NORTH SOUND
MENTAL HEALTH ADMINISTRATION

QUALITY MANAGEMENT OVERSIGHT COMMITTEE

MEETING PACKET

March 28, 2012

1. Please join my meeting.
https://www3.gotomeeting.com/join/723686230

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

Dial +1 (213) 289-0016
Access Code: 723-686-230
Audio PIN: Shown after joining the meeting

Meeting ID: 723-686-230

QMOC GUIDING PRINCIPLES

The QMOC charge is to guide the quality assurance and quality improvement activities of mental health services within the NSRSN 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: 1/17/01

NORTH SOUND MENTAL HEALTH ADMINISTRATION
QUALITY MANAGEMENT OVERSIGHT COMMITTEE AGENDA

Date: March 28, 2012 **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	--Forms for monitoring risk --New NSMHA ED --State Work Group on people with dementia	Inform /discuss	All				*10 min*
Evaluation forms from last meeting, if any	Discuss feedback, if any.	Inform /discuss	Chair/ Greg				*5 min*
Comments from the Chair			Chair				*5 min*
		Quality Topics					
Extended Psychiatric Services	Discuss the need for longer transitions from psychiatric services to PCP services	Inform/ discuss	Mark McDonald	Committee Discussion Form		**3**	*10 min*
OIG HEAT Training	Brief overview of OIG HEAT Training	Inform/ discuss	Lisa	Committee Discussion Form		**4**	*10 min*
Regional PM – Co-occurring identification	Explanation and clarifications to definitions of substance abuse and substance dependence	Inform/ Discuss	Diana	Committee Discussion Form		**5**	*10 min*
Allen/Marr Settlement Reviews	Periodic Update	Inform/ discuss	Tom Yost	Committee Discussion Form		**6**	*15 min*
Status of Online Crisis Plans	Update on progress on getting Crisis Plans online	Inform	Greg				*5 min*
Policy approval	Approval of policies previously reviewed: 1516; 1541; 1551; 1725	Action	Greg/ Charissa/ Kurt	Committee Discussion Forms		**7** **8** **9** **10**	*20 min*
***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: April 25, 2012 - 1:00-3:00 PM

Potential Future Agenda Items:

Draft not yet approved

North Sound Mental Health Administration (NSMHA)
Quality Management Oversight Committee (QMOC)
NSMHA Conference Room
February 22, 2012
1:00 – 3:00 pm
MEETING SUMMARY

PRESENT: Rebecca Clark, Skagit County; Chuck Davis, ombuds; Heather Fennell, Compass Health; Dan Bilson, Advisory Board appointee; David Small, Sea Mar; Kathy McNaughton, CCS; Cindy Ferraro, bridgeways; Mike Manley, Sunrise Services and Mark McDonald, Advisory Board.

PRESENT BY PHONE: Susan Ramaglia, Advisory Board; Richard Sprague, Interfaith; Brad Berry, CVAB and Kay Burbidge, LWC.

STAFF: Greg Long, Charissa Westergard, Diana Striplin, Kurt Aemmer and Barbara Jacobson.

OTHERS PRESENT: Cammy Prince, Sunrise Services. Stacy Alles, Compass Health.

TOPIC	DISCUSSION	ACTION
1. **Introductions, Review of Agenda – Chair**	Rebecca convened the meeting at 1:05 pm and introductions were made. Additions to the agenda are called for and none are mentioned.	
2. Previous Meeting Summary – Chair	Rebecca asked for any corrections/amendments to the previous meeting summary and there was a motion to approve as amended, seconded and motion carried.	Summary approved as amended.
3. Announcements and Updates – All	• Greg noted the Skagit crisis bed conversation from last meeting around the availability of beds; and he stated that Pioneer has opened up an additional bed to handle peak demand for mental health consumers only. It is hoped that this will resolve the issue and he would like feedback on how this is going. We pay at 80% of full census. They have utilized this bed a couple times in the past month already.	Informational
4. Evaluation Forms from Last Meeting – Chair/Greg	Rebecca reviewed the evaluations from the January meeting.	
5. Risk Assessments	Greg thanked all for submissions he received and noted that they are attached here in the packet for review. Please let him know if you have any questions.	Informational
6. EPSDT Follow Up	Greg noted that this is a reminder that this requirement is in all contracts for those serving kids. He stated that it is a requirement, that even if you don't serve kids than you still need to show your ability to handle if it comes in and there are timelines; log the EPSDT referral and contact them within 10 working days to close loop.	Informational
7. Substance Abuse Performance Measure	Diana noted that she and Greg presented on this last meeting and there was discussion about changing the definition of impairment kind. There is a draft attached here with the old definition and the proposed changes. Greg noted that under substance abuse disorder there are two categories of abuse and dependence and we want to look at having these two categories. We checked with the CIS workgroup and adding this would not be difficult, so we want to discuss using the two categories. He also noted this is not to	Informational Report back next meeting

	diagnose, it is to better serve by identifying if this is a complicating factor in their lives. After discussion it is agreed to go with the two separate categories as shown and Greg noted that this change should result in more accurate numbers going forward. The definitions will change to substance abuse and substance dependence. This will go to the Leadership Team for review. This will add another check box to impairment kind.	
8. Consumer Satisfaction Survey	Kurt presented the report on the survey that was done in October 2011 and noted that there were positive results. The survey looked at how satisfied consumers are with their services and how effective the services are; this also gave us baseline data for future surveys. He noted that the comments were enlightening, very heartfelt and encouraging. In addition to this report he will also send a report to each provider individually for their own quality purposes. He would like to work on how to increase the numbers received for the next time as the overall participation rate was about 45%. Kurt noted that one thing that could be a quality improvement is if consumers notice their own improvement and if it is pointed out to them periodically could that have an impact. The survey also showed that though consumers are satisfied it showed family life dissatisfaction. This illustrates the need for providers to include families; providers noted that the short time to serves makes that difficult. NSMHA will look at the Clark County survey to compare with ours and report next month. It was noted that the survey also needs to be unduplicated and also looked at for face to face visits versus phone calls captured in CIS. Susan R would like the peer support piece to be looked at as a recommendation as well.	Informational Report back next month
9. Policies **1516** **1541** **1151** **1725**	**1516**-Kurt noted that this policy was rewritten to clarify information pertaining to MHP waivers and sent to DBHR for review and it is attached here with their recommendations. **1541**-Charissa noted that EQRO asked for a policy to clarify that seclusion and restraints are not used by outpatient providers. This was sent to DBHR for review and DBHR comments were reviewed for inclusion. Greg noted that Anne D sent comments on the E&T policy that will be need to be reviewed as well. **1551** – Charissa noted that this policy was approved recently but has been updated with some language due to the revision of another policy and thus is up for approval as updated. **1725** – This policy on the MOT team has been revised to include that the team can now take direct access calls from the community. This will help to increase utilization of these teams as it was felt calling the crisis line may be a barrier to some. There is no quorum present today so these will be carried forward to the next meeting.	Add to agenda for next month
10. Other	• It was noted that the most EQRO report needs to go on the website. • Greg noted that the crisis plan uploading is on the Planning Committee agenda with the hope to implement by July 1. Stacey noted that this was halted at an earlier point; not that we can't upload but what elements are needed. We need an agreed upon transaction with how many data	Informational

	elements to include to move forward.	
11. Open Forum	None.	
12. Date and Agenda for Next Meeting	The meeting was adjourned at 2:50 pm. The next meeting is scheduled for Wednesday, March 28, 2012.	

NSMHA COMMITTEE DISCUSSION FORM

AGENDA ITEM: Consumer Transition from Psychiatrist to PCP

PRESENTER: Mark McDonald/Greg Long

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

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:
The transfer of consumers from seeing a psychiatrist to seeing a primary care provider (PCP) for psychiatric medication monitoring is very important to some consumers. Some consumers might prefer remaining longer under the supervision of a psychiatrist. For some consumers this transfer may cost the system more as the PCP may not be trained to recognize psychiatric symptoms and symptoms may go unnoticed. The client could decompensate necessitating much more intensive and costly care.

Could some of the reserve funds be used to cover this additional cost for this psychiatric time?

Issues to consider:

- What is the cost difference of seeing a psychiatrist versus a primary care provider?
  NSMHA response: NSMHA pays $324/hr for psychiatrist time. Primary Care provider time is probably less expensive, but it would depend on the system. The cost of primary care provider services is paid by the physical health care system and not the mental health system at the present time.

CONCLUSIONS/RECOMMENDATIONS:
This is an issue of concern raised by a consumer and should be considered by QMOC. This idea could be developed and submitted as a proposal for consideration for funding with the reserve funds that are currently available

TIMELINES: Proposals will need to be in to NSMHA by mid-April.

ATTACHMENTS: Policy 1546: MEDICATION MANAGEMENT TRANSFERS TO PRIMARY CARE PROVIDERS

Effective Date: 5/6/2099; 11/21/2005
Revised Date: 12/7/2011
Review Date: 12/14/2011

North Sound Mental Health Administration

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

Authorizing Source: 42CFR438.208; NSMHA
Cancels:
See Also: Approved by Executive Director Date: 2/22/2012
Providers must comply with this policy and individualized implementation guidelines may be developed by CMHAs.
Responsible Staff: Deputy Director Signature:

POLICY #1546.00

SUBJECT: MEDICATION MANAGEMENT TRANSFERS TO PRIMARY CARE PROVIDERS

PURPOSE

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

POLICY

For individuals receiving mental health specialty medication management services from a Community Mental Health Agency (CMHA), transfer to a Primary Care Provider (PCP) may be considered when:

1. The individual is on a stable medication regimen and there is no longer medical necessity for the specialty care of mental health medication management services at the CMHA. A stable medication regimen includes:

    a. Individuals without a complex medication regimen who have not had medication changes for a minimum of three months.
    b. Individuals with a complex medication regimen and/or have multiple psychiatric diagnoses requiring mental health specialty medication expertise who have not had medication changes for a minimum of six months.

        i. A complex regimen of medications includes, but is not limited to, prescription of two or more medications in the same class or three or more psychiatric medications.

2. The PCP becomes involved in making changes to medications currently prescribed by the CMHA prescriber and will not agree to stop making changes to those medications, even though this lack of coordination may put the consumer at risk.

    a. The CMHA shall continue to coordinate and consult with the PCP throughout the transfer process as noted below (i.e., long enough to ensure that medication management services have been successfully transferred to the PCP as documented in the clinical record).

3. The individual requests transfer of medication management services to his or her PCP.

Transfer of medication management services to a PCP shall occur in a coordinated process as outlined in the Procedure section of this policy.

Mental health specialist prescribers shall continue to provide medication management services except as identified above or when there is no PCP willing to accept the transfer. In addition, an individual who

only needs mental health specialty medication management services from the CMHA will not be referred or transferred to a PCP unless in accordance with this policy.

PROCEDURE

1. For individuals who do not have a PCP, CMHA staff shall refer and assist individuals in obtaining a PCP at the beginning of the treatment episode or as soon as the need is identified.
2. CMHA staff shall request from the individual and send an Authorization for Release of Information (ROI) to the PCP at the individual's first ongoing appointment after intake or as soon as the individual establishes care with a PCP.
3. CMHA staff shall contact the PCP once a need for mental health medication evaluation is identified to develop a plan for the medication evaluation and ongoing mental health medication management such as:

    a. Collaboration with the PCP so the PCP will provide the medication evaluation and ongoing medication management or;
    b. Collaboration with the PCP so the PCP will provide ongoing medication management after the initial medication evaluation at the CMHA or;
    c. Collaborating with the PCP so the PCP will provide ongoing medication management after medication services can be appropriately transferred from the CMHA to PCP.

4. CMHA staff shall communicate with the PCP throughout the individual's treatment episode including as outlined in NSMHA Policy #1517 Coordination of Care with External Health Care Providers.
5. When it is determined that the process for transferring medication management services to the PCP should begin, the following steps for coordinated transfer shall occur:

    a. The transfer of medication prescribing responsibilities shall be discussed with the individual prior to a transfer. The individual's preference shall be considered. This discussion shall be documented in the clinical record.

        i. The individual shall be informed verbally and in writing of their right to file a complaint or grievance in accordance with the current North Sound Mental Health Administration (NSMHA) policy.
        ii. The clinical record shall document the rationale outlining the reasons the individual is being referred or transferred to a PCP.

    b. Prior to the transfer of medication prescribing responsibilities, the PCP must agree to accept the referral or transfer of the individual. The clinical record shall document this understanding. If the PCP does not agree to accept this referral, the mental health specialist prescriber will continue managing the medications until an alternative arrangement can be developed.
    c. A plan shall be developed outlining what happens if the individual becomes unstable on medications and/or the PCP believes it would be better for the mental health specialist prescriber to consult or resume management of medications. The plan must:

        i. Include appropriate steps for the individual to follow if this situation arises after the end of a treatment episode. If these steps are not included in the initial plan, the plan must be updated prior to closing of the treatment episode. It is encouraged that this plan be included in the transition summary for the individual.

ii. Be developed collaboratively between the individual/guardian, mental health specialist prescriber and PCP.
iii. Identify a mental health specialist prescriber at the transferring CMHA who will be available to consult with the PCP accepting the transfer, if requested.

d. Appropriate psychiatric and medication records will be sent to the PCP as permitted by appropriate ROIs.
e. The CMHA shall keep the individual's treatment episode open long enough after transfer of medication management services to the PCP to ensure medication management services have been successfully transferred to the PCP as documented in the clinical record.

ATTACHMENTS

None

NSMHA COMMITTEE DISCUSSION FORM

AGENDA ITEM: HCA-OIG Health Care Fraud Prevention Initiative January 2012

PRESENTER: Lisa Grosso, Operations Manager/Compliance Officer

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

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:

DBHR Compliance forwarded a copy of what the state Health Care Administration (HCA) is sending out regarding the OIG Health Care Fraud Prevention Enforcement Action Team (HEAT). DBHR plans to endorse the use of these training videos as a provider resource, though they have no plans to send it out directly to providers. RSNs provided feedback to DBHR on how we plan to use the videos, with the following plan for NSMHA:

These YouTube training videos were reviewed by NSMHA, discussed by Leadership Team with the following plan endorsed by the Planning Committee:

1. OIG HEAT information to be shared at the next QMOC as a hand out
2. NSMHA to distribute the HCA document outlining the OIG HEAT training videos and their links for ongoing videos with a cover letter to provider agencies requiring this list of resources be made available to their healthcare professionals and included as a training resource as a part of each provider agency Compliance Plan.
    a. OIG HEAT indicates that there will be more information posted in the coming months and that these videos are just the first installment on what is to be a series. We propose to outline this in the NSMHA cover letter and ask that the provider agency Compliance Officer continue to update this resource in their Compliance Plan and internal communications with their healthcare professionals.
    b. NSMHA future audit of provider agencies will include a review of the Compliance Plan for inclusion of this resource and internal communication of this information to their healthcare professionals.

CONCLUSIONS/RECOMMENDATIONS: Execute the plan as described.

TIMELINES: Plan will be executed by the end of March 2012

ATTACHMENTS: HCA OIG Training Videos Communication January 2012

Washington State Health Care Authority

January 2012
Office of Inspector General Health Care Fraud Prevention Initiative

Recently, the Office of Inspector General (OIG) of the Department of Health and Human Services (HHS) released short video and audio presentations on top health care compliance topics. These presentations are part of an award-winning Health Care Fraud Prevention and Enforcement Action Team (HEAT) Provider Compliance Training initiative and are designed to assist providers in enhancing their compliance efforts.

The State of Washington Health Care Authority (HCA) is encouraging all Medicaid providers to take advantage of these presentations including the videos, webcasts and to read all presentation materials that are available on the following website: http://oig.hhs.gov/compliance/provider-compliance-training/index.asp. Additional videos and audio podcasts will be posted on the OIG website over the next few months. We recommend that providers frequently return to this website to keep up to date on the new OIG-HEAT hot topic presentations.

"These presentations provide an overview of the importance of promoting a culture of prevention, detection, and resolution of compliance problems," said Lewis Morris, Chief Counsel to the Inspector General.

The HCA specifically recommends the following videos and materials:

Exclusion Authorities & Effects of Exclusion

Summary: This video discusses OIG exclusion authorities, which are the legal means by which OIG may bar certain individuals and entities from participating as providers in Federal health care programs, including Medicare and Medicaid. This presentation also includes a discussion of the impact of exclusion on providers and the types of activities and actions that may lead to exclusion.

Video:
Exclusion Authorities & Effects of Exclusion

Materials related to presentation:
Understanding Program Exclusions

Navigating the Fraud & Abuse Laws

Summary: These segments of the HEAT Provider Compliance training videos and webcasts discuss information on the different Fraud and Abuse laws. The "Navigating the Fraud and Abuse Laws" webcast give a general overview of the physician self-referral law, anti-kickback Statute, False Claims Act, and

NSMHA COMMITTEE DISCUSSION FORM

AGENDA ITEM: Regional Co-Occurring Performance Measures-Changes to Impairment Kind Definition

PRESENTER: Diana Striplin

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

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY---

Agenda Item- Regional Performance Measure: (Increase Co-occurring Identification Rate for those over 13 years of age. It is captured by diagnosis and/or impairment kind).

1. NSMHA Leadership Team reviewed QMOC recommendation to change definition of impairment kind to clarify that it includes both abuse and dependence. Leadership Team agreed with the recommendation and made the change.

2. The new definition of Impairment Kinds for Substance Use and Substance Dependence is attached. (see attachment A).

3. Providers received a Contract Memorandum outlining the change.

4. Providers may begin using the new substance use and abuse impairment kind codes at this time.

   The complete definitions of the new codes can be found in the NSMHA Data Dictionary at:
   http://nsmha.org/datadict/codes/impk.aspx

5. The old definition and code will be retired June 30, 2012.

CONCLUSIONS/RECOMMENDATIONS: None

TIMELINES: The new definition of impairment kinds for substance use and substance dependence may be used now. The old definition can no longer be used after June 30 2012.

ATTACHMENTS: Attachment A –Change to Impairment Kind Definition

Attachment A

New Definitions

Substance Abuse
Abuse of substance(s) i.e. Currently has one or more of the following: recurrent use resulting in failure to fulfill major role obligations (work, home, or school), or recurrent use in physically hazardous situations, or recurrent substance related legal problems, or continued use despite persistent recurrent social or interpersonal problems caused or exacerbated by substance.

Substance Dependence
Dependence on substance(s) i.e. Currently has 3 or more of the following: tolerance (marked increase in amount or marked decrease in effect); characteristic withdrawal symptoms (substance taken to relieve withdrawal); substance taken in larger amount and for longer period than intended; persistent desire or repeated unsuccessful attempt to quit; much time/activity to obtain, use, recover; important social, occupational, or recreational activities given up or reduced; use continues despite knowledge of having a persistent physical or psychological problem likely caused or exacerbated by the substance.

NSMHA COMMITTEE DISCUSSION FORM

AGENDA ITEM: Annual report on "Allen-Marr" case reviews

PRESENTER: Tom Yost

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

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:

See Introduction and summary section of attached report.

CONCLUSIONS/RECOMMENDATIONS:

See Introduction and summary section of attached report.

TIMELINES: N/A

ATTACHMENTS:
Annual Report on "Allen-Marr" Reviews Covering October 2011 through CY 2011

Annual Report on "Allen-Marr" Reviews
Covering October 2010 through CY 2011

INTRODUCTION AND SUMMARY:

The "Allen-Marr reviews" grew out of a settlement reached in a class-action lawsuit. The suit was brought on behalf of people held in state psychiatric hospitals who have developmental disabilities and who have not been able to return to their communities for lack of necessary services. In NSMHA's region there are 40 people who are members of this "class".

First and foremost, the purpose of the reviews is to ensure that there is real coordination of care between DDD[1], mental health case managers and other service providers (e.g., residential services, vocational services, SOTP therapists, etc.) The team tries to determine if there is good communication between the professionals involved in a person's life. In addition, the review team looks at files and interviews service providers to make sure that class members are receiving the services they need.

In NSMHA's region the reviews are conducted by a team made up of a psychiatrist, a psychologist, a quality specialist from DDD and a representative from NSMHA. Up until recently NSMHA was represented by Tom Yost – a DD/Mental Health specialist. In 2011 Terry McDonough – a quality assurance specialist at NSMHA - took over that responsibility.

The following summarizes the findings and recommendations from the last 5 case reviews:

1. It is encouraging to see to see that 3 of the four consumers were active in other services besides medication management since often, in the past, professionals at many mental health agencies believed that people with developmental disabilities could not benefit from anything more than medication management and behavior modification programs.

2. WE STRONGLY RECOMMEND THAT CASE MANAGERS PARTICIPATE IN THE DEVELOPMENT OF CROSS-SYSTEMS CRISIS PLANS AT DDD AND MAKE SURE THAT A CURRENT PLAN IS KEPT IN THE MENTAL HEALTH CASE FILE (this has been a continuing problem.)

3. PER RCW, INITIAL ASSESSMENTS MUST BE CONDUCTED BY A MENTAL HEALTH/DEVELOPMENTAL DISABILITIES SPECIALIST OR THE ASSESSOR MUST CONSULT SUCH A SPECIALIST (this has been a continuing problem.)

4. Prescribers continue to provide thoughtful treatment and usually coordinate well with residential support providers. However, contact between DDD and mental health case managers is minimal and often non-existent. This is an issue that DDD must also address. DBHR thinks that it is not sufficient that mental health case managers have contact with residential programs in lieu of regular contact with the DDD case manager.

5. Their continues to be a problem with charts not containing state hospital discharge summaries.

6. **WE STRONGLY RECOMMEND THAT MENTAL HEALTH CASE MANAGERS HAVE REGULAR CONTACT WITH ANY OUTSIDE COUNSELOR AND THAT THE MENTAL HEALTH CASE MANAGER OBTAIN A COPY OF**

[1] DDD = Washington State's Division of Developmental Disabilities

THE OTHER COUNSELOR'S TREATMENT PLAN AND PROGRESS REPORTS WHICH ARE REQUIRED AND KEPT BY DDD.

A Couple of Suggestions

The team recommends that assessors or case managers ask DDD case managers what the source of a person's disability is (if known) and that the case manager discuss the relevant characteristics of that condition with the DD/mental health consultant. Important cognitive challenges are quite often not obvious and can hinder a person's ability to solve personal problems.

Most if not all people enrolled in the Allen-Marr lawsuit class have Positive Behavioral Support Plans and Functional Analyses of behaviors in their files at the Division of Developmental Disabilities. The team strongly recommends that assessors obtain these, if possible. If assessors cannot obtain these, case managers definitely should.

REVIEW RESULTS

The review team meets once every 3 months to review the services provided to one of the class members living in NSMHA's region. During the 15-month period covered by this review, the services provided to 5 class members were reviewed. Of those 5, 4 were enrolled in NSMHA-funded mental health services and one had received services previously. One of four was receiving medication services only but the other 3 were receiving medications plus another treatment such as case management or group counseling. It is encouraging to see to see that 3 of the four were active in other services since often, in the past, professionals at some mental health agencies believed that people who have developmental disabilities could not benefit from anything more than medication management and behavior modification programs. This result shows that mental health professionals are recognizing that people with Developmental Disabilities can benefit from the kinds of interventions that non-disabled people use.

Team reviews of mental health services focus on 6 areas:

- Cross-systems crisis planning;
- Any residential or vocational services provided by a NSMHA-funded agency;
- Provision of necessary and appropriate mental health services;
- Psycho-active medications;
- Coordination of care during crises and hospitalizations;
- Collaboration with DDD and other service providers.

AREA: CROSS-SYSTEMS CRISIS PLANNING

For some of their clients, DDD is required to convene a meeting at which a formal Cross-Systems Crisis Plan is developed. Mental health case managers or therapists are encouraged to attend these meetings. The plan is supposed to be reviewed annually and updated after any significant incidents. A copy of a fictitious plan is attached.

All 4 of the people who were enrolled in mental health services had Cross-Systems Crisis Plans. None of their mental health case files, however, contained a current Cross-Systems Crisis Plan. Two files had very old Plans and 2 had none at all. In addition, it appears that no-one from a mental health agency attended the planning meetings in at least 3 of the cases reviewed. WE STRONGLY RECOMMEND THAT CASE MANAGERS PARTICIPATE IN THE DEVELOPMENT OF CROSS-SYSTEMS CRISIS PLANS AND MAKE SURE THAT THEY HAVE A CURRENT PLAN IN THEIR FILES perhaps by contacting the DDD casemanager during scheduled treatment plan reviews. Cross-Systems Crisis Plans often contain information that is not otherwise available in mental health files. This one document contains all of the important contact information, cautions that should be observed in a crisis, specific interventions that work or that make a situation worse and some consumer information that might be helpful when trying to establish rapport with the person.

We have assumed that case managers and therapists know the distinction between the Cross System Crisis Plan written by DDD and the crisis plans they must develop and share with VOA but that may not be the case. It may be important to let case managers know that there may be two crisis plans for people enrolled in DDD services – one created by mental health and one created by DDD.

AREA: NSMHA-FUNDED RESIDENTIAL AND EMPLOYMENT SERVICES

All five of the people whose cases were reviewed were receiving residential support services funded by DDD. Likewise, any that received vocational services received them through DDD.

AREA: PROVISION OF NECESSARY AND APPROPRIATE MENTAL HEALTH SERVICES

Intake and assessment: INITIAL ASSESSMENTS MUST BE CONDUCTED BY A MENTAL HEALTH/DEVELOPMENTAL DISABILITIES SPECIALIST OR THE ASSESSOR MUST CONSULT SUCH A SPECIALIST and should note the results/recommendations coming out of that consult. Three of the five cases reviewed complied with this requirement while 2 did not. This is a requirement in the RCW. This has been a consistent problem.

Specialist consultations are not required after the initial evaluation but the review team strongly recommends it as a good clinical practice. Of the 3 files reviewed only one contained documentation of consultation after the initial evaluation. People who have developmental disabilities with long-term behavioral challenges often have been found to have medical, perceptual, environmental, physical or other problems that exacerbate if not cause their behavioral problems. Often this is not obvious until a counselor or other professional has gotten to know the person well and analyzed the contexts and outcomes of the person's behavior.

Treatment planning: as noted previously, the team was heartened to see that four of the five consumers whose cases were reviewed were provided more than just medication treatment. All treatment plans seemed reasonable given the information obtained at intake.

AREA: PSYCHO-ACTIVE MEDICATIONS

One member of the review team is a psychiatrist and she reviews any medication treatment that a person receives. It appears that prescribers continue to provide thoughtful treatment and often coordinate well with residential support providers. In general, prescribers have plans for tapering medications or good justification for not developing such plans. Of the 5 cases reviewed, 4 involved medication treatment. In three of those cases the prescriber documented that she had assessed the side effects of the prescribed medications. In one case, there was no indication that the prescriber had assessed side effects. Only one prescriber indicated that she routinely assessed side effects and used a standardized, side-effects assessment tool (MOSES, DISCUS, AIMS). In all cases where it might be an issue, it appeared that the prescribers had considered intra-class polypharmacy.

The psychiatrist on the review team has asked for copies of agencies' policies regarding the frequency of assessing side effects and the method that should be used. It appears that no agency has such a policy in this region although all agencies have a policy regarding educating consumers about possible side-effects.

AREA: COORDINATION OF CARE DURING CRISES AND HOSPITALIZATIONS

Their continues to be a problem with charts not containing state hospital discharge summaries. Two charts reviewed should have contained such summaries but neither did. The team specifically requests copies of these in advance of the case review meeting. Consistently DDD files contain these documents.

Coordination during hospitalization was not an issue in either case either because the person had not previously been enrolled in mental health services or the hospitalization was a forensic hospitalization that was converted to a civil one.

AREA: COLLABORATION WITH DDD AND OTHER SERVICES - APPEARS TO BE A PROBLEM AREA

When assessing coordination of care, the review team looks at several issues in order to determine if coordination is happening. We look to see if there is a *current* Cross Systems Crisis Plan in the file, for evidence that the mental health case manager participated in the development of the plan, if there are contacts between the mental health and DDD case managers documented in the DDD or mental health chart and if there is any documented evidence that the mental health case manager has been in touch with significant people in an individual's life.

Coordination between prescribers and residential providers continues to be good as it has been in the past. This is due in large part to the fact that residential staff often accompany their residents to med appointments. Typically, there is less contact between the mental health case manager and the residential provider. Of the 4 active cases reviewed, two showed evidence that there was any contact with a residential provider.

Contact between DDD and mental health case managers is minimal and often non-existent. Of the 5 cases, 2 had documentation that there was contact between the two case managers and, in one of those cases, there were only 2 brief telephone contacts to confirm appointments. In one case, a DDD case manager referred a consumer to a prescriber at a different agency in an emergency. The new prescriber took over the case but the DDD case manager never followed up with the mental health case manager to let her know that the consumer had a new prescriber.

In the past the review team has taken the position that documented contacts between a prescriber and residential staff was usually an adequate amount of coordination. After all, residential staff seem to be more knowledgeable about their residents than any other provider. But DBHR has recently told the team that it should pay more attention to the relationships between DDD and MH case managers. DBHR thinks that it is not sufficient that mental health case managers have contact with residential programs in lieu of regular contact with the DDD case manager.

Of greater concern was the lack of contact between mental health case managers and professionals providing other counseling services. Of the 5 people whose cases were reviewed, 3 were receiving some kind of counseling outside of a mental health agency. Typically they were receiving counseling around sexual behaviors (2 of the 5 were in community protection programs in which they must be under constant supervision.) In only one case was there any documentation that someone from a mental health agency contacted the outside counselor. It would be very easy for two professionals to inadvertently undercut each other's treatment when there is no communication. **WE STRONGLY RECOMMEND THAT MENTAL HEALTH CASE MANAGERS HAVE REGULAR CONTACT WITH ANY OUTSIDE**

COUNSELOR AND THAT THE MENTAL HEALTH CASE MANAGER OBTAIN A COPY OF THE OTHER COUNSELOR'S TREATMENT PLAN AND PROGRESS REPORTS WHICH ARE REQUIRED BY DDD.

OTHER

The team recommends that assessors or case managers ask DDD case managers what the source of a person's disability is (if known) and that the case manager discuss the relevant characteristics of that condition with the DD/mental health consultant. One consumer whose case was reviewed has Kleinfelter's Syndrome and another has Williams Syndrome. Both conditions are often accompanied by significant behavioral or cognitive issues that should be taken into account when providing case management or psychotherapy. Many cognitive features of a person's disability are not obvious but contribute significantly to a person's inability to solve personal problems.

Most if not all people enrolled in the Allen-Marr lawsuit class have Positive Behavioral Support Plans and Functional Analyses in their files at the Division of Developmental Disabilities. The team strongly recommends that assessors obtain these, if possible. If assessors cannot obtain these, case managers definitely should. These contain detailed information about specific behaviors and their contexts. They contain information about very specific ways to approach and support a person in crisis and approaches to avoid. They contain a wealth of information that case managers will rarely have about other people they serve.

NSMHA COMMITTEE DISCUSSION FORM

AGENDA ITEM: February 2012 Revision to P&P #1516.00 MHP Exceptions & Waivers
PRESENTER: Kurt Aemmer
COMMITTEE ACTION: **Action Item (x) FYI & Discussion () FYI only ()**
SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:

1. There has been some confusion in the past pertaining to MHP Waivers, resulting from some erroneous criteria written into the most recent P&P. P&P #1516.00 was rewritten, and a draft of this new policy was forwarded to the Department of Behavioral Health & Recovery (DBHR) where it was reviewed by two different individuals. This revised P&P reflects the suggested edits by those two consulting individuals:
    a. Criteria for Waiver Requests were clarified & narrowed, as "DBHR is moving away from granting waivers to individuals with less than masters degrees."
    b. Documentation of experience supervised by MHPs now requires signatures by the MHP who supervised the applicant.
    c. The *ROLE AND RESPONSIBILITY OF AN MHP* section was deemed unnecessary by DBHR consultants, and was removed.
    d. A statement pertaining to *exceptions not being transferred to another regional support network or to use for an individual other than the one named in the exception* was added.

CONCLUSIONS/RECOMMENDATIONS:

1. The revisions reflected in the attached draft of P&P #1516.00 now meets DBHR requirements, and NSMHA is seeking approval by QMOC.

TIMELINES: 2/22/2012

ATTACHMENTS: POLICY #1516.00

SUBJECT: MINIMUM REQUIREMENTS AND CERTIFICATION PROCESSES FOR REQUESTING MENTAL HEALTH PROFESSIONAL (MHP) EXCEPTIONS & WAIVERS

Effective Date: 6/26/2004
Revised Date: 3/26/08
Review Date:

North Sound Mental Health Administration

Section 1500 – Clinical: Minimum Requirements and Certification Processes for Requesting Mental Health Professional (MHP) Exceptions & Waivers

Authorizing Source: WAC 388-865-0265, WAC 388-865-0120, & RCW 71.24.260
Providers must comply with this policy and individualized implementation guidelines may be developed by CMHAs
See Also: Approved by: Executive Director Date: ~~3/31/08~~
Responsible Staff: Deputy Director~~Quality Manager~~ Signature:

POLICY #1516.00

SUBJECT: MINIMUM REQUIREMENTS AND CERTIFICATION PROCESSES FOR REQUESTING MENTAL HEALTH PROFESSIONAL (MHP) EXCEPTIONS & WAIVERS

PURPOSE

To delineate the requirements for an individual to hold the status of a Mental Health Professional (MHP) and to describe the mechanisms put forth by the Washington State Department of Social and Health Services (DSHS) under which clinicians may apply for, and North Sound Mental Health Administration (NSMHA) may request, exceptions **or** waivers for these requirements.

~~**NOTE: The individual who meets all MHD criteria except the Master's degree credential, and is working toward attaining a Master's degree should apply for the time-limited (2 year) *exception*. The individual who meets all MHD criteria except the Master's degree credential, but has no intention to pursue a master's degree in the near future, or has a Master's degree but cannot document their experience, should apply for the *waiver*. The waiver is only in effect for the duration of the license of the agency which employs the applicant. Because the provider agency must reapply for a license every year, the waiver is only valid as long as the agency is licensed. All waivers are time-limited and must be reapplied for annually.**~~

POLICY

Mental Health Professional (MHP) - Under WAC (Washington Administrative Code) 388-865-0150, a "Mental Health Professional" is:

1. A psychiatrist, psychologist, psychiatric nurse or social worker as defined in chapter 71.05 and 71.34 RCW (Revised Code of Washington);
2. A person with a master's degree or further advanced degree in counseling or one of the social sciences from an accredited college or university. Such person shall have, in addition, at least two years of experience in direct treatment of persons with mental illness or emotional disturbance, such experience gained under the supervision of a mental health professional;
3. A person who meets the waiver criteria of RCW 71.24.260, which was granted prior to 1986;
4. A person who had an approved waiver to perform the duties of a mental health professional that was requested by the regional support network and granted by the mental health division prior to July 1, 2001; or
5. A person who has been granted a time-limited exception ~~or waiver~~ of the minimum requirements of a mental health professional by DSHS consistent with WAC 388-865-0265.

~~**ROLE AND RESPONSIBILITIES OF AN MHP**~~

~~Under WAC 388-865, only an MHP can:~~

~~1. Be eligible for designation as a mental health specialist for children, geriatrics, ethnic minorities and/or disabled persons;~~
~~2. Review and sign off on assessments, treatment plans and revisions of plans; and~~
~~3. Perform clinical supervision.~~

If the Mental Health Care Provider (MHCP) does not meet the definition of an MHP, but the agency needs the MHCP to function in the role of an MHP, there are two options that allow for this for which the MHCP may qualify for:

MHP Time-Limited Exception

A time-limited exception of the requirements of an MHP may be requested for an individual with less than a master's degree level of training when there is a demonstrated need and it is established that the individual is qualified to perform the required functions based on verification of required education and training, including:

1. Bachelor of arts or sciences degree from an accredited college or university; and,
2. Course work or training in making diagnoses, assessments, and developing treatment plans; and,
3. Documentation of at least five years of direct treatment to persons with mental illness under the supervision of an MHP; and,
4. Plan of action to become qualified as an MHP no later than two years from the date of exception. Application for renewal is allowed. The exception may not be transferred to another regional support network or be used for an individual other than the one named in the exception.

The exception may not be transferred to another regional support network or to use for an individual other than the one named in the exception.

~~Under WAC 388-865-0265, an individual who does not meet the Master's degree requirement for an MHP as defined in this exhibit, but is otherwise qualified and is currently enrolled in or intends to enroll in a graduate program wherein graduation from that program will result in the candidate holding at least a master's degree within two years from the date of exception approval, may become an MHP under a time-limited (up to two years) exception process conducted by NSMHA.~~

MHP Waiver

MHP waivers of postgraduate educational requirements applicable to mental health professionals may be requested for individuals who have a bachelor's degree and on June 11, 1986:

1. Were employed by an agency subject to licensure under this chapter (71.24), the community mental health services act, in a capacity involving the treatment of mental illness; and
2. Had at least 10 years of full-time experience in the treatment of mental illness.

Requests for MHP exceptions and waivers shall be directed to NSMHA as NSMHA has the responsibility for review and forwarding of all requests for MHP exceptions and waivers to DSHS. NSMHA will conduct a review process for persons who apply in writing for an MHP exception. After the NSMHA review, requests meeting the identified criteria are sent to DSHS for their approval. All exceptions and waivers must have DSHS approval before the individual acts as an MHP.

PROCEDURE

~~**MHP TIME-LIMITED EXCEPTION PROCEDURE**~~

~~Responsibility for review and forwarding of all requests for MHP exception shall be the responsibility of NSMHA Quality Manager or their designee. NSMHA will conduct a review process for persons who apply in writing for an MHP exception. After the NSMHA review, the request for an exception is sent to MHD for their approval. All exceptions must have MHD approval before the individual acts as an MHP~~

Applying for a Time-Limited Exception

Applicants must complete the attached "EXCEPTION REQUEST MENTAL HEALTH PROFESSIONAL" form (Attachment #1516.01), and include the following information:

1. Name, address & phone number of entity (NSMHA) making request for the applicant;
2. Name of applicant (person for whom exception is being requested);
3. Provider agency with whom the above applicant is employed;
4. Affirmation that the above agency is contracted with NSMHA;
5. Description of functions the applicant will be performing;
6. Statement of need for the exception;
7. Attachments of documentation to verify the following qualifications:
    a. Bachelor of arts or sciences degree from an accredited college or university (must reflect degree, year, and institution);
    b. Course work or training in diagnoses, assessments, and developing treatment plans; and,
    c. ~~Documentation~~ Signed documentation of at least five years of direct treatment of persons with a mental illness under the supervision of a mental health professional.
8. A plan of action to assure that the applicant will become qualified no later than two years from the date of the exception approval;
9. Signed and dated assurance that periodic evaluations of the applicant's job performance are conducted.

In addition to the above information provided by the applicant, NSMHA will augment the application with the following before submitting it to DSHS:

1. Statement, based on verification of required education and training, that the applicant is qualified, based on the applicant's meeting the requirements listed above in items 7a – c;
2. Statement that periodic supervisory evaluations of the individual's job performance are conducted;
3. A plan of action to assure the individual will become qualified no later than two years from the date of exception;
4. Dated signature reflecting NSMHA approval.

~~**MHP WAIVER POLICY:** Under WAC 388-865-0120, a person who does not meet the master's degree criteria to be an MHP as defined in this exhibit, but is otherwise qualified, can become an MHP under a waiver process approved by MHDADSA and conducted by the NSMHA.~~

~~**MHP WAIVER PROCEDURE**~~

~~Responsibility for review and forwarding of all requests for MHP waivers shall be the responsibility of the NSMHA Quality Manager or their designee. NSMHA will conduct a review process for persons who apply in writing for an MHP waiver. After the NSMHA review, a request for the waiver is sent to MHDADSA for their approval. All waivers must have MHDADSA approval before the individual acts as an MHP.~~

Applying for a Waiver
Applicants must complete the attached "WAIVER REQUEST MENTAL HEALTH PROFESSIONAL" form (Attachment #1516.02), and include the following information:

1. Name, address & phone number of entity (NSMHA) making request for the applicant;
2. Name of applicant (person for whom waiver is being requested);
3. The specific section or subsection of these rules for which the waiver is being requested (WAC-388-865-0150);
4. Reason why the waiver is necessary, or method that will be used to meet the desired outcome of the section or subsection in a more effective and efficient manner;
5. Description of how the results/outcome of this improved method will be tested to ensure that the intent of the section or subsection is met;
6. Description of the qualifications of the waiver applicant, justification for the waiver and the plan and timetable to achieve compliance with the minimum standard; and to implement, test, and report results of improved ways to meet the intent of the section or subsection;
7. Description of recommendations from the Quality Review Team or Ombuds staff and a description of how consumers will be notified of changes made as a result of the waiver. Please write in N/A if this section does not apply.

In addition to the above information provided by the applicant, NSMHA will augment the application with the following before submitting it to DSHS:

1. Statement of support;
2. Dated signature reflecting NSMHA approval.

Documentation in Personnel Files
1. Personnel files of all persons functioning as MHPs shall contain either documentation that the WAC standards are met or a copy of the approved exception or waiver.
2. Employees who do not meet WAC standards for MHP cannot function as MHPs unless and until the exception or waiver is submitted and approved by DSHS. The provider shall place appropriate documentation in each MHP personnel file to show that standards have been met.
3. An annual review will be conducted as part of the NSMHA monitoring of performance standards.

ATTACHMENTS

1516.01 – EXCEPTION REQUEST MENTAL HEALTH PROFESSIONAL
1516.02 – WAIVER REQUEST MENTAL HEALTH PROFESSIONAL

Comment [cw1]: Have these been reviewed to ensure that they don't need any changes as well?

NSMHA COMMITTEE DISCUSSION FORM

AGENDA ITEM: Policy 1541 Use of Seclusion and Restraint

PRESENTER: Sandy Whitcutt or Charissa Westergard

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

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY: This policy describes the rationale, conditions and parameters in the use of seclusion and restraint for the purpose of maintaining health and safety for individuals 18 and older who are in danger of harming themselves or others and utilizing these measures as a last resort. The policy went through major revision in 2009. It has been revised this year as a result of an EQRO review recommendation.
There were two points:

- EQRO found the policy to be well written, but needing to specify that outpatient providers will not use seclusion and restraint as a means of coercion, discipline, convenience or retaliation.
- EQRO found that NSMHA monitored the E and T facility policies on seclusion and restraint, but did not review such policies and procedures at outpatient agencies. NSMHA needs to monitor all contracted policies and procedures in this area.

NSMHA made the changes to the policy to reflect the above recommendations. The policy was sent to QMOC for review. It was also sent to DBHR for comments. There were no comments sent back from QMOC. There were comments from DBHR. These are noted below:

- Under the Policy section, Use of Seclusion and Restraint, in the second paragraph beginning with the use of seclusion and/or restraint must be: in 1) and in subsequent sentences (b,c,e,) thereafter delete the phrase "or other authorized licensed practitioner". WAC 388-865-0545 only allows a physician to give authorization.

- In addition to that list add a new item WAC 388-865-0545(2). To item 1) d) add a sentence "No consumer can be restrained/secluded for a period in excess of two hours without having been evaluated by an MHP."

NSMHA's comments

- While WAC 388-865-0545 does not use the phrase "or other authorized licensed practitioner," WAC 246-337-110 (DOH RTF seclusion and restraint WAC) uses the language of "or other authorized health care provider." The language we used "or other authorized licensed practitioner" was negotiated with the providers the last time this policy was revised.

- DBHR indicates adding #2 from WAC 388-865-0545, but it is already in there in the paragraph before where they indicated they wanted it.

- "No consumer can be restrained/secluded for a period in excess of two hours without having been evaluated by an MHP" is in the WAC regarding children (388-865-0546), not adults. WAC 246-337-110 further identifies this two hour requirement for children age 9-17. Our policy indicates it does not apply to individuals under 18 so it would seem this DBHR recommendation should not be included.

CONCLUSIONS/RECOMMENDATIONS: The policy, revised as written, appears to adequately cover the issues addressed by EQRO. The comments offered by DBHR have been reviewed, are felt to be addressed in the current revision, and have not been included. QMOC should discuss the above.
The recommendation is that the policy with the current revisions should be approved.

TIMELINES: This policy, if approved will go into effect 60 days after posting on the web.

ATTACHMENTS: Policy 1541

Effective Date: 4/10/2009; 11/21/2005
Revised Date: 3/25/2009
Review Date: 3/25/2009

North Sound Mental Health Administration

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

Authorizing Source: WAC 246-337-110; WAC 388-865-0545; 42CFR438.100; 42CFR483; 42CFR482
Cancels:
See Also: Approved by: Executive Director Date: ~~4/10/2009~~
Providers must comply with this policy and individualized implementation guidelines may be developed by CMHAs~~E&T Facilities must have a "policy consistent with" this policy~~
Responsible Staff: Quality Manager Signature:

POLICY #1541.00

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

PURPOSE

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

DEFINITIONS

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

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

POLICY

Other than an Evaluation & Treatment facility (E&T), no NSMHA-contracted provider shall utilize seclusion or restraint for any purpose. The remainder of this policy and procedure is intended to describe the rationale, conditions and parameters in the use of seclusion and restraint at an E&T only.

The use of seclusion or restraint must occur only when there is imminent danger to self or others and less restrictive measures have been determined to be ineffective to protect the individual and/or others from harm. All individuals have the following rights and their rights should only be limited when less restrictive measures are clearly evident to be ineffective in protecting the individual or others from harm:

1) Individuals have the right to be free of seclusion and restraint, including chemical restraint.
2) Individuals have the right to be free from any form of seclusion and restraint used as a means of coercion, discipline, convenience, or retaliation.

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

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

PROCEDURE

The procedures that follow are intended to apply only to an E&T as seclusion and restraint may not be used by any other NSMHA-contracted providers.

Interventions Utilized Prior to Seclusion and/or Restraint

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

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

    a) Verbal re-direction/reassurance
    b) Removal of source of stimuli (e.g., music, TV, another individual)
    c) Environmental change
    d) Limit setting
    e) Diversionary activities
    f) Encouragement for individual to express concerns
    g) Alternative/choice
    h) Comfort
    i) 1:1 staff interaction
    j) Voluntary time-out

        i. Time out may take place away from the area of activity or from other individuals, such as in the individual's room (exclusionary), or in the area of activity or other residents (inclusionary)
        ii. Individual in time out must never be physically prevented from leaving the time out area
        iii. Staff must monitor the individual while in time out

    k) Medication
    l) Increased staff presence

Use of Seclusion and Restraint

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

The use of seclusion and/or restraint must be:

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

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

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

2) In accordance with a written modification to the individual's plan of care;

3) Implemented in the least restrictive manner possible;
4) In accordance with safe appropriate restraining techniques;
5) Ended at the earliest possible time;
6) Seclusion may not be used unless the individual is continually monitored 1:1 by staff either face-to-face or using both video and audio equipment. The video and audio monitoring must be done in close proximity to the individual.

7) Restraint may not be used unless the individual is observed under the following conditions:

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

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

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

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

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

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

    a) Safety checks to be conducted and documented every:

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

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

Conditions for the Discontinuation of Use of Seclusion & Restraint

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

Reporting of Injury or Death

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

Education and Training

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

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

2) Certification in the use of cardiopulmonary resuscitation (CPR), including periodic recertification, is required. Staff must demonstrate their competencies in this area on an annual basis.
3) Staff training must include training exercises in which staff members successfully demonstrate in practice the techniques they have learned for managing emergency and safety situations.
4) Training identified in 1 and 2 of this section must be provided by individuals who are qualified by education, training and experience.
5) The facility must document in the staff personnel records that the training and demonstration of competency were successfully completed. Documentation must include the date training was completed and the name of persons certifying the completion of training.
6) All training programs and materials used by the facility must be available for review by NSMHA, Centers for Medicare and Medicaid Services and relevant state agencies.

Conditions for Debriefing/Quality Improvement Activities

1) Staff must conduct and document a post-intervention debriefing with the individual to discuss precipitating factors leading to the need for intervention.

2) Staff involved in the restraint or seclusion will debrief and address effectiveness and safety issues to include the following questions. The results of these questions will be documented and monitored with quality improvement activities initiated as warranted:

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

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

ATTACHMENTS

None

NSMHA COMMITTEE DISCUSSION FORM

AGENDA ITEM: NSMHA Policy 1551 Individual Service Plans (Resiliency/Recovery Plans)

PRESENTER: Charissa Westergard

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

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:
This policy was recently revised and approved (11/29/11), but due to the revision of another policy, language was removed from that policy and added to this policy (see track changes) as it related to special population consultation, which is referenced in 1551. The end result is that specific subject matter information is contained within one policy and the policies don't contain duplicative information, which makes revising policies easier in the future.

The only feedback received was from DBHR. Their feedback indicated that, in regards to 6a, WAC states "The plan includes at least one goal/objective identified by the individual or parent/legal representative if applicable *at the intake evaluation or the first session following the intake evaluation*." NSMHA did not include the italicized phrasing as the NSMHA believes the plan, at all points in time, should include at least one goal/objective identified by the individual/parent/legal representative. This standard has been discussed previously with providers and QMOC when the UR Tool was revised and when the policy was reviewed in October. This is not a change in this revision. NSMHA's standard is written so that compliance with the NSMHA standard would also result in compliance with the WAC in chart review.

CONCLUSIONS/RECOMMENDATIONS:
Request that policy be recommended as written.

TIMELINES:
This policy has been out for comment for 30 days. This is the first presentation to QMOC of this revision.

ATTACHMENTS:
Policy 1551 Individual Service Plans (Resiliency/Recovery Plans)

Effective Date: 10/6/2010; 7/31/2008; 11/21/2005
Revised Date: 9/20/2011
Review Date: 10/19/2011

North Sound Mental Health Administration

Section 1500 – Clinical: Individual Service Plans (ISP) (Resiliency/Recovery Plans)

Authorizing Source: WAC 388-865-0425, WAC 388-865-0405(5); U.S. Code Title 20, Chapter 33, Subchapter III, Section 1436
Cancels:
See Also: Approved by: Executive Director Date: 11/29/2011
Providers must comply with this policy and individualized implementation guidelines may be developed by CMHAs~~Providers shall "comply with" this policy~~
Responsible Staff: Deputy Director Signature:

POLICY# 1551.00

SUBJECT: INDIVIDUAL SERVICE PLANS (ISP) (RESILIENCY/RECOVERY PLANS)

PURPOSE

To ensure development of the Individual Service Plan (ISP) (also referred to as Resiliency/Recovery Plan) is a collaborative effort between the individual, or individual's parent or legal representative if applicable, and Mental Health Care Provider (MHCP) that results in a consumer-driven, strength-based plan that meets the individual's unique mental health needs.

POLICY

The term Individual Service Plan (ISP) is terminology utilized in Washington Administrative Code (WAC). While it is acceptable to use this terminology, NSMHA strongly encourages providers to use the term Resiliency or Recovery Plan or similar terminology (e.g., Individual Recovery Plan or Wraparound Plan). These terms better reflect the region's focus on integrating the fundamentals of recovery as found in the National Consensus Statement on Mental Health Recovery. Further, plans shall reflect the principles and fundamentals found in the NSMHA *Guidelines to Person-Centered Recovery and Resiliency*.

Individual recovery planning is an ongoing, dynamic process that begins at the intake assessment. A clearly articulated plan provides the following benefits to the individual and the treatment team:

1. Serves as a roadmap for the individual and the treatment team, providing direction and allowing the team and individual or family to evaluate the individual's progress toward his/her treatment goals and the effectiveness of interventions;
2. Supports the individual as he/she works through his/her personal recovery process;
3. Documents both individual and provider responsibilities towards recovery.

Resiliency/Recovery Plans reflect:

1. Goals that address individual needs identified at intake and throughout the treatment episode. This may include, but is not limited to:

    a. Mental health needs (i.e., related to diagnosis) necessitating current treatment episode;
    b. Non-mental health needs requiring referral;
    c. Risk factors;
    d. Rationale for deferring treatment/referral of a need.

2. Individual's stated recovery goals and desired outcomes (discharge criteria)
3. Interventions and services that are recovery-oriented and can reasonably be expected to assist

the individual in achieving his/her goals.

If an individual disagrees with specific treatment recommendations or is denied a requested treatment service, they may pursue their rights under WAC 388-865-0255.

PROCEDURE

The Community Mental Health Agency (CMHA) must have a consumer-driven, strength-based Resiliency/Recovery Plan that meets the individual's unique mental health needs and promotes the individual's resiliency and recovery. The plan must be developed in collaboration with the individual, or the individual's parent or other legal representative if applicable. The plan must:

1. Be developed within thirty days from the first session following the intake evaluation.
2. Address age, cultural or disability issues identified by the individual, or their parent or other legal representative if applicable, as relevant to treatment.
3. Include treatment goals or objectives that are measurable and that allow the MHCP and individual to evaluate progress toward the individual's resiliency/recovery goals.
4. Be in language and terminology that is understandable to the individual and his/her family.
5. Identify medically necessary service modalities, mutually agreed upon by the individual and MHCP, for this treatment episode.
6. Demonstrate the individual's participation in the development of the plan.

    a. The plan includes at least one goal/objective identified by the individual or parent/legal representative if applicable.
    b. Participation may be demonstrated by the individual's signature and/or quotes documented in the plan.
    c. Participation must include family or significant others as requested by the individual or as applicable for individuals under 13 or who have a legal representative.

7. Document that the MHCP collaborating on the plan is a Mental Health Professional (MHP) or that the plan has been reviewed by a MHP (i.e., signature of MHP on the plan).
8. Document inclusion of recommendations and/or signature on the plan of the appropriate mental health specialist(s) in cases where the individual is identified as being a member of an under-served population and the MHCP or supervisor involved in developing the plan is not a mental health specialist for that population, per WAC 388-865-0405(5).

    a. Consultation with the appropriate mental health specialist(s) must be completed within 90 days of the first session following the intake evaluation.

9. Include documentation that the individual's plan was reviewed at least every 180 days and as necessary updated sooner to reflect any changes in the individual's treatment needs or as requested by the individual or their parent or other legal representative, if applicable.

    a. For review of individuals' plans for which the treatment is provided under the supervision of or in consultation with a mental health specialist, the mental health specialist shall be included in the review when/if indicated by the mental health specialist.

Comment [cw1]: Previously in Policy 1558

~~9.~~10. Coordinate with any other systems or organizations when required or that the individual identifies as being relevant to his or her treatment with the individual's consent or their parent

or other legal representative, if applicable. This includes, but is not limited to, coordination with any Individualized Family Service Plan (IFSP) when serving children less than three years of age.

~~10.~~11. Contain crisis planning for all individuals Level 4 and up (as identified by Child and Adolescent/Level of Care Utilization System – CA/LOCUS) and all other individuals as clinically indicated. The crisis plan may be a separate document from the Resiliency/Recovery Plan. Elements of a thorough crisis plan include:

a. Individual and family voice.
b. Focus on health and safety of individual, family and others (e.g., natural supports, professionals).
c. Roles, directives and responsibilities of individual and family and others.
d. Early warning signs of decompensation.
e. How to contact both formal and natural supports (contact phone number for MHCP and Crisis Line at minimum).
f. Proactive and progressive measures to prevent a crisis.
g. Proactive and progressive measures for intervening in a crisis.

~~11.~~12. Progress notes shall clearly reflect provision of treatment consistent with the Resiliency/Recovery Plan.

~~12.~~13. The treatment proposed and provided is consistent with NSMHA clinical guidelines. In the absence of a NSMHA clinical guideline, treatment follows generally accepted clinical practice for the individual's diagnosis.

ATTACHMENTS

None

NSMHA COMMITTEE DISCUSSION FORM

AGENDA ITEM: 1725 policy - Mobile Outreach Team

PRESENTER: Sandy Whitcutt or Greg Long

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

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:

The Mobile Outreach Team (MOT) program is part of an integrated, coordinated and seamless crisis response system for the North Sound Mental Health Administration (NSMHA) and its member counties: Island, San Juan, Skagit, Snohomish and Whatcom (the "NSMHA Service Area"). These teams are currently established in Skagit and Whatcom counties.

MOT has a workgroup developed to address program issues and refine this pilot as changes are needed. One such change occurred following the January workgroup. A decision was made to change access to the services in order to increase use of the team. The decision was made to open access to include calls coming in directly to the team in addition to the Care Crisis line. It was felt that individuals needing the MOT may not necessarily call the crisis line, but call from other sources. The policy recently approved by QMOC addresses the slight change in language to capture the change.

Please see the attached policy that addresses the change.

CONCLUSIONS/RECOMMENDATIONS:
Approval of policy with slight change

TIMELINES:
This will officially go into effect 60 days after the numbered memo has been sent to providers**.** The providers have already started functioning on this basis to increase utilization of this program.

ATTACHMENT:
1725 Mobile Outreach Team policy

Effective Date: 11/29/11
Revised Date: 9/13/11
Review Date: 10/19/11

North Sound Mental Health Administration

Section 1700 – Crisis Services – Mobile Outreach Team

Authorizing Source: NSMHA
Cancels:
See Also: Approved by: Executive Director Date: 11/29/2011
Providers must "comply with" this policy
Responsible Staff: Deputy Director Signature:

POLICY #1725.00

SUBJECT: MOBILE OUTREACH TEAM

PURPOSE
To define the role of the Mobile Outreach Team (MOT) which is intended to provide more outreach to individuals in the community to prevent mental health crises, as well as, prevent unnecessary emergency department admissions and inpatient psychiatric hospitalizations.

POLICY
The MOT program is part of an integrated, coordinated and seamless crisis response system for the North Sound Mental Health Administration (NSMHA) and its member counties: Island, San Juan, Skagit, Snohomish and Whatcom (the "NSMHA Service Area"). Initially, these teams will be established in Skagit and Whatcom counties.

The program is intended to provide early intervention to assess, engage, provide temporary support and make appropriate referrals to community resources for individuals who are not currently enrolled in the outpatient public mental health system. The MOTs shall respond to non-emergent mental health situations (i.e., the severity and/or acuity of the individual's behavior/situation does not meet criteria for either emergency services or an involuntary treatment investigation). Non-emergent mental health situations are defined as those situations where the level of stress has overwhelmed the individual's ability to cope and earlier support/intervention may alleviate the effects of the stressful situation.

The MOTs are intended to prevent crises so that:

1. People are stable and safe living in the community;
2. People do to not have to go to emergency departments to prevent crises;
3. The number of people needing admission into inpatient psychiatric services can be reduced.

These teams shall respond to calls dispatched by the Volunteers of America (VOA) Care Crisis Line and integrate with existing Emergency Services and Involuntary Treatment Investigation Services. As indicated above, these teams are not intended to respond to emergent mental health crises.

PROCEDURES

I. MOT Responsibilities:
Each team will:

A. Provide community outreach as defined below;
B. Be comprised of two members, a mental health professional and a peer counselor;

C. Be available Monday through Friday between the hours of 1pm to 9pm;
D. Be stationed at their assigned place of work when not out in the community;
E. Take referrals from calls to the Care Crisis Line and direct access calls from the community;
F. Respond to pages from Volunteers of America Care Crisis within 10 minutes;
G. Respond to calls dispatched by VOA as rapidly as possible, and attempt to make phone or face to face contact with the individual or concerned caller within 24 hours. Attempts to contact the individual or concerned caller should be documented by the MOT;
H. Utilize family, community, and other natural supports;
I. Provide stabilization services that can last up to 4 hours (average per contact), and provide up to 10 hours (average), per individual, of direct services within a 30 day time period;
J. Integrate services with existing Emergency Services system and involved treatment providers as appropriate; and
K. Report these services into the Mental Health Consumer Information System as Crisis Services.

II. MOT Community Outreach expectations:

At a minimum, 75% of MOT services will be provided in the home and in community settings.

Community outreach is considered to be at the person's home, place of work, school, community centers, or other community setting (e.g., restaurant). It does not include hospitals, Emergency Departments, or Community Mental Health Agency (CMHA) offices. Teams will:

A. Assess the situation.
B. Provide support to the individual and other involved parties.
C. Work to engage the person and/or stabilize the situation.
D. Develop a recovery-oriented stabilization/disposition plan with the individual and available supports.
E. Make referrals and connect people to appropriate resources.

    1. Discharge resources can include crisis triage centers, coordination with existing Community Mental Health providers, and other service providers.

F. Provide coordination of care with care providers.
G. Contact VOA Care Crisis with a stabilization/disposition plan upon completion of the initial contact.
H. Provide necessary follow up to the family or other identified caregivers and supports to include phone calls and outreach.
I. Follow-up to ensure engagement into services.