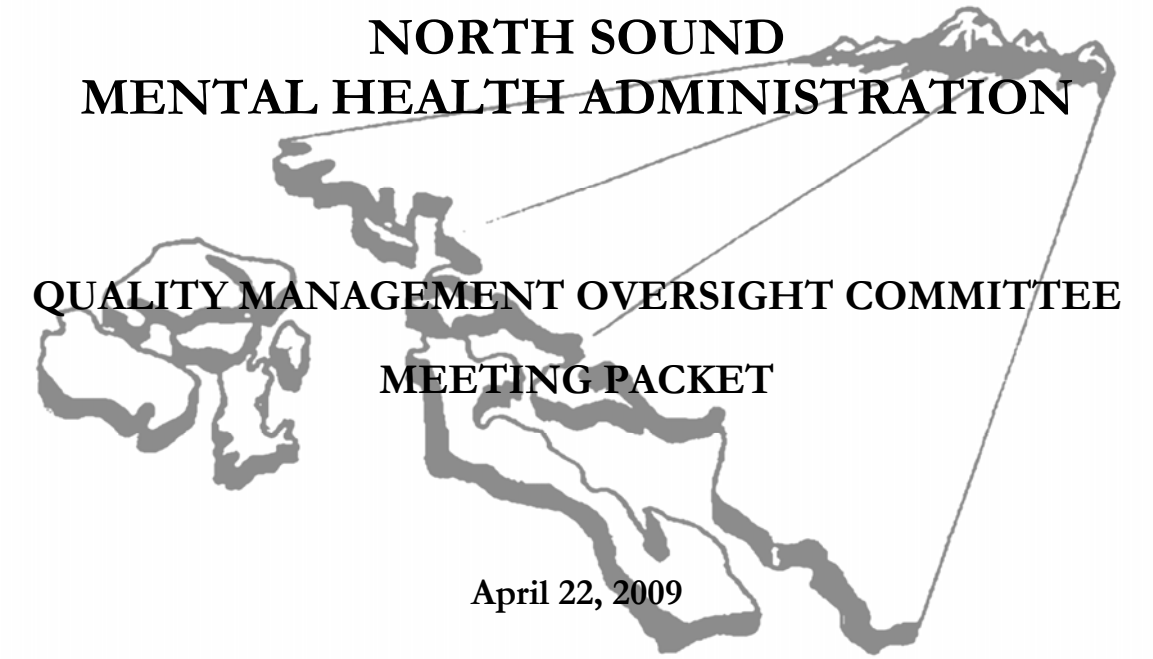
NORTH SOUND
MENTAL HEALTH ADMINISTRATION



QUALITY MANAGEMENT OVERSIGHT COMMITTEE

MEETING PACKET

April 22, 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: April 22, 2009 Earth Day! **Time: 1:00-3:00 PM**
Location: NSMHA Conference Room Note time change; note that LUNCH will NOT be served for providers and paid staff (NSMHA budget reduction decision)
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	Tab	Time
Introductions	Welcome guests; presenters and new members		Chair				5 min
Review and Approval of Agenda	Ensure agenda is complete and accurate; determine if any adjustments to time estimates are needed.	Approve Agenda	Chair	Agenda		**1**	5 min
Review and Approval of Minutes of Previous Meeting	Ensure agenda is complete and accurate; determine if any adjustments to time estimates are needed. Meeting will start and end on time.	Approve Minutes	Chair	Minutes		**2**	5min
Announcements and Updates	Inform QMOC of news, events; change of Chair; lunch decision change; Binder Updates, if any; budget update; 1541 as FYI, Cross-systems collaboration training (DOC/MH); 4/29, 5/28; other topics?	Inform /discuss	ALL			**3** (1541 and training flyer)	10 min
Evaluation forms from last meeting, if any	Discuss feedback, if any		Chair/ Cindy				5 min
Follow-up on old business, if any	Inform/discuss • **Discussion/ about Minutes including names of speaker; Open Meetings Act does not apply to advisory committees link:** http://www.mrsc.org/Subjects/Legal/opma/pg1pkj.aspx • **QMOC Charter Review**		Cindy/ Greg				15 min
Comments from the Chair			Chair				5 min
Policy Sub Committee Report	Inform/discuss			1546		**4**	10 min
ICRS Policy Committee Report	Inform/discuss			1701	**5**		5 min
Ombuds Report	Inform/discuss		Ombuds			**6**	20 min
HCS/MPC protocol & policy	Discuss		Laura/ Greg	1576		**7**	20 min
Expedited auths	Discuss		Terry			**8** (1505)	5 min
QM Plan Update	Discuss		Terry		**9**		10 min
Open Forum			Chair				

Date and Agenda for Next Meeting	Ensure meeting date, time and agenda are planned						
***Review of Meeting**	Were objectives accomplished? How could this meeting be improved? Eval forms						

Next meeting: May 27, 2009 1:00-3:00 PM

Potential Future Agenda Items:
UR Responses
EQRO 2008 report
CMHS issue revisit (7/09)
Dashboard discussion/review

North Sound Mental Health Administration (NSMHA)
Quality Management Oversight Committee (QMOC)
NSMHA Conference Room
March 25, 2009
12:30 – 2:30 pm
MINUTES

Present:	**Excused:**
June LaMarr, Tulalip Tribes, QMOC Chair	Pam Benjamin, WCPC
Arthur Jackson, NSMHA Advisory Board	Rebecca Clark, Skagit County Coordinator
Kathy McNaughton, CCS	Karen Kipling, Volunteers of America
Charles Albertson, NSMHA Advisory Board	Darcy Hocker, Whatcom County
Susan Lange, Ombuds	
Dan Bilson, Whatcom County	**Not Present:**
Jonathan Vander Schuur, Sea Mar	Michele Hall, WCPC
Anne Deacon, Whatcom County Coordinator	
Rochelle Clogston, Compass Health	**Others Present:**
Mike Manley, Sunrise Services	Cindy Ainsley, NSMHA
Kay Burbidge, Lake Whatcom Center	Jennifer Rugg, *bridgeways*
Nathalie Gauteron, *bridgeways*	Greg Long, NSMHA
Andrew Davis, NSMHA Advisory Board	Michael White, NSMHA
Mary Good, NSMHA Advisory Board	Rebecca Pate, NSMHA recorder
Jackie Henderson, Island County Coordinator	
Susan Schoeld, Snohomish County Coordinator	
Cindy Paffumi, Interfaith	

1. Introductions, Review of Agenda, Previous Meeting Minutes

The meeting was convened at 12:30 and introductions were made. June asked for any additions/corrections to the agenda and no changes noted. Dan requested abbreviations and acronyms be spelled out/identified. A motion was made to approve the February minutes as written, seconded and motion carried.

2. Announcements and Updates

Mike announced Sunrise Services is having an open house for their new facilities April 16th from 3:30 to 6:30 with refreshments at 1021 N. Broadway.

Anne said Whatcom County will be holding a stakeholder forum April 1st from 9-12 to discuss how to spend the 1/10th monies. She encouraged participation.

Cindy said Policy 1007.00 is under Tab 3 as an Administrative Policy and just an FYI for members. She added the numbers on the Clinical Guidelines Core Elements sheet discussed last month were corrected and this revision (under Tab 3) is updated information as FYI.

Cindy mentioned providers are missing the timelines for complaints and grievances. She affirmed providers need to stick to timelines outlined in Policies 1001.00 through 1004.00.

Greg distributed a flyer for a 4-hour training regarding collaboration of communication between Department of Corrections (DOC) and Mental Health (MH) with four CEUs available. He encouraged people to attend. Greg

also distributed a request by Tom Yost for providers' contact information whom DOC personnel can contact when mental health records need to be obtained.

3. Evaluation Forms from Last Meeting

June said forms were reviewed with only six (6) responses. Cindy said the majority wanted to start the meeting at 1 and continue providing lunch. The meeting will begin at 1 pm starting in April and end at 3. Lunch will be ready at 12:45.

4. Follow up on Old Business – Cindy

This is a new section of the agenda. Cindy stated in February Edward Page requested information regarding services transfer when someone moves. Cindy said if someone moves out-of-state, there is not an obligation to facilitate/initiate services out-of-state. When someone moves out-of region but stays in the state, the transfer is usually facilitated by current Case Manager per WAC 388-865-0335. Information about other state RSNs is available in the benefits booklet.

Michael White joined the meeting to discuss encrypted email. Michael clarified information regarding encrypted emails and digitally signed emails. Mike requested Michael re-send information about the encrypted email. Kathy suggested NSMHA send out a formal request via email with information about this so it can be shared with appropriate people with authority to make these decisions.

5. Comments from the Chair – June LaMarr

June mentioned Della Hill an Elder within the Tulalip Tribe passed away and will be missed.

6. Discussion about Minutes including Names of Speaker

Cindy said discussion was held in a smaller orientation group setting regarding names recorded in the minutes as the speaker, for public record. Robert's Rules does not require this. Mike said he would be more comfortable if names were not recorded because of the minutes being truncated and being interpreted differently by individuals. Minutes are not recorded as verbatim transcript. He added this could cause concerns for an individual and may have the effect of discouraging comments/participation. Mike stated a summary should be done stating what is done, what was discussed and decisions made by the committee. Arthur countered that stating it was an assumption/assertion of what the public desired. Arthur said the name of the person making an assertion should be made known and at what point in the meeting it was made. In depth discussion followed regarding whether this group was an advisory board, or a governing body, which would need to follow the Open meetings Act.

Greg said the assumption is the Board of Directors (BOD) makes policy decisions as governing body and QMOC is an advisory subcommittee of the BOD. Kathy said depending on which person is correct, she would like more of a summary in accordance to what Mike stated. June suggested we do some homework regarding this and research whether this is an advisory or governing board. June stated Cindy and Greg would research this and report back to the group.

7. Policy Sub Committee Report

Policy 1541.00 – Rationale and Use of Seclusion and Restraint at Evaluation and Treatment (E&T) Facilities

Cindy reviewed the policy stating the E&T director has reviewed it and provided input. Cindy said a Performance Improvement Project (PIP) was instituted regarding seclusion and restraint reduction and to date has worked well and is being considered for conclusion as a PIP. A motion was made to approve the policy, seconded and discussion followed. June called for the vote and eight (8) approved, five (5) against and one (1) abstention.

Greg thanked the group for passing it but said it appears there are still some issues that should be addressed. He added perhaps it should be brought back for more discussion about the source citation of items in the policy statement. Rochelle concurred.

Mike made a motion this group require policy subcommittee review this policy and address concerns mentioned within 6 months if the source information is not satisfactory; seconded and discussion followed. . June called for the vote and motion carried with one abstention.

8. ICRS Policy Sub Committee Report – Greg

There are none at this time.

9. Critical Incidents (CI) – Changes and Training – Kurt Aemmer/Cindy Ainsley

Cindy announced Kurt is at audits today and she is taking his place. Cindy reviewed the policy changes with the group. Susan S. said language consistency needs to agree in both policy and form. Cindy reviewed the changes to the CI form and reminded that the form is available on the website under "Forms" and no longer an attachment to the policy. Cindy said the CMHA formal internal review summary is for providers to utilize to ensure all information is captured in their review information. The form itself is not mandatory, though the information it captures is required in the review. June asked for a motion to approve. A motion was made to approve the policy with language consistency changes, seconded and motion carried.

10. QMOC Charter Review – Cindy/Greg

Cindy said it was proposed to review the revised charter in six months from the July 08 inception, but we ran out of time last month to attend to this. June asked for any questions/comments. Dan said a weakness he sees is not much input is received by this group from the Advisory Board. Cindy clarified that Dan was requesting an Advisory Board report. A motion was made to approve the charter as amended, seconded and discussion followed. Mike stated some language changes would need to be made once clarification of whether QMOC is an advisory board or governing body is decided. Arthur suggested tabling until clarification could be done. Greg said technically the charter has no legal binding. He added it is just a clarification document but Arthur said by its establishment it is binding. Anne made a motion to table the motion to approve the charter, seconded and motion carried.

11. Date and Agenda for Next Meeting/Review of Meeting

June asked if there were any meeting review questions. Kay mentioned back in November a numbered memorandum was sent out stating changes would be published relating to first offered appointments and requests for services, etc. and requested an update. Cindy said those changes were due to an MHD discussion regarding capturing data. She added there was a delay in its start but now issues were resolved and it began March 1st.

The meeting was adjourned at 2:21 pm. The next meeting will be April 22, 2009, in the NSMHA South Conference Room from **1:00 – 3:00**. **NOTE:** The new meeting time (highlighted and in bold)

Effective Date: 11/21/2005
Revised Date:
Review Date:

North Sound Mental Health Administration

Section 1500 – Clinical: Rationale and Use of Seclusion and Restraint at Evaluation and Treatment Facilities

Authorizing Source: WAC 246-337-110; WAC 388-865-0545; 42CFR438.100; 42CFR483; 42CFR482
Cancels:
See Also: Approved by: Executive Director Date:
E&T Facilities must have a "policy consistent with" this policy
Responsible Staff: Quality Manager Signature:

POLICY #1541.00

SUBJECT: RATIONALE AND USE OF SECLUSION AND RESTRAINT AT EVALUATION AND TREATMENT FACILITIES (E&Ts)

PURPOSE

To describe the rationale, conditions and parameters in the use of seclusion and restraint for the purpose of maintaining health and safety for individuals 18 and older who are in danger of harming themselves or others and utilizing these measures as a last resort. *This document is not meant to describe seclusion and restraint policy and procedure for individuals under the age of 18 as North Sound Mental Health Administration (NSMHA) does not oversee any facilities permitted to utilize seclusion or restraint for individuals in that age group.*

DEFINITIONS

Seclusion: The involuntary confinement of a person in a room or an area where the person is physically prevented from leaving.

Restraint: Includes either a physical restraint or a drug that is being used as a restraint. A physical restraint is any manual method or physical or mechanical device, material, or equipment attached or adjacent to the person's body that he or she cannot easily remove and which restricts freedom of movement or normal access to one's body. A drug used as a restraint is a medication used to manage an individual's behavior in a way that reduces the safety risk to the individual and/or others, has the temporary effect of restricting the person's freedom of movement and is not a standard treatment for the person's medical or psychiatric condition.

POLICY

1) The use of seclusion or restraint must occur only when there is imminent danger to self or others and less restrictive measures have been determined to be ineffective to protect the individual and/or others from harm. All individuals have the following rights and their rights should only be limited when less restrictive measures are clearly evident to be ineffective in protecting the individual or others from harm:
   a) Individuals have the right to be free of seclusion and restraint, including chemical restraint.
   b) Individuals have the right to be free from any form of seclusion and restraint used as a means of coercion, discipline, convenience or retaliation.

2) Should these less restrictive measures not ensure safety, persons dangerous to themselves or others who may require the use of seclusion and restraint have a right to the least restrictive use of seclusion and restraint in the safest fashion for the least amount of time.

Comment [c1]: WAC 388-865-0545

Deleted: ¶

Comment [c2]: 42CFR438.100

Deleted: The reasons for the determination to use seclusion or restraint must be clearly documented. ¶

Individuals admitted to an E&T or the legal guardian(s), shall be provided with a copy and be informed of the facility's policy regarding the use of seclusion and restraint. The policy must provide contact information, including the phone number and mailing address, for the regional Ombuds and Department of Health Complaint Investigations (1-800-633-6828 or P.O. Box 47857, Olympia, WA 98504). Written acknowledgement by the individual or legal guardian that he/she has been informed of the facility's policy on the use of seclusion and restraint shall be filed in the individual's chart.

PROCEDURE

Interventions Utilized Prior to Seclusion and/or Restraint

Less restrictive measures are interventions that can effectively keep the individual or others safe without requiring seclusion or restraint. All less restrictive measures to be utilized shall be part of the individual's treatment plan. If the individual has an Advance Directive, refer to that document for notation of preferred less restrictive measures. If those measures identified on the treatment plan are utilized but ineffective, consideration shall be given to other less restrictive measures prior to use of seclusion or restraint. Measures utilized but not previously on the treatment plan shall be added. Seclusion and/or restraint will be utilized only after other less restrictive measures have been attempted as appropriate and are determined to be ineffective.

1) Examples of less restrictive measures include but are not limited to:

    a) Verbal re-direction/reassurance
    b) Removal of source of stimuli (e.g., music, TV, another individual)
    c) Environmental change
    d) Limit setting
    e) Diversionary activities
    f) Encouragement for individual to express concerns
    g) Alternative/choice
    h) Comfort
    i) 1:1 staff interaction
    j) Voluntary time-out
        i. Time out may take place away from the area of activity or from other individuals, such as in the individual's room (exclusionary), or in the area of activity or other residents (inclusionary)
        ii. Individual in time out must never be physically prevented from leaving the time out area
        iii. Staff must monitor the individual while in time out
    k) Medication
    l) Increased staff presence

Use of Seclusion and Restraint

Seclusion or restraint can only be used in emergency situations if needed to ensure the individual's and/or others' physical safety and less restrictive interventions have been determined to be ineffective. When utilizing seclusion and/or restraint for the safety of the individual or others, the individual must be informed of the reasons for the use of seclusion or restraint and the specific behaviors which must be exhibited in order to gain release from these procedures. The reasons for the determination to use seclusion or restraint must be clearly documented.

The use of seclusion and/or restraint must be:

1) In accordance with the order of a licensed physician or other licensed practitioner permitted by the State and facility to order seclusion and/or restraint. The following requirements will be superceded by existing State laws if they are more restrictive:

    a) Orders for the use of seclusion or restraint must never be written as a standing order or on an as needed basis (that is, PRN).
    b) Staff must notify, and receive authorization by, a licensed physician or other authorized licensed practitioner within one hour of initiating individual seclusion or restraint.
    c) Within one hour of initiation of restraint or seclusion, a physician or other authorized licensed practitioner must conduct a face-to-face assessment of the physical and psychological well-being of the individual.
    d) Each written order for a physical restraint or seclusion is limited to 4 hours for adults. The original order may only be renewed in accordance with these limits for up to a total of 24 hours.
    e) If the use of restraint or seclusion exceeds 24 hours, a licensed physician or other authorized licensed practitioner must examine the individual and write a new order if the intervention will be continued. This procedure is repeated again for each 24 hour period that restraint and seclusion is used.
    f) The clinical record must contain documentation of staff observation of the individual at least every fifteen minutes.
    g) The individual's clinical record must document all assessments and justification for the use of seclusion or restraint in addition to the following documentation should seclusion or restraint be used:

        i) Order authorizing the restraint or seclusion including the name of the licensed physician, or other licensed practitioner permitted by the State and facility to order seclusion and/or restraint;
        ii) Date/time order obtained;
        iii) Individual behavior prior to initiation of restraint or seclusion;
        iv) The specific intervention ordered, including length of time and behavior that would determine the intervention be discontinued;
        v) Time restraint or seclusion began and ended;
        vi) Time and results of one hour assessment; and
        vii) Any injuries sustained during the restraint or seclusion.

2) In accordance with a written modification to the individual's plan of care;
3) Implemented in the least restrictive manner possible;
4) In accordance with safe appropriate restraining techniques;
5) Ended at the earliest possible time;
6) Seclusion may not be used unless the individual is continually monitored 1:1 by staff either face-to-face or using both video and audio equipment. The video and audio monitoring must be done in close proximity to the individual.
7) Restraint may not be used unless the individual is observed under the following conditions:

a) Wrist-to-waist restraint in the milieu is continuously monitored by assigned staff member(s).
b) Wrist-to-waist restraint plus seclusion requires continuous monitoring by assigned staff member(s) using video and audio equipment.
c) Gurney five-point restraint must be continually monitored, face-to-face by assigned staff member(s).

8) The facility/licensee must ensure that seclusion and restraint is carried out in a safe environment:

a) Restraint equipment must be clean and in good repair.
b) Equipment used for restraint shall meet current best-practice safety standards and meet infection control standards.
c) The seclusion room must:

i) Be designed to minimize potential for stimulation, escape, hiding, injury or death;
ii) Have a maximum capacity of one individual;
iii) Have a door that opens outward;
iv) Have a staff-controlled, lockable, adjoining toilet room;
v) Have a minimum of three feet of clear space on three sides of the bed; and
vi) Have a negative pressure with an independent exhaust system with the exhaust fan at the discharge end of the system.

9) In most cases, the facility staff restrains in the supine (back) position; however, each situation is evaluated with the ultimate goal of providing maximum safety and comfort for the individual.

10) The condition of the individual who is in a restraint or in seclusion must continually be assessed, monitored, and reevaluated to include:

a) Safety checks to be conducted and documented every:

i) Fifteen (15) minutes: assess and document individual's activity, behavior, food and fluids offered, toileting if needed, interventions used and individual's response and physical condition
ii) 1 Hour: Open door/view individual (if in seclusion)
iii) 2 Hours: Exercise, range of motion out of restraint
iv) 4 Hours: Vital signs (unless otherwise indicated)
v) 12 Hours: Bathing and oral care

b) At the change of shift, the supervisors/charge nurses of both shifts (those leaving duty and those beginning their duty) will enter the seclusion room, evaluate the individual's mental and physical status and assess the need for continuation of restraint.
c) When the individual is removed from seclusion or restraint, a licensed physician or other authorized licensed practitioner must evaluate the individual's well-being immediately and must document the individual's status in the chart.

Conditions for the Discontinuation of Use of Seclusion & Restraint

When utilizing seclusion and/or restraint for the safety of the individual or others, staff must communicate to the individual and document what necessary actions/behaviors are required for release at 60-minute intervals while individual is awake.

Reporting of Injury or Death

The E&T must report any death or injury, per NSMHA's Critical Incident Reporting Policy, that occurs while an individual is restrained or in seclusion, or where it is reasonable to assume that an individual's death/injury is a result of restraint or seclusion.

Education and Training

1) All staff that have direct individual contact must have ongoing education and training and demonstrated knowledge, on a semiannual basis, of:

    a) Techniques to identify staff and resident behaviors, events, and environmental factors that trigger emergency safety situations;
    b) The use of nonphysical interventions skills, such as de-escalation, mediation conflict resolution, active listening, and verbal and observational methods, to prevent emergency safety situations;
    c) The safe use of restraint and the safe use of seclusion, including the ability to recognize and respond to signs of physical distress in residents who are restrained or in seclusion.

2) Certification in the use of cardiopulmonary resuscitation (CPR), including periodic recertification, is required. Staff must demonstrate their competencies in this area on an annual basis.

3) Staff training must include training exercises in which staff members successfully demonstrate in practice the techniques they have learned for managing emergency and safety situations.

4) Training identified in 1 and 2 of this section must be provided by individuals who are qualified by education, training and experience.

5) The facility must document in the staff personnel records that the training and demonstration of competency were successfully completed. Documentation must include the date training was completed and the name of persons certifying the completion of training.

6) All training programs and materials used by the facility must be available for review by NSMHA, Centers for Medicare and Medicaid Services and relevant state agencies.

Conditions for Debriefing/Quality Improvement Activities

1) Staff must conduct and document a post-intervention debriefing with individual to discuss precipitating factors leading to the need for intervention.
2) Staff involved in the restraint or seclusion will debrief and address effectiveness and safety issues to include the following questions. The results of these questions will be documented and monitored with quality improvement activities initiated as warranted:

a) Has a treatment environment been created where conflict is minimized?
b) Could the trigger for conflict (disease, control, environmental, medication, etc) have been avoided?
c) Did staff notice and respond to events in a timely way?
d) Did staff choose an effective intervention?
e) If the intervention was unsuccessful, was another chosen?
f) Did staff order seclusion and/or restraint only in response to imminent danger?
g) Was seclusion and/or restraint applied safely?
h) Was the individual monitored safely?
i) Was the individual released as soon as possible?
j) Did post-event activities/debriefing occur?
k) Did learning occur and was it integrated into the treatment plan and practice?

3) E&Ts must provide a quality management plan for the timely and efficient collection of data for the purpose of continuous quality improvement activities.

ATTACHMENTS

None

A HIGHLY INTERACTIVE, NO-COST TRAINING OPPORTUNITY

Community Corrections & Mental Health

COLLABORATING TO ENSURE OFFENDER SUCCESS IN THE COMMUNITY

THE TRAINING IS FOR:

Community Corrections Officers and Mental Health Professionals who have had little experience in supervising or treating offenders with mental illnesses.

THE TRAINING WILL COVER:

- **Confidentiality and legal requirements for sharing information.**
- **Making assessments and working together to ensure that client and community safety needs are met.**
- **Responding to crises and emergencies.**
- **Treatment and supervision planning.**
- **Resources from mental health, corrections and the community for meeting offenders' needs.**
- **How mental health works and the options that are available to community corrections officers.**

4 CEUs in LAW & ETHICS

Choose from two trainings at different locations

BELLINGHAM
8:30 – 12:30
THURS. MAY 28, 2009
room2think
114 E. Chestnut, Bellingham
For Driving and Parking instructions:
www.room2think.com

EVERETT
8:30 – 12:30
WED. APRIL 29, 2009
COMPASS HEALTH
4526 FEDERAL AVE.
in the SANDERS CENTER
for driving instructions:
www.compasshealth.org/dir_everett.html

TO REGISTER: CALL NSMHA AT (360) 416-7013
OR E-MAIL TOM_YOST@NSMHA.ORG

Quality Management Oversight Committee
Charter *Revision*
Proposed 4/23/08 to begin July 2008, to be reviewed after 6 months in effect

The Quality Management Oversight Committee (QMOC) is a standing advisory committee of the North Sound Mental Health Administration (NSMHA) Board of Directors. It is responsible for the oversight of quality management systems of the entire NSMHA, and for reviewing all quality management activities and making recommendations for quality improvement to the Board. QMOC ensures the gathering and analysis of data and reports to recognize the need for improvement or change (as outlined in the Quality Management Work Plan).

The Quality Management Oversight Committee (QMOC) is chaired by a Member of the Board of Directors (or designated alternate). Two Members of the Board of Directors (or designated alternates) are voting members of QMOC.

Other voting members are:

- Eleven members nominated by the NSMHA Advisory Board, at least three of whom shall be current Advisory Board members, and of the eleven, membership must include a minimum of four current consumers. Facilitation and support will be provided to assist consumers to participate if needed.
- One Ombuds representative
- Three County Coordinators who report QMOC activities to colleague county coordinators who then report to their Advisory Boards
- One representative from each contracted provider who deliver services in each of the five counties.
- In addition, NSMHA would ask our Tribal Committee to appoint a representative to QMOC

Nonvoting member:

- NSMHA's Quality Manager (staff to the committee)

Because of the important role of this Board committee in the oversight of NSMHA's Quality Management program, members of the committee are expected to participate in an orientation session upon joining the committee, attend a majority of meetings unless excused by the Chair, and review all meeting materials. If a QMOC Committee member cannot attend, the designated alternate listed on the Membership list can attend in their place.

At any given meeting where actions are required, a Quorum must be present to vote, with a simple majority of those present being non-provider participants (consumer/advocate/family, Ombuds and County Coordinators). This is both for Coordinated Quality Improvement Program (CQIP) status and to ensure balance.

Members of the Quality Management Oversight Committee are approved annually by the Board of Directors. The Committee meets at least quarterly. Subcommittees of QMOC will meet as often as needed to accomplish their tasks in a timely manner.

The Quality Management Oversight Committee is accountable for:

- Overseeing the development, approval, and evaluation of the biennial NSMHA Quality Management Plan, including its submission to the Board of Directors for adoption, as well as any needed revisions
- Reviewing and recommending action on reports from NSMHA and contracted service providers
- Reviewing data from providers and from NSMHA's measurement tools
- Making recommendations to all providers on actions to be taken for continuous quality improvement
- Reviewing the NSMHA quarterly and biennial quarter (every 6 months) reports related to concurrent/retrospective reviews, consumer and advocate reports and reports on performance indicators; makes recommendations for future service needs

• Establishing ad hoc committees to review issues/concerns that need more time to fully assess and make recommendations
  o All ad hoc committees will include consumer/advocate/family member participation as well as provider participation
• Keeping attendance and minutes of all QMOC and subcommittee meetings

Deleted: Request: list of Membership from Providers as well as a Designated Alternate

Effective Date: 11/21/2005
Revised Date:
Review Date:

North Sound Mental Health Administration

Section 1500 – Clinical: Medication Management Transfers to Primary Care Providers

Authorizing Source: 42CFR438.208; NSMHA
Cancels:
See Also: Approved by Executive Director Date:
Providers must have a "policy consistent with" this policy
Responsible Staff: Quality Manager Date:

POLICY #1546.00

SUBJECT: MEDICATION MANAGEMENT TRANSFERS TO PRIMARY CARE PROVIDERS

PURPOSE

To provide coordinated medication management for individuals who do not require mental health specialty medication management.

POLICY

When an individual is on a stable medication regimen and there is no longer medical necessity for the specialty care of psychiatric medication management services the individual may be transferred to a medical primary care provider, who has knowledge of the individual and knowledge and experience in the prescription of the medications being offered, in a coordinated process with the consent of the individual and all prescribers involved.

Mental health specialist prescribers will provide medication management when an individual has not reached a stable medication regimen, is on a complex medication regimen and/or has multiple psychiatric diagnoses that require specialized expertise, or when there is no medical primary care provider willing to accept the transfer.

a. A complex regimen of medications includes, but is not limited to, medications being prescribed for off label use, two or more medications in the same class, or three or more psychiatric medications.

An individual who only needs medication management will not be referred or transferred to a primary care provider unless in accordance with this policy.

PROCEDURE

1. The transfer of medication prescribing responsibilities will be discussed with the individual prior to a transfer. The individual's preference will be considered. This discussion will be documented in the clinical record.
2. The individual will be informed verbally and in writing of their right to file a complaint or grievance in accordance with the current North Sound Mental Health Administration (NSMHA) policy.
3. The clinical record will document the rationale outlining the reasons the individual is being referred or transferred to a primary care provider.
4. Consultation, which shall be documented in the clinical record, shall occur between the mental health prescriber and the medical primary care provider prior to the transfer and within confidentiality regulations.

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Deleted: Medication management should be handled by a provider prescriber who has knowledge of the individual and knowledge and experience in the prescription of the medications being offered.

Deleted: is unstable on medications

5. Prior to the transfer of medication prescribing responsibilities, the primary care provider must agree to accept the referral or transfer of the individual. The clinical record shall document this understanding. If the primary care provider does not agree to accept this referral, the mental health specialist prescriber will continue managing the medications until an alternative arrangement can be developed.
6. A plan will be developed outlining what happens if the individual becomes unstable on medications and/or the primary care provider believes it would be better for the mental health prescriber to consult or resume management of medications. The plan must include appropriate steps for the individual to follow if this situation arises after the end of a treatment episode. If these steps are not included in the initial plan, the plan must be updated prior to closing of the treatment episode. It is encouraged that this plan be included in the transition summary for the individual. The plan will be developed collaboratively between the individual/guardian, mental health prescriber and primary care provider.
7. A mental health prescriber at the transferring mental health agency will be identified and available to consult with the primary care provider accepting the transfer, if requested.
8. Appropriate psychiatric and medication records will be sent to the primary care provider as requested and permitted by appropriate releases of information.

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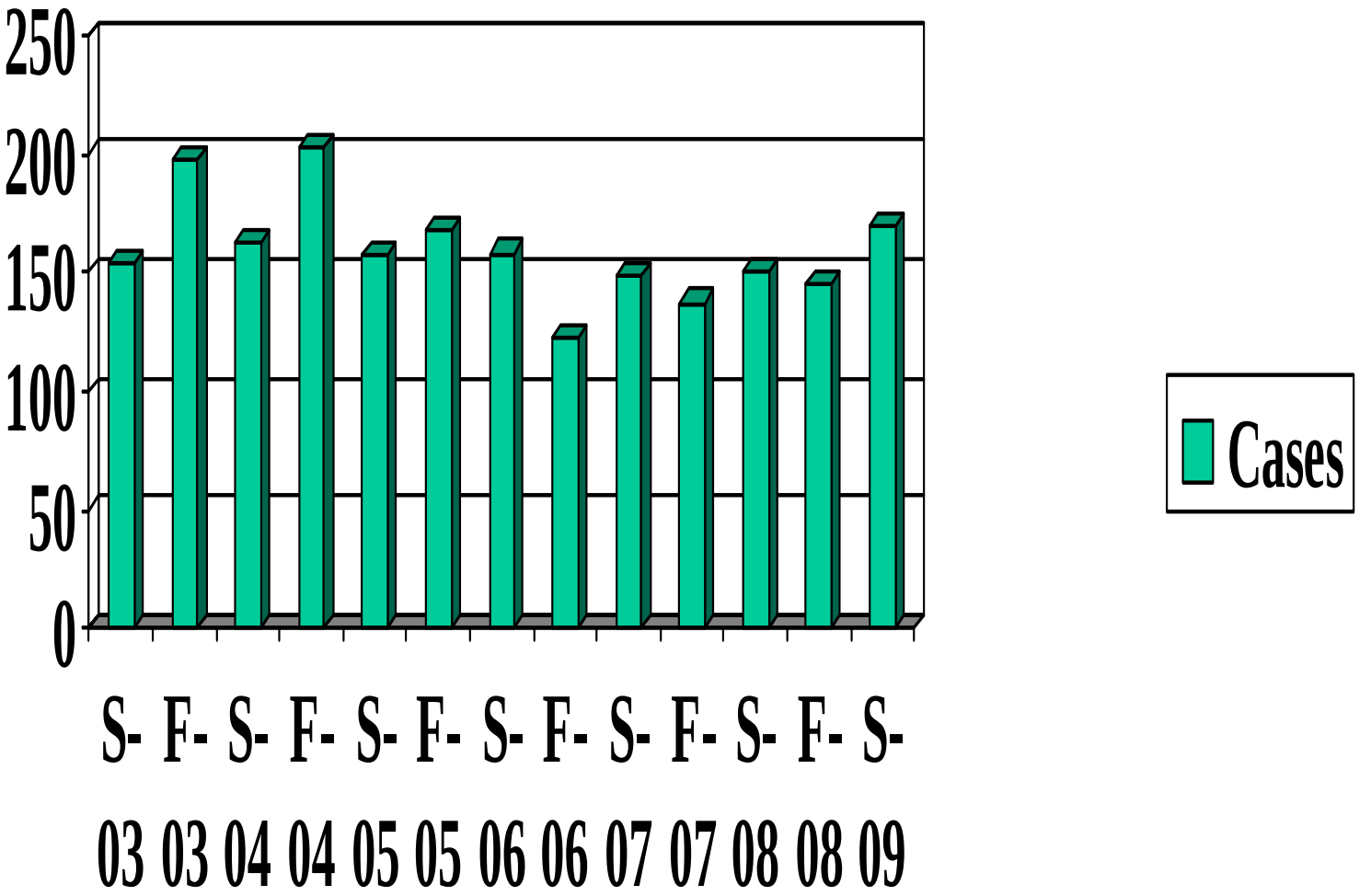
ATTACHMENTS

None

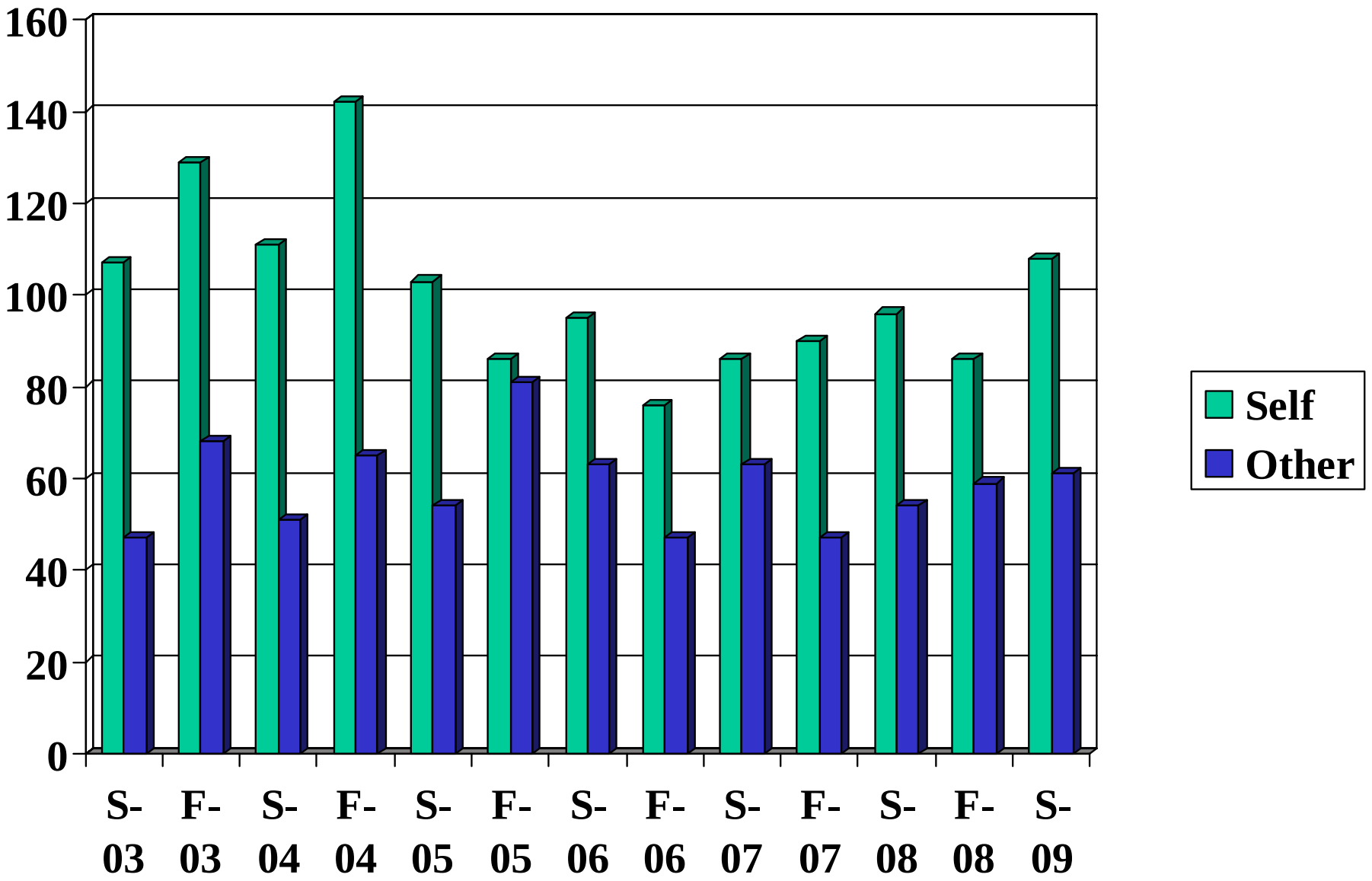
NORTH SOUND REGIONAL OMBUDS REPORT

SPRING 2009

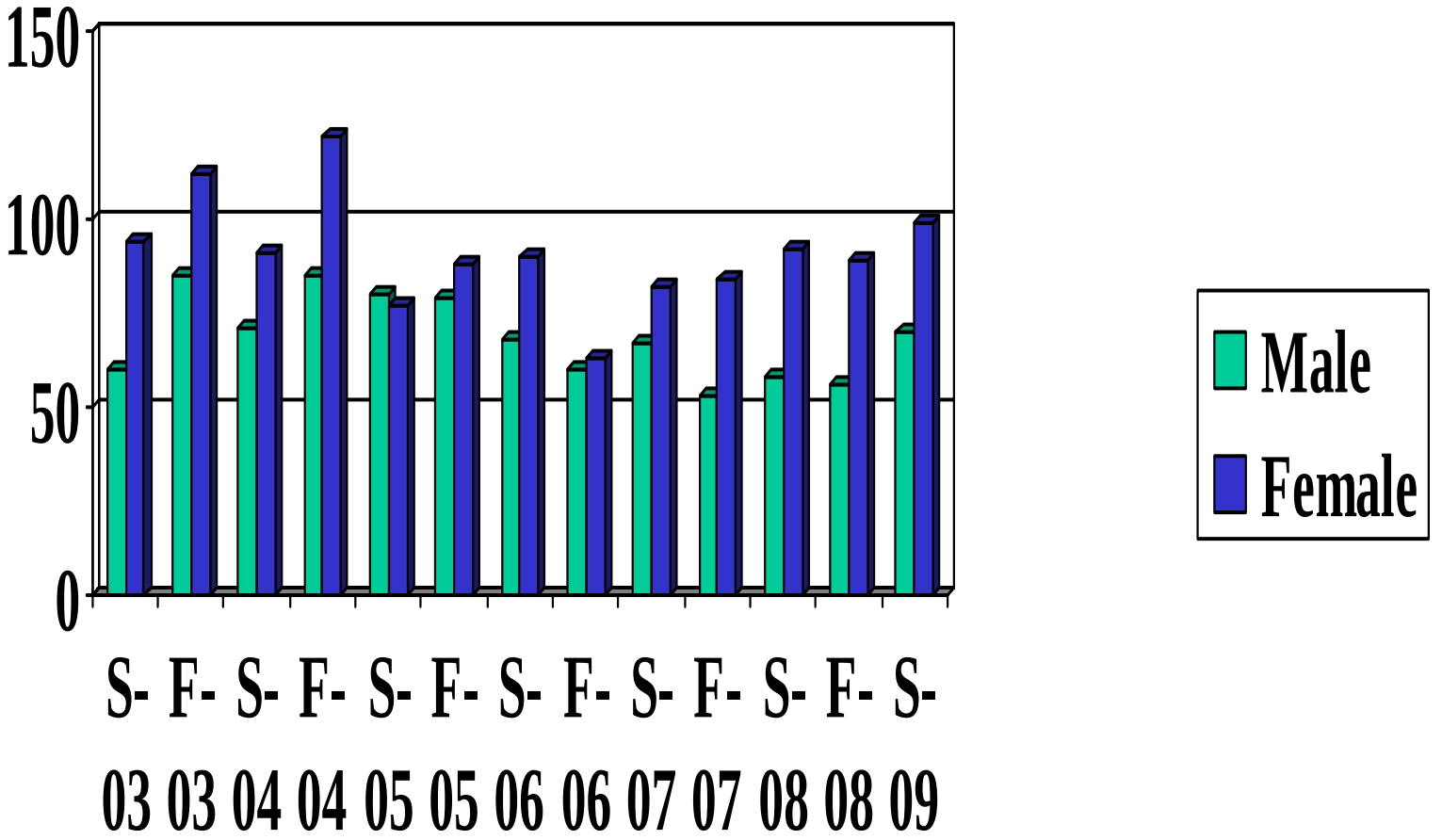
Semi-Annual Cases



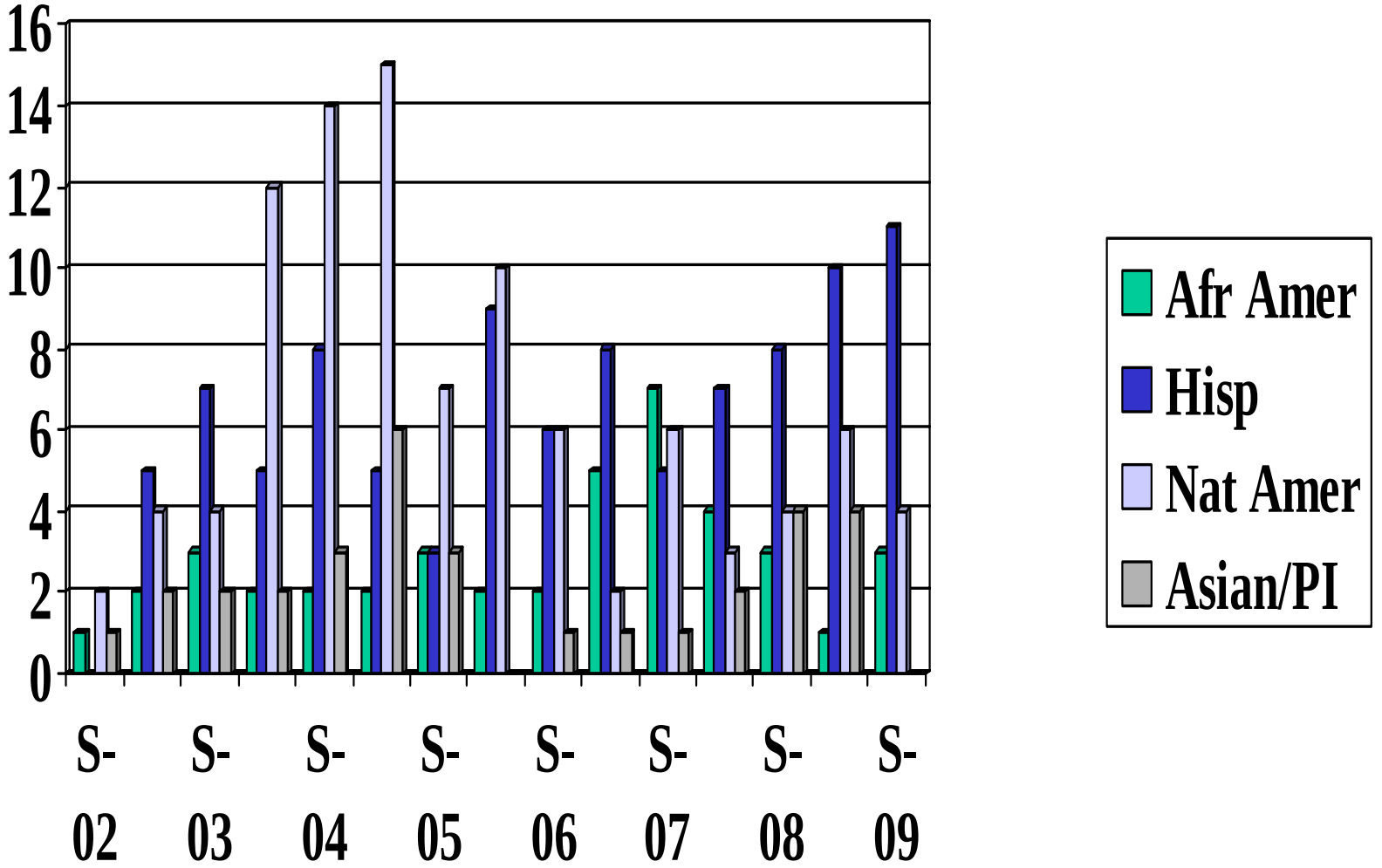
Source of Cases



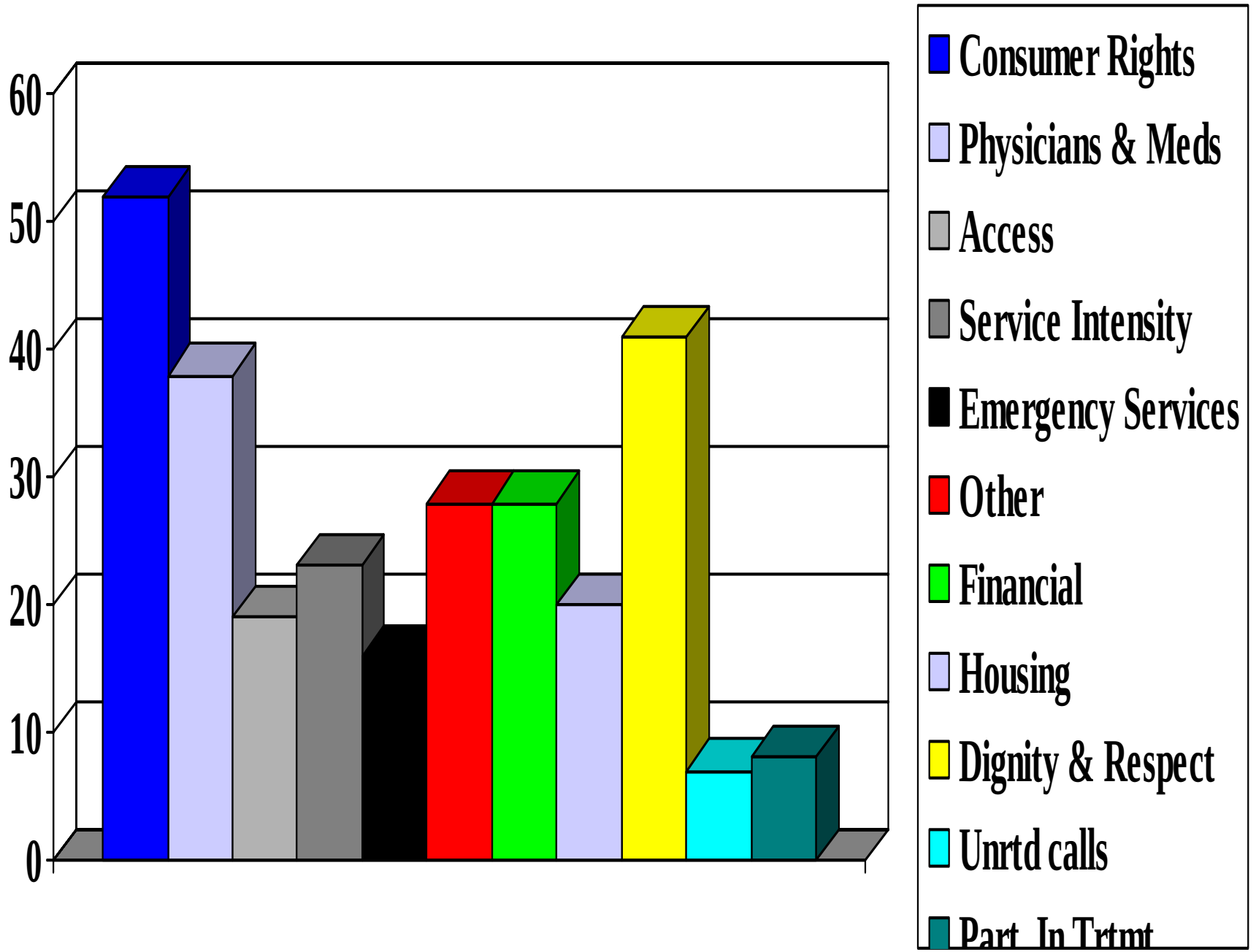
Gender of Client



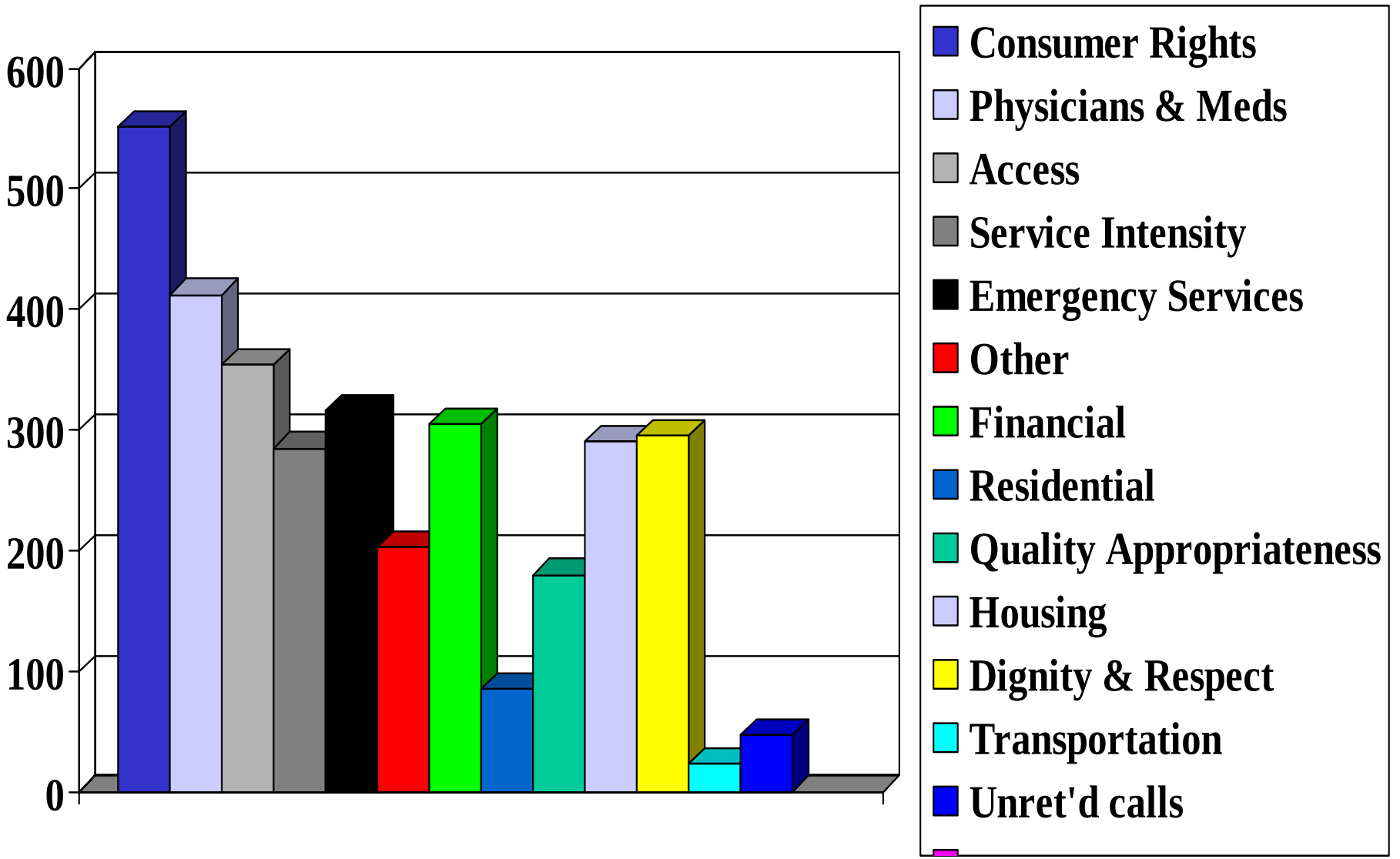
Ethnicity of Client



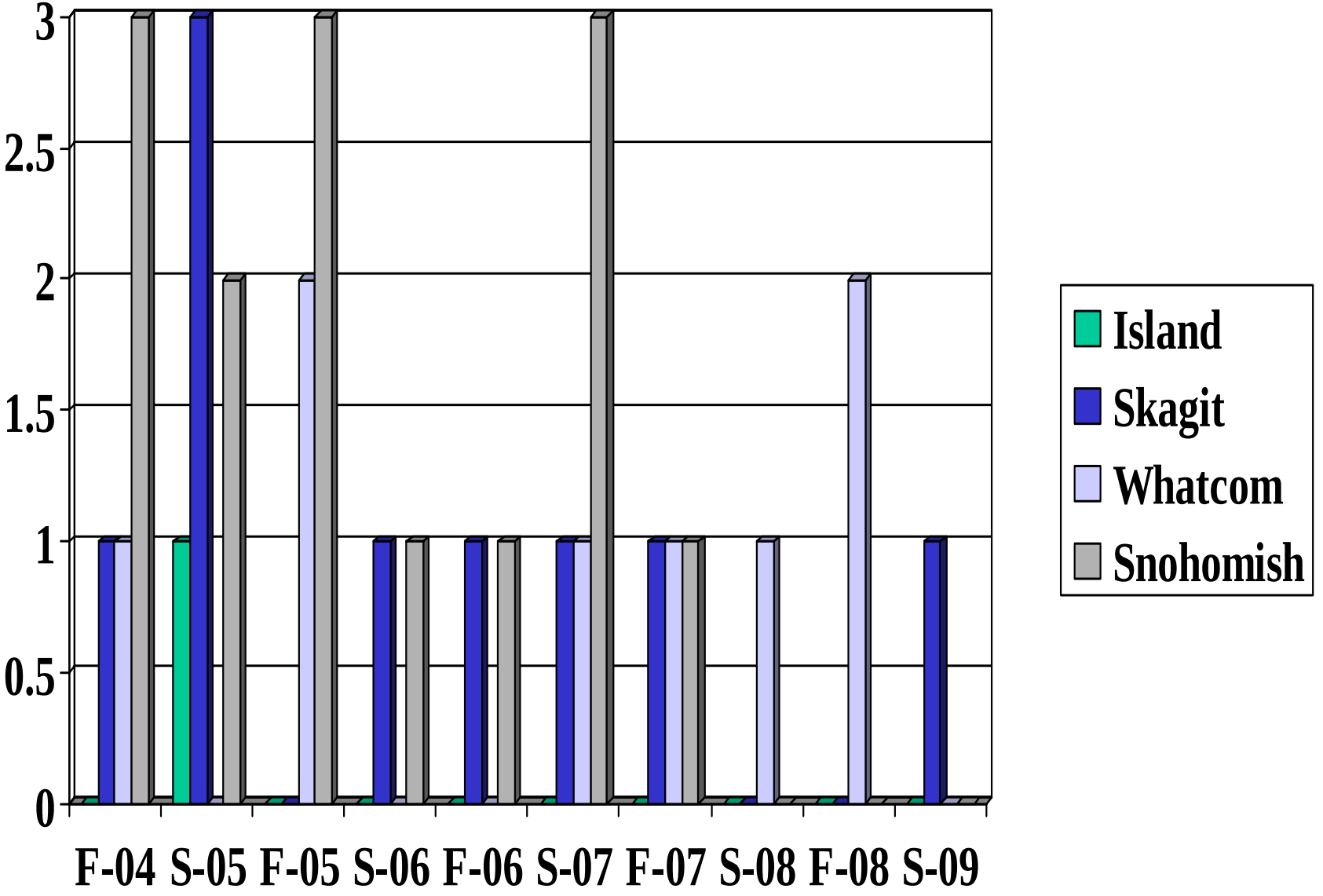
Current Complaint Occurrences



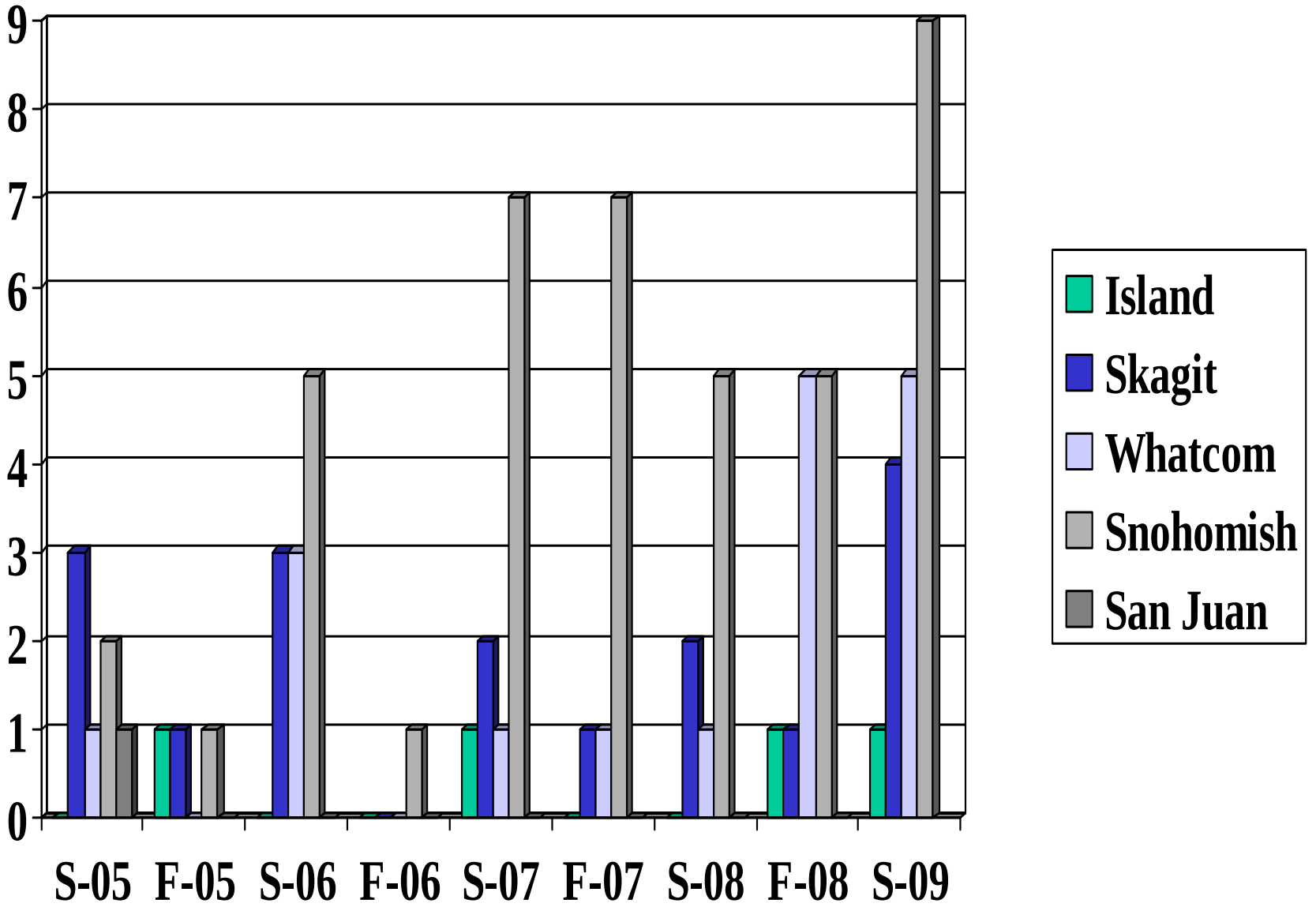
Overall Ombuds Complaint Occurrences since Spring 2002



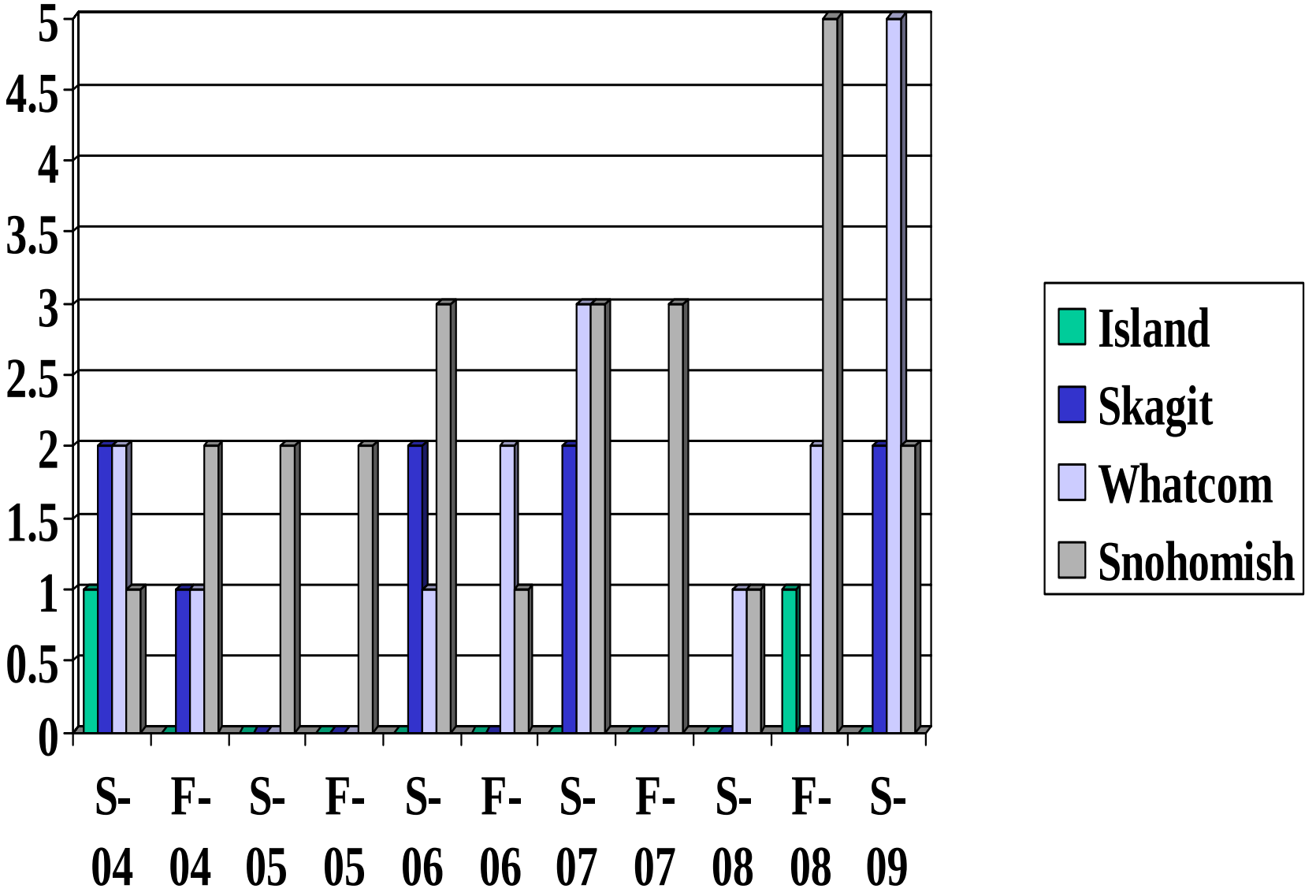
APPEALS CASES



Provider Grievance Cases



NSMHA Grievance Cases



Fair Hearings

- One fair hearing request. Whatcom.
- Occurrences: Consumer rights, Emergency Services, Participation in treatment, Coordination/intensity of services

Final Comments

- Outreach to Hispanic clients
- Dignity & respect
- Information & referral
- Hospitals
- Crisis meds management
- Drop-in centers; clubhouse
- Positive response to complaints
- Client Satisfaction

SPRING 2009 OMBUDS REPORT NARRATIVE

SLIDE 1 (COVER SLIDE) Good afternoon. We are Susan Lange and Chuck Davis from North Sound Regional Ombuds. This is Ombuds' complaint, grievance, fair hearing and appeals report for October 2008 through March 2009. State-wide definitions of complaints are in your handouts. Historically, Ombuds report about 70% of the complaints in the North Sound Region and nearly all its grievances and fair hearings. The North Sound Mental Health Administration (NSMHA) and its providers have established excellent quality management programs that handle 30% of the complaints. NSMHA policy is that complaints are beneficial because they present the consumer voice.

SLIDE 2: "S" (for "Spring") covers the Winter period's statistics that end in Spring. Ombuds opened complaint, grievance, fair hearing and appeal cases on 169 people, including five children, this 6-month period and provided information and referral services to another estimated 500. Many of these cases opened in the past 2 months, indicating the beginning of a rise in cases we expect to see continue in the next year, due to financial concerns.

SLIDE 3: As you can see many cases were referred by clients' support systems that took a strong role in requesting help. Professionals, providers, advocacy organizations, public assistance agencies, family and friends often initiate the request for assistance. Due to consistent outreach, we believe Ombuds has become well known as a resource. We receive referrals from #211, word-of-mouth, state Ombuds contact information on the internet, drop-in centers, community action agencies, the care crisis line, NAMI, providers, parent groups, and many agencies we have done personal outreach and presentations to. This period about 20 cases were referred by the Mental Health Division, the Governor's staff or state legislators' staffs.

SLIDE 4: NSMHA serves a few more men than women but more women routinely request assistance. This time that number was: 99 women and 70 men clients.

SLIDE 5: We left our 151 Caucasian clients (81% of Medicaid eligible clients and 85% of our clients) off this slide. The African American population is about 4% of the regional Medicaid eligible consumers. We had 3 cases: 1.7% of our cases. The Hispanic population is 8% of Medicaid eligibles; we had 11 cases: 6.5% of Ombuds cases. The Native American population is 5% of eligibles; we had 4 cases: 2% of Ombuds cases. Asian/Pacific Islanders are 2% of the eligibles; we had no cases. We aren't positive about these statistics because non-Caucasian clients occasionally tell us they self-report as "Caucasian" to avoid stigma.

SLIDE 6: Here are the past 6 months' complaints. The number of complaint occurrences (complaints themselves – not people) rose from 219 last period to 292 this period. The number one Ombuds complaint area again was Consumer Rights with 74 complaint, grievance and fair hearing occurrences. With 28 subareas under this complaint heading it is frequently the highest complaint topic. The consumer rights that are most problematic are "receiving the amount and duration of services you need" and "receiving quality services that are medically necessary." The second highest complaint topic was Dignity and Respect with 53 complaint and grievance occurrences. Third highest was Physicians & Meds with 43 complaint and grievance occurrences. Fourth and fifth highest were Financial Services and Other Complaints with 32 complaint and grievance occurrences each. Coordination of Services & Service Intensity was next highest with 31 complaint, grievance and fair hearing occurrences. There were 23 Housing, 22 Access, and 18 Emergency Services complaint, grievance and fair hearing occurrences. No other complaint areas had a significant number. Your handouts have breakouts of complaints and grievances by agency.

SLIDE 7: This "big picture" shows all Ombuds complaint occurrences since October 2001.

SLIDE 8: Here is the history on appeals since we started doing them in 2004. Ombuds helped one client this period appeal denial of access to treatment.

SLIDE 9: Provider-level grievances are heard by provider agencies in hopes that they are resolved before they rise to the RSN level. Both provider-level and RSN-level grievance case and occurrence numbers continued their dramatic rise this period. Overshadowing last period's, highest-ever number of 21 cases with 61 grievance occurrences, this period we had 27 cases with 72 grievance occurrences. Clients have become very aware of the grievance process and know it is their right to request one. Many of the current grievance cases are repeat clients. The large number indicates that the clients were not fully satisfied at the complaint level and sought further assistance toward resolution. We continue to remain concerned because the providers and NSMHA simply aren't manned to hold this many grievance meetings and we would hate to see the grievance process in the North Sound region become less robust. Here is the history of provider-level grievance cases since we first began doing them in 2004. This period we had 18 cases and 46 occurrences.

SLIDE 10: Here is the history of NSMHA-level grievance cases since 2003. This period we had 9 cases with 26 occurrences.

SLIDE 11: We had one fair hearing case this period with four occurrences. The client subsequently dropped it.

SLIDE 12: Some closing remarks and recommendations. (1) In our efforts to reach the Hispanic population Ombuds has established a Skagit County community voicemail line for Spanish-only speakers to have direct access to us. We have made outreach to Sea Mar and the local providers. We are starting to receive some calls! If this turns out successful in Skagit County we will open lines in the other counties as well. Additionally, we have rearranged our office to allow us to seek a "Work First" person with connections to the local Hispanic culture to assist us.
(2) As we saw several years ago, when funding tightens there is a direct rise in complaints referencing lack of dignity and respect. The statistics we just presented are bearing this out once again. We make an appeal to the region's providers to be attentive to this issue.
(3) Like everyone in this business, we are concerned about a reduction in services for both community mental health program clients and people with mental illness not in the program. We are providing more and more information & referral services to the region's substantial population of persons who suffer from mental illness, yet are not served by the community mental health program. These people have many mental health issues. With cuts to federal and state assistance and insurance programs we anticipate receiving even more calls, yet having fewer resources to refer them to. We fear our region's hospitals will be their last resort.
(4) Speaking of hospitals, we have a number of concerns. Western State Hospital and our region's remaining senior behavioral health facility are ceasing service to clients with dementia who will not benefit from hospitalization. We recommend that NSMHA, Home & Community Services and the Long-Term Care community work together to develop appropriate community service plans for clients with primary diagnosis of dementia who no longer have the option of going to Western State Hospital or who will be discharged to our local communities. NSMHA must also watch closely to ensure evaluation & treatment facilities don't end up warehousing these clients. We monitored several situations of this type recently that concerned us.
(5)We have initiated a number of complaints with Western State Hospital in the past year as the hospital went through some turmoil closing 3 wards within a fairly short period. We are glad to see that Western State Hospital now has its own Ombuds. We work closely with her.
(6) In other hospital issues, in the past year Ombuds has had three clients charged with assault by regional hospital staff members due to the clients' actions while psychotic and in emergency crises during hospitalization. We urge NSMHA to work with the region's hospitals to ensure physical protection of hospital staff from patients who are suffering psychotic break and who may be violent.
(7) We have seen problems with clients running out of meds after being discharged from hospitals with only 2 weeks' supply. Here are the region's current procedures for dealing with this problem. At the smaller provider agencies, medications are discussed at the intake and hopefully the client can be seen quickly by a prescriber. Smaller agencies have a shortage of prescribers, so the client is often sent to the ER for a refill. At larger agencies the protocol varies. If meds are a problem at the intake appointment, the client is referred to their PCP or the provider fills meds when able through crisis appointments--although they aren't usually for people running out of meds. For non-Medicaid clients, federal block grant funds can sometimes provide 90 days worth

of meds. The complaints we receive show that these procedures don't always work. We suggest NSMHA discuss with local hospitals the possibility of hospitals prescribing 2 weeks of meds initially upon discharge; then offering a 2-week follow up appointment with a hospital meds nurse if necessary. It takes a minimum of 4 weeks to get in to see a community mental health program prescriber.
(8) We have had a number of complaints and grievances against two of the region's drop-in centers and a clubhouse this period. The main issues are a perceived lack of client centered leadership, maintaining a healthy and safe environment for members, lack of activities, and management of the facilities. Besides supporting clients with complaints and grievances, Ombuds staff has visited these facilities several times and discussed the complaints with both clients and management. Ombuds has been scheduling a regular monthly presence at Skagit's Peer Connections drop-in center and hopes to do so with the others in the future.
(9) We have seen frustration from peer counselors in the drop-in centers. Many peer counselors are still active consumers themselves. As such, when they have a problem with their employers, they consider themselves "consumers" and seek Ombuds services. We advise them that consumers who are paid peer counselors must work with their union and their employment chain of command to resolve employment issues. We encourage those teaching the peer counselor courses to incorporate a training program on resolving employee problems.
(10) Ombuds has noted a strong connection between positive response to client complaints and successful resolution of those complaints. Provider responses that are respectful, empathetic and show a willingness to work things out, result in better resolutions and fewer grievances. Even if the response is not what the client wants to hear, an apology and providing information as to why the provider must do what it must do simply produces better results. We encourage providers to take this to heart.
(11) A final item. In the North Sound region, Ombuds is responsible for the quality review team functional requirement in the community mental health program WAC to help determine the region's client satisfaction level. As a result, Ombuds carefully monitors such things as NSMHA's quality program and NSMHA provider audits, NAMI reports (such as the State Report Card), Telesage reports (until they ceased) and various reports published by Disability Rights of Washington, Northwest Justice Project and other such agencies. Ombuds also stays in close contact with consumer groups, advocacy groups and legal advisory agencies, not to mention our own NSMHA Advisory board, county mental health councils and most of all, the many clients who call Ombuds for assistance. We combine all this with what the region's client voice is telling us through Ombuds, provider and NSMHA complaints and grievances. If we see an area of client dissatisfaction arise, we quickly send an Ombuds cluster of events report to NSMHA alerting them to the problem. Then we advise you in this semiannual Ombuds report of the systemic problem issues involving client dissatisfaction we are seeing. For example, in this report today we have alerted you to complaints about the region's drop-in centers and potential problems coming in the area of dignity and respect to the region's clients. There is one other source we review carefully that presents valid and reliable research. It is the Mental Health Statistical Improvement Project (MHSIP) report that is produced annually by The Washington Institute for Mental Illness Research & Training (WIMIRT). Actually, two client satisfaction reports are produced annually, one for adults and one for children. The North Sound region's results on the MHSIP have been generally positive over the past several years. The reports consistently validate many statements in our Ombuds reports. We see no major areas of client dissatisfaction currently from these reports. We do very much agree with a concern in the report in one area: it is difficult to gain participation from Asian and Pacific Islander population. Usually less than 1% of respondents to the MHSIP surveys are of this ethnic background. We have long noted difficulty in out reach to this ethnic background.

AGENCY COMPLAINTS, GRIEVANCES, FAIR HEARINGS, APPEALS, Spring, 2009

Compass Health, Snohomish: 1 Occurrence (7 last period)
Svs Intensity: 1

Compass Health, Marysville: 14 Occurrences (3 last period)
Access: 1
Consumer Rights: 3
Dignity & Respect: 4
Housing: 1
Physicians & Meds: 3
Svs Intensity: 1
Unreturned Phone Calls: 1

Compass Health, Whidbey: 13 Occurrences (14 last period)
Consumer Rights: 2
Financial: 2
Physicians & Meds: 2
Svs Intensity: 2
Unreturned Phone Calls: 2
Provider-level grievance: 3 Occurrences: C,C,D

Compass Health, Smokey Point: 3 Occurrences (4 last period)
Physicians & Meds: 1
Svs Intensity: 1
Unreturned Phone Calls: 1

Compass Health, Lynnwood: 8 Occurrences (11 last period)
Access: 1
Consumer Rights: 1
Physicians & Meds: 3
Provider-level grievance: 3 Occurrences: C,D,S

Compass Health, Mount Vernon: 23 Occurrences (5 last period)
(Now includes ICRS)
Access: 2
Consumer Rights: 3
Dignity & Respect: 2
Emergency Svs: 1
Financial: 1
Housing: 1
Physicians & Meds: 4
Participation in Treatment: 2
Svs Intensity: 3
Provider-level grievance: 4 Occurrences: C,K,P,P

Compass Health, San Juan: 0 Occurrence (3 last period)

Haven House: 1 Occurrence (1 last period)
Other: 1

Green House: 0 Occurrences (6 last period)

Compass Health, Everett: 34 Occurrences (45 last period)
Access: 2
Consumer Rights: 9
Dignity & Respect: 6
Financial: 4
Housing: 2
Other: 4
Physicians & Meds: 2
Provider-level grievance: 5 Occurrences: C,C,F,O,P

North Sound Evaluation & Treatment Center: 4 Occurrences (15 last period)
Access: 1
Emergency Svs: 1
Other: 1
Physicians & Meds: 1

Mukilteo Evaluation & Treatment Center: 1 Occurrence (17 last period)
Physicians & Meds: 1

Snohomish PACT: 0 Occurrences (2 last period)

Interfaith: 20 Occurrences (1 last period))
Access: 1
Consumer Rights: 2
Dignity & Respect: 2
Physicians & Meds: 1
Participation in Treatment: 1
Svs Intensity: 2
Provider-level grievance: 4 occurrences: C,D,P,U
RSN-level grievance: 7 Occurrences: A,C,C,D,P,Pt,S

Sea Mar, Mount Vernon: 13 Occurrences (2 last period)
Access: 2
Dignity & Respect: 2
Physicians & Meds: 3
Violation of Confidentiality: 1
Provider-level grievance: 2 occurrences: Q,S
RSN-level grievance: 3 Occurrences: I,Q,S,

Sea Mar, Everett: 0 Occurrences (6 last period)

Sea Mar, Bellingham: 0 Occurrences (4 last period)

Sea Mar, Lynnwood: 5 Occurrences (2 last period)
Consumer Rights: 1
Provider-level grievance: 4 occurrences: C,D,O,U

Sunrise Services, Everett: 40 Occurrences (34 last period)
Consumer Rights: 5
Dignity & Respect: 3
Financial: 4
Housing: 2

Other: 2
Participation in Treatment: 1
Svs Intensity: 4
Violation of Confidentiality: 2
Quality Appropriateness: 1
Physicians & Meds: 3
Provider-level grievance: 9 Occurrences: C,C,D,F,F,F,Pt,O,S
RSN-level grievance: 4 Occurrences: C,D,Pt,S

Sunrise Services, Mount Vernon: 0 Occurrences (2 last period)

Lake Whatcom Center: 20 Occurrences (10 last period)
Access: 1
Consumer Rights: 5
Dignity & Respect: 1
Financial: 3
Housing: 2
Physicians & Meds: 1
Quality Appropriateness: 2
Unreturned Phone Calls: 1
Provider-level grievance: 4 occurrences: C,C,Q,V

Whatcom Counseling & Psychiatric Clinic: 25 Occurrences (34 last period)
Consumer Rights: 5
Dignity & Respect: 1
Emergency Svs: 1
Financial: 4
Other: 1
Physicians & Meds: 4
Svs Intensity: 1
Violation of Confidentiality: 1
RSN-level grievance: 7 Occurrences: C,C,D,D,O,S,U

***bridgeways*: 12 Occurrences** (0 last period)
Access: 1
Consumer Rights: 1
Dignity & Respect: 2
Housing: 1
Physicians & Meds: 1
Participation in Treatment: 1
Svs Intensity: 1
Unreturned Phone Calls: 1
Provider-level grievance: 3 Occurrences: A,D,H

Catholic Community Services Mount Vernon: 2 Occurrences (0 last period)
Provider-level grievance: 2 Occurrences: O,S

Medicaid Transportation: 0 Occurrence (2 last period)

Stevens Hospital: 3 Occurrences (3 last period)
Access: 1
Emergency Svs: 1
Physicians & Meds: 1

St. Joseph Hospital: 17 Occurrences (13 last period)
Consumer Rights: 3
Dignity & Respect: 6
Emergency Svs: 1
Other: 4
Physicians & Meds: 1
Participation in Treatment: 2

Whidbey Island Hospital: 2 Occurrences (0 last period)
Emergency Svs: 1
Other: 1

Western State Hospital: 11 Occurrences (11 last period)
Consumer Rights: 4
Dignity & Respect: 1
Emergency Svs: 1
Physicians & Meds: 3
Quality Appropriateness: 1
Svs Intensity: 1

Skagit Valley Hospital: 1 Occurrence (2 last period)
Financial: 1

Island County Jail: 0 Occurrences (1 last period)

Skagit County Jail: 4 Occurrences (1 last period)
Financial: 1
Other: 1
Physicians & Meds: 2

Snohomish County Jail: 1 Occurrence (0 last period)
Financial: 1

Snohomish Designated Crisis Responders: 2 Occurrences (1 last period)
Emergency Svs: 2

Skagit Designated Crisis Responders: 4 Occurrences (0 last period)
Emergency Svs: 1
Housing: 1
Provider-level grievance: 2 Occurrences: E,H

Whatcom Designated Crisis Responders: 0 Occurrences (6 last period)

VoA (Access Line & Care Crisis Line): 7 Occurrences (0 last period)
Access: 2
Dignity & Respect: 1
Emergency Svs: 3
Access to Inpatient Tx: 1

Compass Health Drop-In Center: 6 Occurrences (0 last period)
Consumer Rights: 1
Dignity & Respect: 1
Other: 3
Svs Intensity: 1

Skagit Drop-In Center: 2 Occurrences (0 last period)
Housing: 1
Other: 1

Rainbow Center: 20 Occurrences (2 last period)
Consumer Rights: 5
Dignity & Respect: 7
Other: 3
Provider-level grievance: 3 occurrences: C,C,D
RSN-level grievance: 2 Occurrences: C,D

NSMHA: 11 Occurrences (0 last period)
Consumer Rights: 1
Housing: 1
Svs Intensity: 1
RSN-level grievance: 3 Occurrences: A,C,H
Fair Hearing: 4 occurrences: C,E,Pt,S
Appeal: 1 occurrence: A

DSHS Community Service Offices: 15 Occurrences (not counted last period)
Access: 3
Emergency Svs: 1
Financial: 5
Housing: 2
Other: 1
Physicians & Meds: 1
Svs Intensity: 2

Non-Community Mental Health Agencies, but mental health issues: 26 Occurrences (10 last period)
(Includes DSHS, DDD, colleges, adult family homes, sheriff, courts, & other agencies)
Access: 1
Consumer Rights: 1
Dignity & Respect: 2
Emergency Svs: 2
Financial: 2
Housing: 6
Access to Inpatient Tx: 1
Other: 6
Svs Intensity: 2
Unreturned Phone Calls: 1
Violation of Confidentiality: 2

COMPLAINT & RESOLUTION DEFINITIONS

COMPLAINTS:

Access: Concerns (1) access to initial inpatient or outpatient services and (2) terminations from services primarily. Deals with having trouble getting into services or having on-going services cut back or terminated. May deal with eligibility for services or taking too long to receive services. A complaint about access is not only about access into services, but perhaps how long it took, or sometimes about a type of service not available to the consumer.

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

Quality Appropriateness: Appropriate type of service needed either isn't available or isn't being provided. Example: Client has PSTD and is put in an anxiety group. Client questions quality of the therapist, isn't satisfied with anxiety group counseling, and wants individual therapy for PTSD.

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

Service Intensity or Coordination of Services: Has to do with insufficient amount of services being provided. It may involve level of care or a type of therapy not available in that agency (for instance, treatment for eating disorders). Also deals with coordination between provider and another agency or possibly between service providers in the same agency. Example is an alcoholic client where there must be coordination between the person's medical doctor, substance abuse treatment provider and mental health clinician. This could have to do with something like personal care in the home while also in therapy. Could have to do with case manager not coordinating appointments with the right providers.

Consumer Rights: These are listed in the WAC and in our NSMHA brochure. It has a number of sub-categories. Mental health consumers have specific rights as listed in the WACs; this would involve a complaint that one or more had been violated. (Remember that "dignity and respect" is its own category).

Physicians and Medications: When someone wants another type of medication or different dosage. Perhaps they think their psychiatrist isn't listening to what they say about their medications. It may involve interaction with the PCP. Usually it involves medication and refers to psychiatrists and psychiatric meds. Complaints in this area might be around side effects and the doctor not paying attention to the consumer's concerns about them.

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

Residential: This deals with any agency-provided housing. It may be an issue concerning supported living, boarding alone, agency-owned housing. Aurora House is an example of agency-owned housing. These complaints would involve supported living situations managed by the agency.

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

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

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

Participation in Treatment: Client's voice and viewpoint aren't being heard by the treatment provider or reflected in their treatment.

Violation of Confidentiality: An aspect of a client's diagnosis, treatment history, or current treatment has been inappropriately revealed.

Access to Inpatient Treatment: A client is denied access to needed hospitalization.

Other: Any other type of complaint.

RESOLUTIONS:

Information or Referral: Giving information/names/numbers, or referring to another source. May involve significant follow up by Ombuds.

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

Arbitration: Grievance or Fair Hearing ruling by a higher authority.

Fair Hearing: Normally filed with an administrative law judge when an RSN's grievance ruling is unsatisfactory to a client.

Other: Another type of resolution. Perhaps the client moved away or died, is hospitalized, etc.

Not pursued: Client dropped the complaint. Perhaps the client didn't understand the system and were satisfied once they understood the whole situation, or they became satisfied during the working of the complaint or grievance.

Effective Date:
Revised Date:
Review Date:

North Sound Mental Health Administration

Section 1500 – Clinical: Medicaid Personal Care (MPC)

Authorizing Source: MHD and NSMHA contracts
Cancels:
See Also: MPC protocol between HCS AAA and NSMHA Approved by: Executive Director Date:
Providers must have a "policy consistent with" this policy
Responsible Staff: Quality Manager Signature

POLICY #1576.00

SUBJECT: MEDICAID PERSONAL CARE (MPC)

PURPOSE

To clarify the responsibilities of North Sound Mental Health Administration (NSMHA) and its contracted provider agencies as they relate to the application process for Medicaid Personal Care (MPC) services for individuals in NSMHA-funded services.

POLICY

NSMHA has fiscal responsibility for MPC services provided to individuals in NSMHA-funded services who both:

1. Qualify for Medicaid Personal Care services due solely to their psychiatric disability, and
2. Were authorized for services after June 30, 1995.

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NSMHA's Intensive Services Review Committee (ISRC) reviews requests for MPC from Aging and Disability Services Administration's (ADSA) Home and Community Services (HCS) and Area Agencies on Aging (AAAs). In order to facilitate the most appropriate use of MPC, NSMHA requires information from its provider agencies to establish that the individual qualifies for MPC services due to a psychiatric disability.

If MPC is approved by NSMHA, it is expected that clinicians from HCS/AAA and NSMHA provider agencies will have regular contact to provide coordinated care for mutually served individuals. It is the responsibility of each agency to keep updated releases of information in the individual chart such that the above communication is maintained for the duration of the services.

PROCEDURE

Referral and Approval Process for MPC services:

1. When a NSMHA provider agency clinician and/or manager determines that an individual needs a higher level of care to assist with personal care and activities of daily living than they believe are available in the mental health system they will:

   a. Call NSMHA and consult with a member of the Intensive Services Review Committee (ISRC) for the options available to meet the needs of the individual. This consultation will focus on whether MPC or another program is the most appropriate program to meet the individual's need.
   b. If a program is available within NSMHA's network that will likely meet the needs of the individual, the clinician will be instructed to discuss this program with his or her manager.

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c. If MPC appears to be the most appropriate program for the individual, the clinician shall assist the individual in completing the MPC application process by following the steps below.

2. NSMHA provider agency clinicians access MPC services by submitting an application form, including **all** of the following documentation to HCS **and** faxing a copy to NSMHA:

   a. **Necessary Releases of Information authorizing exchange of information between HCS and NSMHA contracted provider agency**
   b. **Reason for request to include a current description of basic needs, current living situation, and history of residential or specialized housing**
   c. **Confirmation that the referred individual is in a current NSMHA authorization period**
   d. **A psychosocial history**
   e. **Diagnoses (psychiatric and medical)**
   f. **Mental health assessment AND treatment plan**
   g. **Proposed use of MPC for individual care**
   h. **Identification of a designated NSMHA provider agency clinician and his or her contact information**

3. HCS/AAA schedules a CARE Assessment (utilizes the Comprehensive Assessment Reporting Evaluation [CARE] tool). NSMHA encourages provider agency clinicians to attend the CARE Assessment whenever possible to improve continuity of care between agencies. If unable to attend the assessment, the NSMHA provider agency clinician will offer availability to discuss the outcome and implications of the CARE Assessment with the HCS/AAA case worker.
4. Every effort will be made to conduct the CARE Assessment and transmit the MPC request to NSMHA within 10 working days from the date HCS/AAA receives the referral packet. *Consideration of timeliness will be based on individual need and acute situations may require a shorter response time, which will be accommodated whenever possible.* If, following the CARE Assessment, HCS/AAA believes NSMHA is responsible for all or part of the funding, the HCS/AAA case worker shall send the following information to NSMHA:

   a. A copy of the CARE Assessment, including Service Summary;
   b. HCS/AAA RSN transmittal form;
   c. Requested payment amount including both daily and monthly rates; and,
   d. Requested approval period.

5. Upon confirming that the individual is authorized for NSMHA-funded services, the NSMHA ISRC shall review the individual's CARE Assessment and documentation from the NSMHA provider agency. NSMHA shall make every effort to transmit the following information back to HCS/AAA within 5 working days from the date the CARE Assessment packet is received *(consideration of timeliness will be based on individual need and acute situations may require a shorter response time)*:

   a. Agreement/disagreement with ADSA's determination that individual's unmet need is due solely to a psychiatric disability;
   b. Determination as to whether MPC or other NSMHA services are most appropriate to meet individual's need; and,

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c. Approval or rejection of financial responsibility for the referred individual's MPC Services. If the MPC request is approved, NSMHA staff shall complete the HCS/AAA RSN transmittal form with the following:

i. Payment amount including both daily and monthly rates;
ii. Approval period; and,
iii. Signature and date.

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6. NSMHA shall also communicate the determination to approve or reject the MPC request to the NSMHA provider agency clinician. If the request is rejected based on provision of other NSMHA services, the Individual Service Plan (ISP) must be updated to address the personal care needs identified in the CARE Assessment.
7. MPC may be approved for up to one year. If it appears that MPC services are needed beyond the approved time period, HCS staff shall submit a new request, following the procedure above, in the month preceding the current approval's expiration.

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8. Case management responsibilities related to personal care needs will be provided by both HCS/AAA and NSMHA provider agency staff as needed and as identified in the individual's HCS Service Summary and mental health ISP including crisis plan, updated copies of which shall be shared between the mental health agency and HCS case worker.
9. In the event that a NSMHA contracted provider agency is planning to end services with an individual in a NSMHA authorization who is currently receiving MPC services, the provider agency will notify both a NSMHA ISRC staff and the HCS/AAA case manager of the planned date of services ending as soon as they have determined when this date will occur. When possible, this notification shall occur at least 30 days prior to the planned end of service date. Notification by phone is sufficient.
10. When outpatient services by the provider agency stop, NSMHA payment for MPC services will also stop as of the same date if no other NSMHA contracted provider is involved with the individual. Stopping mental health services and NSMHA MPC payment may affect the residency status of some individuals living in Adult Family Homes. The provider agency shall inform the individual receiving MPC services of this potential impact on residency and address this issue in the individual's care planning. Notification to the individual may be done verbally or in writing, but must be documented in the chart.
11. In the event that HCS/AAA staff are planning to cease or reduce MPC services to an individual connected to a NSMHA contracted provider agency, HCS/AAA staff will inform both provider agency staff and NSMHA ISRC staff via phone call of the planned MPC reduction or cessation so that the provider agency and NSMHA staff can reevaluate the individual's need(s) and assist with the change in services.

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Policy # 1505.00 Authorization for Ongoing Outpatient Services

Concern:

- Policy is not being implemented consistently by all providers regarding Expedited authorization decisions
    - Page 2, paragraph B

Specific problem:

- Page 3, #6
    - "Phone notification" to NSMHA is not being made by all providers in all requests for Expedited authorization decisions. VOA sends NSMHA a weekly list of all requests relayed to providers. All requests identified by VOA are not being called in to NSMHA staff.
    - Expedited notifications that are called in are not always followed up with the authorization request being faxed to NSMHA staff for review. The intent is for the Fax to be reviewed by NSMHA staff who will then inform the requesting provider of NSMHA's agreement of disagreement with the authorization request.

Request

- Please have Clinical Directors review Policy #1505.00 with provider schedulers and clinical staff so that;
    - All Expedited authorization requests received from VOA staff by provider schedulers are called in to NSMHA staff, and
    - All performed Expedited authorization assessments are faxed to NSMHA review staff upon completion for review and decision by NSMHA staff.