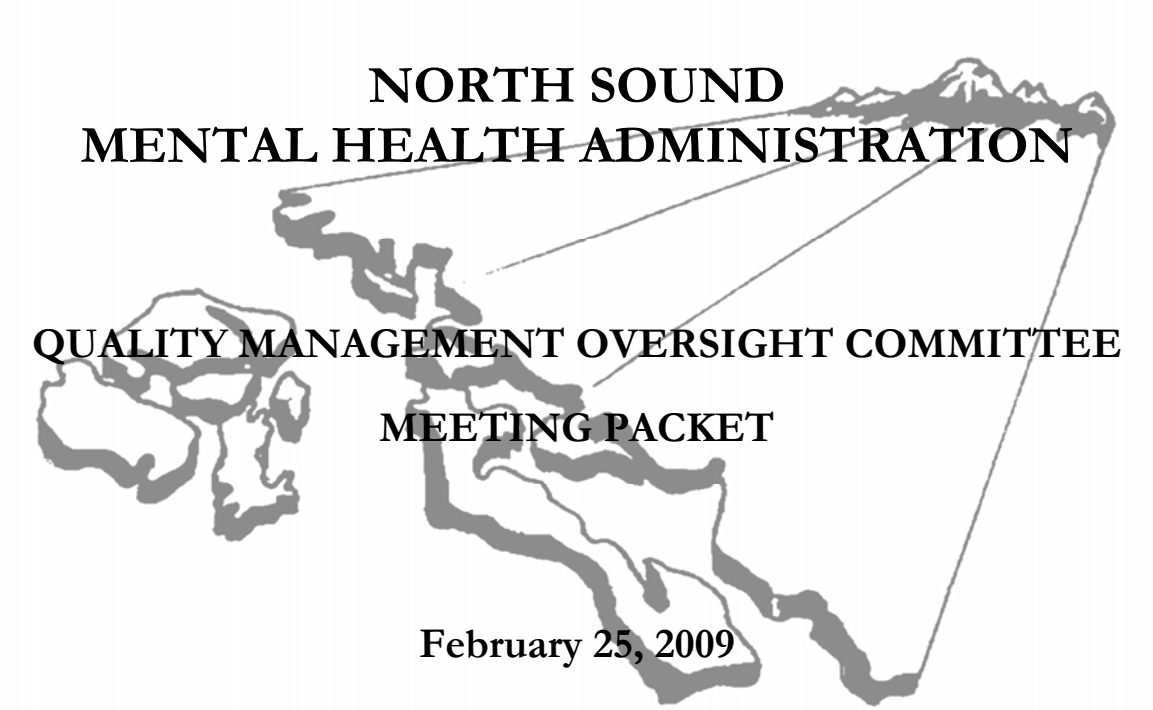
NORTH SOUND
MENTAL HEALTH ADMINISTRATION



QUALITY MANAGEMENT OVERSIGHT COMMITTEE

MEETING PACKET

February 25, 2009

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: February 25, 2009 Time: 12:30-2:30 PM
Location: NSMHA Conference Room
For Information Contact Meeting Facilitator Cindy Ainsley or Greg Long, 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		**1**	5 min
Review and Approval of Minutes of Previous Meeting	Ensure minutes are complete and accurate	Approve minutes	Chair	Minutes		**2**	5 min
Announcements and Updates	Inform QMOC of news, events: budget updates, MHD Audit 4/09; Binder updates, if any; others?	Inform/discuss	ALL				5 min
Evaluation forms from last meeting, if any	Discuss feedback, if any	discuss	CHAIR/CINDY				5 min
Comments from the Chair		Inform	CHAIR: JUNE				5 min
Policy Sub Committee Report	Inform/discuss new process	Approve policies	CINDY	1511; 1545; 1563		**3**	20 min
ICRS Policy Committee Report	*Inform/discuss*	*Approve*	*GREG*	*None at this time*			
WSH Discharge practices changing	inform		Greg				5 min
Practice Guideline Workgroup Recommendation	discuss	approve	Cindy/workgroup	handout		**4**	10 min
Beta testing results for Clinical Guidelines/ Core elements	discuss	decide	Kurt	Handouts (2)		**5**	15 min
Critical Incident changes and training	discuss		Kurt		**6**		15 min
Expedited Auths	discuss	inform	Terry		**7**		15 min
QMOC Charter Review	discuss	approve	Cindy/Greg			**8**	10 min

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? Eval forms		All				

Next meeting: March 25, 2009, 1230-230

Potential Future Agenda Items:
UR Response Times
EQRO 2008 report
QM Report Update

Draft not yet approved

North Sound Mental Health Administration (NSMHA)
Quality Management Oversight Committee (QMOC)
NSMHA Conference Room
Date
12:30 – 2:30 pm
MINUTES

Present:	**Not Present:**
Anne Deacon, Whatcom County Coordinator	Andrew Davis, Whatcom County
Chuck Davis, North Sound Ombuds	Darcy Hocker, Whatcom County
Jonathan Vander Schuur, Sea Mar	Carol Van Buren, Sunrise Community Services
Dan Bilson, NAMI Whatcom County	
Sara Bender, *bridgeways*	
Kay Burbidge, Lake Whatcom Center	**Others Present:**
Susan Ramaglia, NAMI Skagit County	Rebecca Pate, NSMHA
Susan Schoeld, Snohomish County	Chuck Benjamin, NSMHA
Mary Good, NSMHA Advisory Board	Greg Long, NSMHA
Rochelle Clogston, Compass Health	Cindy Ainsley, NSMHA
Kathy McNaughton, Catholic Community Services	Barb McFadden, Compass Health
Karen Kipling, VOA	Heather Fennell, Compass Health
Arthur Jackson, NSMHA Advisory Board	Charissa Westergard, NSMHA
Cindy Paffumi, Interfaith	Terry McDonough, NSMHA
Edward Page, NAMI Skagit	Carole Kosturn, Compass Health
	Mike Manley, Sunrise Services
Excused:	Stacey Alles, Compass Health
June LaMarr, The Tulalip Tribes, Chair	
Charles Albertson, NSMHA Advisory Board	
Nathalie Gauteron, *bridgeways*	

1. **Introductions, Review of Agenda, Previous Meeting Minutes**
   The meeting was convened at 12:35 pm and introductions were made.

   Scheduling of topics: Cindy moved Policy Sub report to after Medicaid Personal Care (MPC) protocol changes to accommodate Greg's schedule.

   Dan mentioned case management training being discussed at previous meetings. He stated he had not heard any updates and wanted to know the status. Anne said it could be mentioned during announcements.

   The minutes from the November meeting were reviewed and a motion was made to approve as amended, seconded and motion carried.

2. **Announcements and Updates**
   Cindy announced the Substance Abuse Mental Health Services Administration (SAMHSA) grant was submitted January 15th. She thanked all for their contributions and said an answer is not expected until October. The abstract is under Tab 3 for those who wish to read it.

   Cindy mentioned she wanted to briefly discuss transfers and requested providers refer to Policy 1510.00 for the process/requirements. She clarified that the previous provider should not close the client file until they have

been through the assessment process with the new provider and accepted. Edward asked about services for people moving in and out of the regional area. Discussion followed. Anne summarized that Edward requested this group look into the development and/or looking into policy development for people moving in and out of the region and minimize disruption of services. Anne asked how a situation like this falls under NSMHA purview. Cindy stated clinicians and case managers should assist the client in finding services in the area where they are moving. Anne asked if this situation was something that should be addressed by Mental Health Division (MHD). Anne asked NSMHA to research this and report back to the group next month.

Greg mentioned that NSMHA has a special project going on for "supported employment" with upcoming training opportunities coming up through Department of Vocational Rehabilitation (DVR). A meeting he attended was done in order to provide better collaboration between mental health, DVR, the North Sound Region and King County Region. He distributed the data summary showing the number of people with mental illness going through the system in the two regions. He added that the numbers are high; and a number of those individuals are re-entering the workforce. Anne asked the dates of the training and Greg stated he distributed an email but believes it is in March. He added this training will be around the basics of "supported employment" and national consultants will be at the training. Cindy mentioned Lisa Hanks stated the first two days are an overview of history of employment services and the second two days were very helpful in terms of nuts and bolts (i.e., what to do, how to do it, etc.). Greg said he would like to encourage providers to have representatives/case managers attend this training.

Greg said there is additional training on Trauma Focused Cognitive Behavioral Therapy and it would be good for providers to send representatives. It is put on by MHD and is evidence-based practices. He distributed information and added seven different provider sites have gone through this training.

Dan mentioned time after time clients have experienced lack of dignity and respect. He added lack of dignity and respect has been mentioned several times to this group and would like to know what is being done to remedy the problem. He said a training manual was created by case managers but was never put into use. He was told that a training program had been established by Jess Jamison and is being utilized so there was no reason to re-invent the wheel. He asked if a training program is being utilized, why clients are continuing to experience the problem of lack of dignity and respect. He said this problem could be a result of lack of training due to being new employees and/or personality conflicts between clients and clinicians. Cindy added that Margaret is spearheading a workgroup regarding this concern and the Recovery Conference focused on this issue. Cindy said all provider agencies give orientation training and this training is part of the orientation and annual ongoing training. Cindy said this sometimes appears at the complaint/grievance level and that provides another opportunity to address it.

Cindy mentioned Monroe's Valley General inpatient psych unit is changing their population. They are no longer taking end stage dementia and/or clients requiring more than one person assist. They are also changing their acceptance age from 55+ to 45+.

3. Evaluation Forms from Last Meeting

Cindy reviewed the responses and encouraged all to fill them out and turn them in to Rebecca at the end of the meeting.

4. Comments from the Chair – Anne Deacon

Anne mentioned the challenges facing all due to the budget cuts and mentioned a meeting is being held tomorrow at Mount Vernon Police Department from 9:30 to 2:30 regarding how proposed budget reductions will be implemented. She requested all not overreact but please listen carefully and feel free to contact legislators with any concerns you might have. Cindy said this is the first of probably several to come and she added it is a brown bag lunch meeting.

Mike mentioned a complexity to this is the sales tax initiative that all five counties have passed. He added a difficult decision counties must make is to what extent the sales tax revenues will/could replace the state only funds being cut by the budget. He affirmed the sales tax funds were initially to enhance existing funding and allow provision of additional services; however, with the prospective budget cuts they may have to be utilized otherwise. He acknowledged the action of this group would/could affect how these funds are used. He respectfully requested all counties should seriously consider how the revenues from the sales tax initiative should be utilized. He said these funds could possibly be used to help alleviate budget cuts.

Dan mentioned that several consumers/advocates went to Olympia January 19th for National Alliance for Mentally Ill (NAMI)/Martin Luther King Day to advocate on behalf of mental health services.

5. ICRS Policy Sub Committee Report – Greg

Greg said there was nothing to report at this time.

6. Mortality Review Summary – Charissa

Charissa said the report is under Tab 5 and reviewed the information with the group. She said this review was done by another individual and she will do her best to present the information and answer any questions. She mentioned this report came about due to some critical incident reviews. She said the report covers adult individuals under the age of 50 that passed away due to natural causes. She requested if anyone had any other information they would like to see once they have had a chance to review the document to please provide feedback to her. Susan S. mentioned the numbers for "cannot determine" appear to be high. Edward said he would like to see more hands on for referrals to get services and request an evaluation as to how the program did/did not work. Susan R. said referrals are more than seeking services it also involves medications, etc. Rochelle would like more clarity on the third recommendation and Anne requested she make that motion and help clarify it. Charissa said perhaps a more current review could be done and perhaps when Utilization Reviews (UR) are done a larger number could be checked for documentation. Anne asked if the recommendations on page 63 of the report are being done by NSMHA, met the approval of QMOC, or if there were other recommendations from this committee. Charissa said the intent is for QMOC to decide whether NSMHA should address none, one, two or all three of the recommendations.

Rochelle requested more clarification regarding the third recommendation and Anne suggested she put that in the form of a motion. Rochelle agreed to put the request in the form of a motion but Sara asked she wait. Sara said in the past NSMHA staff has focused on the first two points and she feels some providers have made significant improvement on documentation in the charts. Discussion followed.

Edward requested a process through referral that would assist individuals in getting connected with services where they move to or create an evaluation survey for resources to utilize to determine how well the program works/does not work in regards to treatment. Susan R said the referrals do not apply only to substance abuse but also primary care providers (PCP). Along with that effects of medications can play a role in early deaths and the prescriber has a responsibility to address these concerns along the way. She suggested when a patient is referred to a PCP issues about the effects of certain medications they are taking should be discussed so those can be watched for during treatment. Edward said he would like a report provided in three months to acknowledge actions have taken place and progress is being made. Edward altered his request to six months.

Rochelle made a motion that NSMHA take the URs and look at the referral process to obtain data to see if this is an ongoing concern or not, Sara seconded. Anne summarized "review data for accuracy and see if recommendations still exist or if changes have been made to meet the report recommendations". Charissa asked Terry if this additional information could be captured and he said if not the UR tool could be revised to allow capture.

7. Dialectical Behavior Therapy (DBT) and People who Self-mutilate – Greg

Greg said a number of serious cases have occurred in the region. He added the problem is serious enough that a meeting was held with NSMHA's Medical Director to discuss the issue. Greg acknowledged that increased care was provided with little or no results; in some instances self-mutilation occurrences increased and/or extended to the care provider injuries. Greg said meetings have been conducted with hospitals regarding them accepting responsibility for the care and well-being of these individuals. It is hoped to have some training around this within the next few months. He added it is/should be a community approach to care for these individuals. He said discussions have been done as to what is/is not appropriate treatment for these individuals. He affirmed crisis plans need to be in place so crisis workers, Volunteers of America (VOA) and emergency room doctors can obtain information on how best to treat these individuals. Anne asked where to go from here. Greg said it was brought here to inform. Chuck B. said perhaps NSMHA should address this through either policy or clinical guidelines. Anne asked if a clinical guideline existed for self-mutilating and was told no. Chuck B. said if this is what QMOC wants perhaps NSMHA staff could do some research and come up with a guideline. Kathy asked for clarification around the community approach. Greg said if a provider has one of these cases it is the provider's obligation to coordinate the necessary care for the individual. Anne said she would like to entertain a motion to go forward with some clinical guidelines. Chuck D. made the motion, Edward seconded and some discussion followed. Anne called for the vote and motion carried.

8. Child Mental Health Specialists (CMHS) Assessment Discussion – Greg/Cindy

Greg said Carole and Kathy M. came and made a request that NSMHA drop the requirement that all assessments be done by a CMHS. Cindy said a summary regarding the issue is under Tab 3. Greg said NSMHA has looked into the issue are aware this higher standard is not required through WAC or RCW. He said NSMHA recommends this requirement be dropped at this time. He emphasized this was a hard decision to make and is part of contract language. Anne said this appears to drop some of the quality and Kathy assured the group Catholic Community Services (CCS) does not believe it sacrifices quality of work performed. Chuck B. mentioned through research he found that other RSNs do not require CMHS personnel to perform every assessment. Anne said contracts would need to be amended regarding the issue. Kathy thanked NSMHA for their willingness to be flexible and emphasized this will in no way decrease the quality of their work. Anne entertained a motion for NSMHA to change their requirements. Rochelle made the motion, seconded and motion carried.

9. Medicaid Personal Care (MPC)

Terry reviewed the protocol regarding MPC under Tab 6. He added this will create changes to the MPC policy. Discussion followed. Several individuals have suggestions for changes and/or feedback to the process. An invitation was extended to send feedback/suggestions to NSMHA for review.

10. Policy Sub Committee Report

Policy 1001.00 – Complaint, Grievance, Appeal, Fair Hearing & Notice-General Policy Requirements

Cindy reviewed the policy with subcommittee recommended changes. She mentioned the first four are related. The changes were acknowledged through track changes in all four.

Policy 1002.00 – Complaint Grievance

Cindy reviewed the policy with subcommittee recommended changes. She mentioned the first four are related. The changes were acknowledged through track changes in all four.

Policy 1003.00 – Appeal

Cindy reviewed the policy with subcommittee recommended changes. She mentioned the first four are related. The changes were acknowledged through track changes in all four.

Policy 1004.00 – Fair Hearing
Cindy reviewed the policy with subcommittee recommended changes. She mentioned the first four are related. The changes were acknowledged through track changes in all four.

Some discussion followed. Anne asked for any further discussion. Some concern was expressed regarding the possibility of consumers being charged during the appeal process.

Chuck D. made a motion to approve policies 1001.00 through 1004.00 with changes, Mary seconded and further discussion followed. Anne called for the vote and motion carried with one abstention.

Policy 1547.00 – Customer Service
Cindy reviewed the policy/changes with the committee. Susan S. questioned whether phones could reflect if NSMHA staff is out of the office; and Cindy said staff has been directed to change their phone options and to inform support staff when they are out so callers will be informed. A motion was made to approve, seconded and motion carried.

Policy 1562.00 – Monitoring of Less Restrictive Orders
Cindy reviewed the policy/changes with the committee. Chuck D. made a motion to approve with changes, Mary seconded and motion carried.

Policy 1570.00 – Children's Short-Term High Intensity Services (STHIS) and attachments 1570.01-.03
Cindy reviewed the policy/changes with the committee. Cindy acknowledged Susan Schoeld also worked on this policy and thanked her. The latest version was distributed at the meeting. She reported the flow chart (attachment 1570.01) has not changed but attachment 1570.02 is new. Attachment 1570.03 is a form utilized for ensuring all aspects of 1570.02 are met. Arthur questioned the meetings required. Susan S. said the first initial meeting must take place within two days and the second team meeting (the multi-disciplinary one) must occur within two weeks. Chuck D. made a motion to approve, Jonathan seconded and motion carried.

Policy 1574.00 – State-Only Funding Plan Mental Health Services
Cindy said this policy is going back to Policy Sub due to changes. Not reviewed.

11. Practice Guideline Workgroup Recommendation
Cindy said the summary under Tab 7 is the issues reviewed and recommendations from the workgroup. She added if any workgroup member noticed any significant issues not properly addressed to please mention them as she goes through the summary. Anne asked if guidelines are broad enough to still be able to individualized treatment plans. Cindy said the object of the guidelines was to be a guideline and not be unnecessarily prescriptive. Rochelle made a motion the first three bullets be accepted, Edward seconded and some discussion followed. Edward made an additional motion that the workgroup re-convene to discuss and re-work the last three bullets. Further discussion followed. Jonathan brought it to the attention of the group there are two separate motions on the floor. Susan R. wished to ensure the American Psychiatric Association (APA) guidelines are utilized and incorporated as links within future guidelines. Anne called for the vote on the first motion and six approved with six abstentions; therefore, motion did not pass. Cindy requested those who abstained please email her with concerns/feedback. Edward's motion was tabled.

12. Date and Agenda for Next Meeting/Review of Meeting
The meeting was adjourned at 2:40 pm. The next meeting will be held on February 25, 2009, in NSMHA Conference Room South.

Effective Date: 7/28/2004
Revised Date: 11/5/2005
Review Date:

North Sound Mental Health Administration

Section 1500 – Clinical: Choice or Change of Mental Health Care Provider (MHCP)

Authorizing Source: WAC 388-865-0345; NSMHA
Cancels:
See Also: Approved by: Executive Director Date:
Providers must have a "policy consistent with" this policy
Responsible Staff: Quality Manager

POLICY #1511.00

SUBJECT: CHOICE OR CHANGE OF MENTAL HEALTH CARE PROVIDER (MHCP)

PURPOSE

To ensure that each individual receiving outpatient mental health services, funded by North Sound Mental Health Administration (NSMHA), has an MHCP (also known as a primary clinician) who is responsible to carry out the individualized service plan (ISP).

POLICY

At the beginning of services as well as during ongoing services, NSMHA and Community Mental Health Agencies (CMHAs) shall allow individuals, parents of individuals under the age of thirteen and guardians of individuals of all ages to select a primary clinician from the available CMHA staff within the NSMHA network. If the individual does not make a choice, the CMHA must assign a primary clinician no later than 15 working days following the request for mental health services or within timeframes specified below for changes in clinician. NSMHA encourages CMHAs to assign individuals to primary clinicians who are anticipated to provide services to the individual throughout the authorization period.

The individual may change primary clinicians in the first 90 days of enrollment and once during a twelve-month period for any reason. Any additional change of a primary clinician during a twelve-month period may be made with documented justification at the individual's request by:

a) Notifying the CMHA of his/her request for a change; and
b) Identifying the reason for the desired change.

An individual whose request to change primary clinicians is denied or whose request for a specific primary clinician is not honored may submit a complaint or grievance with the CMHA or NSMHA, or request an administrative hearing.

Should a change in primary clinician result from a CMHA or clinician decision (e.g., clinician resigning or taking a leave of absence, clinician being reassigned), the CMHA shall ensure that the individual and treatment team (which may include family members, other natural supports and/or other system staff) are informed of the change.

NSMHA requires that children and their parents/caregivers/families are served at the same CMHA whenever possible and that adolescent individuals reaching the age of majority are provided continuity of care without service disruptions or mandatory changes in CMHA or primary clinician.

PROCEDURE

Individual seeking change in primary clinician

1. When an individual requests to change primary clinician, she/he is asked to communicate this desire to the primary clinician or the primary clinician's supervisor. Individuals may request a specific clinician during this process.
2. The individual will be notified within 10 days of the name of the new primary clinician or why a new primary clinician or requested clinician is not being assigned.
3. The current primary clinician's supervisor or designee will arrange for the first appointment with the new primary clinician.
4. If the individual's change in primary clinician is due to a complaint or grievance, this will be noted in the agency's complaint and grievance system.
5. Changes in primary clinician will be entered into the Management Information System (MIS) within 10 days of the change.

Primary clinician resigns or is on a leave of absence

1. If a primary clinician resigns or will be going on a leave of absence, the primary clinician, supervisor or designee will ensure that the individual is aware of the new primary clinician before that clinician's departure. In the event that the new primary clinician is not known, the supervisor or designee will serve in the primary clinician role until a replacement is found. Individuals may request a specific clinician during this process.
2. If a primary clinician will be on an extended leave from the office (greater than 10 business days), that clinician will notify individuals assessed at Level 3 or above (in accordance with Child and Adolescent Level of Care Utilization System or Level of Care Utilization System document) and all members of their treatment teams. If that clinician is the only member from the agency serving the individual, he/she will also offer a meeting to all other team members. If an individual has another agency staff on his/her treatment team, a meeting offer is not required.
3. During the primary clinician's absence any member of the treatment team can ask for a team meeting if he/she feels it is necessary.
4. Changes in primary clinician will be entered into the MIS within 10 days of the change.

Agency decides to reassign primary clinician

1. If a change in primary clinician is not by the individual's choice, the individual will be notified within 10 days by the primary clinician, supervisor or designee as to whom the new primary clinician will be. Individuals may request a specific clinician during this process.
2. The current primary clinician, supervisor or designee will arrange for the first appointment with the new primary clinician.
3. In the event that the new primary clinician is not known, the supervisor or designee will serve in the primary clinician role until a replacement is found.
4. Changes in primary clinician will be entered into the MIS within 10 days of the change.

ATTACHMENTS

None

Effective Date:
Revised Date:
Review Date:

North Sound Mental Health Administration

Section 1500 – Clinical: Voluntary Hospital Certification – Tribal Community Members

Authorizing Source: WAC 388-550-2600; Community Psychiatric Inpatient Instructions and Requirements; MHD-NSMHA Contract 2008-09 and NSMHA
Cancels:
See Also: Approved by Executive Director Date:
Providers must "comply with" this policy
Responsible Staff: Quality Manager Date:

POLICY #1545.00

SUBJECT: VOLUNTARY HOSPITAL CERTIFICATION – TRIBAL COMMUNITY MEMBERS

PURPOSE
To delineate the procedure for facilitating a voluntary hospitalization when it is deemed necessary and appropriate, and to comply with North Sound Mental Health Administration's (NSMHA) current 7.01 Plan.

POLICY
NSMHA and Tribes throughout the North Sound Region commit to actively working together to provide culturally competent and appropriate services when members of tribal communities are referred for and/or receive inpatient psychiatric services. Tribal community members are those who identify themselves as enrolled members of the Nooksack, Lummi, Samish, Sauk-Suiattle, Stillaguamish, Swinomish, Upper Skagit and Tulalip Tribes, their partners and children, and persons receiving services through Tribal social service programs. The commitment to providing culturally competent services will be reflected in seeking out and accessing clinically appropriate less restrictive alternatives to inpatient care, services provided during the inpatient stay, and in discharge planning.

Cultural competency is defined as "a set of congruent behaviors, attitudes and policies that come together in a system or agency and enable that system or agency to work effectively in cross-cultural situations. A culturally competent system of care acknowledges and incorporates at all levels the importance of language and culture, cultural differences, expansion of cultural knowledge and adaptation of services to meet culturally unique needs."(WAC 388-865-0150, NSMHA 7.01 Plan)

Hospitalization should only be considered after all other less restrictive culturally competent and appropriate options have been ruled out as being inappropriate or unavailable for the consumer in the current situation. Other less restrictive options may include referral to or increased coordination with Tribal and governmental social service programs, placement in a crisis respite bed, on-site placement of an in-home stabilization aide, more intensive treatment by the primary clinician, use of natural supports, and/or implementation of pre-planned crisis interventions.

Hospitals finding it necessary to admit consumers with Medicaid funding and other individuals eligible for publicly funded inpatient mental health who reside within NSMHA's region are required to obtain certification from the NSMHA hospital certification team prior to hospitalization. NSMHA will contract with Volunteers of America (VOA) to staff and operate a hospital inpatient certification team to authorize or deny inpatient stays on a twenty-four (24) hour basis. VOA must provide to requesting hospitals, certification and authorization or denial for all inpatient hospital psychiatric admissions for Medicaid eligible consumers and other individuals eligible for publicly

funded inpatient mental health who reside within NSMHA's region. This includes consumers eligible for both Medicare and Medical Assistance who have exhausted their lifetime Medicare benefits at admission or during the course of hospitalization. It also includes consumers with primary commercial or private insurance and who have secondary Medicaid coverage when their primary insurance has been exhausted at admission or during the course of hospitalization.

The voluntary inpatient psychiatric care for all Medical Assistance consumers (e.g. those on Title XIX and state programs) must be:

1. Medically necessary as defined in WAC 388-500-0005 and also include the following:

    a. Ambulatory care resources available in the community do not meet the treatment needs of the consumer, AND
    b. Proper treatment of the consumer's psychiatric condition requires services on an inpatient basis under the direction of a physician (according to WAC 246-322-170), AND
    c. Services can reasonably be expected to improve the consumer's level of functioning or prevent further regression of functioning, AND
    d. The consumer has been diagnosed as having an emotional/behavioral disorder or a severe psychiatric disorder (as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association) which is considered a principal covered diagnosis (see Community Psychiatric Inpatient Instructions and Requirements) and warrants extended care in the most intensive and restrictive setting; OR
    e. The consumer was evaluated and met the criteria for emergency involuntary detention (Chapter 71.05 or 71.34) but agreed to inpatient care.

2. Approved (ordered) by the professional in charge of the hospital or hospital unit; and
3. Certified by the Regional Support Network's Contractor (Volunteers of America). The person making the determination to authorize inpatient care must meet the definition of a Mental Health Professional per WAC 388-865-0150.

PROCEDURE

Generally, for voluntary inpatient care, consumers 18 years of age and older may be admitted to treatment only with the consumer's voluntary and informed written consent, a properly executed advance directive that allows for admission when the consumer is unable to consent, or the consent of the consumer's legal representative when appropriate. Consumers 13-17 years of age may be admitted to treatment only with the permission of: the minor and the minor's parent/legal guardian; or the minor without parental consent; or the minor's parent/legal guardian without the minor's consent. Consumers 12 years of age and under may be admitted to treatment only with the permission of the minor's parent/legal guardian. However, for children and adults who are members of a Native American Tribe, the age of consent of the associated tribe supersedes the age of consent rules above.

Evaluator and/or Referring Party

1. The individual for whom inpatient psychiatric hospitalization is being sought shall have a face-to-face evaluation by a qualified mental health clinician or Tribal-designated Liaison able to evaluate mental health conditions (i.e., a mental health professional or supervised by

a mental health professional). During the evaluation, the evaluator shall consider whether there are less restrictive options to psychiatric hospitalization.

2. If, following the evaluation, the evaluator determines the individual requires inpatient psychiatric hospitalization, the evaluator/referring party shall contact the desired hospital's admission department to secure a bed via the hospital's screening process.
3. Once a bed has been identified, but prior to admission, VOA must be contacted at 800-707-4656 for certification and authorization of the admission. The request does not have to be made by the person who performed the evaluation, but must be made by a clinical professional who is able to discuss the clinical issues related to the specific request. If the referring party is unable to provide the clinical information needed (see #4 below), VOA will identify the additional information needed. If the complete information is not received within 12 hours of the initial request, the authorization request will be categorized as either cancelled or withdrawn, not denied.
4. The evaluator/referring party shall provide VOA with required demographic and clinical information and be prepared to discuss whether less restrictive options might meet the individual's needs.
    a. Minimum demographic information includes individual's name, address, length of time resided at address, county of residence, Medicaid ID and CSO (Community Service Office) if known, date of birth and admitting hospital.
    b. Clinical information includes, but is not limited to, presenting problem/symptoms, current medications and history, co-morbidity issues, other relevant history (e.g., medical issues, substance use, psychiatric treatment), less restrictive options considered/attempted, proposed treatment plan while at hospital and discharge plan.
5. If VOA determines the individual meets medical necessity criteria, the hospitalization episode will be certified and the evaluator/referring party can secure arrangements for admission (e.g., transportation).

Volunteers of America

1. Requests for initial certification and authorization shall be directed to VOA at 800-707-4656.
2. Individuals for whom psychiatric inpatient care is being sought, will have been evaluated within 24 hours of the request by an appropriate professional (i.e., a mental health professional or clinical professional supervised by a mental health professional).
3. All calls requesting certification of the need for psychiatric inpatient care for consumers in community hospital units shall be responded to within two (2) hours by VOA's hospital certification team. VOA must collect the Mental Health Division-required clinical data for **initial** certification as identified in the Community Psychiatric Inpatient Instructions and Requirements (NSMHA Policy Attachment #1571.01).
4. Determinations of certification and authorization or denial for psychiatric inpatient care will be made within twelve (12) hours of the initial call and will be communicated to the caller and the requesting hospital. Decisions to certify and authorize or deny psychiatric inpatient care will be determined whether to be medically necessary per the following dimensions: risk of harm, functional status, co-morbidity, stressors, supports, response to treatment, and engagement.
5. If the decision is made to authorize psychiatric inpatient care, the number of days authorized will be up to five days depending upon the individual's clinical presentation. Once given, inpatient authorizations are not terminated, suspended or reduced. The admitting hospital shall direct requests for length of stay extensions to the assigned VOA clinician at least 24 hours prior to the expiration of the currently authorized period, unless VOA specifies otherwise on the current authorization form.

6. A denial occurs ONLY when the hospital believes medical necessity is met for a hospital level of inpatient care and VOA disagrees and therefore does not authorize hospital level of inpatient care. A psychiatrist employed by or contracted with VOA will conduct a clinical review of medical necessity for any potential denials. A denial may only be issued by a psychiatrist. If the hospital physician does not agree with the potential denial of inpatient care, he or she may request a consultation with VOA's psychiatrist. Once a final determination is made to deny inpatient services, the hospital and consumer are notified in writing.
7. Consumers may appeal a denial and should refer to the following policies regarding their rights: #1001.00 NSMHA Complaint, Grievance, Appeal, and Fair Hearing Policy General Policy Requirements; #1002.00 NSMHA Complaint and Grievance Policy; #1003.00 NSMHA Appeal Policy; and #1004.00 NSMHA Fair Hearing Policy. For those individual's who are known to be tribal community members, any decision to deny a request for voluntary certification will include referral to the tribal liaison for assistance in coordination of care and with appealing the denial.
8. Inpatient providers may refer to policy #1020.00 Inpatient Provider Appeal and Dispute Policy if they disagree with the medical necessity determination (appeal) or have concerns regarding VOA's or NSMHA's compliance with published requirements (administrative dispute).

Tribal-designated Liaison

1. Be available, with appropriate authorization from the consumer, to problem solve and/or consult with tribal programs and the referring clinician to assist in the hospital admission per the current NSMHA 7.01 Plan.
2. Be available to assist with the appeal process as appropriate.

ATTACHMENTS

None

Effective Date: 8/30/2007
Revised Date: 8/6/2007
Review Date:

North Sound Mental Health Administration

Section 1500 – CLINICAL: Program of Assertive Community Treatment (PACT)

Authorizing Source: State Contract
Cancels:
See Also:
PACT -contracted providers are required to have "policy consistent with" this policy — Approved by: Executive Director — Date:
Responsible Staff: Quality Manager — Signature:

POLICY #1563.00

SUBJECT: PROGRAM OF ASSERTIVE COMMUNITY TREATMENT (PACT)

PURPOSE

To define PACT treatment, eligibility requirements and admission and discharge processes in this fidelity model program.

POLICY

The North Sound Mental Health Administration (NSMHA) has PACT teams/service areas located in Snohomish County and Whatcom County. Individuals referred to PACT programs may come from any of NSMHA's 5 counties, but they must live in the PACT service area to receive PACT services.

PACT teams in the North Sound Region comply with the Washington State PACT Program Standards as a minimum set of regulations (See Attachment 1563.01) in addition to other applicable state and federal regulations. PACT team leaders will collaborate with the NSMHA Quality Specialist designated to this program on designing and implementing PACT programs. PACT teams will participate in fidelity reviews conducted by Washington Institute for Mental Health Research and Training (WIMHRT), the Mental Health Division (MHD) and/or NSMHA in addition to utilization reviews and audits.

PACT is a person-centered, recovery-oriented team model of service delivery. The PACT team has a trans-disciplinary approach and provides the majority of services that consumers need. The team is directed by a team leader and a psychiatric prescriber and includes a sufficient number of staff from the core mental health disciplines: at least one peer specialist, a dual-diagnosis treatment specialist, an employment specialist, RNs and a program or administrative support staff who work in shifts to cover 24 hours per day, 7 days per week, and provide intensive services. Regular program hours include 12 hours per day on weekdays and 8 hours per day weekend days and holidays.

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PACT services include the following: comprehensive mental health assessments; individualized treatment planning; service coordination; crisis assessment; symptom assessment and management; medical (psychiatric) prescription, administration, monitoring and documentation; dual-diagnosis substance abuse services; education and work related services; activities of daily living services; social/interpersonal relationship and leisure-time skill training; peer support and wellness recovery services; support services; education, support and consultation to consumers' families and other major supports; consumer medical record maintenance; culturally and linguistically appropriate services (CLAS); performance improvement and program evaluation.

PACT programs have a maximum ratio of 10 consumers to one clinical staff person. The PACT team is mobile and delivers services in community locations. Consumers receive an average of 120 minutes of contact per week, in an average of 3 contacts per week. Seventy-five percent or more of PACT services are delivered in the community. Each consumer's plan of care will be tailored to his or her individual needs, which may include multiple contacts per day at times. The approach with each consumer

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emphasizes relationship building and active involvement in assisting individuals with severe and persistent mental illness to make improvements in functioning, to better manage symptoms, to achieve individual goals and to maintain optimism.

Admissions to the PACT team occur at a rate of 4 to 6 consumers per month until the team reaches its target enrollment, for the full PACT program this is 80 to 100 clients with a minimum average of 90 clients; 42-50 with a minimum average of 46 consumers in the half-PACT program. Once programs reach capacity, admissions continue as discharges occur. Consumers who have discharged from the PACT program are given rapid readmission if they meet medical necessity to return to the PACT program.

PROCEDURES

SCREENING AND ADMISSION PROCESS

Screening forms for each program are available on the NSMHA website or by requesting one from NSMHA. Screening forms may be completed by professionals, family members, consumers or other interested individuals. When a referred individual is receiving services from a NSMHA-contracted provider agency, that agency will be contacted in order to coordinate care for the referred individual. Documentation supporting the need for a PACT level of care, including current symptomology, is helpful when accompanying a referral.

Referrals are sent directly to NSMHA and are then routed to the appropriate Team Leader. Referrals are reviewed by a designated NSMHA Quality Specialist and the PACT Team Leader to determine whether or not the referral appears to meet admission criteria. The Team Leader then notifies the referral source of the decision. If the referral is denied, a Notice of Adverse Determination is sent to the referred individual. If the referral is appropriate, the Team Leader schedules an assessment for the referred individual within 28 days in which their eligibility for the PACT program is determined. After the PACT assessment, individuals are either prioritized for admission to the program or referred to services that can assist them at the level of care they require. Order of admission to the program is based on a number of factors including but not limited to: intensity of symptoms, current supports, availability of transitional housing if needed, or current location of individual. If an individual is denied PACT services after the assessment a Notice of Adverse Determination is sent. If agreement between the Team Leader and the NSMHA Quality Specialist can not be reached about whether or not an individual is appropriate for PACT services, the reasons for recommending denial will be put in writing by the PACT team, signed by the Team Leader, the PACT Psychiatrist and the Executive Director (or formal designee*) of the contracting agency. The NSMHA Medical Director will review the documentation (referral information, assessment, reasons for denial request, and any other additional information available) and make a determination about admission. If the final determination by the NSMHA Medical Director is not acceptable by the PACT contracting agency, a formal contract dispute resolution process may be initiated.

*(*The formal designee must be identified in correspondence to NSMHA from the Executive Director of the PACT-contracted agency)*

ELIGIBILITY CRITERIA

- **For full eligibility criteria please see attachment 1563.01, pages 7&8.**
- Consumers admitted to PACT must have a current diagnosis of a severe and persistent mental illness and be experiencing severe symptoms and have significant impairments. The consumers must also experience continuous high service needs and functional impairments, and have not shown to benefit significantly from other outpatient services currently available. Consumers must meet eligibility standards and not meet any exclusionary criteria to be admitted.

- Individuals must have a current Level Of Care Utilization System (LOCUS) level of 4, 5 or 6 in order to be considered for admission.
- There are no financial eligibility criteria for the PACT program; however, individuals enrolled in a PACT program whose income is above 400% of the federal poverty level and do not have Medicaid coverage will be charged for the services they receive from the PACT team.
- Admission criteria must be in accordance with the Washington State PACT Program Standards

LOCUS (Level Of Care Utilization System)

For those consumers in services requiring NSMHA approval (i.e., PACT), the LOCUS will be completed at the time of request for approval instead of at the 180-day review. The tool will continue to be completed at scheduled re-approvals. If the consumer exits or is not admitted to the services indicated above, then the LOCUS would continue to be completed every 180 days. The LOCUS should be completed any time a consumer experiences events that would impact his/her level of care.
For consumers entering this program directly upon discharge from Western State Hospital, there is a 30-day period post-discharge in which the LOCUS may be completed.

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DISCONTINUATION OF PACT SERVICES

As PACT is a voluntary program, individuals receiving PACT services may request to be disenrolled from the PACT program at any time. PACT staff members are committed to serving individuals who are difficult to engage, and will make every effort to work with enrolled individuals to come to a mutually agreeable plan of care to continue working together. If this is not possible, PACT will assist the individual to find and enroll in other services suitable to the individual prior to closing the consumer from the PACT program. If the individual wishes to reenroll in the PACT program in the future, they are given an rapid readmission to the program.

Individuals in the PACT program also discontinue PACT services when they move away from the PACT service area. If the individual is moving to an area with another PACT program, the team will attempt to transfer the individual to that area's PACT team. If the move is to an area without a PACT program, the team will assist the individual to arrange other services as necessary to meet the individual's needs.

Transfers to other PACT teams will be arranged by the Team Leader in conjunction with the designated NSMHA Quality Specialist. Referrals of individuals currently receiving services from other PACT teams will be considered on an expedited basis.

COMPLAINTS AND GRIEVANCES

Complaints and grievances involving PACT enrollees will follow NSMHA's general policies on complaints and grievances. See policies 1001 thru 1004 for this information. NSMHA will monitor for trends in complaints and grievances specific to the PACT programs and use this information for continuous quality improvement with the programs.

STAKEHOLDER ADVISORY COMMITTEE

PACT programs shall each have a Stakeholder Advisory Committee whose role is to: promote quality programs; monitor fidelity to the PACT Standards; guide and assist the administering agency's oversight of the PACT program; problem-solve and advocate to reduce barriers to PACT implementation; and monitor/review/mediate consumer and family grievances or complaints. The Stakeholder Advisory Committee shall include a NSMHA representative.

ATTACHMENTS

1563.01: WA State Program of Assertive Community Treatment (PACT) Program Standards – (FINAL) 4-16-07

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Clinical Guidelines Workgroup (12/30/08)
Discussion
and Recommendations to QMOC
2/25/09

- ✓ **Workgroup members: Susan Ramaglia, Dan Bilson, Carol Van Buren, Kay Tillema, Terry McDonough, Cindy Ainsley**

Task:

- ✓ QMOC discussion centered on the suggestion (for adults) that we adopt the APA standards and provide the link in the guideline versus encapsulating the APA guidelines into NSMHA practice guidelines.
- ✓ APA and AACAP website guidelines are self-updating and complete. There are Quick Reference Guidelines as well as access to the full guideline on the APA site.

Accomplishments:

We reviewed NSMHA Clinical Guidelines policy, Clark County Practice Guidelines policy and practice guideline links, Thurston County website disorder information, the APA Practice guideline for Adult Schizophrenia and PORT treatment recommendation summaries.

Decisions/suggestions:

- ✓ For children, we could use the American Academy of Child and Adolescent Psychiatry practice parameters. This link is: http://www.aacap.org/cs/root/member_information/practice_information/practice_parameters/practice_parameters
- ✓ Make guidelines not only contractual obligation but also useful to clinicians
- ✓ clinical supervisors in course of supervision address diagnosis and clinical practice guideline on a regular basis (document on supervision logs)
- ✓ Consider a subcommittee of QMOC to review all providers' new staff orientation to make them uniform (suggestion was that orientation was the place to have Clinical Guidelines be introduced)
- ✓ Some workgroup members Liked the idea of clinical guidelines for services (who would benefit from supported employment, treatment planning, etc)
- ✓ Consider making Clinical Guidelines a Regional training module with a Post-test