NORTH SOUND
MENTAL HEALTH ADMINISTRATION

QUALITY MANAGEMENT OVERSIGHT COMMITTEE

MEETING PACKET

April 27, 2011

1. Please join my meeting.
https://www3.gotomeeting.com/join/199732782

2. Use your microphone and speakers (VoIP) - a headset is recommended.
Or, call in using your telephone.

Dial +1 (914) 339-0026
Access Code: 199-732-782
Audio PIN: Shown after joining the meeting

Meeting ID: 199-732-782

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 27, 2011 **Time: 1:00-3:00 PM**
Location: NSMHA Conference Room
For information Contact Meeting Facilitator: Greg Long, NSMHA, 360-416-7013

Topic	Objective	ACTION NEEDED	Discussion Leader	Handout available pre-mtg	Handout available at mtg	Tab	Time
Introductions	Welcome guests; presenters and new members		Chair				*5 min*
Review and Approval of Agenda	Ensure agenda is complete and accurate; determine if any adjustments to time estimates are needed. Meeting will start and end on time.	Approve Agenda	Chair	Agenda		1	*5 min*
Review and Approval of Summary of Previous Meeting	Ensure meeting summary is complete and accurate.	Approve Meeting Summary	Chair	Summary		2	*5 min*
Announcements and Updates	Inform QMOC of news, events; Binder Updates, if any; Advisory Board News; Provider One update, if any; others updates? • Mobile Outreach Teams will start in May. • Scheduling of appointments other than intakes.	Inform /discuss	All			3	*5 min*
Evaluation forms from last meeting, if any	Discuss feedback, if any.		Chair/ Greg				*5 min*
Comments from the Chair			Chair				*5 min*
Advisory Board Report of news							*5 min*
Ombuds quarterly report	**Report**		Chuck Davis	Attached Report		4	*20 min*
Intake appointments for individuals discharging from WSH	Develop and implement a simple way to schedule people discharging from WSH ahead of time for court documents.	Discussion and action	Charissa	Committee Discussion Form		*5*	*10 min*
2011 Routine UR Data	Inform/discuss	Discussion	Charissa	Com-mittee Discussion Form		*6*	*10 min*
Full documentation to support Denials	Follow-up discussion from last month	Inform/discus and action	Charissa	Com-mittee Discussion Form		*7*	*10 min*
Outpatient RFQ: Clinical Elements NSMHA should consider adding	Inform/discuss	Discussion and final recommendations next month.	Greg Long	Com-mittee Discussion Form		*8*	*10 min*
Improving Access to Emergency Medications	Inform/discuss	Discussion and final recommendations next month.	Greg Long	Com-mittee Discussion Form		*9*	*10 min*
Risk Assessments	Inform/discuss	Discussion and action	Greg Long	Com-mittee		*10*	*5 min*

				Discus-sion Form			
Motivational Interviewing	Inform/discuss	Discussion and final recommendations next month.	Greg Long	Com-mittee Discussion Form		*11*	*10 min*
Open Forum			Chair				
***Review of Meeting**	Were objectives accomplished? How could this meeting be improved? Eval forms						
Date and Agenda for Next Meeting	Ensure meeting date, time and agenda are planned						

Next meeting: May 25, 2011 1:00-3:00 PM – Go to Meeting.

Potential Future Agenda Items:

Draft not yet approved

North Sound Mental Health Administration (NSMHA)

Quality Management Oversight Committee (QMOC)

NSMHA Conference Room
March 23, 2011 – Go to Meeting
1:00 – 3:00 pm
MEETING SUMMARY

PRESENT: **Dan Bilson, Fred Plappert and Terry Ann Gallagher**, NSMHA Advisory Board; **Kim Olander,** ombuds; **Greg Long**, NSMHA; **Anne Deacon,** Whatcom County; **Mike Manley,** Sunrise Services; **Pam Benjamin**, WCPC; **Stacey Alles**, Compass Health; **Molly Donovan**, Sunrise Services; **Charissa Westergard**, NSMHA; **Kay Burbidge**; LWC & **Barbara Jacobson**, recording.

BY PHONE: Pat Morris, VOA**; David Small**, Sea Mar; **Susan Schoeld**, Snohomish Co.; **Susan Ramaglia**, NSMHA Advisory Board; **Richard Sprague**, Interfaith & **Kathy McNaughton**, CCS.

EXCUSED: **Joan Lubbe**, NSMHA Advisory Board.

ABSENT:

OTHERS PRESENT:

TOPIC	DISCUSSION	ACTION
1. **Introductions, Review of Agenda – Chair**	Anne convened the meeting at 1:05 pm and introductions were made. Greg noted a change to the agenda in that Jeanette Anderson who was to report on the dignity and respect workgroup has just been hired as a peer counselor and unable to attend; Fred is on that committee and will give the report.	
2. **Previous Meeting Summary – Chair**	Anne asked for any corrections/amendments to the previous meeting summary and a motion was made to approve as corrected.	Summary approved as amended
3. **Announcements and Updates – All**	• Fred noted that the Advisory Board is meeting April 5the at the regular time as the in-service has been postponed, TBD. Fred noted the Tribal Conference is now two days and moved to the Skagit Resort on May 11-12. • Anne noted that the FBG RFP was released on March 17th; there is less money as some funds were carved out to go directly to the peer support centers. The due date of proposals is April 11th. • Stacey noted that Compass has completed the conversion of the Everett crisis beds to a triage center; officially started running on March 14th. There are 16 bed slots and 4 recliner slots. She noted already had one law enforcement drop off that went well; they are up and running. • Fred gave an update on SHB1170 in that it will go to executive session on March 24th. This bill concerns triage facilities with the law enforcement component added in. • Pat Morris noted that VOA is sponsoring suicide intervention/prevention training called SafeTalk that will be held April 27th from 8-11:30 am. It will be held at SV Hospital in the San Juan Conference rooms A&B. If interested email Pat to sign up. This training is for those 15 years and older who are interested or may be impacted or may come in contact with someone at risk of suicide. We have a two day training called Applied Suicide Intervention and Strategies Training (ASIST) geared toward professionals.	Informational

Draft not yet approved

4. Evaluation Forms from Last Meeting – Chair/Greg	None received.	
5. Comments from the Chair – Anne Deacon	Beautiful sunny day!	
6. Using NSMHA Policies Region-Wide	Greg noted this is a continuation of the discussion from the last couple meetings as we are changing over to providers being able to use our policies and only write implementation procedures or policies if needed. The attached documentation of an email string from DBHR and NSMHA is for providers to retain as confirmation of this decision. Greg stated that he did not receive any feedback on the policies that providers thought applied to them, so we will go ahead with this and make needed adjustments over time. Next we will develop an actual policy around this that will go out in the next month or two to act on. Mike M asks about the policies around HIPPA and the High Tech Act and if providers would be able to use NSMHAs for a model; as he was told NSMHAs attorney is reviewing them. Greg noted that they have not yet gotten revisions back from the attorney, however Greg will follow up with the attorney and our policies would then be on our website if you would like to model them.	Greg will follow up with attorney on policies.
7. Over Turned Denials due to lack of collateral documents	Greg noted that one area we need to address is the overturn of recommended denials; as the way we had been doing them was to authorize for a year when we had no collateral documents to review with the denial. NSMHA staff would review around medications and severity of symptoms and without extra info would overturn; causing providers to question the why. We need to look at a different approach to this and we have two options open for discussion. Option one would be to approve a 14 day extension or option two, NSMHA could give 30-60 day authorization to complete assessment. So we are proposing a more thorough assessment period. Diana noted that some come up to the appeal/grievance level and we overturn at that level as perhaps they are not doing as well as they seemed to be at assessment. Stacey asked for clarification as some are denied as needs could be better met in another system of care and their GAF is not below 60; they may be on meds but are not symptomatic. Charissa noted that the documentation is not clear in some of these cases as they would expect the GAF to be above 60. Diana noted that consumers are not always able to relate history and symptoms and more information may come in. Documentation in the denials is key. The 14 day extension would still need to fall within the 28 days allowed. Charissa will need to look at what the procedure would be for denying at the end of the auth period; whether there would need to be a denial or just close, if the consumers status changes during this period and the fact that once authorized they may not need to meet full access to care standards would complicate a denial. For the Open Access Model provider would have more time to gather needed info as they won't be going through Access which would cut out some time. This will be brought back next month.	Charissa will research the authorization and access to care issue for next month.

8. Dignity & Respect Workgroup Report & Presentation	Fred noted that Jeanette is working for Pioneer Human Services for the new triage center/mobile outreach. This workgroup was formed due to the large amount of dignity and respect issues and we first met in June 2010 and have developed a charter over time. Diana noted that the External Quality Review Org. (EQRO) noted having this committee as a strength in our region. The committee will start a campaign for the NSMHA website and will develop a toolbox that will have resources and a self assessment tool for providers. Fred noted that dignity and respect starts from the top down, is very important and requires a culture of change. The committee hopes to have recommendations to the Planning Committee by the end of August with an FYI to QMOC.	Informational
9. Risk Assessment	Greg noted that at the last meeting NSMHA asked providers to report back on the conversation about the concern over adequate documentation of risk assessment that was to be taken to QM and risk management people. Kathy from CCS noted that they have discussed briefly and need to take to our larger QM meeting. Issues for children are different as they are under the custody of someone. It is a longer term discussion it has just started. CCS has an incident report process and policy internally in addition to the RSN critical incident program. It is part of our risk management and important in light of the changes in the program at the RSN level. Stacey noted their conversation started looking at the client specific level and we recently revised our assessment document to focus on risks people most commonly need to address. We have a toolbox training for our staff around risk assessment; that it is not just done at assessment but is perpetual. To make sure they stay on top and not only assess but document risk throughout treatment. Our special occurrence process has been updated to ensure appropriate review, we now have them faxed to the QM department after review by a supervisor to ensure review for issues to address. We continue to address risk management for our agency; we consult with our liability carrier to keep updated on new information. We continue to address safety by utilizing the training available through MHD; it raises awareness of risk overall as well. Richard at Interfaith noted they have a thorough risk assessment and weekly staff meetings and review these. It is mandatory to ask about suicide and other risks factors that the clinician would bring to the weekly meeting to address. There are a lot of different items on the assessment and we have the clinician not only mark risks but document their viewpoint on any risks they see. We have a complete program here as the consumers also see the MDs upstairs and are able to address things immediately that come up. Kay B. noted that LWC uses a standard form at assessment and the case manager develops the crisis plan/addendum within the first 30 days. Our psychiatrist completes a comprehensive risk assessment at the initial appointment, updated at each appointment. We have an MHP protocol for our clinical staff to follow for any found to be at risk and in need of more help. We are going to develop an internal critical incident procedure separate from the RSN and develop a form to go in the clinical record to track this. David noted that at Sea Mar we use the standard form at intake, we have weekly clinical supervision meetings to staff risky clients and more immediate needs are addressed as needed. We recently discussed the issue of	Greg will take back to QS staff and the Leadership Team

	assessing high risk clients and crisis plans; we are considering this for all sites as some sites do crisis plans only on high risk. We are now asking clinicians to do a crisis plan with all levels and new hires are trained for risk assessment and all receive ongoing training. We have periodic discussions and are working toward having our clinicians feel comfortable and supported in handling risky clients. David stated that he feels their process is adequate; room for improvement and they are reviewing policies and things as we go along. We have a clinical psychologist on staff now that can do a consult rather quickly when needed; to attend our staffings and can consult one on one on cases. Molly noted that Sunrise has two risk assessment forms at assessment and there is a summary on the form to bring it all together, communication between clinicians and the psych team is close and the IOP team does a weekly risk assessment with each client. We are relatively new and as such are pretty up to date in policies; our crisis protocol was recently updated around receiving phone calls, clients coming in person and going out to visit clients. Pam noted that WCPC has discussed this agency wide and asked the clinicians if they thought the assessment was adequate; the feedback received was that improvement is needed. They are in the middle of an access redesign process and redoing all our forms and reviewing process from the time of the call until they get into services. In speaking to the triage folks she received a lot of feedback as well on the risk assessment. Pam stated she feels they are doing a good job; IOP team meets weekly to staff clients, supervisors talk daily with staff on clients of concern, there are weekly supervision and the clinical managers meets weekly to review cases. We have good processes in place and the redesign will only improve this. Kay B. noted that she and Mike W. discussed the risk assessments and Mike felt they go not get enough support from DMHPs in requesting intervention for civil commitment. Greg noted that he had heard about this and he spoke to WSH discharge meeting and talking with ICRS about this. Pat noted that there is a process when someone calls, and having a risk assessment already done to pass onto DMHP helps a lot. She stated that some clinicians make themselves more available than others to confer with when needed. She noted that DMHPs have higher criteria to meet in order to commit. Greg noted that it is important for provider staff to spend time with VOA so they are able to do a safety assessment before dispatch. We will need to work on this as pressure increases in the system there will be more difficult clients to handle and collaboration between all will be crucial in order to ensure safety to consumers, staff and the community. Richard at Interfaith noted that they have many clients on pain control contracts and the risk we run into drug and alcohol issues with their pain meds; this risk is hard to address as there is no mandatory to send people to. Mike M noted that WA State has a high bar to commit someone, and there is a gap between the DMHP criteria and what risk factors the clinician assesses when they see them. The clinician sees risk and calls on the DMHP however there is not enough for DMHP to commit and this creates risk. Greg stated that the expectation of providers is that they do everything possible within	

	the law and available resources to try to make a safe situation. We are redesigning two crisis center and Whatcom County as well and we will continue to work on this. Next steps: Greg will take back to QS staff and the Leadership Team that it seems providers feel they are taking reasonable precautions but perhaps they could do more. NSMHA needs to review this and see if we want to put it back on the agenda.	
10. Service Level 1 & 2 monitoring	Charissa noted what we have already discussed the closer monitoring of level 1 and 2 and were looking at what population to look at more closely and it became apparent that those with a B diagnosis as primary is problematic. The recommendation is for NSMHA to run the data and give the report of level 1&2 to the provider on the 10th of the month prior to the month the auth is to expire. Stacey wants to ensure that there is 30 days to close someone; so if there is a 90 auth period to request that would cover it. Anne asks about the treatment goals and limits; are consumers aware of this coming in. Stacey noted going forward we would need to prepare clients that treatment is limited and we need to do this shift. Stacey noted that historically providers have been dinged before for trying to close. There is a recommendation to add the additional category noted on the discussion form to this process; there is no opposition to this. There is a recommendation to implement this process with the additional category; there is a motion and a second with one opposition. Motion carries. (Opposition withdrawn with record of concerns noted.) The timeline will start 60 days after the numbered memorandum goes out; and a review would probably be done after the first 6 months of implementation.	Recommended process approved. Motion passed
11. Comparisons across RSNs	Greg noted there is really no objective comparison across RSNs though we have the EQRO that evaluates RSNs each year and they release a report with recommendations for RSNs to work on; this report was sent out in an email. It tells us where we need improvement and he gave a brief overview and asks for comments. David S asked if this report leads to prioritization of how funding would be allocated in the region; and Greg noted that we look at these recommendations as we go through our contracts but this is more of a needs list though it is not something we need to immediately address. The State has not issued any kind of formal response to EQRO recommendations; he wants QMOC to be aware of these recommendations.	Informational
12. Open Forum	Fred noted that SB239 has been reintroduced and is in regards to the Health Technology Act; it adds behavioral health to those who may get funding for operating with the requirements. Fred noted the upcoming conference in Bellingham on April 12th; Barb will resend this information out.	Barb will send conference info.
13. Date and Agenda for Next Meeting/ Review of Meeting	The meeting was adjourned at 3:00 pm. The next meeting is April 27, 2011. Every meeting will be available by GoToMeeting; and this is an in person meeting month. It was noted that committee would like the minutes sent out as soon as completed and that the website for QMOC be kept up to date.	Barb will cover this.

QMOC Announcements
April 27, 2011

From time to time, VOA Access Line receives a call from an individual with Medicaid who is not in service and who is trying to obtain a service other than an intake evaluation (e.g., court-ordered evaluation, psychological assessment). VOA Access Line staffs explain that the intake evaluation is to assess for an individual's clinical eligibility for routine ongoing services with a CMHA in our region. If after the explanation, the individual wants to proceed with the intake evaluation, VOA Access Line staff will transfer the individual to the chosen CMHA to schedule the intake appointment. On occasion, the individual has called VOA Access Line staff back stating they were denied an intake appointment.

While it makes sense to explain the purpose of the appointment if the individual continues to be confused or request something other than the intake evaluation, if they still wish to schedule the appointment after additional explanation, the appointment should be scheduled. Refusal to schedule the appointment constitutes a denial, which is an action that must be taken by NSMHA rather than a CMHA. Our current procedure is not to deny the request for an intake for an individual with Medicaid. Please ensure appropriate staff are aware of this process. Feel free to contact Charissa (360-416-7013 x228) if you have questions or concerns.

NSMHA/QMOC COMMITTEE DISCUSSION FORM

AGENDA ITEM: Semiannual Ombuds Report

PRESENTER: Chuck Davis and Kim Olander-Mayer

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

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY: This is a mandatory contract report that shows complaints and grievances from clients of the North Sound Region of the community mental health program from October 1st, 2010 to March 31st, 2011.

CONCLUSIONS/RECOMMENDATIONS: Formal recommendations to the NSMHA are included toward the end of the report.

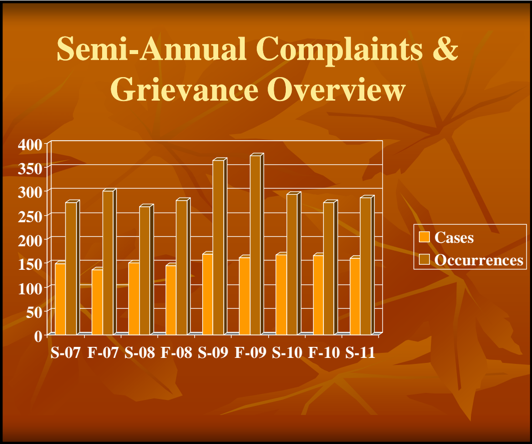
TIMELINES: No mandatory timelines.

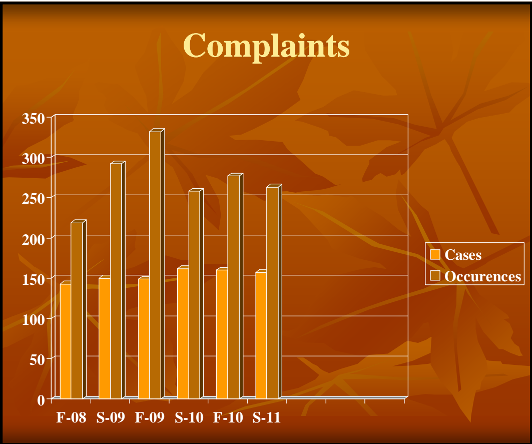
ATTACHMENTS:
Semi-annual Ombuds report

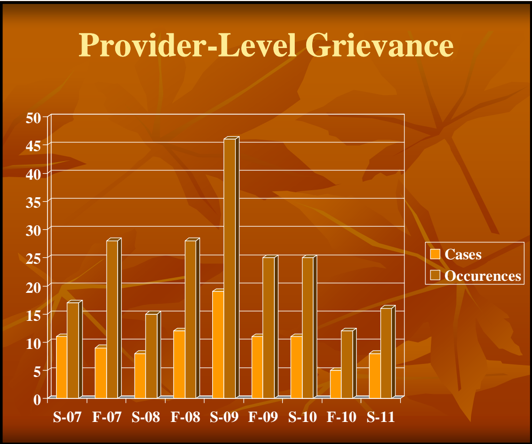
NORTH SOUND REGIONAL OMBUDS & QUALITY REVIEW TEAM REPORT

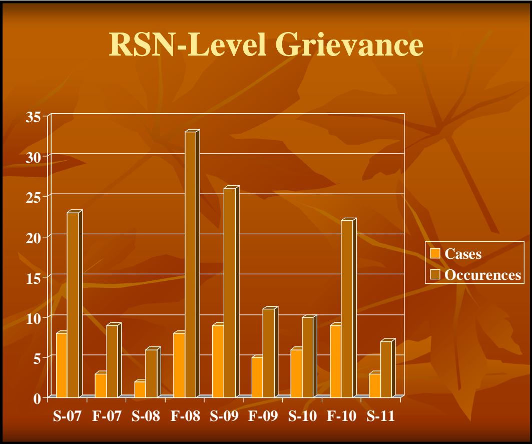
SPRING 2011

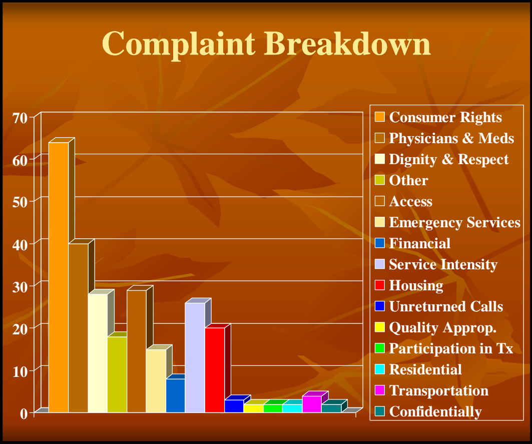
October 2010 – March 2011

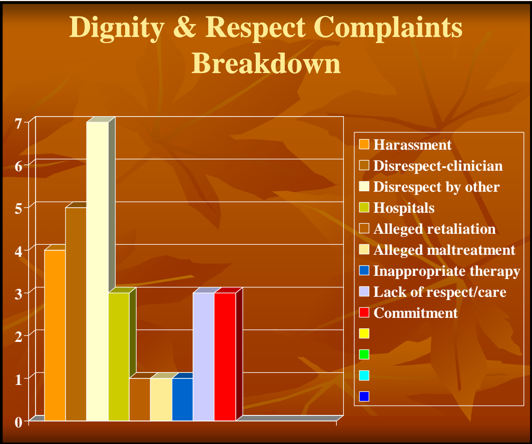


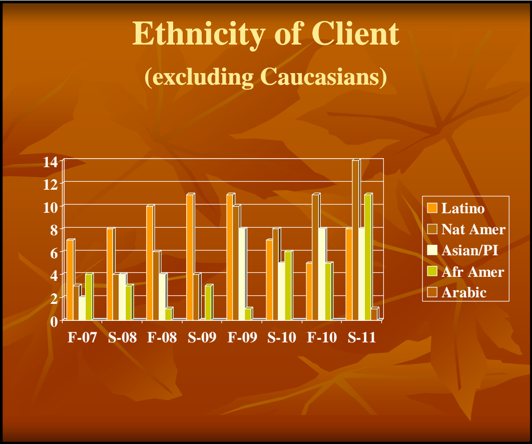


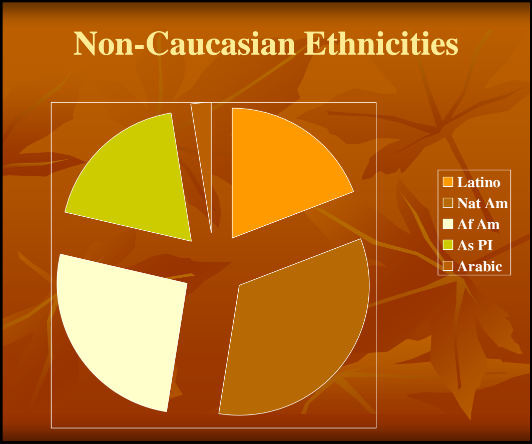

Provider-Level Grievance
50
45
40
35
30
25
20
15
10
5
0
S-07 F-07 S-08 F-08 S-09 F-09 S-10 F-10 S-11
Cases
Occurences


RSN-Level Grievance
35
30
25
20
15
10
5
0
S-07 F-07 S-08 F-08 S-09 F-09 S-10 F-10 S-11
Cases
Occurences


Complaint Breakdown
70
60
50
40
30
20
10
0
Consumer Rights
Physicians & Meds
Dignity & Respect
Other
Access
Emergency Services
Financial
Service Intensity
Housing
Unreturned Calls
Quality Approp.
Participation in Tx
Residential
Transportation
Confidentially


Dignity & Respect Complaints Breakdown
0
1
2
3
4
5
6
7
Harassment
Disrespect-clinician
Disrespect by other
Hospitals
Alleged retaliation
Alleged maltreatment
Inappropriate therapy
Lack of respect/care
Commitment


Ethnicity of Client
(excluding Caucasians)
0
2
4
6
8
10
12
14
F-07
S-08
F-08
S-09
F-09
S-10
F-10
S-11
Latino
Nat Amer
Asian/PI
Afr Amer
Arabic


Non-Caucasian Ethnicities
Latino
Nat Am
Af Am
As PI
Arabic

Comments - Recommendations

- Housing Area Safety
- Penetration Rates & Reconciliations
- Rising Stress and Crisis
- Hopelink Medicaid Transportation
- Emails and HIPAA
- Meds Delivery
- Referral to ER for Meds
- Appointing Personal Representative
- Notice of Involuntary Commitment

Recommendations Continued

- Expand Skagit Intensive Outpatient Program
- Consumer Rights Complaints

Comments - Information

- "Fee for Services" System
- Bearing Firearms – The Rest of the Story
- WA Children's Health Insurance Program
- Customer Satisfaction Surveys
- Traffic Cameras
- Ombuds' Practicum Students

SPRING 2011 OMBUDS AND QUALITY REVIEW TEAM REPORT

SLIDE 1 We are Chuck Davis and Kim Olander-Mayor from North Sound Regional Ombuds. This is our Ombuds and Quality Review Team (QRT) report for October 1st 2010 through March 31st 2011. Three items in your packet accompany it: an "Agency Complaints & Grievances" report, a list of complaint definitions, and last year's outreach documentation. This report presents the client voice on complaints, grievances and general issues of concern. We estimate the region's complaint rate is about 5% of total people served.

SLIDE 2: This slide shows our work historically and for this period. "S-11," bottom right, stands for Spring 2011 and covers October 2010 through March 2011. The F's stand for Fall reports. A case is a person; an occurrence is a type of complaint or grievance. We assisted **161** people (cases) this period with **263** complaint occurrences, **16** provider-level grievance occurrences and **7** RSN-level grievance occurrences. We also provided information and referral services to an estimated **500** people--not included here. Our clients numbered **92** women and **69** men. We assisted **6** seniors and **13** children.

SLIDE 3: This slide shows cases and occurrences of complaints only. We had **263** complaint occurrences and **157** complaint cases (people). 43% of our cases were reported by friends, family members or staff personnel.

SLIDE 4: Provider-level grievances: **8** clients had **16** provider-level grievance occurrences: 5 Consumer Rights; 4 Dignity & Respect; 1 Other Type; 1 Physicians & Meds; 1 Participation in Treatment; 3 Services Coordination/Intensity; 1 Unreturned Phone Calls. We even had a "class-action" provider-level grievance meeting of sorts where 10 clients came to the meeting to present their grievances about the appearance of a facility's restrooms. One of the grievants was hired for a "janitorial" position and the grievance was satisfactorily resolved.

SLIDE 5: RSN-level grievances: **3** clients had **7** RSN-level grievance occurrences: 1 Access; 1 Consumer Rights; 1 Other Type; 2 Physicians & Meds; and 2 Services Coordination/Intensity.

SLIDE 6: Our complaint occurrences this period were, from left, **64** Consumer Rights; **40** Physicians & Meds; **29** Access; **28** Dignity & Respect; **26** Services Coordination/Intensity; **20** Housing; **18** Other Type; **15** Emergency Services; **8** Financial Services; **3** Unreturned Phone Calls; **4** Transportation; **2** Quality Appropriateness; **2** Participation-in-Treatment; **2** Residential; and **2** Violation of Confidentiality.

SLIDE 7: "Dignity & Respect" complaints are traditionally fairly high. We tracked them this period. They include: 4 reports of harassment by security staff; 5 reports of inappropriate comments, insults or inappropriate conduct by a clinician (e.g. clinician calling client a name, or an evaluator saying client will never be able to work); 1 report of provider mistakenly accusing client of inappropriate activities; 1 report of being treated disrespectfully by a provider's aide;1 report of lack of respect by clinician supervisor; 3 reports of being discounted or discourteously spoken to by a provider agency staff; 1 report of provider agency acting dictatorial and rude; 1

report of poor treatment by a provider during clinician change; 1 report of staff person repeatedly asked the same questions and questioning a client repeatedly; 1 report of alleged retaliation for filing a complaint; 1 report of maltreatment by the community mental health program in general; 1 report of a provider showing lack of respect by providing inappropriate therapy; 1 report of treatment not being in accordance with proper intensive outpatient program procedures; 2 reports of lack of respect by inappropriately initiating involuntary commitment; 1 report of client being led to believe he was not being involuntarily committed, but actually was; 3 reports of inappropriate treatment and lack of respect at hospitals; and 3 reports of lack of respect and caring, fostering discouragement by lack of care or not offering professional, supportive assistance. We appreciate NSMHA establishing a "Dignity & Respect" committee. We sit on the committee and have high hopes for positive movement on this issue.

SLIDE 8: Reflecting population ethnicities in the Pacific Northwest, **119** Caucasians were 74% of our clients. This slide omits Caucasians. There were **8** Latino clients, **14** Native American clients, **8** Asian/Pacific Islander clients, **11** African American clients, and **1** Arabic client.

SLIDE 9: This slide shows another breakout of non-Caucasian ethnicities for this period.

SLIDE 10: These are our Ombuds and QRT recommendations and comments:

Recommendations:

- We receive occasional calls from clients who feel their personal safety is in danger in their provider agency housing. Usually these calls follow an assault or other such event in the housing complexes. The clients invariably don't wish to make their complaints public, fearing retaliation and eviction from their residences. We recommend and encourage providers who offer housing to recognize these concerns and take the initiative to reassure residents' safety after such incidents.

- We noted in our last report our concern about the community mental health program having to deal with increases in eligible clients and decreases in funding rates—especially with no actions by the State to modify access requirements or Medicaid-covered diagnoses. Therefore we continue to recommend that NSMHA closely track penetration rates to ensure our region's rates don't exceed those of other RSNs. We recommend NSMHA also continue to carefully review monthly reconciliations (the amount of services each agency provides) to determine who is under serving and who is over serving; then shuffle funding as necessary in order to have funds allocations meet service demands as well as possible.

- As noted above, with increases in eligible clients and decreases in funding the community mental health program will likely experience rising stress. Everyone is concerned about efforts to cope by initiating such measures as discharging Level 1 and 2 clients quicker. However, even with these types of steps, we fear it will be more and more difficult for providers to manage their client loads and as a result, the system will become more crisis-oriented. (Fewer services = more crisis cases). Therefore, we recommend three things: (1) the community mental

health program must unite and communicate on how best to streamline and work smarter, and thereby intensify its efforts to avoid crises. (2) We must keep a close eye on what other RSNs are doing to cope, and adopt good practices. And (3) we must ensure our crisis system works as well as possible.

- Ombuds received numerous complaints from provider agencies about the new Snohomish County Medicaid transportation agency, "Hopelink." Hopelink is a community action program that operates Medicaid transportation for King County and offers various services throughout Western Washington. The complaints are about poor service and how it affects clients. For example, they sometimes bring people to treatment and forget to pick them up, or fail to take people to appointments. It takes approximately ½ hour to schedule a ride because Hopelink wants a lot of information. They require reservations a minimum of 2 days before the appointment. Three specific complaint examples: in February, Hopelink dropped a client off at a provider's building. It was 25 degrees outside and the building wasn't open. The client stood in the freezing cold until it opened. Another client was dropped off at a provider's administrative building rather than their treatment facility. It took a lot of management involvement to get the person picked back up—and after all that, he was late to his appointment. Another person from Compass Health-Lynnwood was left stranded at the office after business hours in the snow and wasn't scheduled for pick up for 1½ hours yet. There are complaints of a disrespectful attitude by some of the drivers. We sent complaints and had several discussions with Hopelink. They said due to a major software transition early this year and taking on Snohomish County, things have been slow going. We recommend people with complaints call the reservation line (1.800.923.7433), use the Hopelink Website electronic complaint process, or call Ombuds.

- Now and then clients show us emails that pass between them and their case managers. These indicate to us that within the community mental health program there is some protected health information going out over email. We believe this is a HIPAA concern and we recommend that on-going confidentiality training target it.

- Several people in Everett complained of not getting their meds delivered to their homes at proper intervals. We resolved the issues with the provider agencies. One of the reasons is, a provider had their delivery van broken into in and meds stolen. This resulted in a loss of meds, and concern by people about personal information getting into the wrong hands. The provider has (wisely) changed distribution times and routes. We recommend all providers who deliver meds take precautionary security measures.

- People were being told by their provider to "just go to the emergency room for meds." Several people had their meds management appointment cancelled and rescheduled. When they ran out of meds, they were informed to "go to the ER." We recommend providers utilize internal resources to assist their clients.

- We have noted several cases lately in which a client has died and a significant other wanted their possessions. The providers don't always treat these situations the same. If there is a

personal representative available (usually a family member), that person should close the deceased person's affairs by receiving the deceased person's belongings and dealing with their obligations. We recommend providers have policies covering this issue.

- It often happens that people coming to the evaluation & treatment facility are under the impression that they are there voluntarily. Sometimes this comes from the DMHP unsuccessfully trying to find them a bed somewhere and ending up with involuntary commitment at the E&T. Whatever the reason, we recommend that it be perfectly clear to the client that they are under involuntary commitment.

SLIDE 11: Recommendations continued.

- We recommend an expansion of the Intensive Outpatient Services Program in Skagit County. Currently, of the three adult service providers in Skagit, only one agency has an Intensive Outpatient Program. That means, if a client in one of the other two adult service providers needs to enter the program, they must switch agencies.

- Ombuds is serving somewhere near 25% to 30% more community mental health program clients this period. We say this because formerly about that percentage of our cases were people who had mental health issues outside the community mental health program. We ceased serving that clientele but our statistics did not drop. One reason for more clients is a high number of **64** "Consumer Rights" complaints. We suspect this is a direct result of budget crunch. The complaints are listed here: 16 people: insufficient case management; 11 people: no clinician assigned or inappropriate clinician change; 5 people: want a clinician change; 6 people: needed second opinion; 4 people: unhappy with client/clinician relationship; 4 people: clinician not helping them transfer services; 4 people: clinician terminated services inappropriately; 4 people: have insufficient services to remain stable; 3 people: denied consumer rights at crisis beds or evaluation & treatment facility; 2 people: insufficient needs assessment or incorrect treatment plan; 1 person: provider not easing standards for client during emergency; 1 person: insufficient treatment in an intensive outpatient program; 1 person: too much paperwork and too many release forms; 1 person: disputed diagnosis; 1 person: right to choose provider. We recommend provider agencies take note of these complaints and focus on consumer rights.

SLIDE 12: Information:

- We applaud the "fee for services" system the region has converted to! Now that we have used that system for several years, the consumer voice tells us it simply provides better service to community mental health program clients.

- This is an update to our last report in which we informed you how a Washington resident gets their rights to bear firearms back in after an involuntary commitment. We noted that the process is fairly expensive (approximately $300 to go through all the procedures). This reporting period we had the opportunity to follow the process up to the Federal level at the

FBI's National Instant Criminal Background Check System (NICS) Department. There we learned the importance of "The NICS Improvement Amendments Act of 2007," NICS transaction numbers, unique personal identification numbers, and the necessity to get the department of Behavioral Health & Recovery involved. The entire process is quite a challenge.

- DSHS has a program for children (through Molina Healthcare) entitled the "Washington State Children's Health Insurance Program." The program allows 20 hours of outpatient mental health treatment, a psychiatrist, meds, unlimited psychiatric testing and crisis coverage at Children's Hospital. Recently, Medicaid-covered children have been eliminated from the program, causing anxiety in some of our Snohomish families.

- We fear the quality of the two annual Washington Institute for Mental Health Research and Training (WIMHRT) annual consumer satisfaction surveys (one on adults and one on children) may be lessened due to WIMHRT not having the staff to conduct thorough surveys. Those surveys are quite valuable in expressing the client voice.

- A client informed us about a traffic camera pointed directly at the entrance of a provider agency. It recorded him entering services there and displayed it on the internet. The client alleged that his ex-spouse sent images of him entering the facility to his business associates and customers, which caused him a good deal of harm. The camera is pointed away now.

- Ombuds & QRT have actively supported Skagit Valley College's Human Services program by providing the opportunity to four students this period to do practicum work, and gain knowledge and experience in the community mental health program.

AGENCY COMPLAINTS, GRIEVANCES, ADMINISTRATIVE HEARINGS & APPEALS
Spring, 2011

Compass Health, Marysville: 2 Occurrences (**23** last period)
Physicians & Meds: **1**
Svs Coordination/Intensity: **1**

Compass Health, Whidbey: 19 Occurrences (**6** last period)
Access: **2**
Consumer Rights: **3**
Dignity & Respect: **1**
Other Type Complaint: **1**
Physicians & Meds: **4**
Svs Coordination/Intensity: **2**
Provider-level Grievance: **1** (Consumer Rights: **1**)
RSN-level Grievances: **5** (Access: **1**; Physicians & Meds: **2**; Svs Coordination/Intensity: **1** Other Type Complaint: **1**)

Compass Health, Lynnwood (Children & Adults): 7 Occurrences (**18** last period)
Access: **1**
Consumer Rights: **1**
Dignity & Respect: **1**
Physicians & Meds: **1**
Svs Coordination/Intensity: **1**
Provider-level Grievance: **2** (Consumer Rights: **1**; Dignity & Respect: **1**)

Compass Health, Mount Vernon: 20 Occurrences (**9** last period)
Access: **3**
Consumer Rights: **4**
Dignity & Respect: **1**
Financial: **1**
Housing: **5**
Other Type Complaint: **1**
Physicians & Meds: **1**
Svs Coordination/Intensity: **1**
Unreturned Phone Calls: **1**
Provider-level Grievance: **2** (Consumer Rights: **1**; Dignity & Respect: **1**)

Compass Health, Everett: 48 Occurrences (**19** last period)
Access: **2**
Consumer Rights: **11**
Dignity & Respect: **8**
Emergency Services: **1**
Housing: **1**
Other Type Complaint: **6**
Physicians & Meds: **8**

Participation in Treatment: **1**
Quality Appropriateness: **1**
Svs Coordination/Intensity: **3**
Unreturned Phone Calls: **2**
Violation of Confidentiality: **1**
Provider-level Grievance: **3** (Consumer Rights: **1**; Dignity & Respect: **1** Other Type: **1**)

Compass Health, Snohomish 5 Occurrences (**0** last period)
Consumer Rights: **1**
Housing: **2**
Svs Coordination/Intensity: **2**

Compass Health, Monroe 4 Occurrences (**0** last period)
Consumer Rights: **1**
Emergency Services: **1**
Physicians & Meds: **1**
Svs Coordination/Intensity: **1**

Compass Health, Smokey Point 1 Occurrence (**1** last period)
Svs Coordination/Intensity: **1**

Compass Health Payee Office: 4 Occurrences (**4** last period)
Financial: **3**
Other Type Complaint: **1**

Compass Residences: 0 Occurrences (**1** last period)

Mukilteo Evaluation & Treatment Center: 6 Occurrences (**5** last period)
Consumer Rights: **2**
Emergency Services: **4**

Snohomish PACT: 15 Occurrences (1**9** last period)
Consumer Rights: **4**
Financial: **1**
Other Type Complaint: **1**
Physicians & Meds: **2**
Svs Coordination/Intensity: **2**
Provider-level Grievance: **5** (Unreturned phone calls: **1**; Svs Coordination/Intensity: **1**; Dignity & Respect: **1** Physicians & Meds: **1**; Participation in Treatment: **1**)

Interfaith: 3 Occurrences (**3** last period))
Consumer Rights: **1**
Physicians & Meds: **2**

Sea Mar, Mount Vernon: 12 Occurrences (**7** last period)
Access: **1**

Consumer Rights: **7**
Dignity & Respect: **2**
Other Type Complaint: **1**
Physicians & Meds: **1**

Sea Mar, Everett: 2 Occurrences (**0** last period)
Consumer Rights: **1**
Physicians & Meds: **1**

Sea Mar, Monroe: 0 Occurrences (**4** last period)

Sea Mar, Bellingham: 3 Occurrences (**0** last period)
Access: **1**
Dignity & Respect: **1**
Svs Coordination/Intensity: **1**

Sunrise Services, Everett: 18 Occurrences (**26** last period)
Access: **3**
Consumer Rights: **5**
Dignity & Respect: **2**
Emergency Services: **1**
Housing: **1**
Other Type Complaint: **1**
Physicians & Meds: **1**
Svs Coordination/Intensity: **2**
Transportation: **1**
Provider-level Grievance: **1** (Services Coordination/Intensity: 1)

Sunrise Services, Mount Vernon: 2 Occurrences (**6** last period)
Consumer Rights: **1**
Physicians & Meds: **1**

Lake Whatcom Center: 27 Occurrences (**30** last period)
Access: **1**
Consumer Rights: **4**
Financial: **3**
Housing: **3**
Other Type Complaint: **2**
Physicians & Meds: **10**
Residential: **2**
Svs Coordination/Intensity: **1**
Violation of Confidentiality: **1**

Whatcom Counseling & Psychiatric Clinic: 12 Occurrences (**18** last period)
Consumer Rights: **5**
Dignity & Respect: **3**

Housing: **3**
Physicians & Meds: **1**

Bridgeways: 21 Occurrences (**8** last period)
Access: **3**
Consumer Rights: **7**
Housing: **2**
Physicians & Meds: **2**
Svs Coordination/Intensity: **3**
Provider-level Grievance: **2** (Consumer Rights: **1**; Svs Coordination/Intensity: **1**)
RSN-level Grievances: **2** (Consumer Rights: **1**; Svs Coordination/Intensity: **1**)

Catholic Community Services Mount Vernon: 3 Occurrences (**1** last period)
Access: **1**
Consumer Rights: **1**
Svs Coordination/Intensity: **1**

Catholic Community Services, Everett: 0 Occurrences (**1** last period)

St. Joseph Hospital: 5 Occurrences (**5** last period)
Access: **2**
Dignity & Respect: **1**
Emergency Services: **2**

Skagit Valley Hospital: 3 Occurrences (**4** last period)
Dignity & Respect: **1**
Emergency Services: **2**

Fairfax Hospital: 1 Occurrences (**4** last period)
Emergency Services: **1**

Providence Hospital: 1 Occurrences (**0** last period)
Emergency Svs: **1**

Valley General Hospital (Monroe): 1 Occurrence (**3** last period)
Dignity & Respect: **1**

Snohomish Designated Crisis Responders: 1 Occurrence (**3** last period)
Dignity & Respect: **1**

Skagit Designated Crisis Responders: 5 Occurrences (**0** last period)
Consumer Rights: **1**
Dignity & Respect: **2**
Emergency Svs: **1**
Participation in Treatment: **1**

Stevens Hospital: 2 Occurrences (**1** last period)
Housing: **1**
Svs Coordination/Intensity: **1**

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

VoA (Access Line, Gatekeeper & Care Crisis Line): **4 Occurrences** (**1** last period)
Access: **2**
Dignity & Respect: **1**
Emergency Svs: **1**

Hopelink (Medicaid Transportation) **3 Occurrences** (New agency)
Consumer Rights: **1**
Transportation: **2**

Lummi Indian Health 2 Occurrences (**0** last period)
Svs Coordination/Intensity: **1**
Dignity & Respect: **1**

NSMHA: 23 Occurrences (**10** last period)
Access: **7**
Consumer Rights: **3**
Dignity & Respect: **1**
Housing: **2**
Quality Appropriateness: **1**
Other: **3**
Physicians & Meds: **3**
Svs Coordination/Intensity: **2**
Transportation: **1**

DBHR: 1 Occurrence (**0** last period)
Other: **1**

Non-community mental health program agencies: 0 Occurrences (**26** last period)

Ombuds 2010 Outreach

January:	Outreach Date:
North Sound Mental Health Administration (NSMHA)	(1-4-10)
Skagit Community Action Agency leadership meeting*	(1-5-09)
NSMHA Advisory Board*	(1-5-10)
Compass Health, Mount Vernon	(1-5-10)
Skagit Human Services program	(1-6-10)
Skagit NAMI leadership	(1-6-10)
Skagit Valley College Human Services Department	(1-11-10)
Peer Connections Center Skagit Drop-In Center **	(1-12-10)
Silverwood (clients') Apartments, Anacortes, WA	(1-20-10)
Low Income Needs Assessment meeting--Community Action Agency	(1-21-10)
NSMHA Crisis Services System Review Committee	(1-22-10)
Lake Whatcom Center Residential & Treatment Center	(1-26-10)
NSMHA Quality Management Oversight Committee*	(1-26-10)
Compass Health, Everett (Cliff Bailey Building, Everett)	(1-28-10)
February:	
State Ombuds and Division of Behavioral Health & Recovery	(2-1-10)
Volunteers of America	(2-4-10)
Skagit County Coalition to End Homelessness	(2-10-10)
Compass Health, Whidbey Island (Coupeville)	(2-11-10)
Meeting with Regional Health Care Assess Interviewer	(2-11-10)
Meeting with Northern Region Long-Term Care Ombudsman*	(2-24-10)
March:	
Skagit Elder Alliance*	(3-4-10)
Training on Suicide (Seattle)	(3-19-10)
Whatcom Counseling & Psychiatric Clinic	(3-23-10)
Anacortes Police Department	(3-29-10)
April:	
Skagit Manor Apartments, Mount Vernon, WA	(4-7-10)
Skagit County Youth Detention Facility	(4-13-10)
Molina Healthcare Clinic (in Cliff Bailey Building, Everett)	(4-15-10)
Meeting with NSMHA Care Coordinators	(4-27-10)
May:	
Dispute Resolution Center	(6-6-10)
Skagit Community Action Agency Quality Committee meeting*	(5-11-10)
Skagit County Senior Information & Assistance	(5-12-10)
Skagit Valley College--Oak Harbor, WA campus	(5-13-10)
Skagit Community Action Agency Volunteer Center Grand Opening	(5-26-10)
Meeting with Washington State Department of Health representative	(5-27-10)

* Monthly outreach event
** Quarterly outreach event

June:

Snohomish County Law Enforcement Critical Intervention Training	(6-7-10)
State Ombuds and Division of Behavioral Health & Recovery	(6-8-10)
External Quality Review Team (EQRO)	(6-8-10)
NSMHA Board of Directors semiannual presentation	(6-10-10)
Lake Whatcom Center (Silver Beach office)	(6-21-10)
Sunrise Community Services	(6-28-10)
Meeting with NSMHA Dignity and Respect Workgroup*	(6-29-10)

July:

Snohomish County Mental Health Advisory Board	(7-12-10)
Meeting with Fairfax Hospital representative	(7-14-10)

August:

NSMHA Performance Improvement Project workgroup meeting*	(8-19-10)
Catholic Community Services – Skagit office	(8-23-10)
Systems of Care Training Institute on Children & Families) at WWU	(8-25-10)
Skagit Valley College President, Advisors and Legal Counsel	(8-30-10)

September:

Sea Mar, Skagit	(9-13-10)
Meeting with Skagit Valley College Human Services program	(9-20-10)
Participation on NMSHA's Dignity & Respect Working Group*	(9-21-10)

October:

NAMI Whatcom event: St. Luke's Community Resource Center	(10-4-10)
Meeting with therapists and ARIS (At Risk Youth program)	(10-14-10)
Silverwood (clients') Apartments, Anacortes, WA	(10-14-10)
Compass Health, Lynnwood	(10-28-10)

November:

Skagit Community Action Agency Health Fair	(11-1-10)
Meeting with Skagit Developmental Disabilities representative/ARC	(11-4-10)
Meeting with Disability Rights-Washington	(11-8-10)

December:

Meeting with NSMHA & Skagit County providers about crisis & stabilization	(12-2-10)
NSMHA Board of Directors semiannual presentation	(12-9-10)
Meeting with Skagit County Community Jobs representative	(12-13-10)
Skagit Community Action Agency Board of Directors	(12-16-10)
Lake Whatcom Center (Silver Beach office)	(12-22-10)
Bridgeways, Everett	(12-28-10)

* Monthly outreach event
** Quarterly outreach event

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.

NSMHA COMMITTEE DISCUSSION FORM

AGENDA ITEM: Intake appointment scheduling for individuals discharging from WSH

PRESENTER: Charissa Westergard

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

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:

In order to discharge an individual from WSH on a court order, the WSH liaisons need to have an intake appointment date to include on the court paperwork prior to going to court. However, due to the way we currently handle intake appointments, when the discharge date is not solid the liaisons are having difficulty scheduling an intake appointment.

CONCLUSIONS/RECOMMENDATIONS:

NSMHA proposes that scheduling of any intake for an individual discharging from WSH be handled in the same way as someone discharging to a residential facility from WSH. This process is proposed as follows:

1. WSH Liaison contacts the VOA Access Line and provides required information, which VOA retains in a pending file.
2. WSH Liaison is transferred to a CMHA to schedule the intake appointment.
3. On the day the individual discharges from WSH, the liaison notifies VOA and the pending file is transferred to the designated CMHA starting the Request for Service and related timelines.
4. The WSH Liaison shall continue working with the CMHA regarding changes to discharge dates that result in a need to change the intake appointment.

TIMELINES:

This has been an ongoing issue that NSMHA would like to resolve and obtain agreement on at this meeting.

ATTACHMENTS:

None

NSMHA COMMITTEE DISCUSSION FORM

AGENDA ITEM: 2011 Routine Utilization Review (UR) Results

PRESENTER: Charissa Westergard

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

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:

NSMHA conducts utilization review at provider agencies to determine if individuals are getting the right type and amount of services at the right time. We review standards related to eligibility, treatment planning, coordination of care, whether recovery/resiliency are being incorporated into service delivery, etc. Providers are currently in remedial action for deficiencies noted in late 2010 and all have submitted Corrective Action Plans to address these issues. Due to the close proximity of the 2010 and 2011 reviews, no additional remedial action is planned for 2011. NSMHA updated the Routine UR Tool for 2011 primarily due to WAC revisions that occurred in 2010. The tool is comprised of 61 standards all of which were reviewed at each provider during January-March 2011.

CONCLUSIONS/RECOMMENDATIONS:

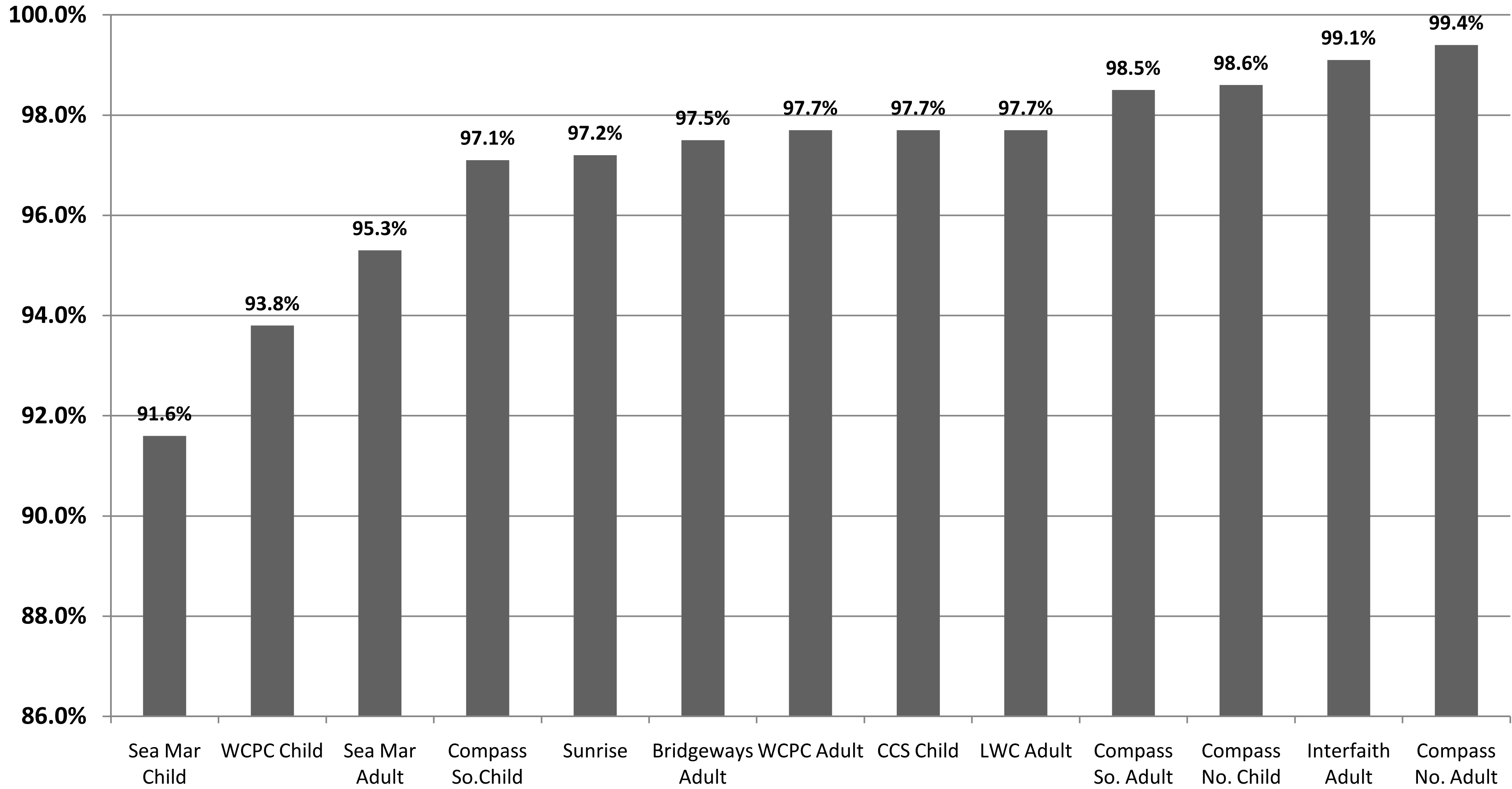
- All providers aggregate compliance rates were above 90%
- Deficiencies noted from the 2011 are noted on the attachment by provider (see attachment). A significant number of those standards noted below 90% were above 80%.
- 2010 & 2011 deficiencies are expected to be improved in the 2012 review cycle.
- The 2012 UR Tool is under revision, but will be very similar to the 2011 tool barring any additional revisions that may arise during the remainder of 2011 (e.g., WAC revisions).

TIMELINES:

Next Routine UR planned for January – March 2012

ATTACHMENTS:

2011 Routine UR Data


OVERALL UTILIZATION REVIEW QUESTION COMPLIANCE RATE
JAN - MAR 2011
BY PROVIDER
100.0%
98.0%
96.0%
94.0%
92.0%
90.0%
88.0%
86.0%
91.6%
93.8%
95.3%
97.1%
97.2%
97.5%
97.7%
97.7%
97.7%
98.5%
98.6%
99.1%
99.4%
Sea Mar Child
WCPC Child
Sea Mar Adult
Compass So.Child
Sunrise
Bridgeways Adult
WCPC Adult
CCS Child
LWC Adult
Compass So. Adult
Compass No. Child
Interfaith Adult
Compass No. Adult

UR QUESTIONS SCORING LESS THAN 90% BY PROVIDER JAN - MAR 2011

	UR QUESTION	Regional	Sea Mar Child	Sunrise Adult	WCPC Child	Sea Mar Adult	WCPC Adult	Bridgeways Adult	Compass So. Adult	CCS Child	Compass So.Child	LWC Adult	Compass No. Child	Compass No. Adult	Interfaith Adult
1	The intake was provided by a mental health professional		85%												
2	The determination of eligibility is consistent with the NSMHA Clinical Eligibility & Care Standards (CECS)		82%												
5	If during intake the consumer reports having no PCP, a referral to a PCP was offered	84%	80%	71%	0%	80%	83%		70%			85%			
7	The intake is culturally relevant and contains a description of the individual's self-identified culture											88%			
8	The intake documents referral for provision of emergency/crisis services, consistent with WAC 388-865-0452, if indicated in the risk assessment.			0%											
9	The intake recommends a course of treatment		33%												
13	The chart contains a Recovery/Resiliency Plan (RRP)				89%										
14	An RRP was developed within 30 days of the first ongoing appointment		73%		76%	81%		84%							
15	Goals for treatment are based on identified needs		88%		80%	81%		84%	89%	81%	84%				
16	The RRP includes goals or objectives that are measurable and that allow the provider and individual to evaluate progress toward the individual's recovery goals				89%										
18	The RRP was developed collaboratively with the individual, or the individual's parent or other legal representative if applicable					85%									
19	The RRP includes roles of family members/natural supports in supporting/augmenting the resiliency/recovery goals included in the plan as requested by the individual			67%				83%	33%						81%
20	With the individual's consent, or their parent or other legal representative if applicable, the RRP includes coordination with any systems or organizations the individual identifies as being relevant to their treatment		71%		78%			67%			81%				
21	The treatment proposed/provided is consistent with NSMHA clinical guidelines (Note: In the absence of a NSMHA clinical guideline, generally accepted clinical practice for the individual's diagnosis)		80%		82%						86%				
23	The RRP is strength-based				88%		85%	85%			88%				
24	The RRP reflects each individual's unique cultural identity						89%								
25	If the individual is assessed as having drug/alcohol issues, there is an appropriate plan to address them								86%						
26	If the individual is assessed as suffering from chronic physical pain, there is a plan to address that pain	84%		89%		77%	80%	71%	88%					75%	
27	A CA/LOCUS has been done at the review date or when clinically indicated (NSMHA)				88%	88%				75%					

	UR QUESTION	Regional	Sea Mar Child	Sunrise Adult	WCPC Child	Sea Mar Adult	WCPC Adult	Bridgeways Adult	Compass So. Adult	CCS Child	Compass So.Child	LWC Adult	Compass No. Child	Compass No. Adult	Interfaith Adult
31	**There is sufficient evidence to support the most recent diagnoses, including provisional diagnoses, identified in the clinical record**		70%	87%											
38	**The clinical record reflects intensity and frequency of interventions that correspond with the individual's needs and severity of symptoms and vary over time as appropriate**											89%	86%		
40	**If the individual has repeated cancellations and/or "No Shows" or has not engaged, there is evidence that the intensity of the efforts to re-engage the individual were congruent with the individual's identified need/risk**		75%		69%		86%			80%			77%		
42	**When required (LOC 4 and up), requested or clinically indicated, a crisis plan exists**		67%		75%	78%	83%			83%					
43	**The crisis plan includes early warning signs of decompensation (NSMHA)**			89%											
44	**The crisis plan clearly defines a process by which to contact formal and/or informal supports including how to connect the consumer/family directly to the Contractor's emergency crisis intervention services (NSMHA)**			82%		80%									
46	**The crisis plan focuses on family/others health and safety (NSMHA)**					67%									
47	**The crisis plan includes individual's roles, directives, and responsibilities (NSMHA)**			89%											
49	**The crisis plan includes proactive and progressive measures to divert or prevent crisis (NSMHA)**			80%								89%			
51	**Referral for medication evaluation is provided when clinically indicated**		50%							82%					
54	**The clinical record contains an informed consent to medications form, which includes possible side effects to the type of medication prescribed, in a language that is understandable to the individual**		67%	87%			80%	86%					82%		
58	**The clinical record inclusively contains the medications effects, interactions (if any), and the side effects (if any) that staff observe or the side effects (if any) the individual reports**						89%								
60	**There is evidence of communication between the prescribers of the delineated psychiatric & non-psychiatric medications**		50%												
	Below 90% regionally														

NSMHA COMMITTEE DISCUSSION FORM

AGENDA ITEM: Process for Collecting Additional Intake Information

PRESENTER: Charissa Westergard

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

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:
On occasion during the denial reviews, appeals and/or grievances, a decision is made to authorize services as the intake documentation has not adequately ruled out the existence of a qualifying diagnosis. This is often due to things such as lack of collateral information or differential diagnosis. However, authorizing these individuals for 6 months to a year of routine services to get diagnostic clarification seems to be an inefficient use of resources. In many cases, scheduling an additional intake appointment or having additional time to obtain collateral information may be enough to clarify the issues in order to make a more informed determination about eligibility.

CONCLUSIONS/RECOMMENDATIONS:
Providing even a brief authorization to clarify diagnosis could prove problematic as identified at March QMOC. NSMHA proposes simply using additional time (an extension of 14 calendar days) to either see the individual again or obtain collateral documentation and then document the reason for delay. While this process has the potential to extend an individual's first ongoing appointment beyond 28 days (should they be found eligible), NSMHA believes that documenting these delays specifically should be sufficient to address contractual obligations as the expectation is that this process should be used minimally.

TIMELINES: NSMHA staff is requesting action at this meeting.

ATTACHMENTS: None

NSMHA COMMITTEE DISCUSSION FORM

4-20-2011

AGENDA ITEM: RFQ for Outpatient Services-Clinical Design Improvements

PRESENTER: Greg Long

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

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:

It has been nearly 5 years since NSMHA went through the formal clinical design process prior to releasing an RFQ for outpatient services. NSMHA has been directed by its Board to begin planning for another RFQ for Outpatient Services. Several potential new providers from around the region have expressed interest in contracting with NSMHA. The current plan of NSMHA for the RFQ Process is as follows:

- Develop an RFQ for release in November 2011,
- Submission in late January 2012,
- Selection of providers by May 2012, and
- New contracts begin in October 2012

During the previous RFQ Process, NSMHA conducted an extensive clinical design and financial design process. NSMHA believes that consumers, advocates, providers and our other stakeholders are relatively satisfied with the changes that came out of the last RFQ. The current recession and government budget deficits make significant expansions of services impossible.

NSMHA would like to collect input from QMOC Members and others regarding any potential clinical design change that you would recommend be built into the new RFQ. The following two agenda items, Emergency Psychiatric Medications and Motivational Interviewing are two issues that NSMHA staff has brought up as potential items to somehow build into the RFQ. Other areas under consideration include improved outcome and performance measures.

CONCLUSIONS/RECOMMENDATIONS:

- NSMHA would like to collect recommendations at this meeting and the next QMOC Meeting regarding clinical design considerations.
- This issue will also be taken to the NSMHA Integrated Provider meeting in May.

TIMELINES: Bring ideas to this meeting or the May 25 QMOC Meeting.

ATTACHMENTS: None

NSMHA COMMITTEE DISCUSSION FORM

4-20-2011

AGENDA ITEM: Emergency Psychiatric Medication Availability

PRESENTER: Greg Long

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

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:
NSMHA receives persistent complaints from consumers, family members, advocates, EDs, and inpatient units that psychiatric prescribers and psychiatric medications are not easily available on an immediate or urgent basis within the NSMHA regional mental health system.

It is claimed that people go unnecessarily to the ED or are even hospitalized when immediate access to a psychiatric prescriber and medications would resolve the issue. The crisis system has some limited emergency medication time available. The perception is that it is hard to access and usually not available. There is not firm data on how often this is a problem. NSMHA would like information on this.

Psychiatric prescribers are a challenge to find, hire and retain. They are also very expensive. The fully loaded cost for a psychiatrist in the NSMHA regional mental health system is about $325/hr and an ARNP with prescriptive authority is about $280/hr. This scarce and valuable resource must be used effectively and efficiently.

There are also difficulties regarding continuity of care with emergency medications. It is pointless for a prescriber to prescribe a medication, if the consumer cannot afford it. Emergent prescribers need to know before prescribing that there will be follow-up monitoring of the medication by a prescriber.

CONCLUSIONS/RECOMMENDATIONS:
This is a complex and expensive problem and is really a nation-wide issue. NSMHA staff is inviting creative solutions to this problem.

- Should this be built into the RFQ in some way?
- Is there a region-wide solution rather than a single provider solution?
- Is there a cross-system solution?

TIMELINES:
NSMHA welcomes input at QMOC in April or May or at the May Integrated Provider Meeting.

ATTACHMENTS: None

NSMHA COMMITTEE DISCUSSION FORM

4-20-2011

AGENDA ITEM: Improving Risk Assessments

PRESENTER: Greg Long

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

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:
This discussion is to conclude the recent discussions on Risk Management for the time being, but it should be reviewed in a year. At the last two QMOC Meetings, NSMHA presented the concern that risk assessments were very limited in clinical records. Typically, most provider risk assessments focus on just suicide, homicide, and violence risk. Risks are usually just checked off in boxes for current risk and historical risk. There are many other types of risk besides these three.

A second concern was there tends to be little or no analysis or summary of the risks. Hence, it is frequently difficult for others to know from the records the severity of the risk.

NSMHA asked in that providers take these concerns back to their provider Quality Management and Risk Management Committees in February for review and recommendation. In March, providers gave brief overviews on what their agencies are doing or planning to do regarding risk assessment. Most providers were reviewing their processes and some were thinking of making quality improvements. NSMHA reviewed this topic internally and developed the recommendations below.

CONCLUSIONS/RECOMMENDATIONS:
NSMHA hopes that providers will be willing to share their changing policies and documents regarding risk assessment in the future. NSMHA will request in six months that providers submit their policies and documents regarding risk assessment and then NSMHA will distribute them in a packet to encourage on-going quality improvement.

TIMELINES:

- NSMHA will request and redistribute risk management policies and paperwork in six months.
- NSMHA will review this topic in a year at QMOC

ATTACHMENTS: None

NSMHA COMMITTEE DISCUSSION FORM

4-20-2011

AGENDA ITEM: Motivational Interviewing

PRESENTER: Greg Long

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

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:
Motivational Interviewing is an evidence-based practice aimed at assisting individuals to engage in treatment and in changing their behaviors. It emerged from the alcohol and drug treatment field over the last 15 years and has now spread to mental health and physical health care treatment. It is respectful of consumer dignity while showing good results in engaging consumers who are at best ambivalent about treatment to make positive changes. Learning these skills is one step towards more integration with the alcohol and drug field and to a lesser extent with physical health care.

Successfully engaging consumers is an ongoing challenge in the public mental health system. There is a rapid and high drop-out rate in public mental health services across the nation. Constructive handling of consumer resistances is another challenge in the system. The public mental health system also employs a large number of inexperienced mental health workers who change jobs rapidly. Having evidence-based practices encourages consistent, quality care in an under-funded system.

Motivational Interviewing is a teachable set of treatment skills. Training has been offered by DBHR, Compass Health, and other training agencies. There are books, manuals and even supervisors guides aimed at teaching this practice. Research shows that it is a year-long effort at least to implement this practice on a systemic basis. Experience and research demonstrates that introducing and maintaining a fidelity-based practice is a process that requires concerted and ongoing efforts.

CONCLUSIONS/RECOMMENDATIONS:
NSMHA staff believes that the introduction of Motivational Interviewing techniques on a wide-spread basis in our system would lead to better engagement of consumers, better outcomes in treatment, higher employee satisfaction, and probably fewer complaints and grievances. NSMHA would like to discuss the following:

- Do consumers, family members, advocates, providers and cross-system partners think this technique should be introduced on a wide-spread basis?
- What would be the best way to disseminate these skills?
- Should NSMHA consider providing training?
- Should NSMHA consider providing supervisory training?
- Should NSMHA build this into the RFQ as an expectation in some way?

TIMELINES:
NSMHA would like recommendation on this topic at either the April or May QMOC Meeting.

ATTACHMENTS: None