporting Period	4/1/2000 - 9/30/200	10/1/200 0 - 3/31/200	4/1/2001 - 9/30/200	10/1/200 1 - 3/31/200	4/1/2002 - 9/30/200	10/1/200 2 - 3/31/200	4/1/2003 - 9/30/200	10/1/200 3- 3/31/200	4/1/2004- 9/30/200 4	10/1/200 4- 3/31/200	4/1/2005- 9/30/200 5	10/1/200 5- 3/31/200	4/1/2006- 9/30/200 6
Access*** Count	26	36	24	8	25	20	39	29	44	36	47	37	34
Access*** Percent	14%	21%	14%	5%	15%	9%	14%	12%	13%	12%	16%	10%	12%

Printed on: 12/15/2006
MSWhite

Attachment C
Complaints, Grievances,
and Fair Hearings Filed

Chart 2 -
Dignity and Respect



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Dignity and Respect Count	10	23	15	26	18	19	23	8	18	22	17	37	38
Dignity and Respect Percent	5%	13%	9%	16%	11%	9%	8%	3%	6%	7%	6%	10%	14%

Reporting Period

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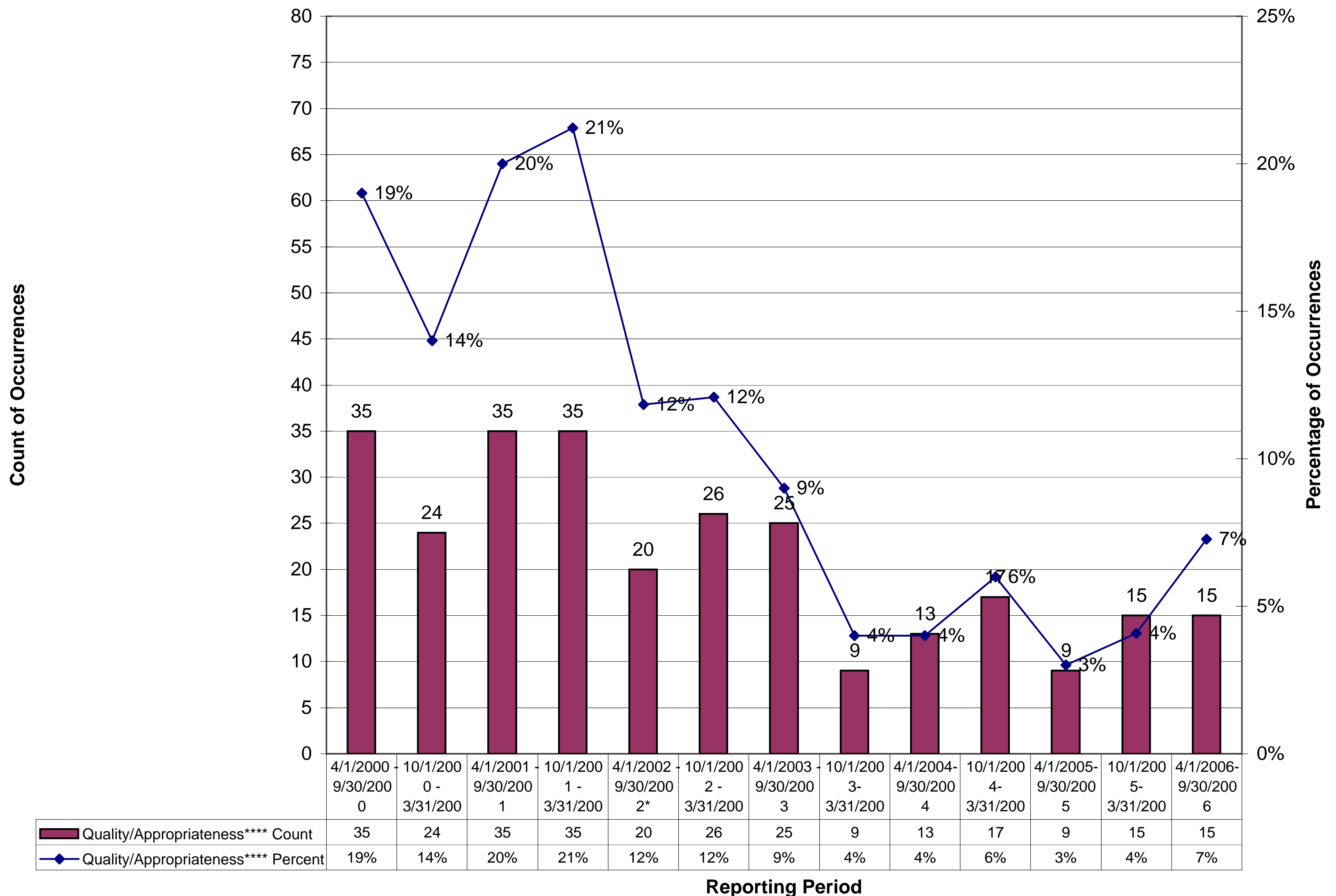
Attachment C
Complaints, Grievances,
and Fair Hearings Filed

Chart 3 -
Quality/Appropriateness



	4/1/2000 - 9/30/2000	10/1/2000 - 3/31/2001	4/1/2001 - 9/30/2001	10/1/2001 - 3/31/2002	4/1/2002 - 9/30/2002*	10/1/2002 - 3/31/2003	4/1/2003 - 9/30/2003	10/1/2003- 3/31/2004	4/1/2004- 9/30/2004	10/1/2004- 3/31/2005	4/1/2005- 9/30/2005	10/1/2005- 3/31/2006	4/1/2006- 9/30/2006
Quality/Appropriateness**** Count	35	24	35	35	20	26	25	9	13	17	9	15	15
Quality/Appropriateness**** Percent	19%	14%	20%	21%	12%	12%	9%	4%	4%	6%	3%	4%	7%

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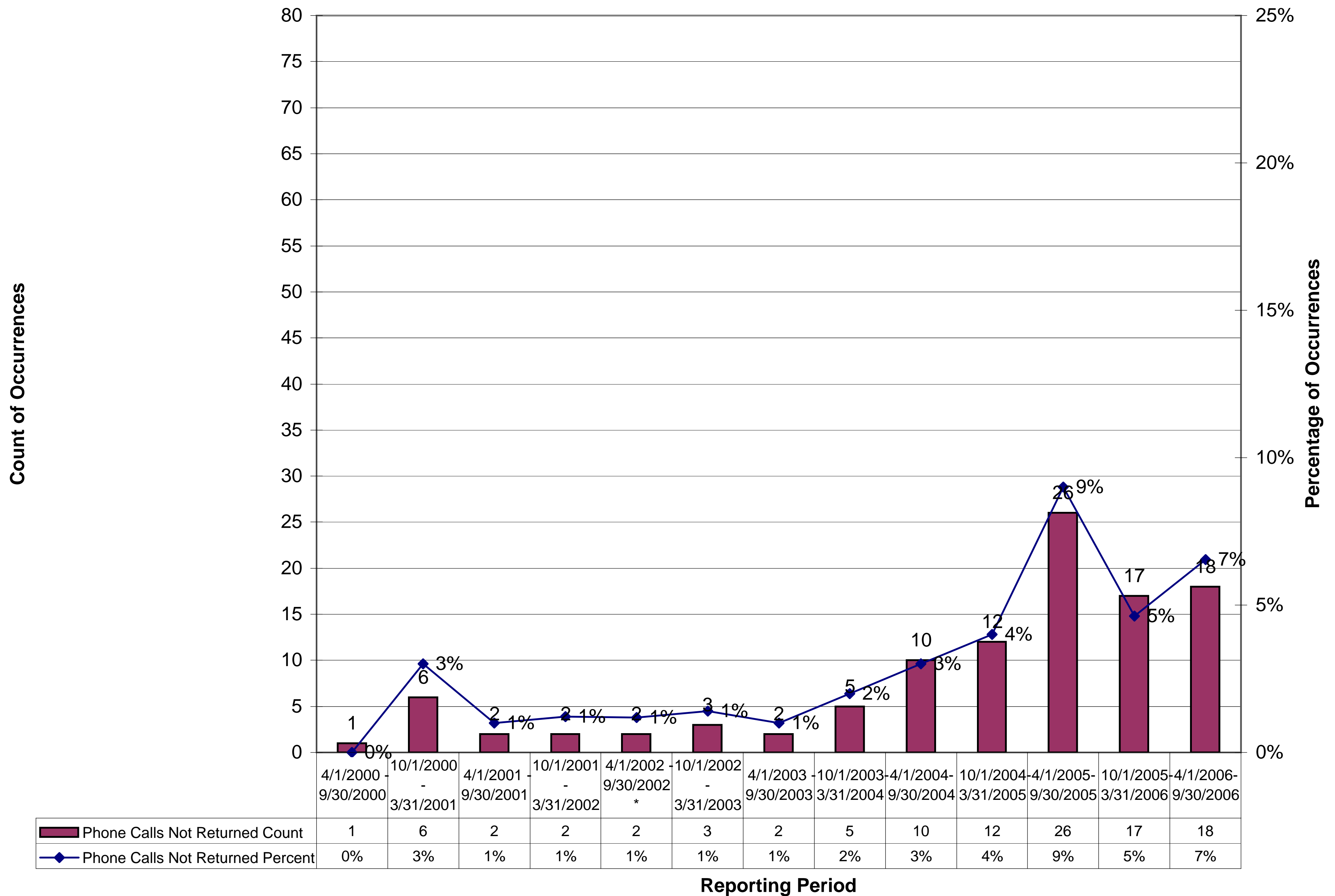
Attachment C
Complaints, Grievances,
and Fair Hearings Filed

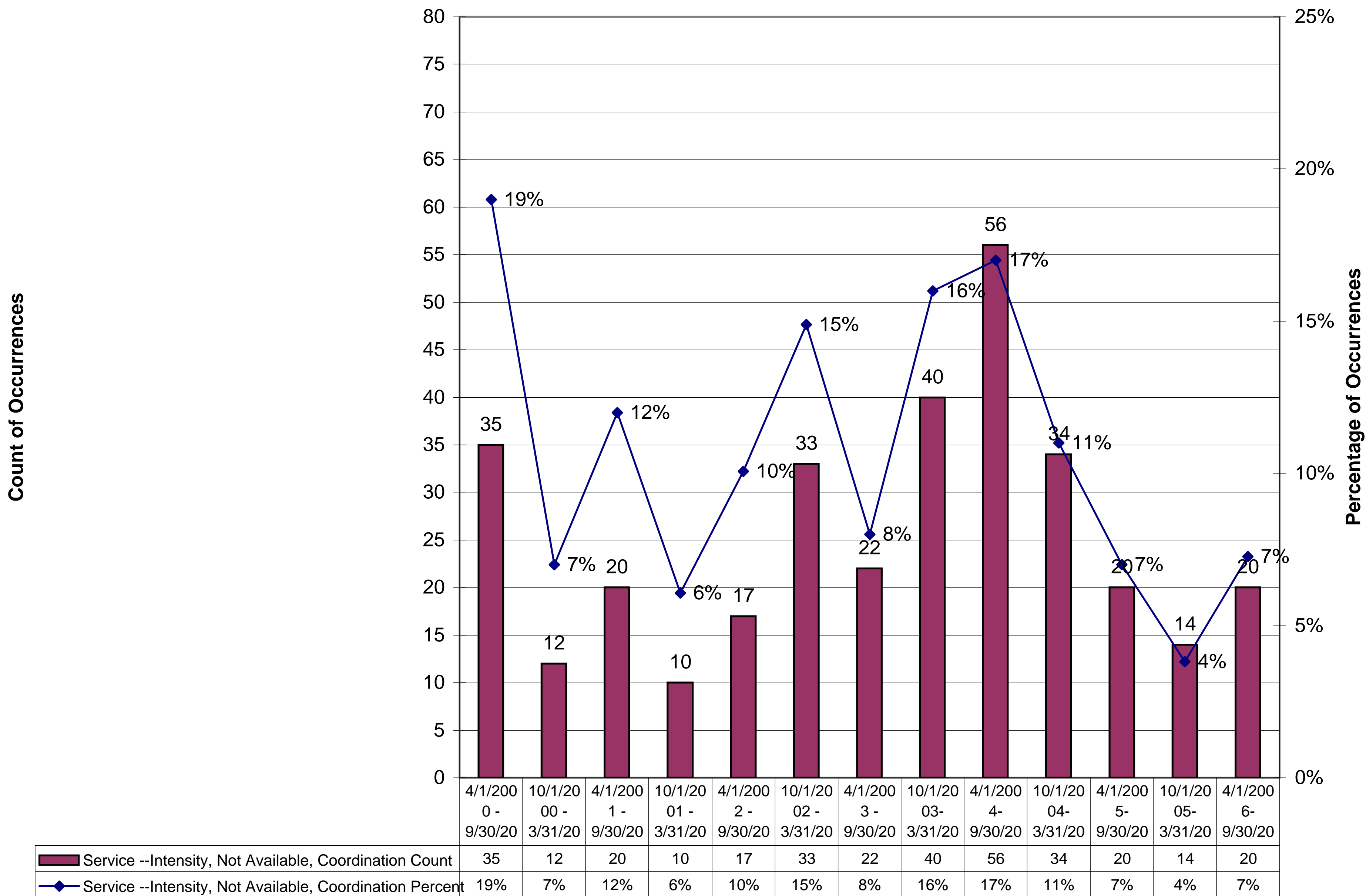
Chart 4 -
Phone Calls



Attachment C
Complaints, Grievances,
and Fair Hearings Filed

Chart 5 -

Service -- Intensity, Not Available, Coordination



	4/1/2000 - 9/30/20	10/1/2000 - 3/31/20	4/1/2001 - 9/30/20	10/1/2001 - 3/31/20	4/1/2002 - 9/30/20	10/1/2002 - 3/31/20	4/1/2003 - 9/30/20	10/1/2003- 3/31/20	4/1/2004- 9/30/20	10/1/2004- 3/31/20	4/1/2005- 9/30/20	10/1/2005- 3/31/20	4/1/2006- 9/30/20
Service --Intensity, Not Available, Coordination Count	35	12	20	10	17	33	22	40	56	34	20	14	20
Service --Intensity, Not Available, Coordination Percent	19%	7%	12%	6%	10%	15%	8%	16%	17%	11%	7%	4%	7%

Reporting Period

Printed on: 12/15/2006
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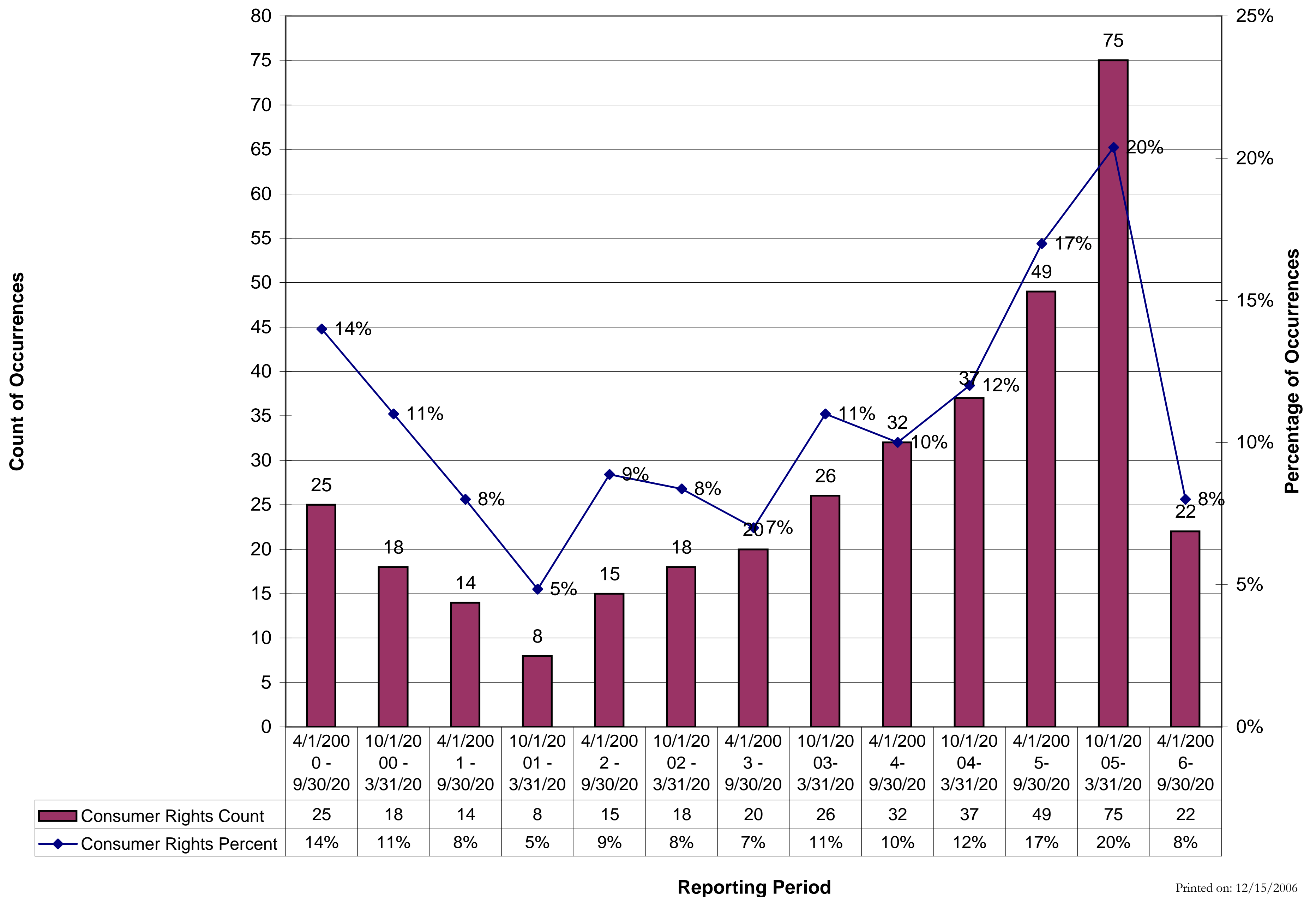
Attachment C
Complaints, Grievances,
and Fair Hearings Filed

Chart 6 -

Consumer Rights



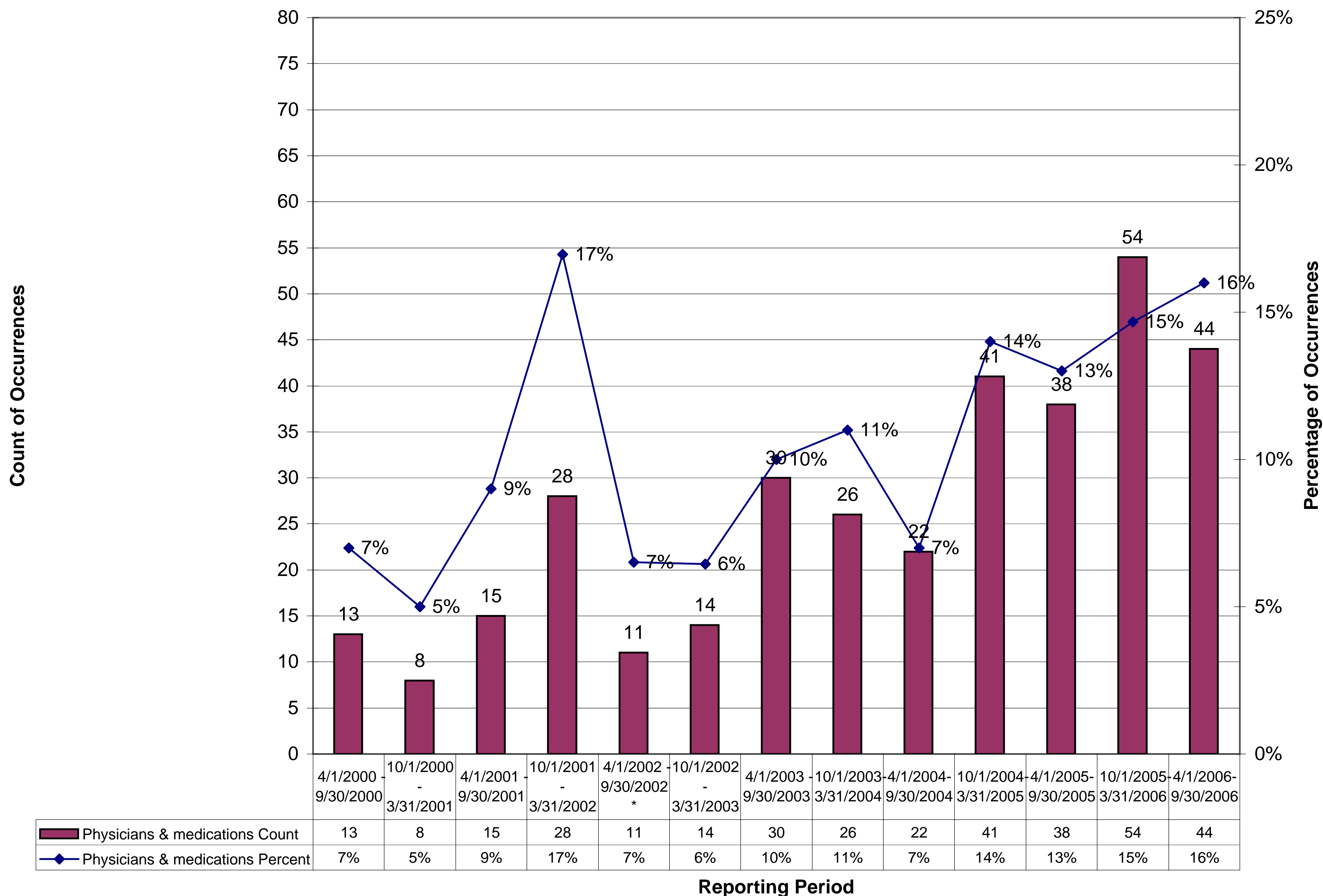
	4/1/2000 - 9/30/20	10/1/2000 - 3/31/20	4/1/2001 - 9/30/20	10/1/2001 - 3/31/20	4/1/2002 - 9/30/20	10/1/2002 - 3/31/20	4/1/2003 - 9/30/20	10/1/2003- 3/31/20	4/1/2004- 9/30/20	10/1/2004- 3/31/20	4/1/2005- 9/30/20	10/1/2005- 3/31/20	4/1/2006- 9/30/20
Consumer Rights Count	25	18	14	8	15	18	20	26	32	37	49	75	22
Consumer Rights Percent	14%	11%	8%	5%	9%	8%	7%	11%	10%	12%	17%	20%	8%

Printed on: 12/15/2006
MSWhite

Attachment C
Complaints, Grievances,
and Fair Hearings Filed

Chart 7 -

Physicians & Medications



	4/1/2000 - 9/30/2000	10/1/2000 - 3/31/2001	4/1/2001 - 9/30/2001	10/1/2001 - 3/31/2002	4/1/2002 - 9/30/2002 *	10/1/2002 - 3/31/2003	4/1/2003 - 9/30/2003	10/1/2003- 3/31/2004	4/1/2004- 9/30/2004	10/1/2004- 3/31/2005	4/1/2005- 9/30/2005	10/1/2005- 3/31/2006	4/1/2006- 9/30/2006
Physicians & medications Count	13	8	15	28	11	14	30	26	22	41	38	54	44
Physicians & medications Percent	7%	5%	9%	17%	7%	6%	10%	11%	7%	14%	13%	15%	16%

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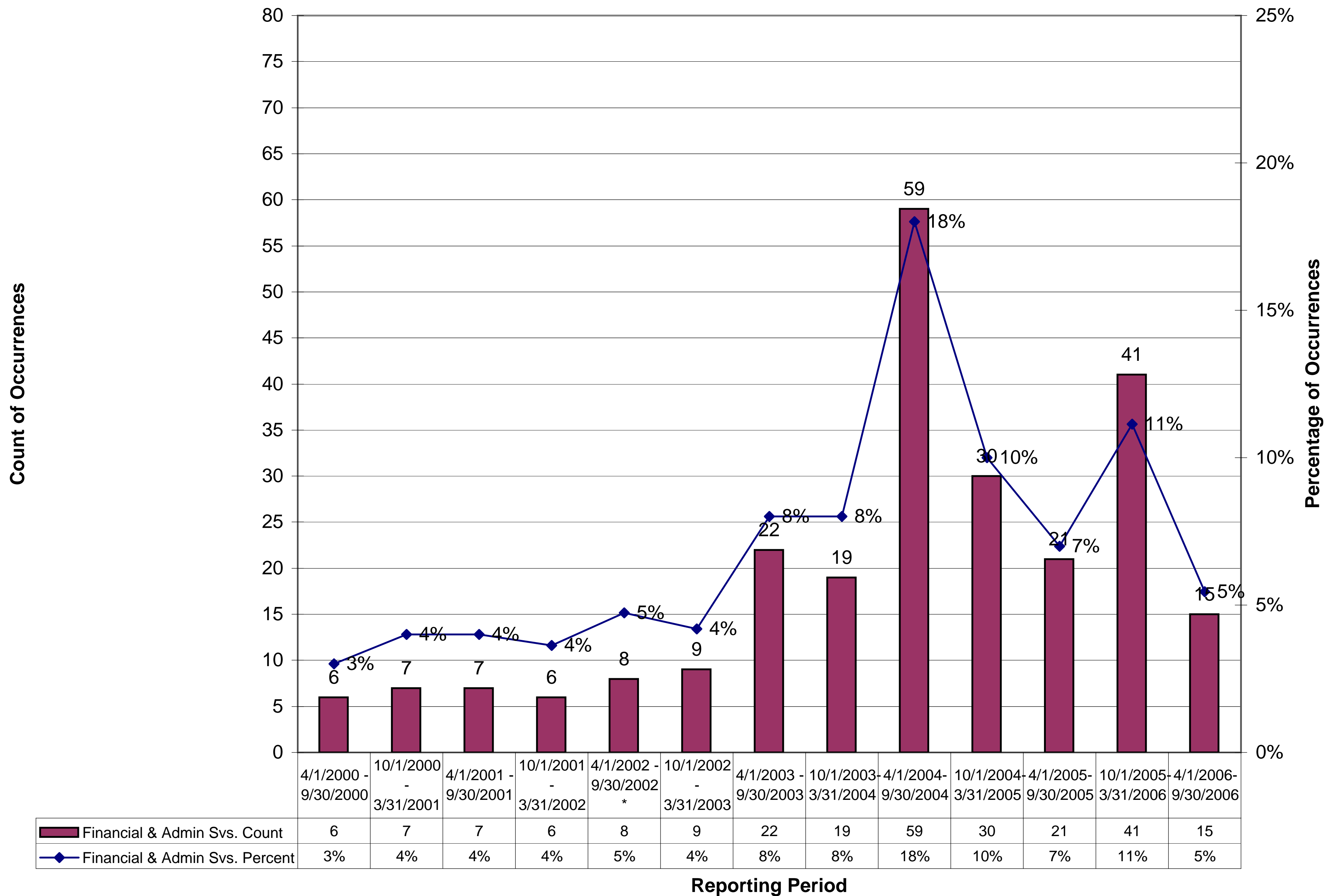
Attachment C
Complaints, Grievances,
and Fair Hearings Filed

Chart 8 -
Financial & Admin. Services



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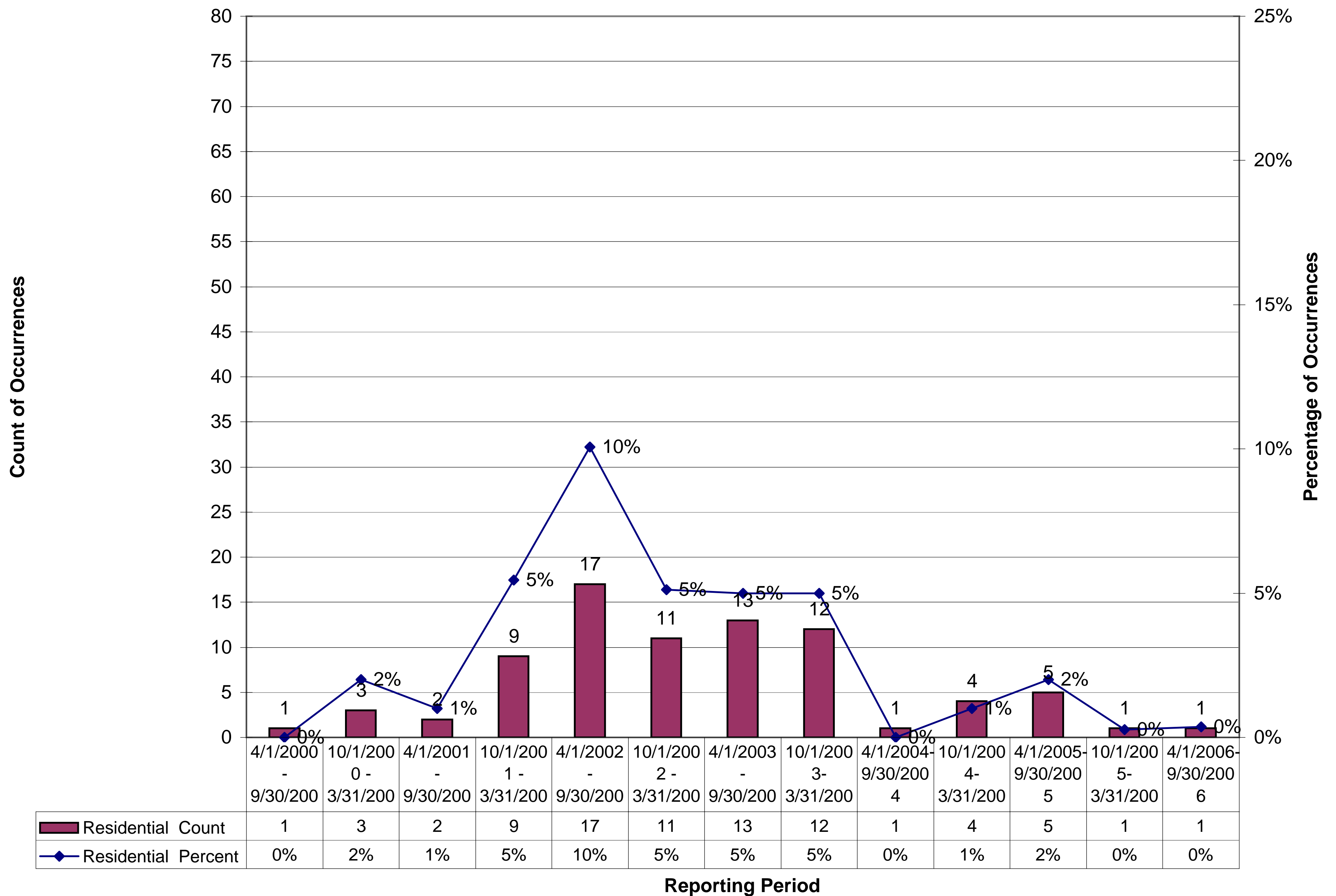
Complaints, Grievances,
and Fair Hearings Filed

Chart 9 -
Residential



	4/1/2000 - 9/30/200	10/1/2000 - 3/31/200	4/1/2001 - 9/30/200	10/1/2001 - 3/31/200	4/1/2002 - 9/30/200	10/1/2002 - 3/31/200	4/1/2003 - 9/30/200	10/1/2003- 3/31/200	4/1/2004- 9/30/2004	10/1/2004- 3/31/200	4/1/2005- 9/30/2005	10/1/2005- 3/31/200	4/1/2006- 9/30/2006
Residential Count	1	3	2	9	17	11	13	12	1	4	5	1	1
Residential Percent	0%	2%	1%	5%	10%	5%	5%	5%	0%	1%	2%	0%	0%

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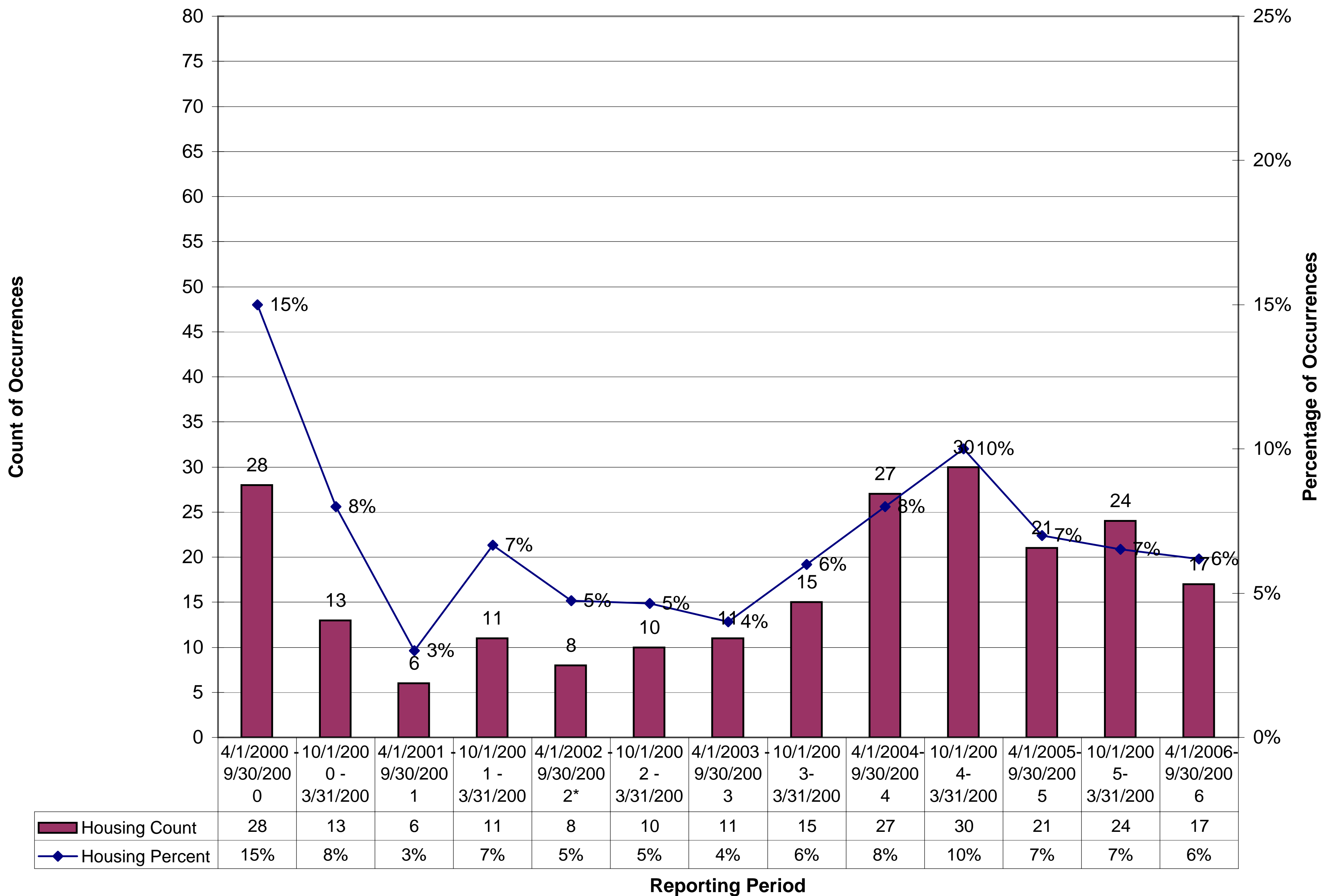
Complaints, Grievances,
and Fair Hearings Filed

Chart 10 -
Housing



	4/1/2000 - 9/30/2000	10/1/2000 - 3/31/200	4/1/2001 - 9/30/2001	10/1/2001 - 3/31/200	4/1/2002 - 9/30/2002*	10/1/2002 - 3/31/200	4/1/2003 - 9/30/2003	10/1/2003- 3/31/200	4/1/2004- 9/30/2004	10/1/2004- 3/31/200	4/1/2005- 9/30/2005	10/1/2005- 3/31/200	4/1/2006- 9/30/2006
Housing Count	28	13	6	11	8	10	11	15	27	30	21	24	17
Housing Percent	15%	8%	3%	7%	5%	5%	4%	6%	8%	10%	7%	7%	6%

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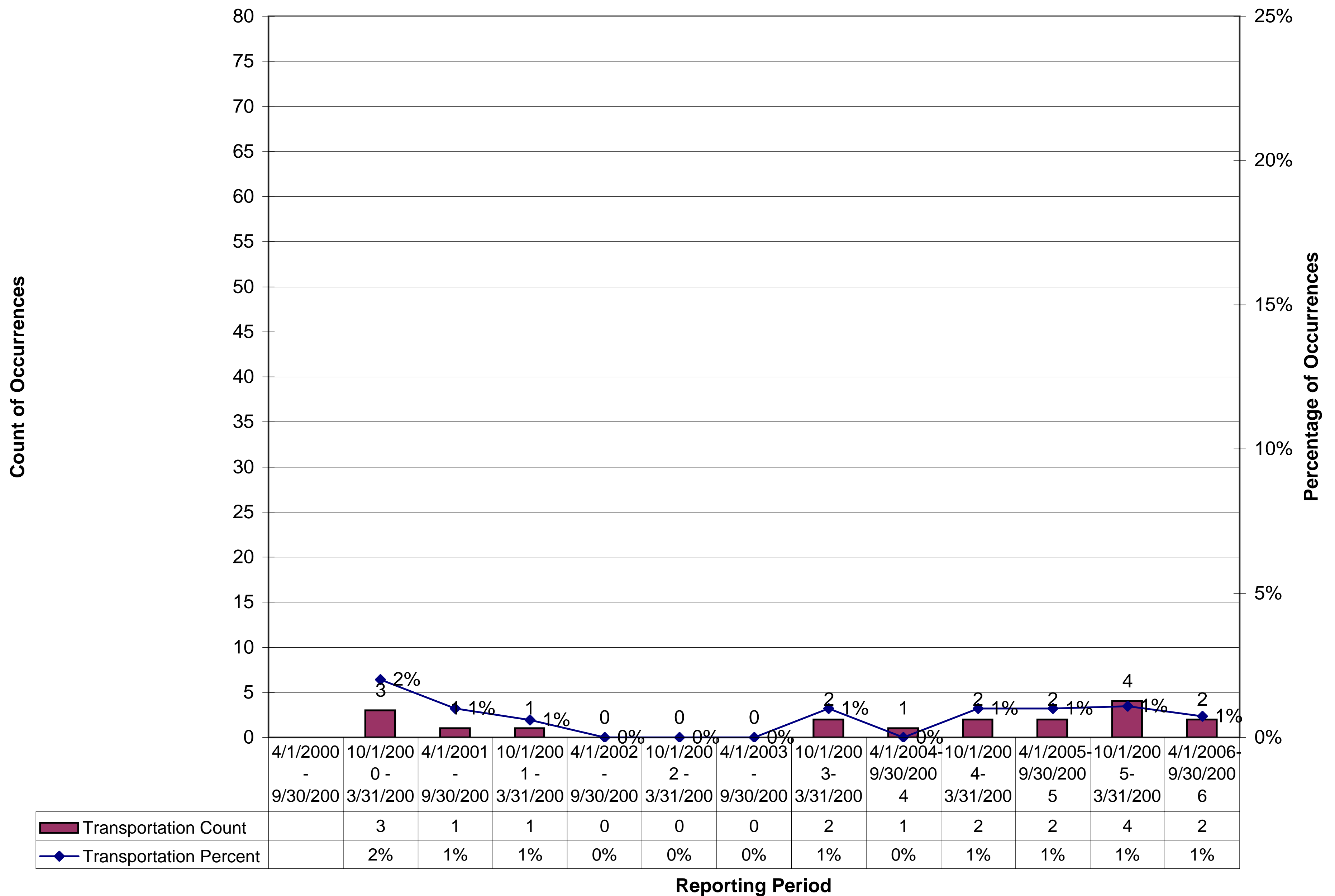
Complaints, Grievances,
and Fair Hearings Filed

Chart 11 -

Transportation



	4/1/2000 - 9/30/200	10/1/200 0 - 3/31/200	4/1/2001 - 9/30/200	10/1/200 1 - 3/31/200	4/1/2002 - 9/30/200	10/1/200 2 - 3/31/200	4/1/2003 - 9/30/200	10/1/200 3- 3/31/200	4/1/2004- 9/30/200 4	10/1/200 4- 3/31/200	4/1/2005- 9/30/200 5	10/1/200 5- 3/31/200	4/1/2006- 9/30/200 6
Transportation Count		3	1	1	0	0	0	2	1	2	2	4	2
Transportation Percent		2%	1%	1%	0%	0%	0%	1%	0%	1%	1%	1%	1%

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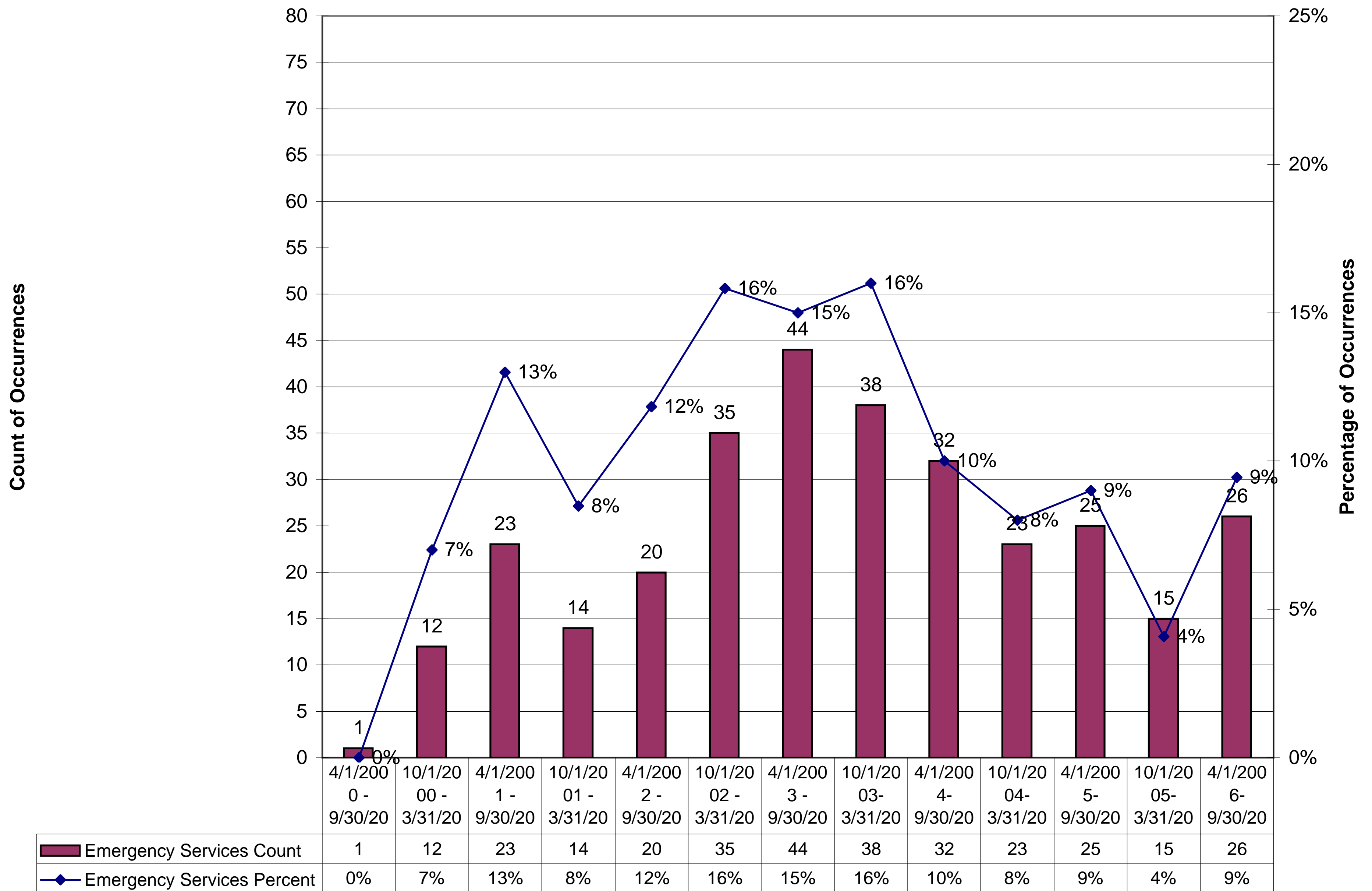
Attachment C
Complaints, Grievances,
and Fair Hearings Filed

Chart 12 -

Emergency Services



	4/1/2000 - 9/30/20	10/1/2000 - 3/31/20	4/1/2001 - 9/30/20	10/1/2001 - 3/31/20	4/1/2002 - 9/30/20	10/1/2002 - 3/31/20	4/1/2003 - 9/30/20	10/1/2003- 3/31/20	4/1/2004- 9/30/20	10/1/2004- 3/31/20	4/1/2005- 9/30/20	10/1/2005- 3/31/20	4/1/2006- 9/30/20
Emergency Services Count	1	12	23	14	20	35	44	38	32	23	25	15	26
Emergency Services Percent	0%	7%	13%	8%	12%	16%	15%	16%	10%	8%	9%	4%	9%

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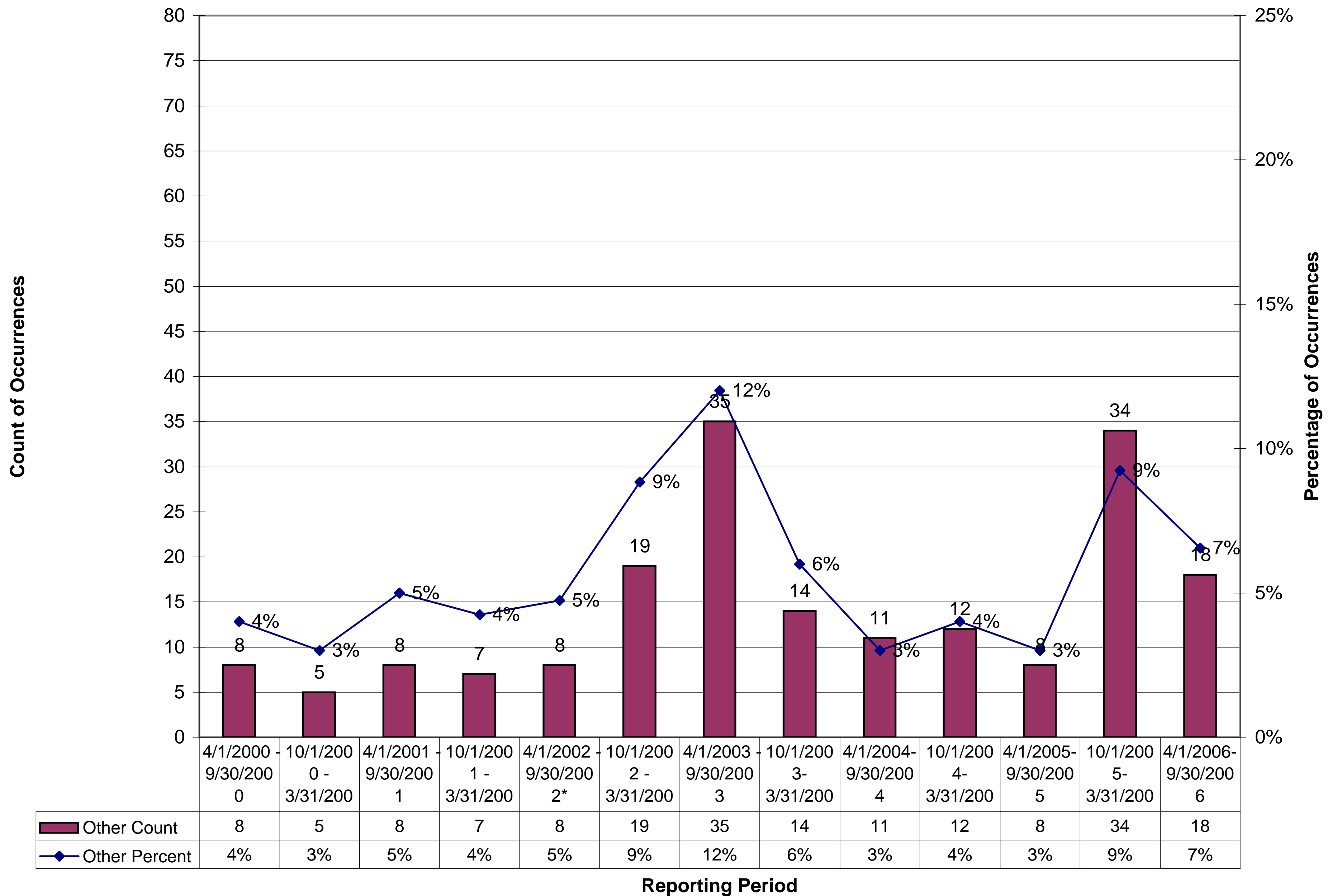
Attachment C
Complaints, Grievances,
and Fair Hearings Filed

Chart 13 -
Other



	4/1/2000 - 9/30/2000	10/1/2000 - 3/31/200	4/1/2001 - 9/30/2001	10/1/2001 - 3/31/200	4/1/2002 - 9/30/2002*	10/1/2002 - 3/31/200	4/1/2003 - 9/30/2003	10/1/2003- 3/31/200	4/1/2004- 9/30/2004	10/1/2004- 3/31/200	4/1/2005- 9/30/2005	10/1/2005- 3/31/200	4/1/2006- 9/30/2006
Other Count	8	5	8	7	8	19	35	14	11	12	8	34	18
Other Percent	4%	3%	5%	4%	5%	9%	12%	6%	3%	4%	3%	9%	7%

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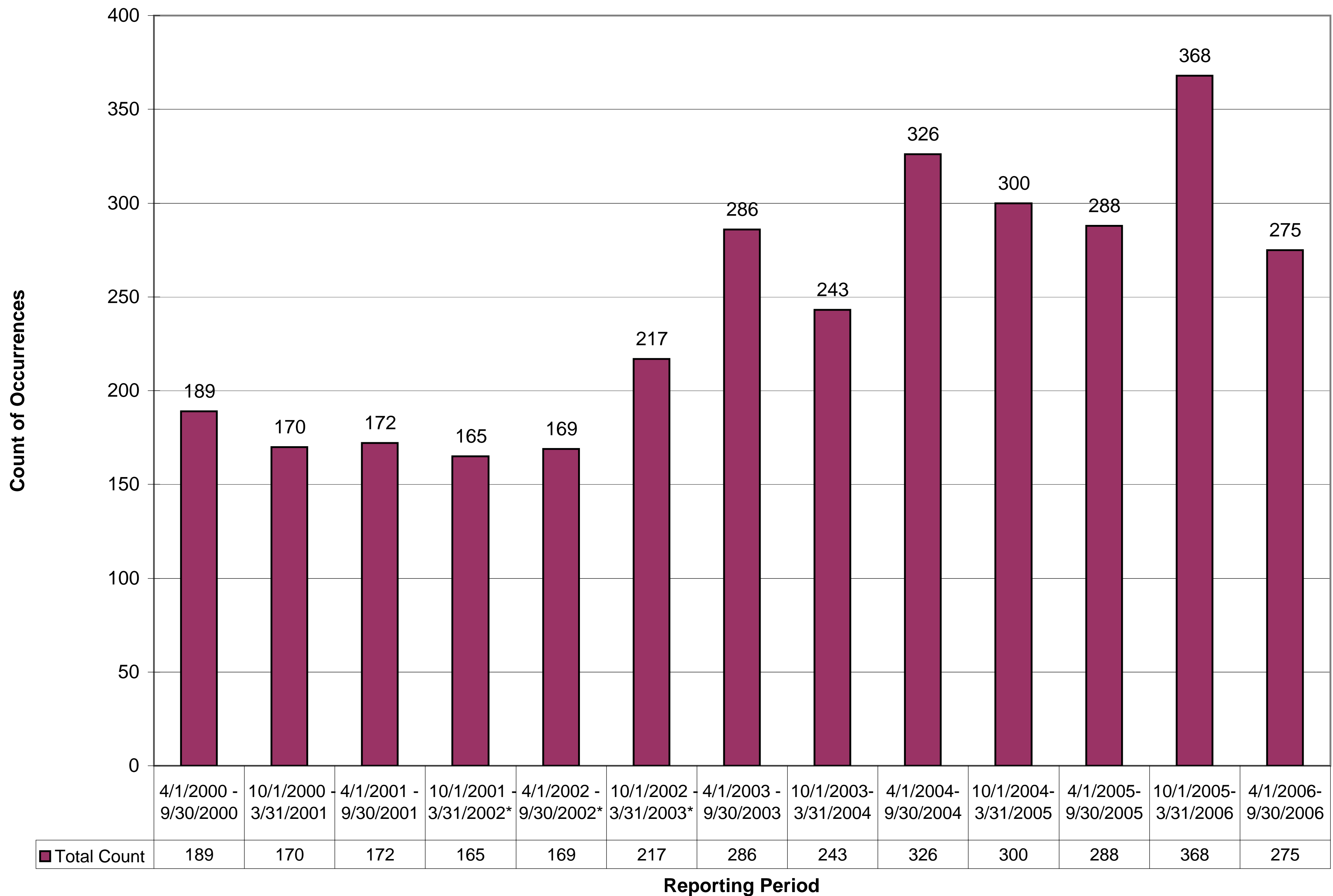
Attachment C
Complaints, Grievances, and Fair Hearings Filed

Chart 14 -

Total Occurrences



	4/1/2000 - 9/30/2000	10/1/2000 - 3/31/2001	4/1/2001 - 9/30/2001	10/1/2001 - 3/31/2002*	4/1/2002 - 9/30/2002*	10/1/2002 - 3/31/2003*	4/1/2003 - 9/30/2003	10/1/2003- 3/31/2004	4/1/2004- 9/30/2004	10/1/2004- 3/31/2005	4/1/2005- 9/30/2005	10/1/2005- 3/31/2006	4/1/2006- 9/30/2006
Total Count	189	170	172	165	169	217	286	243	326	300	288	368	275

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ATTACHMENT C - Totals
TABLE 1 - COMPLAINTS, GRIEVANCES, FAIR HEARINGS FILED
REPORTING FROM 4/1/2000 though 9/30/2006

OCCURRENCES - (Includes occurrences of complaints, grievances, and fair hearings files)	TIME PERIOD																											
	4/1/2000 - 9/30/2000		10/1/2000 - 3/31/2001		4/1/2001 - 9/30/2001		10/1/2001 - 3/31/2002		4/1/2002 - 9/30/2002		10/1/2002 - 3/31/2003		4/1/2003 - 9/30/2003		10/1/2003 - 3/31/2004		4/1/2004 - 9/30/2004		10/1/2004 - 3/31/2005		4/1/2005 - 9/30/2005		10/1/2005 - 3/31/2006		4/1/2006 - 9/30/2006		4/1/2000 - 9/30/2006	
	Total	% Total	Total	% Total	Total	% Total	Total	% Total	Total	% Total	Total	% Total	Total	% Total	Total	% Total	Total	% Total	Total	% Total	Total	% Total	Total	% Total	Total	% Total	Total	% Total
Unduplicated Number of Cases							141		162		193		245		214		287		250		234		238		176		2,140	
Access*	26	14%	36	21%	24	14%	8	5%	25	15%	20	9%	39	14%	29	12%	44	13%	36	12%	47	16%	37	10%	34	12%	405	13%
Dignity and Respect	10	5%	23	14%	15	9%	26	16%	18	11%	19	9%	23	8%	8	3%	18	6%	22	7%	17	6%	37	10%	38	14%	274	9%
Quality/Appropriateness **	35	19%	24	14%	35	20%	35	21%	20	12%	26	12%	25	9%	9	4%	13	4%	17	6%	9	3%	15	4%	20	7%	283	9%
Phone Calls Not Returned	1	1%	6	4%	2	1%	2	1%	2	1%	3	1%	2	1%	5	2%	10	3%	12	4%	26	9%	17	5%	18	7%	106	3%
Service -- Intensity, Not Available, Coordination	35	19%	12	7%	20	12%	10	6%	17	10%	33	15%	22	8%	40	16%	56	17%	34	11%	20	7%	14	4%	20	7%	333	11%
Consumer Rights	25	13%	18	11%	14	8%	8	5%	15	9%	18	8%	20	7%	26	11%	32	10%	37	12%	49	17%	75	20%	22	8%	359	11%
Physicians & medications	13	7%	8	5%	15	9%	28	17%	11	7%	14	6%	30	10%	26	11%	22	7%	41	14%	38	13%	54	15%	44	16%	344	11%
Financial & Admin Svs.	6	3%	7	4%	7	4%	6	4%	8	5%	9	4%	22	8%	19	8%	59	18%	30	10%	21	7%	41	11%	15	5%	250	8%
Residential	1	1%	3	2%	2	1%	9	5%	17	10%	11	5%	13	5%	12	5%	1	0%	4	1%	5	2%	1	0%	1	0%	80	3%
Housing	28	15%	13	8%	6	3%	11	7%	8	5%	10	5%	11	4%	15	6%	27	8%	30	10%	21	7%	24	7%	17	6%	221	7%
Transportation	0	0%	3	2%	1	1%	1	1%	0	0%	0	0%	0	0%	2	1%	1	0%	2	1%	2	1%	4	1%	2	1%	18	1%
Emergency Services	1	1%	12	7%	23	13%	14	8%	20	12%	35	16%	44	15%	38	16%	32	10%	23	8%	25	9%	15	4%	26	9%	308	10%
Other	8	4%	5	3%	8	5%	7	4%	8	5%	19	9%	35	12%	14	6%	11	3%	12	4%	8	3%	34	9%	18	7%	187	6%
Total	189	100%	170	100%	172	100%	165	100%	169	100%	217	100%	286	100%	243	100%	326	100%	300	100%	288	100%	368	100%	275		3,168	100%

Data Notes:

* Access refers to the degree to which services are quickly and readily obtainable to consumers. It includes the responsiveness of the Washington State Mental Health sytem to individual and cultural needs and the availability of mental health services.

** Quality/Appropriatness refers to the degree that service features meet (fit) consumer needs and are free from error and deficiencies.

Complaint and Grievance data has been collected since 4-1-1999.

Beginning 10-1-2001 the data reflects both unduplicated cases (individuals at a point in time) and occurrences (each instance of a complaint, grievance, or fair hearing). If a complaint moves to an RSN grievance it is counted twice. Prior to 10-1-2001 each complaint was counted only once even if the complaint moved to a grievance or fair hearing. Comparison of data across these reporting periods should be interpreted cautiously due to the change in reporting methods.

Beginning 4-1-2001, Provider Level Grievances were also captured as occurrences. For the purposes of this Attachment, all occurrences are rolled-up.

ATTACHMENT C - Adults
TABLE 1 - COMPLAINTS, GRIEVANCES, FAIR HEARINGS FILED
REPORTING FROM 4/1/2000 though 9/30/2006

OCCURRENCES - (Includes occurrences of complaints, grievances, and fair hearings files)	TIME PERIOD 4/1/2000 - 9/30/2000		10/1/2000 - 3/31/2001		4/1/2001 - 9/30/2001		10/1/2001 - 3/31/2002		4/1/2002 - 9/30/2002		10/1/2002 - 3/31/2003		4/1/2003 - 9/30/2003		10/1/2003 - 3/31/2004		4/1/2004 - 9/30/2004		10/1/2004 - 3/31/2005		4/1/2005 - 9/30/2005		10/1/2005 - 3/31/2006		4/1/2006 - 9/30/2006		4/1/2000 - 9/30/2006	
	Total	% Total	Total	% Total	Total	% Total	Total	% Total	Total	% Total	Total	% Total	Total	% Total	Total	% Total	Total	% Total	Total	% Total	Total	% Total	Total	% Total	Total	% Total	Total	% Total
Unduplicated Number of Cases							137		159		180		225		193		251		215		176		185		130		1851	
Access*	17	10%	34	22%	24	15%	8	5%	25	15%	20	10%	37	14%	25	11%	40	14%	33	13%	33	15%	30	10%	23	11%	349	13%
Dignity and Respect	10	6%	23	15%	15	9%	26	16%	17	10%	17	8%	19	7%	7	3%	15	5%	21	8%	13	6%	31	10%	29	14%	243	9%
Quality/Appropriateness **	32	20%	21	13%	32	20%	35	22%	18	11%	22	11%	22	8%	5	2%	9	3%	9	3%	3	1%	7	2%	11	5%	226	8%
Phone Calls Not Returned	1	1%	5	3%	1	1%	2	1%	2	1%	2	1%	2	1%	3	1%	7	2%	9	3%	15	7%	12	4%	13	6%	74	3%
Service -- Intensity, Not Available, Coordination	30	19%	9	6%	19	12%	10	6%	17	10%	29	14%	20	8%	35	16%	47	16%	28	11%	13	6%	11	4%	12	6%	280	10%
Consumer Rights	24	15%	18	11%	14	9%	7	4%	15	9%	17	8%	19	7%	25	11%	30	10%	32	12%	40	18%	66	22%	22	10%	329	12%
Physicians & medications	11	7%	7	4%	12	7%	24	15%	11	7%	14	7%	29	11%	25	11%	20	7%	35	13%	30	14%	43	14%	33	16%	294	11%
Financial & Admin Svs.	4	2%	6	4%	7	4%	6	4%	8	5%	9	4%	21	8%	17	8%	55	19%	30	11%	19	9%	39	13%	14	7%	235	8%
Residential	1	1%	3	2%	2	1%	9	6%	17	10%	11	5%	7	3%	12	5%	1	0%	3	1%	2	1%	1	0%	0	0%	69	2%
Housing	28	17%	13	8%	6	4%	11	7%	8	5%	10	5%	11	4%	15	7%	27	9%	29	11%	21	10%	23	8%	15	7%	217	8%
Transportation		0%	2	1%	1	1%	1	1%	0	0%	0	0%	0	0%	2	1%	0	0%	2	1%	1	0%	4	1%	2	1%	15	1%
Emergency Services		0%	12	8%	21	13%	14	9%	20	12%	34	17%	44	17%	38	17%	31	11%	21	8%	21	10%	14	5%	23	11%	293	11%
Other	4	2%	5	3%	8	5%	7	4%	8	5%	16	8%	30	11%	13	6%	8	3%	11	4%	6	3%	22	7%	15	7%	153	6%
Total	162	100%	158	100%	162	100%	160	100%	166	100%	201	100%	261	100%	222	100%	290	100%	263	100%	217	100%	303	100%	212	100%	2,777	100%

Data Notes:
* Access refers to the degree to which services are quickly and readily obtainable to consumers. It includes the responsiveness of the Washington State Mental Health sytem to individual and cultural needs and the availability of mental health services.

** Quality/Appropriatness refers to the degree that service features meet (fit) consumer needs and are free from error and deficiencies.

Complaint and Grievance data has been collected since 4-1-1999.

Beginning 10-1-2001 the data reflects both unduplicated cases (individuals at a point in time) and occurrences (each instance of a complaint, grievance, or fair hearing). If a complaint moves to an RSN grievance it is counted twice. Prior to 10-1-2001 each complaint was counted only once even if the complaint moved to a grievance or fair hearing. Comparison of data across these reporting periods should be interpreted cautiously due to the change in reporting methods.

Beginning 4-1-2001, Provider Level Grievances were also captured as occurrences. For the purposes of this Attachment, all occurrences are rolled-up.

ATTACHMENT C - Kids
TABLE 1 - COMPLAINTS, GRIEVANCES, FAIR HEARINGS FILED
REPORTING FROM 4/1/2000 though 9/30/2006

OCCURRENCES - (Includes occurrences of complaints, grievances, and fair hearings files)	TIME PERIOD													
	4/1/2000 - 9/30/2000		10/1/2000 - 3/31/2001		4/1/2001 - 9/30/2001		10/1/2001 - 3/31/2002		4/1/2002 - 9/30/2002		10/1/2002 - 3/31/2003		4/1/2003 - 9/30/2003	
	Total	% Total	Total	% Total	Total	% Total	Total	% Total	Total	% Total	Total	% Total	Total	% Total
Unduplicated Number of Cases							4		3		13		20	
Access*	9	33%	2	17%	0	0%	0	0%	0	0%	0	0%	2	8%
Dignity and Respect	0	0%	0	0%	0	0%	0	0%	1	33%	2	13%	4	16%
Quality/Appropriateness **	3	11%	3	25%	3	30%	0	0%	2	67%	4	25%	3	12%
Phone Calls Not Returned	0	0%	1	8%	1	10%	0	0%	0	0%	1	6%	0	0%
Service -- Intensity, Not Available, Coordination	5	19%	3	25%	1	10%	0	0%	0	0%	4	25%	2	8%
Consumer Rights	1	4%	0	0%	0	0%	1	20%	0	0%	1	6%	1	4%
Physicians & medications	2	7%	1	8%	3	30%	4	80%	0	0%	0	0%	1	4%
Financial & Admin Svs.	2	7%	1	8%	0	0%	0	0%	0	0%	0	0%	1	4%
Residential	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	6	24%
Housing	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
Transportation	0	0%	1	8%	0	0%	0	0%	0	0%	0	0%	0	0%
Emergency Services	1	4%	0	0%	2	20%	0	0%	0	0%	1	6%	0	0%
Other	4	15%	0	0%	0	0%	0	0%	0	0%	3	19%	5	20%
Total	27	100%	12	100%	10	100%	5	100%	3	100%	16	100%	25	100%

OCCURRENCES - (Includes occurrences of complaints, grievances, and fair hearings files)	TIME PERIOD													
	10/1/2003 - 3/31/2004		4/1/2004 - 9/30/2004		10/1/2004 - 3/31/2005		4/1/2005 - 9/30/2005		10/1/2005 - 3/31/2006		4/1/2006 - 9/30/2006		4/1/2000 - 9/30/2006	
	Total	% Total	Total	% Total	Total	% Total	Total	% Total	Total	% Total	Total	% Total	Total	% Total
Unduplicated Number of Cases	21		36		35		58		53		46		289	
Access*	4	19%	4	11%	3	8%	14	20%	7	11%	11	17%	56	14%
Dignity and Respect	1	5%	3	8%	1	3%	4	6%	6	9%	9	14%	31	8%
Quality/Appropriateness **	4	19%	4	11%	8	22%	6	8%	8	12%	9	14%	57	15%
Phone Calls Not Returned	2	10%	3	8%	3	8%	11	15%	5	8%	5	8%	32	8%
Service -- Intensity, Not Available, Coordination	5	24%	9	25%	6	16%	7	10%	3	5%	8	13%	53	14%
Consumer Rights	1	5%	2	6%	5	14%	9	13%	9	14%	0	0%	30	8%
Physicians & medications	1	5%	2	6%	6	16%	8	11%	11	17%	11	17%	50	13%
Financial & Admin Svs.	2	10%	4	11%	0	0%	2	3%	2	3%	1	2%	15	4%
Residential	0	0%	0	0%	1	3%	3	4%	0	0%	1	2%	11	3%
Housing	0	0%	0	0%	1	3%	0	0%	1	2%	2	3%	4	1%
Transportation	0	0%	1	3%	0	0%	1	1%	0	0%	0	0%	3	1%
Emergency Services	0	0%	1	3%	2	5%	4	6%	1	2%	3	5%	15	4%
Other	1	5%	3	8%	1	3%	2	3%	12	18%	3	5%	34	9%
Total	21	100%	36	100%	37	100%	71	100%	65	100%	63	100%	391	100%

Data Notes:
* Access refers to the degree to which services are quickly and readily obtainable to consumers. It includes the responsiveness of the Washington State Mental Health sytem to individual and cultural needs and the availability of mental health services.

** Quality/Appropriatness refers to the degree that service features meet (fit) consumer needs and are free from error and deficiencies.

Complaint and Grievance data has been collected since 4-1-1999.

Beginning 10-1-2001 the data reflects both unduplicated cases (individuals at a point in time) and occurrences (each instance of a complaint, grievance, or fair hearing). If a complaint moves to an RSN grievance it is counted twice. Prior to 10-1-2001 each complaint was counted only once even if the complaint moved to a grievance or fair hearing. Comparison of data across these reporting periods should be interpreted cautiously due to the change in reporting methods.

Beginning 4-1-2001, Provider Level Grievances were also captured as occurrences. For the purposes of this Attachment, all occurrences are rolled-up.

Attachment C

Table 2 - NSMHA Complaint, Grievance, Fair Hearing Data - Past Six Months, Past Year, Since 4/1/2000*

REPORTING FROM 4/1/2000 though 9/30/2006

Past Six Months 4/1/2006 - 9/30/2006		
Type	**Total**	**Percentage**
Physicians & medications	44	16%
Dignity and Respect	38	14%
Access*	34	12%
Emergency Services	26	9%
Consumer Rights	22	8%
Quality/Appropriateness **	20	7%
Service -- Intensity, Not Available, Coordination	20	7%
Phone Calls Not Returned	18	7%
Other	18	7%
Housing	17	6%
Financial & Admin Svs.	15	5%
Transportation	2	1%
Residential	1	0%
Total	275	100%

Past Year 10/1/2005 through 9/30/2006		
Type	**Total**	**Percentage**
Physicians & medications	98	15%
Consumer Rights	97	15%
Dignity and Respect	75	12%
Access*	71	11%
Financial & Admin Svs.	56	9%
Other	52	8%
Emergency Services	41	6%
Housing	41	6%
Phone Calls Not Returned	35	5%
Quality/Appropriateness **	35	5%
Service -- Intensity, Not Available, Coordination	34	5%
Transportation	6	1%
Residential	2	0%
Total	643	100%

Since 4/1/2000 4/1/2000 through 9/30/2006		
Type	**Total**	**Percentage**
Access*	405	13%
Consumer Rights	359	11%
Physicians & medications	344	11%
Service -- Intensity, Not Available, Coordination	333	11%
Emergency Services	308	10%
Quality/Appropriateness **	283	9%
Dignity and Respect	274	9%
Financial & Admin Svs.	250	8%
Housing	221	7%
Other	187	6%
Phone Calls Not Returned	106	3%
Residential	80	3%
Transportation	18	1%
Total	3,168	100%

* NSMHA has been collecting Complaint and Grievance data since 4/1/1999. The data for 4/1/1999 through 3/31/2000 is not included in this table, as collection methods were less standardized at that time.

ATTACHMENT D-Appeals and Denials Over Time

TABLE 3 NORTH SOUND MENTAL HEALTH ADMINISTRATION DENIALS AND APPEALS																								
	10/1/2004 through 3/31/2005						**4-1-2005 through 9/30/2005**						**10/1/2005 through 3/31/2006**						**4/1/2006 through 9/30/2006**					
	Denials			**Appeals**			**Denials**			**Appeals**			**Denials**			**Appeals**			**Denials**			**Appeals**		
DENIAL TYPE	Adult	Child	**Total**	Adult	Child	**Total**	Adult	Child	**Total**	Adult	Child	**Total**	Adult	Child	**Total**	Adult	Child	**Total**	Adult	Child	**Total**	Adult	Child	**Total**
Access To Outpatient	59	69	**128**	5	2	**7**	62	61	**123**	4	1	**5**	47	75	**122**	2		**2**	78	99	**177**	**2**	**2**	**4**
Trans																								
Emergency Services																								
Access to Inpatient	*	*	*				3	3	**6**										4		**4**			
Other																								
Total	59	69	**128**	5	2	**7**	65	64	**129**	4	1	**5**	47	75	**122**	2	0	**2**	82	99	**181**	2	2	**4**

Data Notes:

*The NSMHA did not collect data on the number of inpatient denials for this period.

** There were 5 appeals from 4/1/2004 through 9/30/2004. The denial and appeal process began on June 1, 2005 and therefore appeal data for this period does not represent a full 6 months of data.

ATTACHMENT E

Table 4 Percentage of Cases and Occurrences Reported by Ombuds Services and Providers 4-2003 through 9-2006														
Reporting Period	4-2003 through **9-2003**		10-2003 through **3-2004**		**4-2004 through 9-2004**		**10-2004 through 3-2005**		**4-2005 through 9-2005**		**10-2005 through 3-2006**		**4-2006 through 9-2006**	
Ombuds	*Cases*	Occ	*Cases*	Occ	*Cases*	Occ	*Cases*	Occ	*Cases*	Occ	*Cases*	Occ	*Cases***	Occ**
%	*80%*	80%	*77%*	72%	*70%*	73%	*63%*	67%	*69%*	70%	*67%*	75%	*56%*	64%
#	*(196)*	(229)	*(165)*	(175)	*(201)*	(238)	*(157)*	(202)	*(162)*	(203)	*(158)*	(273)	*(99)*	(175)
Providers	*Cases*	Occ	*Cases*	Occ	*Cases*	Occ	*Cases*	Occ	*Cases*	Occ	*Cases*	Occ	*Cases*	Occ
%	*20%*	20%	*23%*	28%	*30%*	27%	*37%*	33%	*31%*	30%	*33%*	25%	*44%*	36%
#	*(49)*	(57)	*(49)*	(68)	*(86)*	(88)	*(93)*	(98)	*(72)*	(85)	*(79)*	(92)	*(77)*	(100)
Total	*100% (245)*	100% (286)	*100% (214)*	100% (243)	*100% (287)*	100% (326)	*100% (250)*	100% (300)	*100% (234)*	100% (288)	*100% (237)**	100% (365)*	*100% (176)*	100% (275)

Data Notes: *The NSMHA reported 1 case and 3 occurrences that were not captured by Providers or Ombuds
** The NSMHA Ombuds services narrowed their complaint reporting to those complaints about NSMHA providers

Table 5 Reported Emergency Services Complaints by Reporting Source* 4-2003 through 9-2006								
Reporter	4-3003 through 9-2003	10-2003 through 3-2004	**4-2004 through 9-2004**	**10-2004 through 3-2005**	**4-2005 through 9-2005**	10-2005 through 3-2006	4-2006 through **9-2006**	**Total**
Ombuds Services	31	26	23	13	22	12	22	**149**
Volunteers of America	8	8	5	8	0	1	1	**31**
Snohomish County ITA	5	3	2	2	0	2	0	**14**
Lake Whatcom	0	0	0	0	0	0	0	**0**
Catholic Community Services	0	0	0	0	0	0	0	**0**
Sea Mar	0	0	0	0	0	0	0	**0**
Whatcom Counseling and Psychiatric Clinic	0	1	0	0	1	0	1	**3**
Associated Provider Network	0	0	0	0	0	0	0	**0**
bridgeways	0	0	0	0	0	0	0	**0**
Compass Health	0	0	2	0	2	0	2	**6**
Total	**44**	**38**	**32**	**23**	**25**	**15**	**26**	**203**

Data Note: * Complaint, Grievance, and Fair Hearing occurrences have been collapsed into one category.

6.7.1. The Contractor must monitor the following performance measures for maintenance of baselines provided by MHD. MHD will calculate and review the following indicators two times during this contract period September through December and January through April. If the Contractor does not meet MHD defined target baselines on any measure, the Contractor must submit a plan to increase performance to meet baseline. If requested by MHD the contractor's plan will include the submission and implementation of a formal Performance Improvement Project.

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6.7.1.1. Non-Crisis services must be offered within seven days of discharge from a psychiatric inpatient hospital or evaluation and treatment program. This will be calculated as number of enrollees who receive an outpatient service within seven days of discharge divided by the total number of enrollees discharged.

6.7.1.2. Telesage Outcome Assessment initiated at time of an intake evaluation. This will be calculated as the number of enrollees that complete or are offered an outcome assessment divided by the number of enrollees that receive an intake evaluation.

6.7.2. The Contractor shall participate with MHD in the development and implementation of a standard set of performance indicators to measure access, quality and appropriateness. Participation must include:

6.7.2.1. Provision of all necessary data;

6.7.2.2. The analysis of results and development of system improvements based on that analysis on a local and statewide basis; and

6.7.2.3. Incorporation of the results into quality improvement activities.

6.7.3. The Contractor shall participate with MHD in completing annual Mental Health Statistics Improvement Project (MHSIP) survey for youth and families. Participation must include at a minimum:

6.7.3.1. Provision of individual contact information to MHD;

6.7.3.2. Involvement in the analysis of results and development of system improvements based on that analysis on a statewide basis; and

6.7.3.3. Incorporation of results into RSN specific quality improvement activities.

6.7.4. The Contractor shall attempt to initiate and complete a TeleSage outcome survey on every individual.

7.6.1. The Contractor shall monitor the following performance measures for maintenance of baselines provided by MHD. MHD will calculate and review the following indicators two times during this contract period: September through December and January through April. If the Contractor does not meet MHD defined target baselines on any measure, the Contractor must submit a plan to increase performance to meet baseline. If requested by MHD the Contractor's plan will include the submission and implementation of a formal Performance Improvement Project.

7.6.1.1. Non-Crisis services must be offered within seven days of discharge from a psychiatric inpatient hospital or evaluation and treatment program. This will be calculated as number of enrollees who receive an outpatient service within seven days of discharge divided by the total number of enrollees discharged.

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7.6.1.2. Telesage Outcome Assessment initiated at time of an intake evaluation. This will be calculated as the number of enrollees that complete or are offered an outcome assessment divided by the number of enrollees that receive an intake evaluation.

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7.6.2. An additional measure will be added beginning January 1, 2007. This contract period will be used to establish baselines.

7.6.2.1. Time from request for services to first routine service shall not exceed 28 days.

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7.6.3. The Contractor shall participate with MHD in the development and implementation of a standard set of performance indicators to measure access, quality and appropriateness. Participation must include:

7.6.3.1. Provision of all necessary data;

7.6.3.2. The analysis of results and development of system improvements based on that analysis on a local and statewide basis; and

7.6.3.3. Incorporation of the results into quality improvement activities.

7.7. The Contractor shall participate with MHD in completing annual Mental Health Statistics Improvement Project (MHSIP) surveys. The schedule will rotate annually between adults and youth/families. Participation must include at a minimum:

7.7.1 Provision of enrollee contact information to MHD;

7.7.2. Involvement in the analysis of results and development of system improvements based on that analysis on a statewide basis; and

7.7.3. Incorporation of results into the Contractor specific quality improvement activities.

7.8. The Contractor shall attempt to complete a TeleSage outcome survey on every individual at the time of the intake evaluation and attempt to complete a follow-up assessment after 180 days.

Intake matching for the Consumer Outcomes System (COS)

RSN	***Baseline*** *(CY2005 - January 1, 2005 - December 31, 2005)*		***Interim Period*** *January 1, 2006 - August 31, 2006*		**Change in Percent Between Baseline & Interim Period**	***First Contract Period*** *September 1, 2006 - December 31, 2006*		**Change in Percent Between Baseline & First Contract Period**	***Second Contract Period*** *January 1, 2007 - April, 30, 2007*		**Change in Percent Between Baseline & Second Contract Period**
	Total # of intakes	% registered in Telesage	Total # of intakes	% registered in Telesage		Total # of intakes	% registered in Telesage		Total # of intakes	% registered in Telesage	
Chelan Douglas	893	43.7%	794	37.9%	-5.8%	356	43.0%	-0.7%			
Clark	3,036	79.1%	2,350	80.3%	1.1%	1,051	72.5%	-6.6%			
Cowlitz	1,515	62.6%	1,172	84.3%	21.7%	238	78.2%	15.6%			
Greater Columbia	5,919	25.2%	3,496	23.3%	-1.9%	1,637	23.5%	-1.8%			
Grays Harbor	1,222	36.6%	925	13.3%	-23.3%	419	5.0%	-31.6%			
King	15,083	38.4%	11,153	30.4%	-8.0%	4,345	28.6%	-9.8%			
North Central	1,015	53.8%	681	58.0%	4.2%	8	12.5%	-41.3%			
Northeastern	710	63.5%	547	50.3%	-13.3%	0	NA	NA			
North Sound	6,127	79.1%	4,276	72.0%	-7.1%	2,009	66.2%	-12.9%			
Peninsula	2,265	51.7%	1,412	63.9%	12.1%	721	50.1%	-1.7%			
Pierce	3,929	37.5%	2,919	44.4%	6.9%	1,229	57.2%	19.7%			
Spokane	3,962	5.6%	2,341	11.5%	5.9%	1,164	11.1%	5.5%			
Timberlands	1,541	38.9%	1,127	55.2%	16.3%	624	45.0%	6.2%			
Thurston Mason	2,126	51.1%	1,585	43.5%	-7.6%	616	36.2%	-14.9%			
Statewide	***48,814***	***45.6%***	***34,580***	***40.8%***	-4.8%	***14,397***	***40.9%***	-4.7%			

Data Notes:

(1) Intake is defined by the State Plan modality of intake/evaluation. The CPT/HCPC codes contained in this modality are: H0031, 90801, 90802, 90885, 99201, 99202, 99203, 99204, 99205, 99301, 99302, 99303, 99315, 99321, 99322, 99323, 99341, 99342, 99343, 99344, and 99345.

(2) TeleSage counts included all consumers ages 5 and older who were registered in the system, including consumers who opt out or who are unable.

(3) TeleSage counts for each contracting period will include registries six month prior to and six months post the contracting period.

(4) Intake evaluations excluded children under 5 years of age and were based on MHD encounter data submitted to MHD through February 11, 2007.

(5) Telesage registries began on May 17, 2004 through February 7, 2007.

CY2005: Percentage of clients who receive any outpatient services within 7 days of discharge from any inpatient setting

RSN	***Baseline*** *(CY2005 - January 1, 2005 - December 31, 2005)*			***Interim Period*** *January 1, 2006 - August 31, 2006*			**Change in Percent Between Baseline & Interim Period**	***First Contract Period*** *September 1, 2006 - December 31, 2006*			**Change in Percent Between Baseline & First Contract Period**	***Second Contract Period*** *January 1, 2007 - April, 30, 2007*			**Change in Percent Between Baseline & Second Contract Period**
	# Clients Seen Within 7 Days	Total Number of Discharges	% Seen Within 7 Days	# Clients Seen Within 7 Days	Total Number of Discharges	% Seen Within 7 Days		# Clients Seen Within 7 Days	Total Number of Discharges	% Seen Within 7 Days		# Clients Seen Within 7 Days	Total Number of Discharges	% Seen Within 7 Days	
Chelan Douglas	88	126	70%	44	78	56%	-13%	14	31	45%	-25%				
Clark	226	481	47%	180	342	53%	6%	60	120	50%	3%				
Cowlitz	178	280	64%	90	150	60%	-4%	19	71	27%	-37%				
Greater Columbia	532	903	59%	288	536	54%	-5%	122	229	53%	-6%				
Grays Harbor	58	129	45%	30	66	45%	0%	8	20	40%	-5%				
King	1665	3,667	45%	996	2323	43%	-3%	358	885	40%	-5%				
North Central	109	195	56%	50	115	43%	-12%	9	76	12%	-44%				
North Sound	1318	2,167	61%	820	1374	60%	-1%	321	509	63%	2%				
Peninsula	502	707	71%	328	467	70%	-1%	157	216	73%	2%				
Pierce	705	1,360	52%	371	748	50%	-2%	78	212	37%	-15%				
Spokane	625	1,133	55%	403	834	48%	-7%	159	351	45%	-10%				
Timberlands	66	107	62%	49	77	64%	2%	23	37	62%	0%				
Thurston Mason	182	387	47%	105	230	46%	-1%	31	82	38%	-9%				
Statewide	***6254***	***11,642***	54%	***3754***	***7,340***	51%	-3%	***1359***	***2839***	48%	-6%				

Data Notes:

(1) To be included in the numerator or denominator, the discharge had to occur within the time period of interest, but the outpatient services could have occurred outside of the time period of interest.

(2) # of clients seen within 7 days: counts are discharges, not persons. A person may have multiple discharges within the time period of interest.

(3) If a person has less than 7 days between a hospital discharge and admission (across all inpatient settings including community hospital, evaluation and treatment centers, and state hospitals) this is considered one episode. For the purposes of this

(4) Outpatient Services include crisis service.

(5) The interim period data is being calculated to assist RSNs in monitoring their progress in meeting the contract language of maintaining or exceeding the baseline. This data will not be used to monitor the contract. It is for informational purposes

(6) The First and Second Contract Period data is calculated using a 12-month moving window that includes the individual contract periods. A 12-month moving window is used to ensure an adequate number of discharges are available for all RSNs to calculate

Effective Date: 11/29/2005
Revised Date: 1/4/2007
Review Date:

North Sound Mental Health Administration

Section 1700 – Crisis Services: Crisis System Clinical Dispute Resolution

Authorizing Source: Per NSMHA and ICRS Management
Cancels:
See Also:
Responsible Staff: Sandy Whitcutt, Quality Specialist

Approved by: Executive Director
Signature:
Date:

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POLICY #1707.00

SUBJECT: CRISIS SYSTEM CLINICAL DISPUTE RESOLUTION

PURPOSE
To clarify what happens in the event of professional clinical disagreements in the mental health crisis system and to outline the process by which decisions will be made.

POLICY
It is recognized that when concerned, conscientious providers from different systems and perspectives interact with the same client in crisis, differences of opinion as to what constitutes the best care for that consumer will inevitably occur.

The goal of this protocol is to provide rapid and timely resolution of disputes, and the ability to use this information to improve services and community relations. The intention is to resolve conflict at the lowest administrative level possible.

PROCEDURE

A. **Definitions:**

1. Clinical disputes are defined as a disagreement between agencies or a provider in response to crises.
2. Stakeholders can include, but are not limited to: mental health providers involved in the case, other service providers and collateral contacts such as hospital or medical providers, residential providers, criminal justice system, developmental disabilities system, chemical dependency system.

B. Complaints by consumers, family members or complaints on behalf of the consumer by family members or others will be handled through the designated agencies complaint process and not under this policy. These consumer complaints will be handled as expeditiously as the consumer's conditions require which may necessitate an expedited process.

C. When a clinical dispute arises involving an agency or other service provider, Integrated Crisis Response System staff will ensure that information and referrals related to the dispute are clearly communicated to the service requester and documented in the clinical record.

During the crisis episode, the emphasis should be on providing the best service possible to the consumer. Services should be provided with the minimum amount of delay and should be what the client wants when possible, or with their input before the decision is made.

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D. INTER-SYSTEM DISPUTES (between ICRS providers and the community)

1. In cases that come through Care Crisis Line, the clinical opinion of the Triage Clinician prevails during the immediate crisis. Triage has the responsibility to assess the nature of the crisis, develop a plan to resolve the immediate crisis, coordinate services and track outcomes.
2. The Triage Clinician is authorized to dispatch face-to-face services. Outreach and CDMHP/DCR staff may not decline a dispatch request from Triage.
3. When involved, the Triage Clinician also mediates immediate conflicts between outside agencies/community, Outreach and CDMHP/DCR staff, and informs parties of next day follow up procedure. In the event of a dispute which cannot be resolved at the time, the following shall occur:

    a. The Care Crisis Clinical Program Manager will follow up by telephone on the next working day, and inform the appropriate Crisis Services Supervisor or their designee of the situation.
    b. If an issue comes first to the attention of Crisis Response supervisors, they will initiate a phone contact to the outside agency or community member and may inform the Care Crisis Clinical Program Manager on the next working day.
    c. If the dispute cannot be resolved by telephone, information is then brought to a case review. Venues for this case review can include staff meetings, local oversight committees and the Regional Crisis Management Team. All relevant information will be gathered and reviewed to determine if the dispute arose from a systems issue, problem with customer service, extraordinary occurrence, training issue, or other reason. When the reason for the dispute is ascertained, appropriate measures will be taken to address the cause.
    d. Disputes will be reported to the Regional ICRS Committee for monitoring and quality improvement purposes.

E. INTRA-SYSTEM DISPUTES (between ICRS providers)

1. When clinical disputes arise between ICRS staff, the Triage Clinician will have the final determination as to what service will be provided at that time. Information on the incident should be brought to the appropriate program supervisors the next business day. Supervisors will connect and come to a resolution informally whenever possible. Supervisors may also bring the incident to staff meetings, local crisis oversight committees and/or the Regional Crisis Management Team for review, discussion, and resolution.
2. Issues related to system functioning/resolution of disputes will be shared with the Regional Crisis Management Team, Regional Quality Management Committee and the NSMHA Quality Management Oversight Committee.

ATTACHMENTS

None

Policy Status

Has gone through ICRS and will go to QMC and QMOC in March.

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Effective Date:
Revised Date:
Review Date: 1/4/2007

North Sound Mental Health Administration

Section 1700 – Crisis Services: ICRS System Shift Change Protocol

Authorizing Source: Per NSMHA and ICRS Management
Cancels:
See Also: Approved by: Executive Director Date:
Responsible Staff: Sandy Whitcutt, Quality Specialist Signature:

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POLICY #1713.00

SUBJECT: ICRS SYSTEM SHIFT CHANGE PROTOCOL

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

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

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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.

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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:

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   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,

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   OR

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

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

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For the Snohomish County Children's Crisis Team

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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.

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Skagit Children's Crisis Team Schedule

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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 prior to 18:00, the CCT clinician will be expected to begin the outreach. If a

case comes in after 18:00,(and prior to 19:00) the CCT clinician will follow procedure 2. If an outreach is necessary after 19:00, 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.

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ATTACHMENTS

None

Policy Status

Policy has gone through ICRS and will go to QMC and QMOC in March.

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North Sound
Mental Health Administration

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

NSMHA Regional Training Sub-Committee Charter
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Charge to the Group
To support planning throughout the region for training to ensure high quality and effective treatment within NSMHA's values and mission.

Primary Objectives

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

Membership
Membership is open to all NSMHA providers. There will be at least one representative from the NSMHA Mental Health Advisory Board. Membership will also be open to one consumer representative as appointed by the NSMHA Mental Health Advisory Board. The Advisory Board representative and the consumer representative may be the same person. There will also be one representative on the committee who is a Tribal Liaison.
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Decision-making
All decision-making is according to the consensus model.

Responsibility for Committee Support:
1. NSMHA will chair the meeting.
2. NSMHA support staff will take minutes and provide support to the committee as needed.

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

Expected Project Completion Date: Ongoing

Reporting Relationships:

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

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

Timelines:
Review of current biennial Regional Training Plan completed by June 30, 2006. New Regional Training Plan due August 1, 2006.

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

NORTH SOUND MENTAL HEALTH ADMINISTRATION
REGIONAL TRAINING PLAN 2006-2007

Created by NSMHA Regional Training Committee

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The Regional Training Committee appreciates the contributions and support of all agencies in the North Sound to develop this plan. We also would like to credit the University of California Los Angeles Medical Center for the format of the plan

NORTH SOUND MENTAL HEALTH ADMINISTRATION
REGIONAL TRAINING PLAN 2006-2007

Background

I. Purpose

The purpose of the North Sound Mental Health Administration Regional Training Plan is to provide an effective, efficient process that builds the requisite skills for optimum performance at all levels of staff. The ultimate purpose of the NSMHA Plan is to provide a learning environment that supports progressive learning and optimum performance in providing exemplary mental health services for consumers.

II. Philosophy

- Education, training and development is an ongoing process rather than a single event, that occurs at any time or any place.
- Within the various organizations that provide services in the NSMHA each employee, together with their manager, is responsible for ongoing achievement of competencies and learning objectives.
- Each organization within the NSMHA will develop an annual training plan and is responsible for providing means for employees to develop their knowledge and skills. The annual training plan will be pertinent to each employee's position, improve quality of care and incorporate a recovery, strength-based system of care. The NSMHA and its providers: Compass Health, Lake Whatcom RTC, Whatcom Counseling and Psychiatric Clinic, bridgeways, Volunteers of America, Catholic Community Services Northwest and Sea Mar, will collaborate to design and implement a regional training plan that identifies core competencies and how to provide competency trainings that are cost-effective, efficient and of high quality.

III. Goal of the Education Plan

The goal of the NSMHA's Regional Training Plan is to

1) Ensure that employees are provided with an adequate orientation that validates qualifications and assures the employee's ability to perform job duties.
2) Provide an environment that supports continuous learning and individual optimum performance to achieve the organization's mission.
3) Assure the effective collection and aggregation of data such as needs assessments and evaluations to provide information for improvement of education processes and the performance of the process components.

IV. Process

The leaders of each organization ***establish the organization's vision and mission.***

A. Leaders ***determine the process components*** necessary to support the vision, mission and NSMHA requirements.
B. Leaders ***define qualifications and job expectations*** of all staff and determine qualifications on hire as well as evaluate the initial and annual competency and performance of individual job expectations.
C. Leaders use a variety of ***needs assessment*** methods to determine the education needs of individuals, the department, and the organization.
D. Based on assessed education needs, leaders determine education and training systems that do not exist and ***develop programs*** to meet those needs.
E. Leaders ***facilitate development of programs and implement the education and training plans*** at the NSMHA, organizational, departmental, and individual level.
F. Leaders provide support in assessing existing education and training systems, and ***facilitate evaluation of the effectiveness*** of those systems.
G. ***Aggregate data*** is collected to determine the effectiveness of the education and training programs.
H. Based on assessed effectiveness of education and training systems, ***modifications are made* to improve effectiveness**.

V. Process Components

1. The Regional Training Committee– The function of this committee is to bring forth regional education needs determined from trending of individual needs, assessment of organizational needs and inclusion of all mandated training requirements. This group functions in an advisory capacity to make recommendations regarding education and training program needs and effectiveness and is comprised of representatives across the NSMHA system. The purpose of this group is to:
   a) Identify, evaluate the effectiveness of existing education and training programs and to recommend improvements to those programs.
   b) To achieve economies of scale by identifying opportunities for sharing of programs and resources to meet identified education and training needs.
   c) To work together to develop, recommend and implement new education and training programs.
   d) To develop delivery and communication strategies for assuring effective utilization of education and training programs.

2. Education Needs Assessment – individual, agency and regional needs are assessed on a variety of levels and with a broad range of methods such as (including but not an exclusive list):
   Formal surveys
   Focus groups
   Interviews
   Performance Improvement data
   Risk Management Data

Committee participation such as Environment of Care, Safety and Quality Management
Aggregate Performance Management Data
Chart/file reviews
Utilization of information systems
Observation
Self-Assessment/evaluation

3. Organizational and Departmental Orientation activities provide initial job training and information including an assessment of a new employee's qualifications, knowledge, and competency.

4. Education and Training programs such as Management Development programs, clinical continuing education and information systems training are designed to maintain or improve staff competency.

5. Coaching, Preceptor & Mentoring, and Cross Training programs provide the employee with individualized, self paced information required to achieve new knowledge and competency or to improve the current level of performance.

6. Performance Management and Evaluation methods provide the employee with specific feedback regarding their actual performance. Additionally, performance management and evaluation methods provide the opportunity for the employee and the evaluator to develop remedial or ongoing education goals and objectives. Performance management and evaluation provides a broad view of education and development needs and opportunities.

7. Competency Assessment is an annual process to objectively validate the employee's current level of competency in performing cognitive and psychomotor skills in the performance of their job duties.

8. Evaluation Methods provide data for the organization regarding the effectiveness of the process components of the education program.

9. Aggregate Data Collection from evaluation methods and performance improvement activities is used to identify those areas and process components that need further refinement/improvement to achieve the purpose of the education plan.

VI. Evaluation

1. Evaluation is a systematic collection and analysis of data needed to make decisions regarding the effectiveness and improve the quality of the education program. Evaluation will be conducted with a variety of methods to:

2.

1. Determine the effectiveness of programs for participants
2. Document program objectives have been met

3. Provide information about service delivery that will be useful to program directors/instructors
4. Assure the desired behavior changes are occurring as a result of the education program
5. Measure the impact of the education program on the organization.

The *process, outcome and impact* of the education plan and programs will be evaluated through four levels. The attached grid demonstrates evaluation levels and methods.

Level I is a *process* measure of the participant's opinion of the program, their own participation and learning.

Level II is both a *process and an outcome* measure of the participant's achievements of the behavioral objectives of the program.

Level III is an *outcome* measure of the behavior change as a result of the program.

Level IV is an *impact* measure of the effect a behavior change of a group of learners has on the organization's products and processes.

3. Responsibility for evaluation: All members of the organization are responsible for evaluation of their own learning and performance. Staff members are expected to keep their manager informed of their on going continuing education needs to achieve the goals of the plan.

4.

5. Process evaluation (Levels I and II) are the responsibility of the program director/instructor. Data from process evaluation will be collected, aggregated and used to improve the instructional methods and teaching environment to maximize learning.

6. Outcome evaluation (Levels II and III) are the responsibility of the program director/instructor. Data from outcome evaluation will be collected, aggregated and used to document effectiveness, document competency and validate the transfer of knowledge to performance. Aggregated outcome data will be presented to the Regional Training Committee for use in making decisions about education needs and programs effectiveness.

7. Impact evaluation (Level IV) is the responsibility of the program director/instructor and Regional Training Committee. Impact data will be used to identify the need for further investigation of education needs, to assure program effectiveness, and to justify costs. In 2003 a region-wide survey was conducted to evaluate the RTP and this revision incorporates changes made as

a result of the feedback obtained and further review by the Regional Training Committee.

8.

9. Key changes:

1. *Elimination of the COD fifteen hour training requirement, all new employees will complete a COD training module instead.*
2. *Removal of the "Best Practices in GLBT, Hearing Impaired and Developmental Disability -second year requirements. It was felt that these were excessive requirements and they will be subsumed into the Special Populations module.*
3. *There will not be a Regional self-study module for the Telesage Outcomes system. This training will be agency-specific.*
4. *New Regional modules to be developed include the NSMHA System, COD, Tribal, Consumer Rights, Trauma and Risk Assessment.*
5. *The plan will be reformatted by be less complicated and repetitive. Agency-specific core competencies will be removed and instead providers will submit their training plans to be compiled by the NSMHA on an annual basis.*
6. *The committee will continue to explore opportunities to collaborate with providers in region-wide training programs to meet identified needs.*

10.

11.

ACCESS, COMMUNICATION, AND RESOURCE ISSUES

The Regional Training Committee is continuing to convert didactic education programs to on-line and self study wherever feasible. Managers will be trained to identify individual education needs, develop individualized education goals and objectives and plan staffing appropriately to accommodate the employee's attendance at a program.

Improving the communication of education programs that are available will also positively impact access. An NSMHA education website is being planned that will provide information regarding educational opportunities across the entire system.

12.

EVALUATION METHODS

Evaluation Levels	Asks the following	Examples of Methods	Appropriate level of evaluation for:
Level I : Participant Opinion	What's your opinion?	Participant evaluation	All programs
Level II: Participant Learning	What do you know?	Post Tests Return Demonstration Competency Testing Observation	Certification programs Competency Training Programs Compliance Programs
Level III: Participant Behavior	What do you do differently as a result of learning?	Competency Testing Observation PI Study results Chart/Documentation Reviews	Skill based training (i.e. restraint management) Unit Inservice Compliance Training
Level IV: Organizational Impact	What has changed or improved as a result of training?	Trend reports (e.g. decrease in medication errors) PI Studies Financial reports HR Management Aggregate Data Risk Management Data	Organizational training programs (e.g. customer service) Compliance Training Customer Service Survey Climate Surveys

13.

Regional Training Plan for 2006-2007

The regional training plan is comprised of a matrix that identifies cross-system and agency specific core competencies and training approaches with related curriculum type, methods for validation, time frames, frequency and references to the source for the training requirement. The plan is developed to span a two year period in order to accommodate the extensive volume of training that is provided in our system.

I. Training Requirements per WAC, RCW

WAC 388-865-0150 Definitions

Mental Health Specialist:

For children: 1) A minimum of 100 actual hours of special training in child development and treatment of seriously disturbed children and youth and their families; and 2) the equivalent of one year of full-time experience in the treatment of seriously emotionally disturbed children and youth and their families under the supervision of a child mental health specialist.

Geriatric: 1) A minimum of 100 actual hours of specialized training devoted to the mental health problems and treatment of persons sixty years of age or older; and 2) the equivalent of one year of full-time experience in the treatment of persons sixty years of age or older, under the supervision of a geriatric mental health specialist.

Ethnic minorities: A mental health professional who has demonstrated cultural competence attained through major commitment, ongoing training, experience and/or specialization in serving ethnic minorities, including evidence of one year of service specializing in serving the ethnic minority group under the supervision of an ethnic minority mental health specialist; and

(a) Evidence of support from the ethnic minority community attesting to the person's commitment to that community; **or**
(b) A minimum of 100 actual hours of specialized training devoted to ethnic minority issues and treatment of ethnic minority consumers.

Note: "Ethnic minority" or "racial/ethnic groups" are defined as any of the following:

(a) African American;
(b) An American Indian or Alaskan native, which includes:

(1) A person who is a member or considered to be a member of a federally recognized tribe;
(2) A person determined to be eligible by the Secretary of the Interior and
(3) An Eskimo, Aleut, or other Alaskan native;

(4) A Canadian Indian, meaning a person of a treaty tribe, Metis community, or non-status Indian community from Canada

(c) Asian/Pacific Island; or
(d) Hispanic

Disability: A mental health professional with special expertise in working with an identified disability group. For purposes of this section only, "disabled" means an individual with a disability other than a mental illness, including developmental disability, serious physical handicap, or sensory impairment.

If the consumer is deaf, the specialist must be a mental health professional with knowledge about the deaf culture and psychosocial problems faced by people who are deaf; and ability to communicate fluently in the preferred language system of the consumer.

The specialist for consumers with developmental disabilities must be a mental health professional who has at least one year's experience with people with developmental disabilities or is a developmental disabilities professional.

(5) WAC 388-865-0250 Ombuds services

The regional support network must maintain an ombuds service that…….receives training and adheres to confidentiality consistent with this chapter and chapter 71.05, 71.24, and 70.02 RCW.

Note: This WAC only applies to persons serving in the role of Ombuds

WAC 388-865-0260 Mental health professionals and specialists

The regional support network must …… develop a training program using in-service training or outside resources to assist service providers to acquire necessary skills and experience to service the needs of the consumer population.

If there are more than 500 members of an ethnic minority population within the regional support network, the regional support network must:

(a) Develop a specialized training program for staff members of licensed service providers to become qualified specialists; or

(b) contract or establish a working relationship with the required specialists to

(i) Provide all or part of the treatment services for these populations; or

(ii) Supervise or provide consultation to staff members providing treatment services to these populations.

WAC 388-865-0282 Quality Review Teams

The regional support network must assure that quality review teams…….receive training and adhere to confidentiality standards

Note: This WAC only applies to persons who are serving as members of a quality review team.

WAC 388-865-0405 Community Support Service Providers, competency requirements for staff

An individualized annual training plan must be implemented for each direct service staff person and supervisor in the skills he or she needs for their job description and the population they serve.

Note: This WAC also applies to providers of crisis telephone services only

WAC 388-865-0530 Competency requirements for staff, certification requirements, inpatient evaluation and treatment facilities

An individualized annual training plan must be implemented for each direct service staff person and supervisor in the skills he or she needs for their job description and the population they serve. Such training must include at least:

(a) Least restrictive alternative options available in the community and how to access them;
(b) Methods of patient care;
(c) Management of assaultive and self-destructive behavior; and
14. The requirements of chapters 71.05 and 71.34 RCW, this chapter, and protocols developed by the mental health division.
15.

II. Training Requirements per NSMHA CONTRACT

16.
All providers must ensure that all staff are qualified for the position they hold and have at a minimum the education, experience, and skills to perform their job requirements, per WAC 388-865. In addition they shall collaborate with NSMHA to implement, maintain, and revise the Regional Training Plan and any successors.

All staff in NSMHA per agency training plan

Title	Training Method	How Validated	Time Frame	Reference
Clinical Risk Assessment	Agency-specific per training plan	Agency-specific per training plan	Clinical Orientation	NSMHA Contract
Community-Based Cross System Collaboration	Agency-specific per training plan	Agency-specific per training plan	Clinical Orientation	NSMHA Contract
Treatment Planning and Documentation	Agency-specific per training plan	Agency-specific per training plan	Clinical Orientation	NSMHA Contract
Co-occurring Disorders	Agency-specific per training plan	Agency-specific per training plan	Clinical Orientation	NSMHA Contract
PTSD Screening and Treatment of Trauma-based Illness	Self-study module	Post-test	Second year of employment	NSMHA Contract
Tribal	Self-study module	Post-test	Second year of employment	NSMHA Contract
Behavior Management for Children	Agency-specific per training plan	Agency-specific per training plan	Within first year of employment	NSMHA Contract
Case management	Agency-specific per training plan	Agency-specific per training plan	Within first year of employment	NSHMA Contract
Access and Triage	Agency-specific per training plan	Agency-specific per training plan	Within first year of employment	NSMHA Contract
ICRS Standards and Protocols	Self-study module	Post-test	Within first year of employment	NSMHA Contract
De-escalation (child specific)	Agency-specific per training plan	Agency-specific per training plan	Within first year of employment	NSMHA Contract
Use of Natural Supports and Community-Capacity Building	Agency-specific per training plan	Agency-specific per training plan	Within first year of employment	NSMHA Contract
Recovery Model	Self-study module	Post-test	Orientation	NSMHA Contract
Confidentiality/Ethics/ HIPAA/ Mandatory Reporting/Dual Relationships/Fraud and Abuse	Agency-specific per training plan	Agency-specific per training plan	Orientation	HIPAA, WAC
Cultural/Disability/Special Populations Sensitivity	Self-study module	Post-test	Orientation	NSMHA Contract
Consumer Rights/Respect and Dignity/Relationships/Perspectives/Complaints and Grievances	Agency-specific per training plan	Agency-specific per training plan	Orientation	NSMHA Contract
Bloodborne Pathogens/Infection Control	Agency-specific per training plan	Agency-specific per training plan	Orientation	Agency-specific per training plan
Patient Safety/Critical Incident Reporting	Agency-specific per training plan	Agency-specific per training plan	Orientation	NSMHA Contract
NSMHA System/Organizational Chart	Self-study module	Post-test	Orientation	NSMHA Contract
Customer Service/Consumer Satisfaction	Agency-specific per training plan	Agency-specific per training plan	Orientation	NSMHA Contract
Workplace Violence/De-escalation/Crisis/Risk Management	Agency-specific per training plan	Agency-specific per training plan	Orientation	NSMHA Contract

North Sound Mental Health Administration
Regional Training Committee
Training Module

American Indian Policy

DSHS Administrative Policy 7.01

The North Sound Mental Health Administration (NSMHA) in conjunction with the eight federally recognized Tribes in the North Sound Region are committed to inclusive planning and appropriate service delivery to American Indian governments and communities. Following is an overview of the process to ensure this.

Table of Contents:

1. Training Module
2. Washington State Memorandum 7.01 – American Indian Policy
3. Centennial Accord
4. The Mental Health Needs of American Indians in Washington State
5. North Sound Mental Health Administration 7.01 Plan from contract
6. DSHS Policy 7.01 from contract

Training Objectives*:*

1. Familiarize clinical staff regarding the unique political/legal status of American Indian Tribes.
2. Familiarize clinical staff with social/cultural issues that are unique to American Indian Tribes.
3. Familiarize clinical staff with DSHS Administrative Policy 7.01 and provision of mental health services to American Indian Tribes.
4. Present resources for more in-depth study.

Administrative Policy 7.01
American Indian Policy

Brief History:

Prior to European settlers and other immigrants coming to this country over 150 years ago, the American Indians living in the Northwest had no need for government–to-government rules and regulations. Each American Indian Tribe was a sovereign nation without constraints from any outside governments. With the influx of white settlers into this country, issues such as land rights, sovereignty and citizenship became volatile issues. The numerous wars and battles between the white settlers and the American Indian Tribes resulted in the native peoples losing much of their land and many of their rights. In 1855, the Elliot Bay Treaty moved many Indian People living in the Northwest area onto reservations. For example, The Tulalip Tribe is actually five (5) different tribes that were moved onto the Marysville area reservation and were subsequently named "The Tulalip Tribes". All the tribes in the North Sound area were moved to designated reservations, and many of the tribes had to work hard to regain their Federal Recognition status.

There are eight tribes in the North Sound region that have been able to work with the Federal Bureau of Indian Affairs and the Supreme Court to gain back their Federal Tribal Recognition.

The Federally Recognized Tribes in the North Sound Region are:

The Tulalip Tribes – Marysville, Washington

The Stillaguamish Tribe of Indians – Arlington, Washington

The Swinomish Tribal Community – La Conner, Washington

The Upper Skagit Tribe – Sedro-Woolley, Washington

The Sauk Suaittle Tribe – Darrington, Washington

The Lummi Nation - Bellingham, Washington

The Nooksack Tribe – Sumas, Washington

The Samish Tribe – Anacortes, Washington

There was a tribal request to Washington State to work government-to-government with the current twenty-nine Federally Recognized American Indian Tribes in Washington State. This tribal request then led to the ***Centennial Accord Agreement of 1989*** and later to the current Department of Social and Health Services policy ***Memorandum 7.01.*** The DSHS

Memorandum 7.01 requires that by April 2 of each even-numbered year, prior to the development of the biennial budget request, each administration/department shall develop a biennial service plan for American Indian tribes, communities and participants. This plan is called the ***7.01 Plan.*** As a result of this plan, the American Indian tribes have a unique status within the public mental health network:

- All Tribal community members in the North Sound Region are eligible for crisis mental health services from the Prepaid Inpatient Health Plan (PHIP) administered by the North Sound Mental Health Administration. Tribal members who receive (or are eligible to receive) Medicaid coupons also qualify for all the mental health services offered by NSMHA contract providers.

- According to Federal and State law, as well as NSMHA contract, contracted providers must inform American Indian and Alaskan Native clients that they may receive traditional/cultural treatment services in addition to or instead of standard services.

- Providers are encouraged to coordinate treatment of Tribal members with Tribal Mental Health departments.

- Collaboration with Tribes helps assure that Native American/Alaskan Native clients receive culturally appropriate services.

1. What is contained in a 7.01 Plan?

As a result of the Centennial Accord and DSHS Memorandum 7.01,
The North Sound Mental Health Administration is mandated to work with the Federally Recognized American Indian tribes and all other enrolled American Indian/Alaskan Natives in our five counties. Federal Recognition means that each tribe in North Sound Region (listed above) has been recognized as its own NATION. In addition, any consumer living in the North Sound region who identifies her/himself as American Indian/Alaskan Native (AI/AN) has access to services under these guidelines.

17. This means each of the eight tribes is able to govern itself and make all decisions regarding their tribal government, community, and individual citizens' needs. As a sovereign nation, tribes are able to provide their own judicial system, police and fire departments, health clinics and behavioral health facilities. Many of the smaller tribes have some direct tribal services and then work government-to-government with County, City and the State of Washington to deliver other services to their tribal members.

18.

19. The **7.01 Plan** is based on the following premises:

20.

21. The State of Washington is committed to delivering services to American Indians in a manner that is in harmony with existing Federal, State, and Tribal law. Enrolled Tribal members are citizens of the United States and citizens of their respective Tribal Nation.

22. The State of Washington is committed to partnering with tribes in the development of policies and procedures for all programs in DSHS. The intent of the Policy is to minimize potential conflicts for future policies and procedures.

23. The Centennial Accord and the subsequent Memorandum 7.01 will set the basic principals for "government-to-government" consultation with all Washington State DSHS Divisions.

24. Above all, that each DSHS Division or contractor must seek consultation with each Tribe assessing any potential impact of a given policy or practice that may impact tribal law.

25.

26.

The **7.01 Plan** provides a framework for all DSHS Divisions and contracted providers who receive either state and/or federal funds to work with the tribes. The plan contains provisions to:

1. Ensure meaningful input by the tribes, including but not limited to state budgets, policies, manuals, and operational procedures which affect American Indian People;
2. Ensure programs and services provided to American Indian People are culturally relevant and in compliance with this policy;
3. Ensure that programs and services provided to reservation and off-reservation American Indian People are designed to meet American Indian social and health needs;
4. Ensure the agency and contractor/licensee is in compliance with all American Indian-related sections of the Washington State Administrative Codes and other Federal regulations;
5. Develop policies outlining sanctions for failure to comply with any or all of the DSHS American Indian Policy;
6. Develop specific, written protocols establishing how each administrator will contact and work with American Indian Tribes;
7. Provide culturally-specific training to divisions or programs working with American Indian Tribes or communities.

2. The North Sound Mental Health Administration in conjunction with the eight federally recognized Tribes in the North Sound Region are committed to inclusive planning and appropriate service delivery to American Indian governments and communities.

The tribes in the North Sound Region have had the opportunity to sit on the NSMHA Board of Directors as voting members since 1999. To our knowledge, NSMHA is the only Regional Support Network in the state that offers Tribes the choice to become board members.

The North Sound Mental Health Administration's current 7.01 Plan ensures:

a. Optimum access and inclusion in NSMHA contracted mental health programs, including tribal initiated voluntary inpatient certification.
b. Programs provide culturally appropriate Mental Health Treatment to AI/AN People according to the current 7.01 plan.
c. Provision of training opportunities for tribal behavioral health workers and encourage linkages among Tribes, DSHS agencies and county health programs that promote seamless services to treatment access.
d. Efforts to increase numbers of enrolled American Indians as employees of NSMHA contracted PIHP's.
e. Education and training of all concepts in the Centennial Accord and 7.01 planning.
f. Maintenance of the 7.01 plan as a *living, focused, working document*, with optimal tribal participation and involvement in every aspect of the process.
g. Recognition of the government-to-government relationship between Tribes and NSMHA Board of Directors and county services.

3. Designing and delivering mental health services for American Indians/Alaskan Natives:

There are important elements to be considered when designing and providing mental health services to Tribal members:

❖ The concept of *Cultural Predominance* helps clarify the appropriate starting point for the clinical treatment of American Indians. This means that mental health services encompass <u>belief systems, lifestyle, and perceived problems</u>; and <u>culturally identified service</u> needs determine the choice of services to be provided.

- ❖ This position requires the clinician to re-orient away from conventional mental health practices toward services derived from the culture of American Indian being served. Since standard mental health approaches have been shown to be ineffective for a great many American Indian clients, it is necessary for our mental health system to make this shift in perspective in order to become culturally competent.

- ❖ Guidelines for Culturally Congruent Mental Health Services include:

    a. An understanding of the cultural concepts of illness and health which are incorporated into the treatment approach.
    b. Diagnostic or classification systems that are culturally accurate and acceptable to the client, family and community.
    c. Culture-specific symptom patterns that are recognized.

4. The Tribal Voluntary Inpatient Certification Policy:

This policy is an attachment to the current 7.01 plan. The procedure provides a process for the Tribes who wish to initiate and facilitate voluntary hospitalization for members of their Tribal Communities when deemed necessary and appropriate, and to comply with Section 1.6 of the North Sound Mental Health Administration 7.01 Plan. The basic policy consists of six items:

a. The Associated Provider Network and Tribes throughout the North Sound Region commit to actively working together to provide culturally competent/appropriate services.

b. A culturally competent system of care acknowledges and incorporates, at all levels, the importance of culture and cultural differences (WAC 388-856-0150, and NSMHA 7.01 Plan Updated 4/24/03).

c. Hospitalization is considered after all other less restrictive culturally competent/appropriate options have been ruled out as inappropriate or unavailable for the consumer in their current situation.

d. Hospitals wishing to admit consumers with Medicaid funding and those without any source of funding are required to obtain certification from the hospital certification team provided by Volunteers of America for NSMHA.

e. Whenever possible, tribal community members must be evaluated face-to-face within 4 hours of the request by a tribal-designated liaison, able to evaluate mental health conditions. Exceptions to this requirement may be made on a case-by-case basis, but all persons being referred must have a face-to-face contact within 24 hours of the request for certification.

f. The Hospital Certification Team may consult, as necessary, with the assigned Primary Clinician, the Tribal-designated Liaison, NSMHA Quality Specialist, the referring MD, consulting MD, and/or clinicians working in the NSMHA Integrated Crisis Response System.

5. **What do culturally competent/culturally congruent services look like?**
Culturally competent or culturally congruent services include the following elements:

a. Client-therapist pairs are culturally similar.

b. Service providers have achieved a positive personal cultural integration.

c. Settings of services are easily accessible and culturally familiar to clients.

d. The nature and timing of the intake process reflect cultural priorities and acceptable and inoffensive to clients.

e. The degree of social involvement or enmeshment of mental health workers with the client is culturally determined.

f. The client's religious/spiritual beliefs are understood, supported, and, if culturally appropriate, integrated into the therapeutic process.

g. Traditional healing practices and traditional healers are integrated into the therapeutic process when culturally appropriate.

h. Treatment techniques are culturally comprehensible and acceptable.

i. Therapeutic goals are consistent with the client's cultural values.

j. Therapeutic expectations are consistent with cultural biases toward inner or outer control.

k. Record keeping systems are minimally intrusive and culturally accurate.

l. The support of appropriate American Indian/Alaskan Native (AI/AN) authorities or institutions is obtained.

Conclusion

American Indian/Alaskan Native clients receiving culturally congruent mental health services receive an overall message of personal and cultural validation that honors their heritage, especially the cultural and spiritual aspects. This positive, healing message is not possible when services are culturally incongruent. Cultural congruence ensures that the client's value

system, life experiences and expectations about the therapeutic process will be integrated into all aspects of mental health services, which are delivered with dignity and respect.

Administrative Policy 7.01
American Indian Policy

POST-TEST

Please Print.
Name: ______________________________ Last ______________________________ First

Program: ______________________________ Mailstop ______________

1. Memorandum 7.01 is a result of State and Federal Documents:

   ☐ Centennial Accord.
   ☐ New Millennium Agreement
   ☐ American Indian Commerce Clause
   ☐ Indian Child Welfare Act of 1978
   ☐ All of the Above

2. Memorandum 7.01 is only for the tribes in the North Sound Region:

   ☐ True
   ☐ False

3. Who is responsible for the DSHS 7.01 plans?

   ☐ American Indian Sovereign Tribes
   ☐ Just American Indian Tribes that are IHS 638
   ☐ All DSHS Divisions and Tribal Governments
   ☐ Non of the above

4. Tribes who wish to initiate voluntary hospitalization do not have to be certified by the NSMHA Hospital Certification Team:

   ☐ True
   ☐ False

5. Tribal members who receive public mental health services have the right to receive treatment of their mental illness by a tribal shaman, if they wish:

   ☐ True
   ☐ False

6. Each Department within DSHS 7.01 plan must include American Indian input on:

- ☐ Budgets
- ☐ Program development
- ☐ Agency manuals
- ☐ Cultural relevance
- ☐ All of the above
- ☐ None of the above

7. By April 2 of each even-numbered year, prior to the development of the biennial budget request, each administration/department shall develop a biennial service plan for American Indian tribes, communities and participants. What is this plan called?

- ☐ Centennial Accord of 1998
- ☐ Elliot Bay treaty of 1854
- ☐ New Millennium Agreement, Signed by Governor Locke
- ☐ Non of the above

8. American Indians and Alaskan Natives have a unique status as a result of the DSHS Memorandum 7.01:

- ☐ True
- ☐ False

9. Tribal members who receive (or who are eligible to receive) Medicaid coupons also qualify for all the mental health services offered by NSMHA contract providers:

- ☐ True
- ☐ False

10. The 7.01 Plan requires which of the following?

- ☐ Meaningful input by the tribes
- ☐ Culturally-specific training to divisions or programs working with AI/AN
- ☐ Programs designed to meet American Indian social and health needs
- ☐ All of the above
- ☐ None of the above

1 point per question; 10 points available; 80% or 8 points = pass.

Name ________________________________ Mailstop ______________

PLEASE NOTE: This section will not be scored, but will be reviewed by your supervisor.

A. How will you apply the information in this module to your clinical work?

B. What else would you like to know about working with members of American Indian/American Native tribes?

Please detach the post-test and send to your supervisor.

Name ______________________________ Mailstop _____________

PLEASE NOTE: This section will not be scored, but will be reviewed by your supervisor.

A. How can the information in this module be applied to your clinical work?

B. Would you like to know more about American Indian Policy?

Please detach this post-test and send to your supervisor.

North Sound Mental Health Administration
Regional Training Committee

Bibliography

Centennial Accord (1989) Legal Document between Washington State Tribes and the State of Washington

Gathering of Wisdoms (2001) 2nd Addition, The Swinomish Tribal Community

Broken Promises Broken Treaties (2001), Overview of American Indian History, presented at Tribal Conference, Sharri Dempsey

The Mental Health Needs of American Indians in Washington State, (2003), The Governors Office of Indian Affairs IPSS, Primary Author: Mile L. Steenhout and Joe St. Charles

North Sound Mental Health Administration, 7.01 Plan 2003-2005, The Eight Tribes in the North Sound Region and NSMHA Board of Directors

The Meriam Commission and Health Care Reform (1926 – 1945, "Getting Stared" Report to congress – Lewis Meriam

Further Documents attached to NSMHA 7.01 Plan 2004-2005,

- Voluntary Inpatient Facilitation by Tribal Mental Health Departments
- Qualifications Provider Mental Health Specialists who treat American Indians/Alaskan Natives

North Sound Mental Health Administration
Regional Training Committee
Training Module

Post-Traumatic Stress Disorder

Table of Contents:

1. Training Module
2. Resources
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4. Appendix B – Trauma Task Force Screening Tool
5. Appendix C – Complex PTSD

Training Objectives:

After completing this module, you will be able to:

1. Define Post-Traumatic Stress Disorder (PTSD)
2. List the effects of traumatic experiences
3. List the types of traumas that can lead to PTSD
4. List co-occurring disorders and health problems that often accompany PTSD
5. List indicators in a client's history that would lead to investigating the possibility of PTSD
6. List the diagnostic, clinical criteria for PTSD
7. Describe treatment options for people with PTSD
8. Describe the qualities for effective treatment of PTSD

1. Effects of Traumatic Experiences

As a society, we value and teach the importance of self-reliance, inner strength, and the ability to overcome adversity. In fact, it is common for people to feel that no matter what they've faced or lived with, no matter how extreme the ordeal, they should be able to carry on.

But regardless of how competent people may be, personally or professionally, sometimes they face trauma of such magnitude that they become unable to cope and function in their daily lives. Some people become so distressed by memories of trauma – memories of trauma that won't go away – that they begin to live their lives trying to avoid any reminders of what happened to them.

When people find themselves suddenly in danger, sometimes they are overcome with feelings of fear, helplessness, or horror. These events are called *traumatic experiences*. Some common traumatic experiences include being physically attacked, being in a serious accident, being in combat, being sexually assaulted, being in a fire or natural disaster like a hurricane or a tornado, and being abused as a child.

After traumatic experiences, people may have problems they did not have before the event. If these problems are severe and the trauma survivor does not get help for them, they can begin to cause problems in the survivor's daily functioning and in their relationships, particular within their family. The extreme effects of trauma cause a *psychiatric injury*, not a mental illness or personality disorder.

2. What is Post-Traumatic Stress Disorder?

Post-traumatic Stress Disorder, or PTSD, is marked by *emotional, biological,* and *psychological* symptoms. It is a complex psychiatric disorder that can occur after a person experiences extreme trauma. PTSD sufferers often feel alone and isolated by their experience and tend to disconnect from others, and in a sense, from their own lives. Clusters of symptoms may or may not appear for months—or even years—following the traumatic experience. Often symptoms can be dramatic, with the individual reliving the traumatic experience through nightmares and flashbacks. Symptoms can also appear more subtle—difficulty sleeping, excessive feelings of anger, irritability, lack of concentration, avoiding reminders of the trauma, harming themselves, loss of appetite, feeling depressed and lacking interest in their lives. However, any of these symptoms may cause a significant impairment to the person's daily life---inability to function in social or family life, job/work instability, marital problems and divorces, family discord and difficulties in parenting.

Physical complaints, any or all which may be accompanied by depression can include:

- chronic pain with no medical basis (frequently gynecological in women)
- stress-related conditions such as chronic fatigue syndrome or fibromyalgia
- stomach pain or other digestive problems
- eating disorders

- breathing problems or asthma
- headaches
- muscle cramps or aches such as low back pain
- cardiovascular problems
- sleep disorders.

PTSD is often complicated by the fact that it frequently occurs in conjunction with related disorders such as depression, substance abuse, problems of memory and cognition, and other problems of physical and mental health.

3. Background of PTSD

Though the American Psychiatric Association formally recognized PTSD in 1980, PTSD is not a new disorder. The concept of trauma-related emotional disturbance has existed for over a century, having names such as "shell shock," "war neurosis," and "rape trauma syndrome." There are written accounts of similar symptoms that go back to ancient times, and there is clear documentation in the historical medical literature starting with the Civil War, when a PTSD-like disorder was known as "Da Costa's Syndrome." There are particularly good descriptions of post-traumatic stress symptoms in the medical literature on combat veterans of World War II, and on Holocaust survivors.

Careful research and documentation of PTSD began in earnest after the Vietnam War. The National Vietnam Veterans Readjustment Study estimated in 1988 that the prevalence of PTSD in that group was 15.2% at that time and that 30% had experienced the disorder at some point since returning from Vietnam.

PTSD has no boundaries. While responses may differ from culture to culture, it can affect anyone, regardless of age, gender, race, ethnicity and socio-economic background. It is important to consider any cultural influences that are part of a person's background or life. "Cultural" factors may include ethnicity, religious/spiritual beliefs, or social identities, among others, and these factors can affect the way the individual perceives and deals with trauma. Inquiries about these influences can be made during initial treatment sessions as well as on an ongoing basis, so that the clinician's cultural competence is increased and treatment is more effective. Showing a willingness to learn about the cultural factors present in a person's life builds trust and enhances the therapeutic relationship.

4. How common is PTSD?

An estimated 7.8 percent of Americans will experience PTSD at some point in their lives, with women (10.4%) twice as likely as men (5%) to develop PTSD. About 3.6% of US adults, aged 18-54 (5.2 million people) have PTSD during the course of a given year. This represents a small portion of those who have experienced at least one traumatic event. It is estimated that 70% of adults in this country have experienced a traumatic event at least once in their lives and that up to 20% of these people go on to develop PTSD. Furthermore, the National Center for PTSD estimates that up to 43% of both boys and girls experience a

traumatic event at least once in their lifetime. Of those children, up to 15% of girls and 6% of boys could meet clinical criteria for PTSD.

The traumatic events most often associated with PTSD for men are: rape, combat exposure, childhood neglect, childhood physical abuse. The most traumatic events for women are: rape, sexual molestation, physical attack, being threatened with a weapon, and childhood physical abuse. The traumatic events most often associated with PTSD in children/adolescents are: exposure to violent crimes including domestic violence to or murder of a parent, school shootings, motor vehicle accidents, exposure to community violence, peer suicide, physical and sexual abuse, natural or man made disasters (including terrorism and war).

It is important to know that not everyone who experiences a traumatic event is likely to develop PTSD. It is also important to understand that responses to trauma vary widely. Some people will have few problems, and the problems they do have will resolve themselves without treatment.

5. Who is most likely to develop PTSD?

- Victims of physical and sexual assault face the greatest risk of developing PTSD.
- Those who experience a greater degree and intensity of a stressor, unpredictability, uncontrollability, sexual (as opposed to nonsexual) victimization, real or perceived responsibility, and betrayal;
- Those with prior vulnerability factors such as: genetics, early age of onset and longer-lasting childhood trauma, lack of functional social support, and concurrent stressful life events;
- Those who report greater perceived threat of danger, suffering, upset, terror, and horror or fear;
- Those with a social environment that produces shame, guilt, stigmatization, or self-hatred.
- Women and girls are about twice as likely as men and boys to develop PTSD.

6. What are the diagnostic criteria for PTSD?

The Diagnostic and Statistical Manual of Mental Disorders (DSM)-IV-TR, lists the criteria for PTSD. In addition to the criteria listed in the DSM-IV-TR, a person might experience symptoms of despair, hopelessness, anxiety or fear, or feeling in danger again. They might experience anger or aggressive feelings and feel the need to defend themselves.

In children, symptoms and behaviors associated with PTSD might *also* include distressing dreams or nightmares and somatic complaints such as stomachaches and headaches. Young children may also engage in repetitive play where they reenact and thus relive the trauma in their play. For example, a young child who has been exposed to violent crimes or domestic violence might reenact the violence by breaking toys, having dolls or action figures “fight” or “kill” each other or, reporting a fear that monsters are going to hurt them. Parents,

caregivers, teachers and other adults are a valuable resource in evaluating changes in a child's behavior, as the child may not be able to self-report or articulate their symptoms.

If an individual meets the diagnostic criteria for PTSD, it is likely that he or she will meet DSM-IV-TR criteria for one or more additional diagnoses. These disorders include: Acute Stress Disorder, Generalized Anxiety Disorder, Major Depressive Disorder, alcohol or substance abuse disorders, or personality disorders. In addition to the DSM-IV-TR, the North Sound Mental Health Administration (NSMHA) has developed Clinical Guidelines for PTSD, which is used by all provider agencies in the region. Please see Appendix A for these guidelines.

It is important to note that people can also have physical reminders and/or reactions to the trauma. They might have experienced a head injury, burns or other physical injury as a result of the trauma. They may also feel shaky and sweaty, have a pounding heart, and have trouble breathing, loss of appetite, frequent headaches or other unexplained symptoms.

7. How is PTSD assessed?

Since 1980, there has been a great deal of attention devoted to the development of instruments for assessing PTSD. There are reliable and valid tools available for assessing both the psychometric and psychophysiological aspects of PTSD. It can be difficult to know whether distress is a normal reaction or a symptom of something more serious. PTSD is only one of many possible reactions to a traumatic experience. Responses to trauma can range from anxiety and depression, to experiencing profound effects of the trauma lasting for several months or even many years, indicating PTSD.

Accurate assessment is critical for effective treatment. NSMHA formed a Trauma Committee that was in effect from March – October 2004, with a mission to study trauma and examine best practice in an effort to enhance the trauma services provided in the North Sound region. A screening tool was developed by the task force and is included in Appendix B.

Diagnosing PTSD in an office visit can be challenging. The diagnosis is frequently missed because clients may present with symptoms that might not clearly relate to past trauma. In addition, the client might not typically volunteer information about the traumatic event. Although directing questions is necessary, making the diagnosis requires more than checking off a list of symptoms. It often requires a nonjudgmental approach and expressions of empathy and interest. Gently probing for symptoms facilitates the rapport clients need to be more forthcoming about their distress.

To ensure that the diagnosis is not missed, it is advisable to include a brief trauma history in evaluations for anxiety or depression. Traumatic events of adulthood can be asked about directly, for example, "Have you ever been physically attacked or assaulted? Have you ever been in a severe accident? Have you ever been in a war or disaster?" A positive response then alerts the examiner to inquire further about the relationship between the event and the current symptoms. Traumatic childhood experiences require reassuring statements of normality to put the client at ease, for example, "Many people continue to think about

frightening aspects of their childhood. Do you?" There are resources available that provide numerous examples of sensitive, respectful questions that can be used in a dialogue with a client when investigating the possibility of PTSD.

The nature of an evaluation for PTSD can vary widely, depending on how the evaluation will be used and the training of the professional evaluator. Various survey-type tools have been developed that can either be administered by a clinician or can be completed by the client, according to their comfort level in disclosing and discussing any trauma they have experienced. An interviewer may take as little as 15 minutes to get a sense of a client's traumatic experience and the effect it has on their life to determine whether treatment for PTSD is called for. On the other hand, a specialized PTSD assessment can take eight or more 1-hour sessions when the information is needed for legal or disability claims. In all cases, diagnosis depends on the client's disclosure of their experience of trauma, the symptoms they are experiencing and how they are impacting their life.

Although there has been much research about PTSD, there has also been a lot of criticism from the perspective of cross-cultural psychology and medical anthropology, especially with respect to refugees, asylum seekers, and political torture victims from non-Western regions. Clinicians and researchers working with such survivors argue that since PTSD has usually been diagnosed by clinicians from Western industrialized nations working with patients from a similar background, the diagnosis does not accurately reflect the clinical picture of traumatized individuals from non-Western traditional societies and cultures. Researchers have only recently begun to delineate possible differences between Western and non-Western societies regarding the psychological impact of traumatic exposure and the clinical manifestations of such exposure.

1. When diagnosing PTSD, it is additionally important to consider differential diagnosis. According to the DSM-IV-TR, with Posttraumatic Stress Disorder, "the stressor must be of an extreme nature." Other possible diagnosis must also be considered such as Adjustment Disorder where the stressor and the response to the stressor can be of any severity. The DSM-IV-TR also recommends differential diagnosis of Acute Stress Disorder, Obsessive-Compulsive Disorder and Malingering. Along with differential diagnosis, assessment for PTSD should also include assessment for co-morbid substance use, which should be addressed if identified. A large body of information exists about Complex PTSD, another form of PTSD, although it is not currently a diagnosis listed in the DSM-IV-TR. More information about Complex PTSD can be found in Appendix C of this module.

8. How is PTSD treated?

2.

Once a PTSD diagnosis has been established, there are three key aspects to treatment: patient education, pharmacology, and psychotherapy. Nearly every patient can benefit from education, which is started at the time of diagnosis. Families may also welcome education about PTSD, so that they are better able to cope with the situation and provide needed support to the individual.

There is no definitive treatment, and no cure for PTSD, but some treatments appear to be quite promising, especially cognitive-behavioral therapy (CBT), group therapy, exposure therapy and Eye Movement Desensitization and Reprocessing (EMDR). Effective therapy usually involves helping the survivor maintain safety, managing symptoms, working through the traumatic experience, and focusing on rebuilding the ability to trust others in order to view the world as a tolerable place to function. Dr. Keith Brown, NSMHA Medical Director, adds that treatment should be trauma focused as supportive psychotherapy alone is not typically sufficient. The type of therapy used with children should be based upon their developmental age. Trauma-focused play therapy is one type of therapy that can be helpful with children.

Exposure therapy involves having the client repeatedly relive the frightening experience under controlled conditions to help her or him work through the trauma.

> **EMDR is a relatively new treatment for traumatic memories that involves elements of exposure therapy and CBT combined with techniques (eye movements, hand taps, sounds) that create an alternation of attention back and forth across the person's midline. While the theory and research are still evolving for this form of treatment, evidence suggests that it is the exposure and cognitive components of EMDR that make it effective, rather than the attentional alternation.**

Studies have also shown that medications help ease associated symptoms of depression and anxiety and help with sleep. The most widely used drug treatments for PTSD are the selective serotonin reuptake inhibitors, such as Prozac and Zoloft. At present, cognitive-behavioral therapy appears to be somewhat more effective than drug therapy, although drug trials for PTSD are at a very early stage. Drug therapy appears to be highly effective for some individuals and is helpful for many more. Medications and cognitive-behavioral therapy have been shown to alleviate the three clusters of PTSD symptoms: re-experiencing, avoidance and hypervigilance.

There is a wealth of information and research being conducted about PTSD, since it is such a prevalent, pervasive, and important disorder. Most communities offer support groups for survivors of trauma and their family members. The availability of information and support is promising for the recovery of individuals with PTSD.

9. Creating an effective treatment environment for people with PTSD.

The first steps in treating PTSD require skill and sensitivity—recognizing the problem and offering appropriate guidance and support. There are many reasons why this may be challenging:

- A person who has experienced an extremely traumatic event may hope or even expect to be able to "handle it" or "get over it" on their own.
- Sometimes victims feel guilty about what happened and may mistakenly believe that they were to blame or deserved the pain and hurt. Sometimes the experience may be too personal, painful, or embarrassing to discuss.

- One of the hallmark symptoms is the avoidance of thinking or talking about anything related to the trauma, especially as survivors try to restore activities in their daily lives.
- Some trauma survivors have learned from experience that the world is a dangerous place where trust has little meaning. PTSD tends to foster isolation, making it difficult for some to reach out for help.
- People with PTSD don't always make the connection between the traumatic event and the emotional emptiness, anger and anxiety and sometimes physical symptoms they unexpectedly find themselves feeling months, even years, after the trauma.
- In domestic violence situations, victims may not realize that their prolonged, constant exposure to abuse puts them at risk for PTSD.
- Often people don't know that treatment is available or where to turn for help.

It is vital to break through the isolation and silence. Professionals treating individuals with PTSD can increase their effectiveness by keeping the following factors in mind during the course of treatment:

- Learn to recognize and assess the signs of PTSD from what may seem to be unrelated symptoms.
- Develop a communications approach that enables you to assess a client for a history of trauma in a respectful, non-threatening way.
- Establish a level of trust that encourages a client to open up to you within what may be a limited amount of time for interaction.
- Know how to access available resources in your area so that you can effectively refer clients in need.
- Support the continuum of diagnosis and treatment beyond the parameters of your professional involvement and responsibility.

In working with individuals with PTSD, follow the **RICH** model:

- ✓ **RESPECT** the client as a person. Respect their experience, reserve judgment, provide assurance of confidentiality, and offer yourself as a professional worthy of their trust.
- ✓ **INFORMATION** – provide appropriate resources and referrals and encourage the individual and their family members to seek help.
- ✓ **CONNECTION** – be supportive and try to connect with the person even if the exchange is brief. Help them understand that you care and are concerned for their personal well-being.
- ✓ **HOPE** – offer hope for healing and recovery. Let them know that with appropriate diagnosis, treatment is available. Help them take the next step in seeking help.

Post-Traumatic Stress Disorder
POST-TEST

Please Print.
Name: ______________________________ ___________________________________ First
Last

Program: Mailstop

1. A person who has been physically assaulted may experience which of the following?
   - ☐ horror
   - ☐ helplessness
   - ☐ detachment
   - ☐ insomnia
   - ☐ All of the Above

2. Sometimes, PTSD manifests years after the traumatic event.
   - ☐ True
   - ☐ False

3. Symptoms of what is now recognized as PTSD have been reported since the Civil War.
   - ☐ True
   - ☐ False

4. There is a higher incidence of PTSD among men.
   - ☐ True
   - ☐ False

5. Who is most likely to develop PTSD?
   - ☐ People who are poor
   - ☐ Those who report greater perceived threat of danger, suffering, upset, terror, horror, or fear.
   - ☐ People who are depressed
   - ☐ People have anxiety attacks and have trouble breathing

6. PTSD is commonly treated by:
   - ☐ Education
   - ☐ Exposure therapy
   - ☐ Cognitive-behavioral therapy and drug therapy
   - ☐ All of the above

7. People who survived a natural or man-made disaster are at increased risk for developing PTSD.

- ☐ True
- ☐ False

8. PTSD occurs across age groups, gender, cultural groups and socio-economic classes.

- ☐ True
- ☐ False

9. Why is it difficult to diagnose PTSD?

- ☐ Clients might not voluntarily disclose information about trauma
- ☐ Diagnosing PTSD involves more than just checking off a set of symptoms
- ☐ A client might initially be seen due to a complaint of depression
- ☐ All of the above
- ☐ None of the above

10. PTSD is marked by emotional, biological and psychological symptoms.

- ☐ True
- ☐ False

1 point per question; 10 points available; 80% or 8 points = pass.

Name ______________________________ Mailstop _____________

PLEASE NOTE: This section will not be scored, but will be reviewed by your supervisor.

A. What are the implications of the information in this module to your clinical work?

B. What types of treatment for PTSD are available at your agency, and how do consumers access this treatment?

RESOURCES FOR INFORMATION ABOUT PTSD

General resources:

1. Sidran Traumatic Stress Foundation
   200 E. Joppa Road, Suite 207
   Baltimore, MD 21286
   Phone: (410) 825-8888
   www.sidran.org

   The Sidran Institute is considered to be a leader in traumatic stress education and advocacy. It is a nationally-focused nonprofit organization devoted to helping people who have experienced traumatic life events.

2. National Alliance for Mental Illness (NAMI)

   Colonial Place Three
   2107 Wilson Blvd., Suite 300
   Arlington, VA 22201-3042

   Main: (703) 524-7600
   Fax: (703) 524-9094
   TDD: (703) 516-7227
   Member Services: (800) 950-NAMI

   www.nami.org - NAMI website with information on advocacy for those with mental illness, including affiliates who provide family support groups in different states.

3. Anxiety Disorders Association of America
   11900 Parklawn Drive, Suite 100
   Rockville, MD 20852
   Phone: (301) 231-9350
   www.adaa.org

4. National Center for Victims of Crime's toll-free information and referral service. This is a comprehensive database of more than 6,700 community service agencies throughout the country that directly support victims of crime.
   1-800-FYI-CALL
   www.ncvc.org

5. PTSD Alliance Resource Center
   (877) 507-PTSD
   http://www.ptsdalliance.org

6. National Center for PTSD
   http://www.ncptsd.va.gov

7. The International Society for Traumatic Stress Studies
   60 Revere Drive, Suite 500
   Northbrook, IL 60062
   Phone: (847) 480-9028
   www.istss.org

8. MH Sanctuary
   PO Box 10563
   Yakima, WA 98909
   http://www.mhsanctuary.com/ptsd/index.htm

9. http://www.ptsdinfo.org/ - this website is the gateway to four non-profit organizations that provided resources and support for PTSD.

10. National Institute of Mental Health

    National Institute of Mental Health (NIMH)
    Public Information and Communications Branch
    6001 Executive Boulevard, Room 8184, MSC 9663
    Bethesda, MD 20892-9663

    301-443-4513 (local)
    1-866-615-6464 (toll-free)
    301-443-8431 (TTY)
    1-866-415-8051 (TTY toll-free)

    301-443-4279 (fax)

    http://www.nimh.nih.gov

    E-mail address:
    nimhinfo@nih.gov

11. http://www.bullyonline.org – This website contains outstanding information about Complex PTSD and PTSD

Resources for Veterans:

1. VA Health Benefits Service Center toll free at 1-877-222-VETS!

2. Vietnam Veterans of America (VVA) - Comprehensive information for veterans, including how to file a disability claim (due to PTSD) with the VA.

   8605 Cameron Street, Suite 400
   Silver Spring, MD. 20910.
   (301) 585-4000 (telephone); (301) 585-0519 (fax); veteransbenefits@vva.org (e-mail).
   http://www.vva.org/benefits/ptsd.htm

3. http://www.lexisnexis.com/veterans/offer/ - comprehensive information for veterans

4. http://www.ptsdsupport.net/ -resources primarily for military personnel and veterans

Resources Children and Adolescents:

1. National Center for Child Traumatic Stress (NCCTS)
   NCCTS - University of California, Los Angeles
   11150 W. Olympic Blvd., Suite 650
   Los Angeles, CA 90064
   Phone: (310) 235-2633
   Fax: (310) 235-2612
   http://www.nctsnet.org

   NCCTS - Duke University
   905 W. Main St; Suite 24-E, Box 50
   Durham, NC 27701
   Phone: (919) 682-1552
   Fax: (919) 667-2350

   National Resource Center for Child Traumatic Stress - Duke University
   905 W. Main St.
   Suite 23-D
   Durham, NC 27701
   Phone: (919) 682-1552
   Fax: (919) 667-9578

2. Program Office of the National Child Traumatic Stress Initiative
   Center for Mental Health Services
   Substance Abuse and Mental Health Services Administration
   Department of Health and Human Services
   1 Choke Cherry Road
   Room 6-1105
   Rockville, MD 20857
   Phone: (240) 276-1856

Books:

The PTSD Workbook: simple, Effective Techniques for Overcoming Traumatic Stress Symptoms, by Mary Beth Williams

Trauma and Recovery: The Aftermath of Violence—from Domestic Abuse to Political Terror, by Judith Herman

Seeking Safety: A Treatment Manual for PTSD and Substance Abuse, by Lisa M. Najavits

Too Scared to Cry: Psychic Trauma in Childhood, by Lenore Terr

Appendices (Supplemental Information)

Appendix A

North Sound Mental Health Administration

Clinical Guidelines – Post-Traumatic Stress Disorder

Posttraumatic Stress Disorder DSM-IV-TR codes 309.1, 308.3)	
Diagnostic Features	Consistent with DSM IV –TR criteria. In cases where the client is not benefiting from treatment the diagnosis will be reassessed.
Assessment Components and Considerations	1. Post Traumatic Stress Disorder is the development of characteristic symptoms following exposure to an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one's physical integrity or witnessing an event that involves death, injury, or a threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate. Criterion A) The person's response to the event must involve intense fear, helplessness, or horror. Criterion A-2) The characteristic symptoms resulting from the exposure to the extreme trauma include persistent re-experiencing of the traumatic event. Criterion B) Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness. Criterion C) Persistent symptoms of increased arousal Criterion D) The full picture must be present for more than 1 month Criterion E) Disturbance must cause clinically significant distress or impairment in social, occupation, or other important areas of functioning Criterion F) Traumatic events that are experienced directly include, but are not limited to, military combat, violent personal assault (sexual assault, physical attack, robbery, mugging), being kidnapped, being taken hostage, terrorist attack, torture, incarceration as a prisoner of war or in concentration camp, natural or manmade disasters, severe auto accidents, or being diagnosed with a life-threatening illness. Multi-generational trauma among both mainstream and minority cultures also needs to be assessed and considered.
Treatment Guidelines	1. Initial and periodic psychiatric screening to determine need for consultation, evaluation and/or medications. 2. Treatment plan includes interventions consistent with the level of risk for self-harm. 3. Acute PTSD will require active treatment during this acute phase of PTSD may help to reduce the otherwise high risk of developing chronic PTSD. 4. Chronic PTSD Long-term symptoms may need longer and more aggressive treatment and are likely to be associated with a higher incidence of comorbid disorders. a. The most Common Co-morbid Disorders in a Patient with PTSD: i. Substance abuse or dependence ii. Major depressive disorder iii. Panic disorder/agoraphobia iv. Generalized anxiety disorder v. Obsessive-Compulsive Disorder vi. Social Phobia vii. Bipolar Disorder viii. Personality Disorders, especially Borderline 5. Patients presenting with the co-morbid disorders of major depression, bipolar disorder, panic disorder, social phobia, obsessive-compulsive disorder, psychotherapy should be combined with medication from the start of therapy.

	6. Patients presenting with co-morbid substance abuse, treatment or both substance abuse and PTSD should be provided simultaneously. Serous consideration should also be given to postponing treatment for PTSD until substance abuse problems have been treated first. 7. Medication visits should occur as often as clinically indicated and medically necessary for the duration of treatment. 8. Case management services may be helpful for coordination and family support and advocacy. 9. Brief Descriptions of the Most Recommended Psychotherapy techniques i. Relaxation training ii. Breathing retraining iii. Positive thinking and self-talk iv. Assertiveness training v. Anxiety management vi. Thought stopping vii. Cognitive therapy viii. Exposure therapy ix. Imaginal exposure x. In vivo exposure xi. Psychoeducation 10. Individual and/or group psychotherapy can be provided to promote mood stabilization and provide skill building and support. 11. Education about the illness, incidence and treatment options are important. Family members and significant others may be included in this process whenever appropriate and possible. 12. Varied employment strategies including prevocational and supported employment to assist clients ready to pursue employment. 13. Co-occurring disorder treatment as indicated. 14. Crisis planning focusing on early signs of decompensation, safety and management strategies. 15. Because of the chronic nature of the disorder, treatment may be long term. Relapse prevention should be included in treatment planning. 16. Residential Treatment/Housing/Crisis beds for those requiring 24 hour care or access to appropriate community-based housing. 17. Inpatient services for acute stabilization as necessary.
Optimal Outcome of Treatment	**The client will attain symptom relief, learn skills to prevent or manage future episodes and improve functioning in daily life.**
References	**DSM IV-TR** **The Expert Consensus Guideline Series Treatment of Post-Traumatic Stress Disorder, Consultation with Edna Foa, Ph.D., Jonathan R.T. Davidson, MD, Allen Frances, M.D., Ruth Ross, M. A. Journal of Clinical Psychiatry** **VA/DoD Practice Guideline for Management of PTSD and Acute Stress Reaction Module**

Appendix B

Post-Traumatic Stress Disorder Screening Tool

Trauma Screening Tool

Instructions: Below is a list of problems and complaints that people sometimes have in response to stressful life experiences. Please read each one carefully, then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

		Not at all	A little bit	Moderately	Quite a bit	Extremely
1.	Repeated disturbing memories, thoughts or images of a stressful experience from the past?	1	2	3	4	5
2.	Repeated, disturbing dreams of a stressful experience from the past?	1	2	3	4	5
3.	Suddenly acting or feeling as if a stressful experience from the past were happening again (as if you were reliving it)?	1	2	3	4	5
4.	Feeling very upset when something reminded you of a stressful experience from the past?	1	2	3	4	5
5.	Having physical reactions (e.g., heart pounding, trouble breathing, sweating) when something reminded you of a stressful experience from the past?	1	2	3	4	5
6.	Avoiding thinking about or talking about a stressful experience from the past or avoiding feelings related to it?	1	2	3	4	5
7.	Avoiding activities or situations because they reminded you of a stressful experience from the past?	1	2	3	4	5
8.	Trouble remembering important parts of a stressful experience the past?	1	2	3	4	5
9.	Loss of interest in activities that you used to enjoy?	1	2	3	4	5
10.	Feeling distant or cut off from other people?	1	2	3	4	5
11.	Feeling emotionally numb or being unable to have loving feeling for those close to you?	1	2	3	4	5
12.	Feeling as if your future somehow will be cut short?	1	2	3	4	5

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13.	Trouble falling or staying asleep?	1	2	3	4	5
14.	Feeling irritable or having angry outbursts?	1	2	3	4	5
15.	Having difficulty concentrating?	1	2	3	4	5
16.	Being “super-alert” or watchful or on guard?	1	2	3	4	5
17.	Feeling jumpy or easily startled?	1	2	3	4	5

PLC-C for DSM-IV (11/1/94) National Center for PTSD Behavioral Sciences Division

Appendix C

North Sound Mental Health Administration

Complex PTSD

***Another form of PTSD is the subject of much discussion in the United States and other countries – Complex PTSD, although it is not currently a diagnosis listed in the DSM-IV-TR. Information about this form of PTSD is presented below, and there is a wealth of literature available for further study.**

1. Complex PTSD – a newly-recognized form of PTSD

The diagnosis of PTSD accurately describes the symptoms that result when a person experiences a short-lived trauma. For example, car accidents, natural disasters, and rape are considered traumatic events of time-limited duration. However, **chronic** traumas continue for months or years at a time. Clinicians and researchers have found that the current PTSD diagnosis often does not capture the severe psychological harm that occurs with such prolonged period of negative stress, or repeated trauma. For example, ordinary, healthy people who experience chronic trauma can experience changes in their self-concept and the way they adapt to stressful events. Dr. Judith Herman of Harvard University suggests that a new diagnosis, called **Complex PTSD**, is needed to describe the symptoms of long-term trauma.

Situations which might give rise to Complex PTSD include bullying, harassment, abuse, domestic violence, stalking, long-term caring for a disabled relative, unresolved grief, exam stress over a period of years, mounting debt, contact experience, etc. Those working in regular traumatic situations, e.g., the emergency services, are also prone to developing Complex PTSD.

The nature of the traumatic experience includes other factors such as: which may include any of captivity, lack of means of escape, entrapment, repeated violation of boundaries, betrayal, rejection, bewilderment, confusion, and - crucially - lack of control, loss of control and disempowerment. It is the overwhelming nature of the events and the inability (helplessness, lack of knowledge, lack of support etc) of the person trying to deal with those events that leads to the development of Complex PTSD.

A key feature of Complex PTSD is the aspect of captivity. The individual experiencing trauma by degree is unable to escape the situation. Despite some people's assertions to the contrary, situations of domestic abuse and workplace abuse can be extremely difficult to get out of. In the latter case there are several reasons, including financial vulnerability (especially if you're a single parent or main breadwinner), unavailability of jobs, ageism (many people who are bullied are over 40), partner unable to move, and kids settled in school and you are

unable or unwilling to move them. The real killer, though, is being unable to get a job reference - the bully will go to great lengths to blacken the person's name, often for years, and it is this lack of reference more than anything else which prevents people escaping.

Examples of captivity include:

- Concentration camps
- Prisoner of War camps
- Prostitution brothels
- Long-term domestic violence
- Long-term, severe physical abuse
- Child sexual abuse
- Organized child exploitation rings

Until recently, little (or no) attention was paid to the psychological harm caused by bullying and harassment. Misperceptions (usually as a result of the observer's lack of knowledge or lack of empathy) still abound: *"It's something you have to put up with"* (like rape or repeated sexual abuse?) and *"Bullying toughens you up*" (ditto). Armed forces personnel faced threats of being labeled with "cowardice" and "lack of moral fiber" if they gave in to the symptoms of PTSD. In World War I, 306 British and Commonwealth soldiers were shot as "cowards" and "deserters" on the orders of General Haig in an act which today would be treated as a war crime.

In the United Kingdom (UK), at least 16 children kill themselves each year because they are being bullied at school. This figure is established in the book, Bullycide: death at playtime. Each of these deaths is **unnecessary**, **foreseeable**, and **preventable**. Since Andrea Adams first identified workplace bullying and gave it its name in 1988, recognition of adult bullying has grown steadily.

2. Common features of Complex PTSD from bullying

People suffering Complex PTSD as a result of bullying report consistent symptoms which further help to characterize psychiatric injury and differentiate it from mental illness. These include:

- Fatigue with symptoms of or similar to Chronic Fatigue Syndrome
- An anger of injustice stimulated to an excessive degree (sometimes but improperly attracting the words "manic" instead of motivated, "obsessive" instead of focused, and "angry" instead of "passionate", especially from those with something to fear)
- An overwhelming desire for acknowledgement, understanding, recognition and validation of their experience
- A simultaneous and paradoxical unwillingness to talk about the bullying
- A lack of desire for revenge, but a strong motivation for justice
- A tendency to oscillate between conciliation (forgiveness) and anger (revenge) with objectivity being the main casualty
- Extreme fragility, where formerly the person was of a strong, stable character

- Numbness, both physical (toes, fingertips, and lips) and emotional (inability to feel love and joy)
- Clumsiness
- Forgetfulness
- Hyperawareness and an acute sense of time passing, seasons changing, and distances traveled
- An enhanced environmental awareness, often on a planetary scale
- An appreciation of the need to adopt a healthier diet, possibly reducing or eliminating meat - especially red meat
- Willingness to try complementary medicine and alternative, holistic therapies, etc
- A constant feeling that one has to justify everything one says and does
- A constant need to prove oneself, even when surrounded by good, positive people
- An unusually strong sense of vulnerability, victimization or possible victimization, often wrongly diagnosed as "persecution"
- Occasional violent intrusive visualizations
- Feelings of worthlessness, rejection, a sense of being unwanted, unlikable and unlovable
- A feeling of being small, insignificant, and invisible
- An overwhelming sense of betrayal, and a consequent inability and unwillingness to trust anyone, even those close to you
- In contrast to the chronic fatigue, depression etc, occasional false dawns with sudden bursts of energy accompanied by a feeling of "I'm better!", only to be followed by a full resurgence of symptoms a day or two later
- Excessive guilt - when the cause of PTSD is bullying, the guilt expresses itself in forms distinct from "survivor guilt"; it comes out as:
    - ✓ an initial reluctance to take action against the bully and report him/her knowing that he/she could lose his/her job
    - ✓ later, this reluctance gives way to a strong urge to take action against the bully so that others, especially successors, don't have to suffer a similar fate
    - ✓ reluctance to feel happiness and joy because one's sense of other people's suffering throughout the world is heightened
    - ✓ a proneness to identifying with other people's suffering
    - ✓ a heightened sense of unworthiness, undeservingness and non-entitlement (some might call this shame)
    - ✓ a heightened sense of indebtedness and undue obligation
    - ✓ a reluctance to earn or accept money because one's sense of poverty and injustice throughout the world is heightened
    - ✓ an unwillingness to take ill-health retirement because the person doesn't want to believe they are sufficiently unwell to merit it
    - ✓ an unwillingness to draw sickness, incapacity or unemployment benefit to which the person is entitled
    - ✓ an unusually strong desire to educate the employer and help the employer introduce an anti-bullying ethos, usually proportional to the employer's lack of interest in anti-bullying measures
    - ✓ a desire to help others, often overwhelming and bordering on obsession, and to be available for others at any time regardless of the cost to oneself

- ✓ an unusually high inclination to feel sorry for other people who are under stress, including those in a position of authority, even those who are not fulfilling the duties and obligations of their position (which may include the bully) but who are continuing to enjoy a salary for remaining in the job.

3. Complex PTSD and Fatigue

The fatigue is understandable when you realize that in bullying, the target's fight or flight mechanism eventually becomes activated from Sunday evening (at the thought of facing the bully at work on Monday morning) through to the following Saturday morning (phew - weekend at last!). The fight or flight mechanism is designed to be operational only briefly and intermittently; in the heightened state of alert, the body consumes abnormally high levels of energy. If this state becomes semi-permanent, the body's physical, mental and emotional batteries are drained dry. Whilst the weekend theoretically is a time for the batteries to recharge, this doesn't happen, because:

- the person is by now obsessed with the situation (or rather, resolving the situation), cannot switch off, may be unable to sleep, and probably has nightmares, flashbacks and replays;
- sleep is non-restorative and unrefreshing - one goes to sleep tired and wakes up tired
- this type of experience plays havoc with the immune system; when the fight or flight system is eventually switched off, the immune system is impaired such that the person is open to viruses which they would under normal circumstances fight off; the person then spends each weekend with a cold, cough, flu, glandular fever, laryngitis, ear infection etc so the body's batteries never have an opportunity to recharge.

When activated, the body's fight or flight response results in the digestive, immune and reproductive systems being placed on standby. It is no coincidence that people experiencing constant abuse, harassment and bullying report malfunctions related to these systems (loss of appetite, constant infections, flatulence, irritable bowel syndrome, loss of libido, impotence, etc). The body becomes awash with cortisol, which in high prolonged doses is toxic to brain cells. Cortisol kills off neuroreceptors in the hippocampus, an area of the brain linked with learning and memory. The hippocampus is also the control centre for the fight or flight response, thus the ability to control the fight or flight mechanism itself becomes impaired.

4. Implications of Complex PTSD

The word "breakdown" is often used to describe the mental collapse of someone who has been under intolerable strain. There is usually an (inappropriate) inference of "mental illness". All these are lay terms and mean different things to different people. There is a distinction between the different types of breakdown:

- **Nervous breakdown** or **mental breakdown** is a consequence of mental illness
- **Stress breakdown** is a psychiatric injury, which is a *normal* reaction to an *abnormal* situation

The two types of breakdown are distinct and <u>not to be confused</u>. A stress breakdown is a natural and normal conclusion to a period of prolonged negative stress; the body is saying "I'm not designed to operate under these conditions of prolonged negative stress so I am going to do something dramatic to *ensure* that you reduce or eliminate the stress otherwise your body may suffer irreparable damage; you must take action now". A stress breakdown is often predictable days - sometimes weeks - in advance as the person's fear, fragility, obsessiveness, hypervigilance and hypersensitivity combine to evolve into paranoia (as evidenced by increasingly bizarre talk of conspiracy). If this happens, a stress breakdown is only days or even hours away, and the person needs urgent medical help. The risk of suicide at this point is heightened.