NORTH SOUND
MENTAL HEALTH ADMINISTRATION

QUALITY MANAGEMENT OVERSIGHT COMMITTEE

MEETING PACKET

June 22, 2011

1. Please join my meeting.
https://www3.gotomeeting.com/join/740534966

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

Dial +1 (312) 878-3070
Access Code: 740-534-966
Audio PIN: Shown after joining the meeting

Meeting ID: 740-534-966

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: June 22, 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 • Motivational Interviewing • Consumer Satisfaction Study • Peer Counselor Guidelines • Address changes	Inform /discuss	All				*5 min*
Evaluation forms from last meeting, if any	Discuss feedback, if any.		Chair/ Greg				*5 min*
Comments from the Chair			Chair				*3min*
Advisory Board Report							*3Min*
Quality Topics							
Expedited Assessments	Inform/discuss	Inform/ discuss	Terry/ Greg	Committee Discussion Form		**3**	*5 min*
MPC Policy #1576	Inform/Discuss	Action Requested	Terry	Committee Discussion Form		**4**	*10 min*
2011 CIRC P & P #1009 Revision	Discuss and act. This is a change requested by DBHR and should have no effect on providers.	Action Requested	Kurt/ Greg	Committee Discussion Form		**5**	*5 min*
Performance Measures	Inform/discuss	Discussion	Diana			**6**	*15min*
PIPs Update			Charissa	Committee Discussion Form		**7**	*15 min*
Clinical Guidelines	Discuss and Action		Greg	Committee Discussion Form		**8**	*15min*
Access to outpatient Services for people discharging from WSH	Discuss and act on	Action Requested	Greg	Committee Discussion Form		**9**	*10min*

Short-Term Treatment for Level 1 & 2 Consumers	Continue discussion on how to present and manage care to Level 1 & 2 consumers so it is short-term and recovery oriented.	Discussion	Mike Manley/ Greg Long		Committee Discussion Form	**10**	*15min*
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: July 27, 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
May 25, 2011
1:00 – 3:00 pm
MEETING SUMMARY

PRESENT: Rebecca Clark, Skagit County; Chuck Davis, Ombud; Richard Sprague, Interfaith; Stacey Alles, Compass; Heather Fennell, Compass; Carol Van Buren, Sunrise; Cammy Prince, Sunrise; Mike Manley, Sunrise; Mark McDonald, NSMHA Advisory Board; Candy Trautman, NSMHA Advisory Board; Fred Plappert NSMHA Advisory Board; Anne Deacon, Whatcom County; Susan Schoeld, Snohomish Co; Kathy McNaughton, CCS; and Susan Ramaglia, NAMI Skagit.
BY PHONE: Kay Burbidge, LWC; Cindy Ainsley, bridgeways; Pam Benjamin, WCPC; and David Small, Sea Mar.
NSMHA STAFF: Greg Long, NSMHA; Diana Striplin, NSMHA Charissa Westergard, NSMHA and Barbara Jacobson, NSMHA, recording.
ABSENT: Terry Gallagher, NSMHA Advisory Board.

OTHERS PRESENT:

TOPIC	DISCUSSION	ACTION
1. **Introductions, Review of Agenda – Chair**	Anne convened the meeting at 1:03 pm and introductions were made. Additions to the agenda were called for and none are mentioned.	
2. Previous Meeting Summary – Chair	Anne asked for any corrections/amendments to the previous meeting summary; with none a motion was made to approve as submitted.	Summary approved as submitted.
3. Announcements and Updates – All	• Care in using email with Personal Health Information (PHI). Greg noted that Chuck D brought this up; we need to be mindful of client info as not all have secure email. Susan S stated also not to reply to an email with PHI without redacting.	Informational
4. Evaluation Forms from Last Meeting – Chair/Greg	Anne reviewed the responses from the last meeting; there were four received with marks in the 4 and 5 range.	Informational
5. Follow up on Old Business –	• Motivational interviewing training was discussed at Planning Committee last Friday. There were two options for the training proposed though no quorum was available to vote. • RFQ for outpatient services was also discussed at the Planning Committee meeting last Friday with providers wanting to delay the release of the RFQ. These items will be reviewed again at Planning on Friday June 3rd, 12:30 to 2:00pm.	Informational
6. Comments from the Chair – Anne Deacon	*Anne noted that it was raining and she washed her car.*	Informational
7. Reengagement guidelines	Charissa noted that the guidelines around the 30 day letter were vague and it was requested they be looked at. The proposal from NSMHA is on the discussion form and feedback is being sought today. Chuck D noted that client and agency go around in circles around reengagement and the 30 day letter let them know what was going on. Also when a case manger leaves it takes too long to	Send out revised policy for review.

	reassign clients and they get dropped. The 30 day letter gives them a chance to act on it. Currently the 30 day letter is required of all levels and Stacey noted that she objects to Chuck's statement that providers drop clients all the time and Chuck agreed his wording of all the time is not accurate. He noted that the 30 day letter is very important for clients. Kathy M noted that providers asked NSMHA to look at the requirement of the 30 day letter as they strive to manage the back door and the pressure around this. Greg noted we are trying to streamline by exiting clients more rapidly if they would like. Greg stated the vast majority just stop coming and believes they make this choice though it creates uncertainty on providers and slows down things. Carol V discussed the Discontinuation of Services letter that Sunrise uses that client and clinician both sign when the client wants to end services that goes in their file. Stacey noted that though it seems to work it is not compliant. Richard stated the letter protects his agency especially in regards to meds and lets client know what they must do and that Interfaith would continue this even if the policy changes. Rebecca suggested a shorter time period of perhaps 10 or 15 days notice and does not like requiring the letter on basis of LOCUS level alone. Stacey noted there is a difference between the ones we want to engage and those who want to leave; loosening the policy gives providers judgment on this. After discussion the recommendation is to go with this proposal after the no letter/additional re-engagement efforts bullet is removed. If it is a voluntary drop documentation in the chart must back this up. Charissa noted this will be incorporated into policy 1540 as a draft and sent out with 30 days to review.	
8. System recommendations	Diana noted that these are recommendations that come from the grievance system and usually go on the Exhibit N report. The attached have been through the Leadership Team. The first is a current recommendation with the rest being ongoing recommendations. • NSMHA recommends that there is consultation with a consumer's current prescriber during the assessment process prior to recommending a denial if the consumer is currently taking psychiatric medications. The second part is to include a list of medications with a denial for the NSMHA reviewers. She would like the committee's approval on this recommendation. There is discussion around timelines as trying to consult with the prescriber's office can bump up against timelines. It was noted that timelines cannot be violated and that the policy should be clear, not contradictory. It was agreed that providers would seek this information if they plan to issue a denial; ask for an extension if needed and clearly document the why if information was unable to be obtained. This way the concern over timelines and corrective action could be avoided.	Approval to continue this new recommendation.

	• Diana noted that risk assessment had been addressed already in QMOC. • Letters of termination had been addressed in QMOC and Diana noted that she will be sending a letter to all providers that they ensure that services are continued in any grievance process. • The Dignity and Respect workgroup that was formed had been meeting and came up with three recommendations. A campaign that will include updates to our website, a toolkit and an organizational self assessment. • There has been a PIP developed around medication management. • NSMHA will work towards developing a method to collect data on notice of action and notice of adverse determination; with grievance process elements added later.	
9. Access to crisis beds	Greg noted that sometimes the crisis system is not always well connected to the outpatient system and wanted the public to know that the crisis stabilization centers have been redesigned and policies have been redesigned to make it easier to get consumers in. We want to encourage all of your outpatient programs to consider the crisis stabilization beds whenever possible. He noted the correct phone number for Larry Van Dyke is **360.757.7738** and he will resend the memo with the corrections. Another large change is that Skagit and Snohomish counties are working on being able to accept direct referrals from law enforcement. Fred P noted that 1170 passed and Greg stated that this will allow Snohomish Co. to do 12 hr. detentions and have locked doors which law enforcement really appreciates. Rebecca noted that you do not have to go through VOA to access; though Greg noted that the best way is through VOA and this is what the current policy states.	Informational Send out memo with corrected contact phone number for Skagit.
10. Emergency Psychiatric Medication	This topic was discussed last month at QMOC and at the integrated provider meeting on May 13th. The issue mostly is improving consultation services to encourage PCPs to prescribe these meds and we are still looking for input. Emergent can mean different things depending on type of medication and need. Occurs when consumers are not connected to services, discharging from inpatient and enrolled consumers as well. Mike M noted same issues for those flipping between CNP/Molina and spend-down consumers. There was a statement that it should be built into the RFQ only if there is capacity to purchase. Greg noted part of it is how an agency prioritizes spending their funds; we need a shift in processes to come up with solution. Susan S. stated that it would fit as an RFP with dollars set aside to address, not an RFQ. Fred P suggested a workgroup. Anne asked providers of their challenges and what creative things you do that NSMHA could facilitate. Stacey noted they triage based on need and may get someone in sooner. Carol noted they would like to have their own prescribers to provide continuity though it is hard to find prescriber which is a national problem hard to address	Informational

	in region. Anne asked about no shows for initial medication appointments. Kathy M noted they have worked on this and improved. Each provider has a different mix of services and communities. She felt that emergency medication needs to be a system not provider solution and not for an RFQ. Anne asked if a workgroup would help and Kathy M noted only if money were added to purchase services; and that there needs to be a different solution for children and adults. Susan S. noted the PEP phone consult program with Bob Hilts. A statement was made that a regional solution is to set aside money to address this and Greg noted that could be a partial solution. This discussion needs to continue and we need to look at building capacity Anne noted. Candy noted that seeking a PCP that wants to provide this could be a solution as some like providing that service. Looking at family practice Drs to expand their knowledge is a long term solution. Anne suggested that NSMHA look into getting a PCP and Kathy M noted that it would be better to do by county so all PCPs can be comfortable collaborating locally.	
11. Access to outpatient	Greg noted this was discussed at the last meeting and NSMHA has two options to discuss. NSMHA recommends option 2. In option 2 WSH liaisons bypass VOA access and call agency which will create account in Raintree and schedule the appointment though he noted the timeline tracking issue. Susan S asked if feedback was sought from liaisons, and Greg noted they will be alright with it. Stacey noted that because we do not have a date of discharge it is hard to schedule and Greg noted that it is hard to estimate discharge dates. It was suggested that pressure be applied to the judges in Pierce County to change their expectations. Greg stated that this has been tried and has been unsuccessful. Perhaps the order could state that the person will be seen in a timeframe like an expedited assessment. Stacey noted that option 1 is preferred and Interfaith concurs that option puts less burden on them. Greg noted if option one is preferred that is fine. Carol V at Sunrise asked if providers are bypassed and not given chance to serve when VOA is handling and Greg stated no. Greg will send out an email and get further input for next month.	Informational Return to agenda
12. Clinical guidelines	Greg noted that we need two clinical guidelines and NSMHA has four suggested ones listed and would like feedback and suggestions. Susan R. suggested titration. Rebecca asked what are most needed and Greg noted the guidelines are on our website and are mostly diagnostically based with a program one. This will come back next month, send any input to Greg.	Informational Return to agenda

13. Expedited assessment	Deferred.	
14. Open Forum	Fred P. noted that the Behavioral Health Conference is coming up on June 8-10 and the next Advisory Board meeting is June 7th.	
15. Date and Agenda for Next Meeting/Review of Meeting	The meeting was adjourned at 3:02 pm. The next meeting is June 22, 2011– Go to Meeting.	

NSMHA COMMITTEE DISCUSSION FORM

AGENDA ITEM:

- **Expedited Assessment Request (EAR) Six Month report, July through December 2010**

PRESENTER: Greg Long

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

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:

- Most providers either meet or exceed the Regional average for reporting the number of EARs received from VOA and called into NSMHA
- Most providers either meet or exceed the Regional average for sending in the completed EAR to NSMHA for review
- Some providers continue to struggle with the EAR process, both in reporting the number of EARs received from VOA and in sending in completed EARs to NSMHA for review
- Providers are advised to compare themselves to their own average in both EAR categories cited above rather than to the Regional average in both categories because the Regional average is significantly lowered by the scores of Providers who continue to struggle
- Terry McDonough is working with providers whose EAR scores are low to assist them to develop strategies that will improve their scores

CONCLUSIONS/RECOMMENDATIONS:

- Most providers are following the EAR process by reporting scheduled EARs to NSMHA and sending completed EARs to NSMHA for review.
- Terry is working with providers who are struggling with the EAR process.
- Please direct any questions about this EAR report, the EAR process and/or agency specific EAR concerns to Terry McDonough

TIMELINES:

- The next scheduled EAR Report will address the period from January through June 2011.

ATTACHMENTS:

- EAR Six month Report, January through June 2010
- EAR Six month Report, July through December 2010

EAR Narrative Report

July – December 2010

Between July and December 2010, a total of 143 EARs were requested from providers by VOA. This compares with a total of 160 EARs between January and July 2010.

The Regional average for EARs received from VOA and called into NSMHA was 67%. This compares to a Regional average between January and July of 73%.

The Regional average for completed EARs that were sent to NSMHA was 59%. This compares to a Regional average between January and July of 54%.

The Regional average for EARs that were received from VOA and not called in to NSMHA was 32%. This compares to a Regional average between January and July of 27%.

Per NSMHA Policy #1505

- VOA Access receives the Intake request and determines that the request needs to be expedited
- VOA calls the provider agency and requests the EAR
- The provider agency contacts the client and schedules the EAR
- The provider agency calls NSMHA and notifies NSMHA of the EAR, reporting the client name, ID number, date of EAR request, date accepted by the client, location and time of the EAR. NSMHA staff enter all pertinent information in the EAR log
- The provider agency intake clinician FAXs a copy of the EAR to NSMHA for review upon completion
- NSMHA staff review the EAR upon receipt and call the provider back with a decision to uphold or deny the EAR. If NSMHA upholds the request, the provider submits an authorization request to Raintree and contacts the client to schedule their first ongoing outpatient appt. If NSMHA denies the EAR, NSMHA staff send a Notice to the client informing them of the decision and their right to appeal
- NSMHA updates the EAR log to reflect their decision and makes a paperless copy of the EAR

Expedited Assessment Request Six Month Report

January through June 2010

	CH-48	CH-53	WCPC	CCS	Sea Mar	bridgeways	Sunrise Services	Interfaith
# of EAR requests from VOA	26	55	26	21	21	5	4	2
# of EAR's called in to NSMHA **Regional Average: 73%**	23 88%	46 84%	24 92%	21 100%	4 19%	5 100%	4 100%	0 0%
# of EAR's sent to NSMHA **Regional Average: 54%**	13 50%	23 42%	24 92%	19 90%	4 19%	3 60%	3 75%	0 0%
# of EAR's received from VOA but not called in to NSMHA **Regional Average: 27%**	3 12%	9 16%	2 8%	0 0%	17 81%	0 0%	0 0%	2 100%

Expedited Assessment Request Six Month Report

July through December 2010

A total of 143 EARs were requested by VOA

	CH-48	CH-53	WCPC	CCS	Sea Mar	bridgeways	Sunrise Services	Interfaith
# of EAR requests from VOA	24	49	13	12	20	4	18	3
# of EAR's called in to NSMHA	22	48	13	11	1	3	15	0
Regional Average: 67%	92%	98%	100%	92%	5%	75%	83%	0%
# of EAR's sent to NSMHA	16	32	13	10	2	3	14	0
Regional Average: 59%	66%	65%	100%	83%	10%	75%	78%	0%
# of EAR's received from VOA but not called in to NSMHA	3	2	0	1	18	1	3	3
Regional Average: 32%	12%	4%	0%	8%	90%	25%	17%	100%

NSMHA COMMITTEE DISCUSSION FORM

AGENDA ITEM: Revised NSMHA Policy #1576.00
(Medicaid Personal Care)

PRESENTER: Terry McDonough

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

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:

- NSMHA will only pay for Medicaid Personal Care (MPC) requests when the individual's eligibility for MPC services is based upon a solely psychiatric disability
- NSMHA Policy #1576.00 has been revised to expand and define the implementation of this policy
- Revisions done in consult with Regional ADSA staff
- Revised NSMHA Policy #1576.00 DRAFT sent out to QMOC members on May 10, 2011. No subsequent feedback received.

CONCLUSIONS/RECOMMENDATIONS:

- Request QMOC approve NSMHA Policy #1576.00

TIMELINES:

- Request QMOC approval on June 22, 2011

ATTACHMENTS:

- Draft Policy #1576.00

Effective Date: 5/29/2009
Revised Date: 5/9/2011
Review Date: 6/22/2011

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
Providers must "comply with" this policy
Responsible Staff: Deputy Director

Approved by: Executive Director
Signature

Date:

POLICY #1576.00

SUBJECT: MEDICAID PERSONAL CARE (MPC)

PURPOSE

To clarify the responsibilities of Aging and Disability Services Administration (ADSA) Home and Community Services (HCS), Area Agencies on Aging (AAA's) and the North Sound Mental Health Administration (NSMHA) as they relate to Medicaid Personal Care Services provided to NSMHA clients by HCS and AAA's.

ASSUMPTIONS

This protocol is based on the following assumptions:

1. The Department of Social and Health Services (DSHS) is the state agency responsible for the administration of the Title 19 Medicaid Personal Care Program. ADSA/HCS has responsibility for some of the adult DSHS clients eligible for MPC services.
2. Regional Support Networks (RSNs) have fiscal responsibility for Medicaid Personal Care (MPC) Services provided to Regional Support Network (RSN)-enrolled clients who both:

    a. Qualify for MPC Services due solely to their psychiatric disability.
    b. Were authorized for services after June 30, 1995.

3. MPC services can be provided to clients whose unmet need for personal care is based solely on a psychiatric disability. HCS clients who appear to meet this criteria will be referred to the RSN for review and, if appropriate, approval of the MPC services. The CARE assessment must document the client's needs and how MPC and other services (as determined by the needs of the individual client) would address the identified needs. MPC would not be provided if the client's personal care needs could be met through provision of other available RSN resources.

REFERRAL AND AUTHORIZATION PROCESS FOR MPC SERVICES/RSN INITIATED

1. When a NSMHA provider agency clinician/manager determines that a client needs a higher level of care with personal care and activities of daily living than they believe is 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 client. This consultation will focus on whether NSMHA has a program available to meet the needs of the client, or if it appears that MPC may be the most appropriate program to meet client's need.

b. If NSMHA has a program that will likely meet the needs of the individual, the clinician will be instructed to discuss this program with their manager.
c. If MPC appears to be the most appropriate program for the client, the clinician will be instructed to assist the client in completing the MPC Application form, and will follow the steps below.

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

    a. Necessary Releases of Information authorizing exchange of information between HCS and
    b. NSMHA contracted provider agency
    c. Reason for request to include an overview of the situation including a current description of basic needs, current living situation, and history of residential or specialized housing
    d. Confirmation that the referred consumer is an NSMHA-enrolled client
    e. A psychosocial history
    f. Diagnoses (psychiatric/medical)
    g. Mental health assessment AND treatment plan
    h. Proposed use of MPC for consumer care
    i. Identification of a designated mental health clinician and their contact information

REFERRAL AND AUTHORIZATION PROCESS FOR MPC SERVICES/HCS INITIATED
HCS workers are directed to proceed as follows per LTC Manual chapter 7; MPC services for individuals with a mental illness are funded in one of the following ways:

1. RSN Reimbursement - If it appears all the personal care tasks the client requires are based solely on a psychiatric disability:

    a. You must, prior to authorization, assemble a packet for RSN review. The packet consists of:

        i. A completed 13 712, Medicaid Personal Care Client RSN Transmittal form;
        ii. CARE service summary and assessment details. ADSA has an interagency agreement that allows HCS/AAA to share this information with the RSN without a signed release of information from the client.

    b. If the RSN agrees to the reimbursement, authorize the payment using the
    c. MPC SSPS code with the designated RSN reason code;
    d. The 13-712, Medicaid Personal Care Client RSN Transmittal form, indicating RSN approval, must be in the client's file;
    e. If the RSN denies payment for MPC services, refer the client back to the RSN.

(NOTE: if the RSN states client is NOT an RSN eligible client, HCS will staff case with chain of command for direction).

2. RSN/ADSA funded: After December 1, 2010, the RSN is limited to funding MPC for clients whose "need for MPC services is based solely upon a psychiatric disability". The only exception to this policy will be when a person cannot be placed out of a hospital without an increased MPC payment and when the MPC cost to NSMHA exceeds the cost of a hospital stay. If approved, these payments will be time limited and aimed at allowing the individual to receive more intensive care while they adjust to living in a new and less restrictive living situation. These cases will be reviewed at three or six months following placement, depending on the individual case. Upon receipt of an MPC request, NSMHA Intensive Services Review Committee (ISRC) staff will review the request to determine if the MPC eligibility is based upon a solely psychiatric disability. If the ISRC has difficulty determining the relative severity of psychiatric or medical conditions, they will consult with the NSMHA Medical Director to determine if the MPC eligibility is based upon a solely psychiatric disability. If NSMHA reviewers determine that a received MPC request is not based upon a solely psychiatric disability, they will send notification that NSMHA will be denying payment.

   For those individuals receiving MPC payments approved by NSMHA prior to December 1, 2010 and whose subsequent MPC request is determined by NSMHA reviewers not to be based upon a solely psychiatric disability, payments will be terminated by NSMHA as outlined below;

   a. NSMHA will continue to pay the previously agreed upon MPC payment for up to three (3) months beyond the expiration of the current MPC approval period so that any necessary contingency planning to secure alternative funding and/or services for the individual may be initiated.
   b. In cases where the NSMHA decision to rescind the MPC payment is disputed by the requesting entity, NSMHA will continue to pay the previously agreed upon payment amount while the dispute is being processed and/or resolved, per conditions outlined in the Medicaid Personal Care Protocol between Aging and Disability Administration (ADSA), Area on Aging (AAA) and NSMHA.
   c. All relevant requests for MPC services should be sent to NSMHA with the knowledge that the standards defined above will be followed. Rapid (within five (5) business days) by NSMHA to MPC requests will assure that these requests can be processed expeditiously.

3. ADSA funded - If the client has a combination of mental health and medical diagnosis, which make him/her eligible for MPC and RSN denies funding, the cost of care will be paid by ADSA. Authorize the payment in SSPS using the ADSA funded reason code.

   (NOTE: If the client's CARE cost is not accepted by a prospective provider, and an ETR is needed follow internal HCS procedures related to Exception To Rule requests.)

4. HCS/AAA case manager contacts mental health clinician and invites them to attend CARE assessment, with client's permission/agreement. NSMHA encourages clinicians to attend CARE assessments whenever possible to improve continuity o{ care between agencies. If unable to attend the assessment, or if client is unwilling to have clinician attend, the mental health clinician will offer availability to discuss the outcome and implications of the CARE assessment with the HCS/AAA case worker.
5. Following the CARE assessment HCS shall send the following information to the NSMHA: (every effort will be made to transmit this information within 10 working days from the date they receive the referral package. *Consideration of timeliness will be based on consumer need-acute situations may reflect a need for shorter response time, which will be accommodated when possible).*

    a. HCS/AAA RSN transmittal form.
    b. A copy of the CARE Assessment, including Service Summary.

6. The NSMHA ISRC shall review the client's CARE Assessment and communicate the following to HCS/AAA: (The NSMHA will make every effort to transmit this information within 5 working days from the date they received the CARE Assessment. The ISRC meets weekly to review these cases. *Consideration of timeliness will be based on consumer need-acute situations may require a shorter response time).*

    a. Confirm client's status as NSMHA-enrolled consumer.
    b. Agree/disagree with ADSA's determination of client's unmet need and MPC Services authorization information.
    c. Determine whether MPC or other NSMHA services are most appropriate to meet client's need.
    d. Accept or reject financial responsibility for the referred clients MPC Services.

7. HCS/AAA shall send the following information to the NSMHA:

    a. A completed copy of the Social Services Payment System (SSPS) authorization form (documenting client's name, hours of service, payment amount, start date, termination date, etc.).

8. HCS/AAA will submit SSPS authorization for MPC Services to be billed to NSMHA ONLY AFTER receiving written agreement from NSMHA (fax transmittal form) that NSMHA accepts financial responsibility.

Steps 3 thru 8 also apply to annual reassessments and reauthorizations of ongoing clients

COORDINATION OF CARE

Case management responsibilities related to personal care needs will be provided by both HCS/AAA and NSMHA provider agency designated staff as needed and as identified in the client's service plan, Service Summary, mental health treatment plan and mental health crisis plan, updated copies of which shall be shared between the mental health agency and HCS case manager.

Clinicians from HCS/AAA and NSMHA provider agencies will have regular contact to provide coordinated care for mutually served clients. It is the responsibility of each agency's designated staff (clinician) to keep updated releases of information in the client chart such that the above communication is maintained for the duration of the services (not required for HCS).

In the event that a NSMHA contracted provider agency is planning to end services with a NSMHA client who is currently receiving MPC services, the provider agency will notify both NSMHA and HCS/AAA of the planned date of services ending. 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 client. Stopping mental health services and NSMHA MPC payment may affect the residency status of some NSMHA clients living in Adult Family Homes, which needs to be considered in client care planning.

In the event that HCS/AAA staff are planning to cease or reduce MPC services to a client connected to a NSMHA contracted provider agency, HCS/AAA staff will inform both provider agency and NSMHA staff of the planned MPC reduction or cessation so that the provider agency and NSMHA staff can planfully assist the client with the change in services and reevaluate the client's needs from the mental health provider agency.

DISPUTE RESOLUTION

All parties agree to participate in discussions when circumstances arise regarding disagreements pertaining to eligibility, effectiveness and appropriateness of the MPC Services, including changes in psychiatric symptoms, environment and related risk factors. Disagreements regarding the need for MPC Services and assignment of financial responsibility shall be worked out between the NSMHA and Region 3 HCS/AAA Deputy Directors or their designees. Each party agrees to participate in discussions and case staffings; as needed, to resolve differences.

NSMHA financial obligation for MPC services shall not occur until the disagreement has been resolved to the satisfaction of all parties.

FAIR HEARINGS

All parties agree to participate/cooperate in any fair hearings resulting from an NSMHA-enrolled client referred to and/or receiving MPC Services who disagrees with the determination of need for MPC or service level authorization.

The undersigned have agreed to implement this protocol as of the date and year written below and agree that it will remain in full force and effect until such time as the parties agree to amend it. All parties agree to review the protocol on an annual basis.

ATTACHMENTS

None

NORTH SOUND MENTAL HEALTH ADMINISTRATION
AGING

Chuck Benjamin, Executive Director Date

REGION 3-HOME & COMMUNITY SERVICE AREA AGENCIES ON

Greta

Greta Kaas, Regional Administrator Date

Mary King, Administrator, Snohomish County Long Term Care & Aging Date

Victoria Doerper, Executive Director, Northwest Regional Council Date

NSMHA COMMITTEE DISCUSSION FORM

AGENDA ITEM: 2011 CIRC P&P #1009.00 Revision

PRESENTER: Greg Long

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

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY: A DBHR Critical Incident Reporting Audit was conducted recently. It was very successful, resulting in NSMHA receiving a recommendation to add two pieces of contract language to the current CIRC policy. One pertains to the requirement of NSMHA to report incidents of Medicaid fraud to the Medicaid Chief Criminal Investigator. The second involves the contract language pertaining to the need for the NSMHA Critical Incident reporter(s) to "utilize professional judgment and report incidents that fall outside the scope of this section," i.e. the section pertaining to critical incident categories.

CONCLUSIONS/RECOMMENDATIONS: These items do not affect the process involving provider reporting. It just formalizes two required reporting practices that have been undertaken by NSMHA, but had not been spelled out in the most recent policy update. Thus, there are no recommendations other than to approve these additions to the policy.

TIMELINES: TBD

ATTACHMENTS: P&P # 1009.00 with track changes.

Effective Date: 10/19/2009; 4/28/2008; 6/25/2007; 11/10/2005; 10/9/2003, Motion #03-054
Revised Date: 6/27/2008
Review Date: 7/7/2008

North Sound Mental Health Administration

Section 1000 – Administrative: Critical Incident Reporting and Review Requirements
CIRC Quality Assurance and Improvement Process

Authorizing Source: PIHP Contract; 42CFR482 & 42CFR483
Cancels:
See Also: Approved by: Executive Director Date: 2/3/2010
Providers must have a "policy consistent with" this policy
Responsible Staff: Quality Manager Signature:

POLICY #1009.00

SUBJECT: CRITICAL INCIDENT REPORTING AND REVIEW REQUIREMENTS CRITICAL INCIDENT REVIEW COMMITTEE (CIRC) QUALITY ASSURANCE AND IMPROVEMENT PROCESS

PURPOSE

This policy describes the processes, circumstances, methods and timelines by which contracted providers in the North Sound Region must provide information to North Sound Mental Health Administration (NSMHA); the processes, circumstances, methods and timelines by which NSMHA must provide information to the Washington State Department of Social and Health Services (DSHS); and, the quality assurance and improvement activities involved regarding reporting and responding to critical incidents (extraordinary occurrences) affecting consumers of NSMHA services and NSMHA providers.

The purpose of the Critical Incident Reporting and Review Requirements and the NSMHA Critical Incident Review Committee (CIRC) quality improvement and assurance process is to:

1. Ensure that, in its ongoing commitment to quality assurance and improvement initiatives, NSMHA promotes consumer safety and risk reduction by requiring the recognition and reporting of extraordinary occurrences. Specifically, NSMHA wants to ensure that:
    a. Care and services delivered meet the requirements of the DSHS/NSMHA and NSMHA/provider contracts, including NSMHA Clinical Eligibility and Care Standards, relevant WACs (Washington Administrative Code), RCWs (Revised Code of Washington) and the CFR (Code of Federal Regulations).
    b. There is a timely and systematic reporting mechanism that promotes appropriate responses to critical incidents/extraordinary occurrences.
2. Provide a framework, structure and set of guidelines for the timely reporting of critical incidents, as defined by DSHS.
3. Support and protect the reporting and documentation of critical incidents under NSMHA's Coordinated Quality Improvement Program (CQIP). NSMHA maintains CQIP status through the Washington State Department of Health for the purpose of improvement of the quality of health care services rendered to consumers and the identification and prevention of medical malpractice as set forth in RCW 43.70.510. NSMHA encourages the development of a system-wide culture, which minimizes individual blame or retribution for involvement in critical incidents and emphasizes accountability, trust, system improvement and continuous learning. To provide quality assurance all documents related to critical incident reporting will contain the following language:

COORDINATED QUALITY IMPROVEMENT DOCUMENT

This is a protected Coordinated Quality Improvement document solely for the purpose of assuring Continuous Quality Improvement and Quality Assurance by the North Sound Mental Health Administration, its providers and component counties. This document is strictly confidential to the fullest extent allowed by RCW 43.70.510 and is not subject to disclosure pursuant to Chapter 43.17 RCW.

POLICY

NSMHA and its providers are required to report on incidents involving persons with mental illnesses and having an open case with NSMHA. An open case is defined as an individual that is currently receiving outpatient mental health services, crisis services or jail services from a NSMHA provider.

1. Outpatient consumers are those who have received an intake assessment and meet eligibility criteria for outpatient services. These individuals are considered outpatient consumers until their case has been officially closed.
2. Crisis Services consumers are currently being served by Crisis Services personnel, and remain so until their case has been closed and/or they have begun receiving outpatient services.
3. Jail Mental Health Services consumers are those who have received an initial assessment and meet eligibility criteria for Jail Mental Health Services, and remain so up to 90 days post-release, and/or they have begun outpatient services as described above.

Note: By definition, a precipitating event that causes an individual to seek any of the above services should not be considered a reportable critical incident as it occurred prior to that individual having an open case with any of the above services.

The following are the categories of critical incidents that must be reported to NSMHA. *Reporting guidelines and/or operational definitions are in italics*:

1. **Death or serious injury of consumer, staff, or public citizen:** ***Only report deaths and serious injuries that occur at a DSHS facility, or a facility that DSHS licenses, contracts with, and certifies. Serious injuries include any permanent injury, or one that requires admission to a hospital.***
2. **Unauthorized leave (UL) of a mentally ill offender or sexually violent offender:** ***Only report incidents where a UL involves a designated offender, and occurs from a Mental Health Facility or a Secure Community Transition Facility, which includes Evaluation and Treatment Centers (E&T) or Crisis Stabilization Units (CSU).***
3. **UL of any non-offender consumer from an E&T:** *This category is reported to NSMHA for regional quality improvement data gathering for follow-up on quality improvement activities, and will not generally be forwarded to DSHS.*
4. **Alleged consumer abuse or neglect of a serious or emergent nature:** ***The willful action or inaction that inflicts injury, unreasonable confinement, intimidation, punishment on, or abandonment of a vulnerable adult by a DSHS employee, volunteer, licensee, contractor, or another consumer. In an instance of abuse of a vulnerable adult who is unable to express or demonstrate physical harm, pain, or mental anguish, the abuse is presumed to cause physical harm, pain, or mental anguish.***
5. **Natural disaster:** ***Only report those presenting substantial threat to facility operation or consumer safety. These may include earthquake, volcano eruption, tsunami, urban fire, flood, an outbreak of communicable disease, etc.***
6. **Breach of consumer information:** ***Any breach or loss of consumer data in any form which would allow for the unauthorized use of consumer information.***
    - A letter of notification shall be sent to each individual whose information was breached. This notification shall occur without unreasonable delay and in no case later than 60 days after discovery of the breach. In cases where the information was stolen, a copy of the police report shall be included as an attachment in the report to DSHS.

~~6.~~7. **Violent act:** ***Any alleged or substantiated non-fatal injuries, rape, sexual assault, homicide, attempted homicide, arson, or substantial property damage (> $100,000.00), committed by a consumer.***

8. **Allegation of financial exploitation (FE) involving an agency, a consumer or other:** ***The illegal or improper use of the property, income, resources or trust funds of a vulnerable adult by any person for any person's profit or advantage other than for the vulnerable adult's profit or advantage.***

- When any allegation of financial exploitation or Medicaid fraud is reported, NSMHA-designated CI reporting staff shall notify the Medicaid Chief Criminal Investigator (CCI) by phone then call the DBHR (Division of Behavioral Health and Recovery) Incident Manager to request that he/she forward an electronic copy of the DSHS CI Report to the CCI.

~~7.~~9. **Assault of a consumer by a staff**

~~8.~~10. **Assault of a staff by a consumer resulting in hospitalization**

~~9.~~11. **Incident involving a consumer or staff reported by the media, or having potential for media interest**

~~10.~~12. **Crime involving a consumer or staff reported by the media, or having potential for media interest**

~~11.~~13. **Suicide attempt requiring medical care:** ***Only report suicide attempts that occur at a DSHS facility, or a facility that DSHS licenses, contracts with, and certifies, and require care from a physician.***

Note: In addition to the categories described above, NSMHA designated reporting staff shall utilize professional judgment and report incidents that fall outside the scope of this section.

PROCEDURE

Critical Incident Reporting and Review Requirements

When any critical incident occurs, it is the reporting responsibility of the service provider to:

1. Fax the completed NSMHA Critical Incident Form (available online at http://www.nsmha.org/forms/index.asp) to NSMHA within one (1) business day of the determination that the event meets the definition of a critical incident. When faxed, the form must include a cover sheet with a confidentiality disclaimer.
2. Submit any additional information necessary to understanding the incident to NSMHA within five (5) business days.

Critical incidents listed below shall require a formal review by the provider Quality Committee unless waived by CIRC, and findings shall be submitted to CIRC within five (5) business days of the review:

- **Death or serious injury of consumer, staff, or public citizen**
- **Unauthorized leave (UL) of a mentally ill offender or sexually violent offender**
- **UL of any non-offender consumer from an E&T**
- **Alleged consumer abuse or neglect of a serious or emergent nature**
- **Assault of a consumer by a staff**
- **Assault of a staff by a consumer resulting in hospitalization**
- **Suicide attempt requiring medical care**

Critical incidents listed below may require a formal review by the provider, at the discretion of the provider Quality Committee or CIRC, and findings shall be submitted to CIRC within five (5) business days of the review:

- **Violent act**
- **Allegation of financial exploitation (FE) involving an agency, a consumer or other**
- **Incident involving a consumer or staff reported by the media, or having potential for media interest**
- **Crime involving a consumer or staff reported by the media, or having potential for media interest**
- **Natural disaster**
- **Breach of consumer information**

Additionally, the provider ensures that all plans for corrective action following a review or investigation are implemented for quality assurance and improvement and incorporated into all administrative areas as necessary for quality assurance and improvement.

The NSMHA staff designee tracks all reported critical incidents, maintains a log, database and timeline, and writes any follow-up reports required. In some instances, the designee initiates region-wide quality improvement activities related to an incident or group of incidents.

Additional reporting and review requirements for DSHS reportable critical incidents for NSMHA staff designee:

1. Notifies County Coordinators, NSMHA Board Chair, and NSMHA Executive Director via a blinded copy of the DSHS critical incident report. Notification shall occur within one (1) business day of NSMHA's receipt of the provider critical incident report.
2. Notifies DSHS via the electronic incident reporting system, or the standardized form if indicated, within one (1) business day of NSMHA receipt of the provider critical incident report.

<u>NSMHA CIRC Quality Improvement Process</u>

1. NSMHA will maintain a Critical Incident Review Committee (CIRC) whose purpose is to review all critical incidents submitted. The NSMHA CIRC membership will include a NSMHA Clinical Oversight Quality Specialist with expertise in adult services, a NSMHA Clinical Oversight Quality Specialist with expertise in child/youth services, a non-clinical NSMHA staff member, and a NSMHA support staff member. The NSMHA Medical Director shall consult as requested in manners pertaining to medical/psychiatric matters. The CIRC will meet regularly to review all critical incident reports, request written follow-up reports from providers, investigate critical incidents utilizing internal selective reviews and make quality improvement recommendations related to critical incidents to the Clinical Oversight Team for further appropriate action.
2. During the regularly scheduled CIRC meeting, a designated Quality Specialist will facilitate review and discussion of each new critical incident and critical incidents from previous months on which the committee determined further review was required before proper disposition of the case could be determined.
3. During a CIRC review, the committee members shall address each incident in the following context:
    a. Does the description of the critical incident and/or subsequent information warrant concern about quality or appropriateness of care delivered by the provider?
    b. Does the incident report indicate that appropriate action was taken immediately after the incident to lessen or prevent consumer loss or harm?

c. Does the incident report indicate that an appropriate plan for future action has been made to decrease the likelihood of this type of incident occurring again?
d. Can/should any further action be pursued by NSMHA or the provider?

4. When the CIRC members reach a consensus that the critical incident report and any follow-up information answer the preceding questions satisfactorily, the incident is considered "closed."
5. NSMHA may deem further action is warranted in the case of a particular critical incident or group of incidents. Actions may include but are not limited to:

    a. NSMHA selective review
    b. Request for provider internal case review
    c. Request for parts of or complete medical records
    d. Request for special meetings or quality initiatives (e.g., Root Cause Analysis) regarding quality concerns involved
    e. Request for provider initiated quality assurance and improvement activities based on incidents or groups or types of incidents
    f. Other requests as deemed necessary

    Actions taken as a result of the occurrence, results of said actions, additional actions that are planned in the future and efforts that have been undertaken designed to lessen the potential for recurrence shall be reported to CIRC within 21 days of becoming available. A copy of the written report should be sent to the provider Quality Manager.

6. CIRC will develop a semi-annual summary report and data analysis each July and January. Copies of the semi-annual report will be distributed to NSMHA Board of Directors, NSMHA Advisory Board, NSMHA Quality Management Oversight Committee (QMOC) and County Coordinators.

ATTACHMENTS

None

NSMHA COMMITTEE DISCUSSION FORM

AGENDA ITEM: 3 Regional Performance Measures

PRESENTER: Diana Striplin

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

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY

NSMHA is required to develop and implement 3 Regional Performance Measures (PMs) as part of our Quality Strategy. (in addition to the 5 core state-wide performance measures).

The 3 Regional PMs are described on the NSMHA Performance Measure Grid (see attached Grid).

They are:

1. Increase Crisis Stabilization Bed Utilization
2. Increase Diversion: (Percentage of dispatches that result in other than detention or refer to voluntary inpatient service).
3. Increase Co-occurring Identification Rate for those over 13 years of age

NSMHA has been reviewing the Regional PM data and is also reviewing the data on an individual provider level. NSMHA has also been reviewing what interventions are needed on Regional and provider levels to meet the annual performance target for each measure.

We will be sending each provider individual letters with their Regional PM data report, which will also outline the interventions that need to be taken or supported at the provider level. Providers may also submit ideas for interventions to the NSMHA for approval.

CONCLUSIONS/RECOMMENDATIONS: None

TIMELINES: None

ATTACHMENTS: NSMHA PM Grid 2011 Master

NSMHA REGIONAL PERFORMANCE MEASURES (PMs)

					INTERIM YEAR REGIONAL PMs					YEAR 1 REGIONAL PMs			
	Regional Performance Measures (Oct 10-Sep 11)	Annual Improvement Target Recommendation	Annual Target Goal Recommendation	Baseline (Oct 08-Sep 09)	1st Qtr Report (Oct 09-Dec 09)	2nd Qtr Report (Oct 09-Mar 10)	3rd Qtr Report (Oct 09-June 10)	4th Qtr Report (Oct 09-Sep 10)		1st Qtr Report (Oct 10-Dec 10)	2nd Qtr Report (Oct 10-Mar 11)	3rd Qtr Report (Oct 10-June 11	4th Qtr Report (Oct 10-Sep 11) Annual Report
1	Diversion rates: Dispatches whose outcome is other than detention or refer to voluntary inpatient service	4.10%	78.00%	73.90%	70.83%	71.48%	72.43%	72.50%		74.82%	75.65%		
2	Crisis Respite Bed	21.60%	80.00%	58.40%	60.43%	60.95%	65.38%	63.69%		57.93%	70.96%		
	Regional Performance Measures (Oct 10-Sep 11)	Annual Improvement Target Recommendation	Annual Target Goal Recommendation	Baseline (Oct 08-Sep 09)	1st Qtr Report (Jan 09-Dec 09)	2nd Qtr Report (Apr 09-Mar 10)	3rd Qtr Report (Jul 09-June 10)	4th Qtr Report (Oct 09-Sep 10)		1st Qtr Report (Jan 10-Dec 10)	2nd Qtr Report (Apr 10-Mar 11)	3rd Qtr Report (Jul 10-June 11)	4th Qtr Report (Oct 10-Sep 11) Annual Report
3	Co-occurring disorder identification rate	3.06%	17.00%	13.94%	16.98%	16.62%	16.32%	15.79%		15.18%	15.08%		

COLOR KEY

	Each cell calculated on a "rolling year"

RULES FOR DATA RUN DATES:

1. Data collected for given periods cannot be run until 2-3 months past the end date of the period due to data lag.
2. All data run dates will be noted through addition of a cell comment [can be viewed in the spreadsheet on-line).
3. Assume cumulative quarters unless color coded as "rolling year."

NSMHA COMMITTEE DISCUSSION FORM

AGENDA ITEM: Performance Improvement Projects (PIPs)

PRESENTER: Charissa Westergard

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

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:
Prescriber PIP:

- Chart review conducted in May showed improved utilization and documentation of the intervention from the Fall 2010 review.
- Quarter 2 of the intervention (Oct-Dec 2010) compared to Quarter 2 of the baseline (Oct-Dec 2009) showed a statistically significant decrease in the number of days from the request for service to the first medication appointment.

Inpatient PIP:

- Rate of outpatient follow up within seven days of discharge from inpatient has decreased when compared to the previous intervention period.

CONCLUSIONS/RECOMMENDATIONS:
NSMHA will be convening a workgroup to work on the next intervention for the Prescriber PIP.

Per last year's workgroup on the Inpatient PIP, one potential intervention could be a liaison that goes to the hospital to engage individuals prior to discharge. Funding was a barrier to implementation of this intervention. There may be a solution that would allow for implementation of this intervention, but NSMHA is waiting on additional information. Therefore, NSMHA recommends waiting to convene a workgroup for this PIP.

TIMELINES:
Notify Charissa Westergard (360-416-7013 x 228 or charissa_westergard@nsmha.org) of interest in workgroup membership by close of business on Wednesday, June 29th.

ATTACHMENTS:
Prescriber PIP June 2011
Inpatient PIP June 2011

Performance Improvement Project – Decrease in the Days to Medication Evaluation Appointment after Request for Service

June 2011 Summary

The purpose of Performance Improvement Project (PIP), Decrease in the Days to Medication Evaluation Appointment after Request for Service, is to identify, at the first ongoing appointment, those individuals who enter treatment with a need for a medication evaluation and to then start the referral process for them. The hope is that, for those individuals with an identified need, the intervention will assist in decreasing the number of days between the time an individual calls Access (request for service) and the medication evaluation appointment.

To facilitate the early identification of someone with a need for referral to a medication evaluation, a Decision Tree was designed to be utilized by the clinician at the first ongoing appointment. The Decision Tree outcome is then documented on the treatment plan and, if a need for referral is identified, the referral process is initiated.

In order to validate that this intervention process was occurring, NSMHA completed a chart review in September and October 2010. These results were presented at January Quality Management Oversight Committee (QMOC) and to the individual agencies with areas of strength and recommended improvements noted. A follow up review was conducted in May 2011. Following are some notable points in comparing the 2010 and 2011 regional review results:

- Use of the Decision Tree at the first ongoing appointment improved from 64% to 73%.
- Documentation of the Decision Tree outcome on the Recovery Plan improved from 66% to 93%.
- If a need for referral is identified, the documentation is consistent with that determination (100%). If no need for referral is identified, the documentation supports that determination in 88% of the charts reviewed.
- Initiation of the medication evaluation referral process as the outcome of the Decision Tree decreased by 10% from 2010 to 2011.
- Initiation of the referral process on the same day as identification of the need for referral increased from 50% to 60%. Initiation of the referral process beyond one calendar week of the identification of the need for referral also increased from 15% to 26%. This means that most referrals were initiated the same day or beyond one calendar week of when a need is identified. Initiation of the referral process may not mean scheduling of the appointment, but gathering of records, consultation, etc. However, scheduling of the medication evaluation appointment follows a similar trend as initiation of the referral (i.e., most are scheduled the same day or beyond one calendar week of identification of need for referral).

Due to the timing in obtaining the most complete data set and inclusion of individuals who receive a medication appointment within 180 days of the initial request for service in this project, determining whether the intervention may have had an impact takes time. In analyzing data from the first two quarters of the intervention (7/1/2010 – 12/1/2010) the following has been noted:

- There was not a statistically significant difference between Quarter 1 Baseline and Quarter 1 Intervention. The average days from request for service to first medication appointment actually increased from 68.5 to 72.6.
- There was a statistically significant difference between Quarter 2 Baseline and Quarter 2 Intervention. The average days from request for service decreased from 68.9 to 63.8. It should also be noted that the number of individuals in this comparison decreased from 654 to 481 from baseline to intervention (4.14% decrease).

2011 PIP Intervention Validation Review

Review Questions	Region	Bridgeways	CCS	CH North	CH South	Interfaith	LWC	Sea Mar	Sunrise	WCPC
The Decision Tree was utilized at the first routine appointment	73%	100%	90%	92%	55%	100%	100%	50%	60%	67%
The Decision Tree outcome is documented on the initial treatment plan	93%	100%	90%	100%	100%	100%	100%	50%	100%	60%
The outcome of the Decision Tree was initiation of the medication evaluation referral process	53%	100%	33%	50%	33%	75%	100%	40%	80%	80%
If need for referral is identified, the documentation is consistent with this determination	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
If need for referral is identified, the referral process was initiated the same day	60%	20%	0%	83%	70%	67%	80%	50%	25%	100%
If need for referral is identified, the referral process was initiated the next calendar day	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
If need for referral is identified, the referral process was initiated within one calendar week	2%	20%	0%	0%	0%	0%	0%	0%	0%	0%
If need for referral is identified, the referral process was initiated beyond one calendar week	26%	20%	67%	17%	20%	33%	20%	0%	75%	0%
If the referral was initiated, the referral process was completed the same day as identification of need	36%	0%	0%	33%	44%	0%	80%	0%	25%	67%
If the referral was initiated, the referral process was completed the next calendar day after identification of need	6%	0%	0%	17%	11%	0%	0%	0%	0%	0%
If the referral was initiated, the referral process was completed within one calendar week of identification of need	6%	0%	0%	17%	11%	0%	0%	0%	0%	0%
If the referral was initiated, the referral process was completed beyond one calendar week of identification of need	39%	100%	50%	33%	22%	50%	20%	0%	75%	33%
If no need for referral is identified, the documentation is consistent with this determination	88%	N/A	100%	86%	81%	100%	N/A	100%	100%	100%

Regional

Review Questions	*2010*					*2011*				
	N	Total Yes	Rate	Total No	Rate	N	Total Yes	Rate	Total No	Rate
The Decision Tree was utilized at the first routine appointment	139	89	64%	50	36%	85	62	73%	23	27%
The Decision Tree outcome is documented on the initial treatment plan	138	91	66%	47	34%	80	74	93%	6	8%
The outcome of the Decision Tree was initiation of the medication evaluation referral process	108	68	63%	40	37%	80	42	53%	38	48%
If need for referral is identified, the documentation is consistent with this determination	68	67	99%	1	1%	42	42	100%	0	0%
If need for referral is identified, the referral process was initiated the same day	66	33	50%	33	50%	42	25	60%	17	40%
If need for referral is identified, the referral process was initiated the next calendar day	66	3	5%	30	45%	42	0	0%	17	40%
If need for referral is identified, the referral process was initiated within one calendar week	66	10	15%	20	30%	42	1	2%	16	38%
If need for referral is identified, the referral process was initiated beyond one calendar week	66	10	15%	10	15%	42	11	26%	5	12%
If the referral was initiated, the referral process was completed the same day as identification of need	56	16	29%	40	71%	36	13	36%	23	64%
If the referral was initiated, the referral process was completed the next calendar day after identification of need	56	4	7%	36	64%	36	2	6%	21	58%
If the referral was initiated, the referral process was completed within one calendar week of identification of need	56	14	25%	22	39%	36	2	6%	19	53%
If the referral was initiated, the referral process was completed beyond one calendar week of identification of need	56	17	30%	5	9%	36	14	39%	5	14%
If no need for referral is identified, the documentation is consistent with this determination	N/A	N/A	N/A	N/A	N/A	43	38	88%	5	12%

Performance Improvement Project (PIP):
Delivery of Non-crisis Outpatient Appointments after a Psychiatric Hospitalization
June 2011 Summary

In 2007, RSNs agreed to combine efforts on a non-clinical PIP. The decision was made to focus on increasing the number of individuals attending non-crisis outpatient appointments within seven days of discharge from a psychiatric hospitalization as all RSNs were below the Mental Health Division's (MHD, now Division of Behavioral Health & Recovery - DBHR) 80% benchmark in fiscal year 2006-2007. This PIP also happens to be a Core Performance Measure, which means the RSN is expected to demonstrate improvement as outlined in contract. Each RSN is responsible for identifying and implementing its own intervention.

Since 2007, NSMHA has implemented three interventions to attempt to improve the rate of individuals that have an outpatient appointment within seven days of discharging from inpatient care with the following results:

- 2008 – Contacting individuals by phone just prior to discharge from the hospital to answer questions and address concerns that may prevent someone from attending the outpatient appointment. Unfortunately, the intervention was difficult to implement as planned as we were only able to make contact with the individual/parent/guardian about 11% of the time. While improvement cannot be attributed to the intervention, there was a significant improvement in outpatient follow up within seven days of hospital discharge over the intervention period from 50% to 56%.
- 2009 – Provided our top ten most utilized hospitals with a quarterly "status report" that indicated the rate of individuals discharging from their facilities that received an outpatient appointment within seven days of hospital discharge. While we did not lose previous gains (56% follow up rate for the first intervention and 55% for the second intervention), we did not see significant improvement as a result of this intervention.
- 2010 – Presentations at the seven most utilized hospitals to improve staff understanding of NSMHA-funded services. Development of quick reference sheet for consumers & families that can be handed out by hospital staff and that highlight how to access services, agency choices in each county, brief description of the intake process and outpatient service examples. Despite multiple attempts to contact hospitals and schedule presentation times, only two facilities responded initially and only one followed through with actually scheduling a presentation. Materials that had been prepared for hospital staff and consumers were sent to hospitals for distribution. For those individuals who have services established with an outpatient provider at hospital admit, the rate of outpatient follow up within seven days of discharge is much higher than the overall rate (76.83% vs. 40.38% in Quarter 2 of Intervention 3). This supports the historical trend that individuals without an outpatient provider when hospitalized have a much lower rate of outpatient services within seven days of hospital discharge. Rates of outpatient follow up have decreased since Quarter 2 of Intervention 2. At least some of the decline may be attributed to the fact that North Sound E&T had a higher rate of establishing outpatient follow up than some other inpatient facilities.

Non Clinical PIP Snapshot :

Improved Delivery of Non-Crisis Outpatient
Appointments After a Psychiatric Hospitalization

MedicaidGroup	Medicaid
ageGroup	adult
Inpatient_Transfer	0

Count of Discharges	tient Service after discharge status		
Row Labels	Received a service in 7 days	no service in 7 days	Grand Total
baseline Q1	50.21%	49.79%	100.00%
baseline Q2	50.00%	50.00%	100.00%
baseline Q3	49.19%	50.81%	100.00%
baseline Q4	52.21%	47.79%	100.00%
intervention Q1	55.14%	44.86%	100.00%
intervention Q2	61.64%	38.36%	100.00%
intervention Q3	57.87%	42.13%	100.00%
intervention Q4	55.29%	44.71%	100.00%
intervention 2 Q1	58.53%	41.47%	100.00%
intervention 2 Q2	51.96%	48.04%	100.00%
intervention 2 Q3	51.44%	48.56%	100.00%
intervention 2 Q4	51.80%	48.20%	100.00%
Intervention 3 Q1	46.94%	53.06%	100.00%
Intervention 3 Q2	40.38%	59.62%	100.00%
Grand Total	**52.38%**	**47.62%**	**100.00%**

Intervention 3 Q2 period ends 12/31/2010

MedicaidGroup	Medicaid
ageGroup	adult
Inpatient_Transfer	0

Count of Discharges	Outpatient Service after discharge status		
Period	Received a service in 7 days	no service in 7 days	Grand Total
baseline Q1	122	121	243
baseline Q2	121	121	242
baseline Q3	121	125	246
baseline Q4	130	119	249
intervention Q1	118	96	214
intervention Q2	135	84	219
intervention Q3	136	99	235
intervention Q4	162	131	293
intervention 2 Q1	175	124	299
intervention 2 Q2	172	159	331
intervention 2 Q3	125	118	243
intervention 2 Q4	144	134	278
Intervention 3 Q1	138	156	294
Intervention 3 Q2	86	127	213
Grand Total	**1,885**	**1,714**	**3,599**

Non Clinical PIP Snapshot : people in an outpatient episode only

Improved Delivery of Non-Crisis Outpatient
Appointments After a Psychiatric Hospitalization

MedicaidGroup	Medicaid
ageGroup	adult
Inpatient_Transfer	0
PEPIS	PEPIS

Count of Discharges	Outpatient Service after discharge status		
Row Labels	Received a service in 7 days	no service in 7 days	Grand Total
baseline Q1	74.36%	25.64%	100.00%
baseline Q2	72.22%	27.78%	100.00%
baseline Q3	74.49%	25.51%	100.00%
baseline Q4	85.22%	14.78%	100.00%
intervention Q1	75.68%	24.32%	100.00%
intervention Q2	78.86%	21.14%	100.00%
intervention Q3	79.83%	20.17%	100.00%
intervention Q4	87.50%	12.50%	100.00%
intervention 2 Q1	87.16%	12.84%	100.00%
intervention 2 Q2	84.03%	15.97%	100.00%
intervention 2 Q3	82.46%	17.54%	100.00%
intervention 2 Q4	79.72%	20.28%	100.00%
Intervention 3 Q1	80.15%	19.85%	100.00%
Intervention 3 Q2	76.83%	23.17%	100.00%
Grand Total	**80.27%**	**19.73%**	**100.00%**

MedicaidGroup	Medicaid
ageGroup	adult
Inpatient_Transfer	0
PEPIS	PEPIS

Count of Discharges	Outpatient Service after discharge status		
Row Labels	Received a service in 7 days	no service in 7 days	Grand Total
baseline Q1	87	30	117
baseline Q2	78	30	108
baseline Q3	73	25	98
baseline Q4	98	17	115
intervention Q1	84	27	111
intervention Q2	97	26	123
intervention Q3	95	24	119
intervention Q4	105	15	120
intervention 2 Q1	129	19	148
intervention 2 Q2	121	23	144
intervention 2 Q3	94	20	114
intervention 2 Q4	114	29	143
Intervention 3 Q1	109	27	136
Intervention 3 Q2	63	19	82
Grand Total	**1347**	**331**	**1678**

NSMHA COMMITTEE DISCUSSION FORM

AGENDA ITEM: Clinical Guidelines

PRESENTER: Greg Long

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

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:
This topic was discussed at last month's meeting and recommendations were requested by e-mail. NSMHA has not received any additional responses as of 6.15.2011.

Background:
NSMHA is required to develop two clinical guidelines each year. These guidelines are meant to assist in decisions about prevention, diagnosis, treatment and management of clinical conditions. While many of the guidelines have focused on treatment for specific disorders, they may also focus on clinical processes. At this time, NSMHA has developed the following list of options for your consideration:

- Inpatient admission, coordination and discharge planning by outpatient providers
- Borderline Personality Disorder
- Titration of services and discharge planning in outpatient services
- Depression (Youth Guideline)
  There is already a NSMHA youth guideline for depression. Perhaps, the suggestion is that this be changed to Major Depression or broken down into the various categories of depression (Major, dysthymic disorder, adjustment disorder with depressed mood).

NSMHA requests presentation of any other proposals for 2011 clinical guidelines at this QMOC as well as feedback on the above options.

CONCLUSIONS/RECOMMENDATIONS:
NSMHA staff request recommendation from QMOC of two guidelines for development in 2011. A decision needs to be made on this for this is the second presentation of this topic at QMOC.

TIMELINES:
This is the second presentation of this topic at QMOC.

ATTACHMENTS:
None

NSMHA COMMITTEE DISCUSSION FORM

AGENDA ITEM: Intake appointment scheduling for individuals discharging from WSH

PRESENTER: Charissa Westergard/Greg Long

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

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:

No decision was made on this issue at our last meeting. Input was requested from WSH Liaisons and providers. Only one response was received and it was to make a decision. That respondent preferred one but could live with either option.

Background:

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. At April QMOC, several obstacles to handling this issue simply were identified.

CONCLUSIONS/RECOMMENDATIONS:

At this point in time there appear to be two options for addressing this situation.

Option 1

- WSH Liaisons call VOA Access at the time they need to get the appointment scheduled (i.e., before court). In order to track the number of WSH referrals and not penalize the providers for the long Request for Service to Intake timeframe that these referrals create, a new referral source (WSH) would be added to the Referral Source code table and be part of the already existing Request for Service Additional Info transaction.

Option 2

- WSH Liaisons call agency schedulers directly. The agency would create the individual account in Raintree and schedule an appointment.
- This would prevent being able to monitor days from request for service to intake appointment. However, monitoring in these situations is not particularly meaningful because the timeline will typically be exceeded as the individual has not yet discharged from WSH.

NSMHA believes either option will work and has no preference between the two options.

TIMELINES:

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

ATTACHMENTS: None