NORTH SOUND
MENTAL HEALTH ADMINISTRATION

QUALITY MANAGEMENT OVERSIGHT COMMITTEE

MEETING PACKET

March 27, 2013
1:00 – 3:00 pm

1. Please join my meeting, Wednesday, March 27, 2013 at 1:00 PM Pacific Daylight Time.
https://www3.gotomeeting.com/join/829787046

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

Dial +1 (213) 289-0016
Access Code: 829-787-046
Audio PIN: Shown after joining the meeting

Meeting ID: 829-787-046

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.**
- **Manage your BEHAVIOR, be mindful of how you respond to others, understand intent vs. impact, and be responsible for your words and actions.**
- **Demonstrate RESPECT and speak with RESPECT toward each other at all times.**
- **LISTEN, people feel respected when they know you're listening to their point of view.**
- **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: 11/28/12

NORTH SOUND MENTAL HEALTH ADMINISTRATION
QUALITY MANAGEMENT OVERSIGHT COMMITTEE AGENDA

Date: March 27, 2013 **Time:** 1:00-3:00 PM

Location: NSMHA Conference Room **Chair:** Rebecca Clark, Skagit County Human Services

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**	
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	• Illness Management and Recovery Consultation • RFQ Update • Peer Training in spring and fall • Youth Mental Health First Aid Trainers • Agency Affiliated Counselors Bill • MPC Request Process Reminder • Other						*15 min*
Update on Regional Healthcare Alliance and Health Care Reform	Brief update	Inform /discuss	Chair/ Greg				*10 min*
Quality Topics							
Critical Incident Report	Review of the critical incident reports for the last six months of 2012	Inform /discuss/ Approval	Kurt Aemmer	Committee Discussion Form		**3**	*10 min*
Second Opinion Report	Review of the 2nd Opinion Requests for the last six months of 2012	Inform /discuss/ Approval	Kurt Aemmer	Committee Discussion Form		**4**	*10 min*
NSMHA Strategic Plan, Goals and Objectives	Review of NSMHA's recently approved Strategic Plan	Inform/ discuss	Greg	Committee Discussion Form		**5**	*10 min*
Match of Ethnicity of Consumers and Staff	Presentation of data and discussion regarding the match of ethnicity consumers with staff expertise.	Inform /discuss	Greg Long Rebecca Clark	Committee Discussion Form		**6**	*15 min*
Conversion to DSM V	Discussion regarding the conversion from the DSM IV-TR to the DSM V	Inform /discuss	Greg Long Stacy Alles	Committee Discussion Form		**7**	*15 min*
WSH Adequacy of Discharge Options	Presentation of data and discussion regarding the discharge options for people from WSH.	Inform /discuss	Mike Manley	Committee Discussion Form		**8**	*15 min*
Other issues							
***Review of Meeting**	Were objectives accomplished? How could this meeting be improved? Complete Evaluation Forms						*5 min*
Date and Agenda for Next Meeting	Ensure meeting date, time and agenda are planned						

Next meeting: April 24, 2013- 1:00-3:00 PM **Potential Future Agenda Items:**

North Sound Mental Health Administration (NSMHA)
Quality Management Oversight Committee (QMOC)
NSMHA Conference Room
February 27, 2013
1:00 – 3:00 pm
MEETING SUMMARY

PRESENT: Mark McDonald, Joan Lubbe & David Kincheloe, NSMHA Advisory Board; Dan Bilson, NAMI Whatcom; Mike Watson, LWC; Larry Van Dyke, Skagit Triage Center; Chuck Davis, ombuds; Stacey Alles, Compass Health; Rebecca Clark, Skagit County; Mike Manley, Sunrise Services and Kathy McNaughton, CCS.
BY PHONE: Kate Scott, Sea Mar; Pam Benjamin, WCPC; Anne Deacon, Whatcom County and Richard Sprague, Interfaith.
STAFF: Greg Long, Charissa Westergard, Kurt Aemmer, Dennis Regan and Barbara Jacobson.
OTHERS PRESENT: Cammy Prince, Sunrise Services.

TOPIC	DISCUSSION	ACTION
1. **Introductions, Review of Agenda – Chair**	The meeting is called to order at 1:00 pm and introductions were made. Additions and corrections to the agenda were called for and none were mentioned.	
2. Previous Meeting Summary – Chair	The minutes from the previous meeting were reviewed and they were approved as presented.	Approved
3. Announcements and Updates – All	• **Illness Management Recovery (IMR) Consultation-**Greg noted that NSMHA is moving ahead and is contracting with the same person that led the original training and he will be working with her to set things up. There are nine programs across 4 agencies that are signed up and Greg asked if there is a preference on dividing the consultations by program or agency. Mike W mentioned that LWC is obtaining their own training from WIMIRT and will not need to be included. Providers are flexible in this regard however it may be better to have programs together to have a mix of perspectives. Greg hopes to have it starting in March and will be sending out emails. • **2013 Request for Qualifications (RFQ)-**Greg noted that all the current providers and three new agencies submitted proposals and the selection committee has met and scored them. NSMHA is projecting that funding will go up about 10 percent with the increase in Medicaid eligibles. A funding model was developed and has gone to the county coordinators and will go to Advisory Board next week; at which time it will be a public document. After that it will go to the Board of Directors and after the final approval process negotiations with agencies will begin. Kathy M asked if there will be an opportunity for provider feedback before it is finalized and Greg noted that in contract negotiations things will be more concrete as there are economies of scale to look at. • **Peer Training-** Greg noted that the training in the spring the state is paying for and there is a training in the fall NSMHA will pay for. We also want to have more training in 2014.	Informational

	• **Youth Mental Health First Aid-**Compass and NSMHA are sponsoring a trainer to come and do a train the trainer 5 day course. Stacey noted it could be for youth or for adults that work with youth; to qualify to train with this module. This training is being scheduled for May at this time and details will be forthcoming. • Mike W noted that LWC is recruiting a PCP. • Larry noted the new 388 WAC and asked if NSMHA has looked at the impact this will have. Greg noted that there has been ongoing dialog between the RSNs and the state and he noted children's wraparound being written into it as one example of the issues. • Stacey noted that Compass Skagit PACT is up and admitting. There will be an informational session at the Burlington public library on March 15th at 1:30 pm and an open house on March 20th at 12:30 at the PACT office on Milwaukee.	
4. Update on Regional Healthcare Alliance (RHA)	Greg noted that a core group continues to meet to set up a RHA that is comprised of NSMHA staff, county coordinators and some of the emerging health care coordinating agencies in Whatcom and Skagit. Looking at what projects a RHA would take on, such as reducing ER utilization and boarding in emergency departments.	Informational
5. Customer Satisfaction Survey	Kurt noted the survey was repeated in October 2012 and he gave an overview and noted that responses in 2011 and 2012 closely mirrored each other. Eight questions have to do with satisfaction and there are six questions that track outcomes. Kurt noted that the questions related to satisfaction scored high and the questions related to outcomes were not as high. Stacey noted that the outcomes that are measured are when individuals are in middle of treatment instead of at the end of treatment. Kurt noted that perhaps different stages of treatment should be looked at and how long have you been in treatment and how frequent. Greg mentioned the PHQ9 depression screening tool and using region wide and what other tools may be best to use and should they be standardized across region or individual to provider. More work needs to done on the tools with outcomes; keeping in mind the separate populations. Need to develop intervention that will increase response to the customer satisfaction survey. There is a motion to convene a strategic planning committee made up largely of providers to improve the response rate; seconded and in discussion the motion is withdrawn with Greg and Kurt to address this.	
6. DBHR Disparities	Greg noted the state put out this report on their study and is attached here. The state will add to our new contracts the requirement that the quality of data is improved and require us to increase services to special populations where we are below state averages.	Informational
7. Service Access Timelines	Charissa noted that NSMHA tracks the request for service to intake and also to the first ongoing appointment. The data for first ongoing is not yet available and Charissa is seeking feedback on barriers such as data issues to meeting the timelines.	Add data element to next agenda.

	Open access has a positive effect on meeting timelines thus far. One of the reasons they do not occur in the timeline is the provider did not have one to offer. The data element is discussed and will go on next agenda as well. Open access and capacity are discussed; Kathy noted that open access would be difficult in a small agency or with families; schedules may be more conducive for families. Kathy noted the challenges they are having and the fact that they have been trying to meet these timelines and would like NSMHA to look at capacity and payment in regards to this issue.	
8. Children's Performance Improvement Project (PIP)	Charisa noted that NSMHA is required by the state to have two PIPs; NSMHA is continuing the Prescriber PIP which is to reduce time between request for service and a medication evaluation. A new intervention is needed for the Prescriber PIP; invitation to workgroup will be forthcoming. Our other PIP will be around children's services and Greg noted that all should think about what may be a good PIP for children.	Informational
9. Prioritizing Evidence Based Practices (EBPs)	Greg noted that EBPs have become a priority in the legislature and NSMHA recommends developing a short term workgroup to look at what EBPs we should adopt region wide; perhaps two sessions to come up with some recommendations. There was a motion to form a workgroup to determine which EBPs should be prioritized for the region; seconded and motion carried.	Motion carried
10. Evaluations	The evaluations were reviewed and new filled out.	Informational
11. Open Forum		Discussion
12. Date and Agenda for Next Meeting	The meeting was adjourned at 3:00 pm. The next meeting is March 27, 2013 at 1:00 pm.	

NSMHA COMMITTEE DISCUSSION FORM

AGENDA ITEM: 3rd & 4th Quarter 2012 Semi-annual CIRC Report

PRESENTER: Kurt Aemmer

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

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:

1) Forty-one (41) CI were reported to NSMHA in 2nd half of 2012. Eleven (11) were screened out.
2) Thirty (30) were reported to DBHR and were investigated by CIRC. Dispositions were determined for eleven (11).
3) Fifteen (15) of the thirty (30) actual critical incidents (50%) fell within the "incidents or crimes reported by, or having potential to be reported in the media" categories. This 50% rate is the same at the rate for the first half of 2012 (7/14).

CONCLUSIONS/RECOMMENDATIONS: None

TIMELINES: TIMELINES: This report will be given annually in the future, with a NSMHA Work Plan due date of April 30 of the following year.

ATTACHMENTS: 3rdst & 4th Quarter Semi-annual CIRC Report

NSMHA Semi-Annual CIRC Report

July - December 2012

PURPOSE: To inform NSMHA Board of Directors, Executive Director, County Coordinators, the Critical Incident Review Committee (CIRC), the Quality Management Oversight Committee (QMOC), and other stakeholders in the region interested in critical incident (CI) data and activities on a semi-annual basis.

HIGHLIGHTS OF CI DATA FROM July - December 2012

CIRC screened forty-one (41) reported CI in the 2nd half of 2012. Eleven (11) of the reported CI were determined to not meet the formal definition of a CI, so thirty (30) were reported to Division of Behavioral Health & Recovery (DBHR) and investigated by CIRC (APPENDIX I & II). Fifteen (15) of the thirty (30) actual critical incidents (50%) fell within the "incidents or crimes reported by, or having potential to be reported in, the media" categories. Of the remaining fifteen (15) CI, twelve (12) involved violent acts, deaths or non-fatal injuries. These findings demonstrate the further movement of the CIRC process toward a risk management focus in the last three revisions of the DBHR CI reporting and investigating process, the most recent implemented October 1, 2012. The changes in the most recent October revision can also be seen in the CI categories. See the change of delineated CI Types, reflected in the APPENDIX I and APPENDIX II column headers below.

CIRC INVOLVEMENT IN REGION-WIDE QUALITY IMPROVEMENT ACTIVITIES

Preventing elopements from Evaluation & Treatment Facilities (E&Ts): Gains have been held in the quality improvement efforts to prevent elopements from E&Ts. Since the relatively large number of elopements (8) in 2005 and subsequent quality improvement efforts, there have been no more than 2 elopements in any quarter. There were 2 in the 2nd Quarter of 2007. Other than that quarter, there has been zero or one elopement per quarter. There was only 1 reported in all of 2008, and none in 2009, 2010, 2011 and 2012. ***NSMHA recognizes the continued excellent work of E&T staff in addressing this issue!***

Attachments: APPENDIX I: Table Showing # of Reported CI by County, by Quarter, July - September 2012 (3rd Quarter)
APPENDIX II: Table Showing # of Reported CI by County, by Quarter, October - December 2012 (4th Quarter)

APPENDIX I: Table Showing # of Reported CI by County, by Quarter, July – September 2012

County of Incident	Unauthorized leave by a non-offender from an E & T	Death or serious injury of a consumer, staff or public citizen on DSHS owned, licensed or contracted property	Unauthorized leave by an offender from an E & T	Alleged consumer abuse or neglect	Assault of a consumer by a staff	Assault of a staff by a consumer resulting in hospitalization	Suicide attempt on DSHS owned, licensed or contracted by DSHS requiring medical care	Violent act perpetrated by a consumer	Alleged financial exploitation involving a consumer, agency or other	Incident involving a consumer reported by the media, or having potential for media interest	Crime involving a consumer reported by the media, or having potential for media interest	Natural disaster presenting substantial threat to facility operation or consumer safety	Breach of consumer information	Totals
San Juan	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Island	0	0	0	0	0	0	0	0	0	1	0	0	0	1
Skagit	0	0	0	0	0	0	0	0	0	4	0	0	1	5
Whatcom	0	0	0	0	0	0	0	0	0	1	0	0	0	1
Snohomish	0	2	0	0	0	0	0	1	1	4	0	1	0	9
Other	0	0	0	0	0	0	0	0	0	0	0	0	0	0
3rd QUARTER TOTALS	0	2	0	0	0	0	0	1	1	10	0	1	1	16

APPENDIX II: Table Showing # of Reported CI by County, by Quarter, October – December 2012

County of Incident	Death or serious injury of a consumer, staff or public citizen on DSHS owned, licensed or contracted property	Unauthorized leave by an offender from an E & T	Violent act perpetrated by a consumer	Incident involving a consumer reported by the media	Alleged consumer abuse or neglect	Substantial threat to facility operation or client safety resulting from a natural disaster	Breach or loss of consumer information	Suicide attempt on DSHS owned, licensed or contracted by DSHS requiring medical care	Alleged financial exploitation involving a consumer, agency or other	Incident involving a consumer or staff having potential for media attention	Any incident reported to the Medicaid Fraud Control Unit	Life safety event that requires evacuation or substantial disruption to the facility	Totals
San Juan	0	0	0	0	0	0	0	0	0	0	0	0	0
Island	0	0	**1**	0	0	0	0	0	0	0	0	0	**1**
Skagit	0	0	**3**	0	0	0	0	0	0	0	0	0	**3**
Whatcom	0	0	**2**	0	0	0	0	0	0	0	0	0	**2**
Snohomish	0	0	**3**	**5**	0	0	0	0	0	0	0	0	**8**
Other	0	0	0	0	0	0	0	0	0	0	0	0	0
4th QUARTER TOTALS	0	0	**9**	**5**	0	0	0	0	0	0	0	0	**14**

NSMHA COMMITTEE DISCUSSION FORM

AGENDA ITEM: 3rd & 4th Quarter 2012 Semi-annual Second Opinion Report

PRESENTER: Kurt Aemmer

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

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:

1. There were only two (2) request for 2nd opinions in the 3rd Quarter, and four (4) in the 4th quarter of 2012 (APPENDIX I).
2. All were completed within the required 30-day window (APPENDIX I).
3. At the direction of the NSMHA Leadership Team after the 1st & 2nd Quarter 2012 Semi-annual Report, agreement rates were calculated (# of 2nd opinions that agreed with the original opinion/# of all completed 2nd opinions). The 3rd Quarter rate was calculated, and found to be 50% (APPENDIX II).

CONCLUSIONS/RECOMMENDATIONS:

1. Second Opinions are being managed by NSMHA in a systematic, timely and appropriate manner.
2. *NSMHA providers, across the board, have been extremely supportive insuring that high quality 2nd opinion consults are getting scheduled and completed.

TIMELINES: This report will be given annually in the future, with a NSMHA Work Plan due date of April 30 of the following year.

ATTACHMENTS: 3rd & 4th Quarter 2012 Semi-annual Second Opinion Report

NORTH SOUND MENTAL HEALTH ADMINISTRATION
SEMI-ANNUAL SECOND OPINION REPORT
July 1, 2012 - December 31, 2012

Introduction

At any time during the course of outpatient mental health treatment, the principals to treatment (e.g., consumer, custodial parents of children and adolescents, others with legal custody, NSMHA, a NSMHA-contracted Community Mental Health Agency [CMHA], or primary Mental Health Care Provider [MHCP]) may submit a request for a second opinion regarding any outpatient clinical decision to NSMHA either verbally or in writing. If other parties (family member, primary medical health provider) desire a second opinion, the request is made through the MHCP. NSMHA-contracted CMHA staff and Ombuds are available to assist consumers, custodial parents and legal guardians in accessing a timely second opinion.

Second opinions may be requested for many reasons, including situations in which:

1. There is a question regarding medical necessity;
2. There is a question regarding the reasonableness or necessity of recommended interventions and/or medications;
3. There is a question regarding a diagnosis or plan of care;
4. The clinical indications for a diagnosis are not clear or a diagnosis is in doubt due to conflicting test results;
5. The treatment interventions in progress are not improving the condition of the consumer within an appropriate period of time given the diagnosis and plan of care.

In accordance with the 2012 NSMHA Comprehensive Work Plan, this is the semi-annual report that is due on April 30.

Historic Findings

NSMHA has been monitoring the requests for and provision of 2nd Opinions since September of 2004. Prior to this report, frequency of 2nd Opinion requests was reported annually during External Quality Review Organization (EQRO) Surveys. (APPENDIX I).

1. In recent years the annual average number of 2nd opinion requests per quarter increased from 2.0 to 5.8, with only 2009 showing a decrease from 4.0 in 2008 to 3.5 in 2009. It then rose to 5.0 in 2010, and then to 5.8 in 2011. During the first half of 2012 the year-to-date average number of requests dropped significantly to 1 per quarter, but increased to 2.0 per quarter in the second half of the year (APPENDIX I).
2. Subsequent to the last semi-annual report, the NSMHA Leadership Team requested that findings from the 1st opinions be compared with findings from the 2nd opinions be tracked. This "agreement rate" was calculated from the 1st Quarter of 2011 through the 3rd Quarter of 2012. *[The 4th Quarter was omitted as at the time of the writing of this report, two of the opinions in this quarter had not yet been fully completed. As the frequency of yielded 2nd opinions is so small, it was determined that omitting those two cases from the rate numerator and denominator would greatly skew the findings.]* Since the beginning of 2011 monthly agreement rates have ranged from 50% (2nd Qtr 2011 & 3rd Qtr 2012) to 100% (1st & 4th Qtrs 2011; 1st & 2nd Qtrs 2012). The rolling average stood at 73% after the 3rd Qtr of 2012 (APPENDIX II).

3rd & 4th Quarter 2012 Findings

1. There was 1 request in the 1st Quarter & 1 in the 2nd, a sudden decrease of annual averages following increases in each of the previous 2 years. However, with 2 requests in the 3rd Quarter and 4 in the 4th quarter, the average requests per quarter for 2012 grew slightly to 2 per quarter, still significantly less than the average of 5.8 requests per quarter in 2011 (APPENDIX I).

2. Subsequent to the last semi-annual report, the NSMHA Leadership Team requested that findings from the 1st opinions be compared with findings completed within the 30 day window required in WAC 388-865-0355 (APPENDIX I).

Conclusions

1. Second opinion requests occur with too little frequency to draw any conclusions as to what may be indicated by what appears to be a significant fluctuation in frequency, month-to-month.
2. NSMHA providers continue to schedule and complete 2nd opinions in a timely manner, ensuring the protection of a consumer's right to receive 2nd opinions within 30 days of the request.

Recommendations

1. Continue the process
2. NSMHA Clinical Oversight will continue to track agreement rates, as positive or negative trends may emerge over time in the aggregate data, and consider questions like:
    a. Is there a preponderance of requests generated in any of the five reasons delineated in the introduction section of this report;
    b. Do agreement rates differ significantly between physician consultants and non-physician consultants; and,
    c. Do agreement rates differ significantly between physician consultants and non-physician consultants from differing agencies?

Attachments:

APPENDIX I: Table Showing Requests History October 1, 2004 - December 31, 2012
APPENDIX II: Line Chart Showing Monthly Rate at Which 2nd Opinions Agreed With the Original Opinions in the North Sound Region With The Regional Rolling Average 1st Quarter 2011 - 3rd Quarter 2012

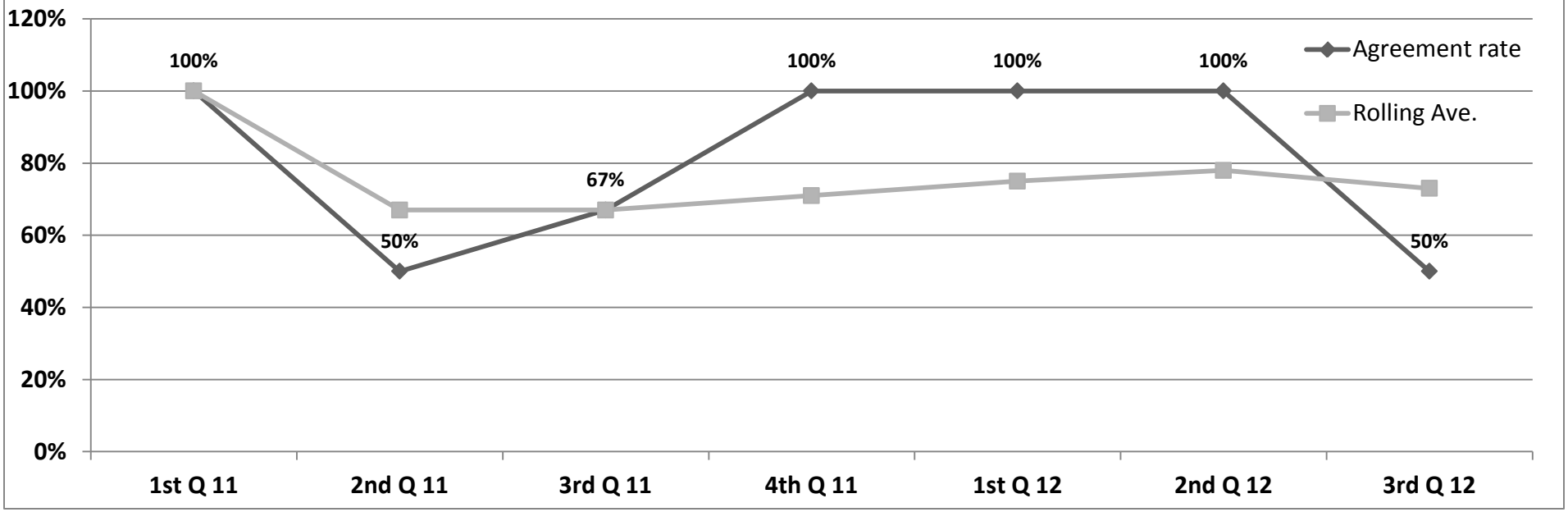
APPENDIX I
Table Showing
Requests History
October 1, 2004 - June 30, 2012

Quarter	# Requested	Ave. # of Requests Per Year	# Completed in 30 days	# Rescinded or 30-Day Window Waived by Consumer	#30-Day Completion Rate
4th Q 04	4	4.0	2	2	100%
1st Q 05	1	2.5	1	0	100%
2nd Q 05	0	2.5	0	0	100%
3rd Q 05	6	2.5	3	1	60%
4th Q 05	3	2.5	0	1	0%
1st Q 06	3	2.5	2	1	100%
2nd Q 06	3	2.5	2	0	67%
3rd Q 06	3	2.5	1	0	33%
4th Q 06	1	2.5	1	0	100%
1st Q 07	4	2.0	1	0	25%
2nd Q 07	0	2.0	0	0	0%
3rd Q 07	2	2.0	1	0	50%
4th Q 07	2	2.0	0	0	0%
1st Q 08	2	4.0	1	1	100%
2nd Q 08	8	4.0	5	3	100%
3rd Q 08	3	4.0	1	1	50%
4th Q 08	3	4.0	1	1	50%
1st Q 09	4	3.5	1	3	100%
2nd Q 09	3	3.5	2	1	100%
3rd Q 09	3	3.5	1	0	33%
4th Q 09	4	3.5	2	2	100%
1st Q 10	3	5.0	2	0	67%
2nd Q 10	5	5.0	2	3	100%
3rd Q 10	8	5.0	5	3	100%
4th Q 10	4	5.0	3	1	100%
1st Q 11	6	5.8	2	4	100%
2nd Q 11	3	5.8	2	2	100%
3rd Q 11	8	5.8	2	6	100%
4th Q 11	6	5.8	1	5	100%
1st Q 12	1	2.0	1	0	100%
2nd Q 12	1	2.0	1	0	100%
3rd Q 12	2	2.0	1	1	100%
4th Q 12	4	2.0	3	1	100%

APPENDIX II

Line Chart Showing Monthly Rate at Which 2nd Opinions Agreed With the Original Opinions in the North Sound Region With The Regional Rolling Average

1st Quarter 2011 - 3rd Quarter 2012



NORTH SOUND MENTAL HEALTH ADMINISTRATION

QUALITY MANAGEMENT OVERSIGHT COMMITTEE (QMOC)

March 27, 2013

AGENDA ITEM: 2013-16 NSMHA Strategic Plan—Goals and Strategies

REVIEW PROCESS: Planning Committee (x) Advisory Board (x) Board of Directors (x)

PRESENTER: Greg Long

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

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:

OBJECTIVE:
To inform and discuss with QMOC NSMHA's newly adopted Strategic Plan

BACKGROUND:
NSMHA is required to have a Strategic Plan by State Contract. This plan was developed over the last 9 months since Joe Valentine became NSMHA's new Executive Director. It lays out seven strategic goals of which the first 3 are top priority. For each goal there are several strategies and then several tasks are being developed for each strategy.

QMOC members need to be aware of these goals and strategies as it advises NSMHA. Greater emphasis is going to be focused on cultural competency, peer support, evidence-based practices, work force development, outcomes, tribal mental health and integration of care with the primary health care system.

PREVIOUS ACTION(S) TAKEN:
Many of these goals and strategies are familiar, but there will be an intensive focus on them. These goals and strategies were included in the RFQ for Outpatient Services and are also priorities in the Federal Mental Health Block Grant RFP that is now out for bid.

This plan and its underlying goals, strategies and objectives have been approved by the Planning Committee, County Coordinators, Planning Committee and NSMHA Board of Directors.

CONCLUSIONS/ACTION REQUESTED:
Comments and questions are welcome.

FISCAL IMPACT:
NSMHA initiatives and funding will be focused on these goals in the coming years.

ATTACHMENTS: 2013-16 NSMHA Strategic Plan—Goals and Strategies

2013-16 NSMHA Strategic Plan, Goals Strategies

id	Goal Short Name	Goal	Strategies
01	Organizational Structure and Health Care Reform	Adapt the organizational structure of NSMHA to play a vital role in the regional implementation of Health Care Reform initiatives to improve care coordination between primary health care and Behavioral Health Services.	Facilitate the development of a North Sound Regional Health Alliance to develop regional strategies to improve the integration of health care, behavioral health care, and long term care services.
			Actively participate in the development of a regional and/or multi-county "Health Home Network" to improve the coordination of services to high risk persons who are dually eligible for both Medicaid and Medicare.
			Invest in sufficient staffing and resources in the NSMHA network to build the NSMHA information technology infrastructure to support our role as an active participant in Health Care Reform initiatives.
02	Access to Quality Services	Develop innovative strategies to ensure all eligible individuals have equal access to quality behavioral health services.	Expand the use of Evidence Based Practices and the level of cultural competence in NSMHA services through training and contractual requirements.
			Increase the availability of services in all geographic areas in the Region.
			Support the sustainability of recovery-oriented services such as housing services and supported employment .
03	Peer Support and Consumer Involvement Initiatives	Lead the North Sound Region in the development and promotion of peer support and consumer involvement strategies.	Increase the number of peers employed in our system through clear contract performance measures.
			Build a regional peer network and training plan to support consumer empowerment initiatives.
			Promote youth and family involvement at all levels of the system.
04	Work Force Development	Enhance work force development of the public mental health system through increased education, training opportunities and strategies for retention	Address future workforce needs as Medicaid expands and older workers retire.
			Provide supervisory training for middle level supervisory and management staff throughout the net work.
			Increase workforce capabilities to provide culturally competent services through long-term consistent training.
			Develop strategies to reduce staff turnover of direct service staff including improved material and non-material compensation.

2013-16 NSMHA Strategic Plan, Goals Strategies

id	Goal Short Name	Goal	Strategies
05	Information Technology	Expand the capabilities of our information technology infrastructure to support the organizational and marketing needs of the Region, promoting quality improvement, health integration and cross-system collaboration.	Promote sharing of data between Electronic Health Record systems to improve care, increase efficiency, and contain costs.
			Train, hire or sub-contract for an increased level of data analysis to meet our role in Health Care Reform initiatives.
			Demonstrate through reliable data analysis how decisions for NSMHA funded services achieve the fundamental outcomes of improved care and cost-containment.
			Partner with other systems of care and service through data sharing to identify people who are high system users and target opportunities for improved care through integration of services as well as cost-containment.
			Redesign the NSMHA Web site to make it more consumer friendly, better meet the needs of different audiences, and provide quicker access to information and updates.
06	Communications and Marketing	Implement a NSMHA Communications and Marketing Plan that increases public awareness of NSMHA services and accomplishments and facilitates public access to information about services and consumer resources.	Continue with the monthly NSMHA E-Newsletters and expand the target audience.
			Redesign the NSMHA Web site to make it more consumer friendly, better meet the needs of different audiences, and provide quicker access to information and updates.
			Communicate stories and information on a more regular basis that illustrate the accomplishments of NSMHA services and the success of our provider agencies.
07	Tribes	Collaborate and partner with the 8 North Sound Sovereign Tribes to establish a culturally competent work force and service delivery system that promotes a tribal centric mental health system.	Work with Tribal representatives to continue to implement and update the Goals and Activities listed on the NSMHA “7.01 Implementation Plan”.
			Actively participate on the state workgroup to work with Tribal representatives on the development of a “Tribal Centric Mental Health System”.
			Continue to sponsor the annual NSHMA Tribal Mental Health Conferences.

NORTH SOUND MENTAL HEALTH ADMINISTRATION

QUALITY MANAGEMENT OVERSIGHT COMMITTEE (QMOC)

March 27, 2013

AGENDA ITEM: Match of Special Populations with CMHA staffing

REVIEW PROCESS: Planning Committee ( ) Advisory Board ( ) Board of Directors ( ) QMOC (**X**)

PRESENTER: Greg Long/Rebecca Clark

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

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:

OBJECTIVE:
To begin the discussion of how the regional mental health system needs to change with the changing demographics of the people it serves.

BACKGROUND:
Improving the cultural competency of the North Sound Mental Health System is one of NSMHA's strategic objectives established last year and again confirmed by the NSMHA Board of Directors in February 2013.

The serving of special populations is a challenge due to the difficulty of attracting, hiring and retaining of specially trained staff or staff from these cultures. The Medicaid population tends to have a higher percentage of special population people in it because it serves low income people. Hence, it makes sense to compare the mental health systems service rates to special populations to their prevalence in the Medicaid program. Another factor is there is a major unknown group which if better identified could change these service penetration rates.

The biggest and growing ethnic population in the Region is the Hispanic population. The region is underserving this population despite some efforts. The Region is also underserving Native Americans; however there are also tribal mental health programs for Native Americans, so this under service issue merits further study. The other ethnic populations are relatively small and are being served at close to parity.

PREVIOUS ACTION(S) TAKEN:
NSMHA has contracted for nearly 20 years with Sea Mar to have a provider that had a tradition of serving the Hispanic population. In the early 1990s, NSMHA contracted to provide specialized services across the Region to Asian and Pacific Islanders. That program shrank and was finally discontinued in the budget reductions of the last five years.

Approximately six years ago, NSMHA made a significant effort to better identify GLBT people requesting services and encourage better and more specialized services. This effort also faded and NSMHA's data on the prevalence of GLBT people in our system is of questionable quality. King and Clark Counties have made special efforts to improve their data on these populations and have been successful.

CONCLUSIONS/ACTION REQUESTED:
The improving and expanding of culturally competent services is a challenge that we must all address along with the other dramatic changes going on in the health care system. Small and continuous steps are needed to improve the public mental health system; identifying small steps that can be taken that would get us moving seems warranted.

FISCAL IMPACT:
Unknown, but depends on actions.

ATTACHMENTS:

Utilization of Services by Ethnicity
NSMHA Counts of Mental Health Specialties and Languages

Utilization of Services by Ethnicity

	Medicaid Eligibles	Medicaid Revenue	Percent Eligibles	Percent of Revenue	Percent of Services	
11/1/2012	*147,180*	*$3,592,258.44*	*100.0%*	*100.0%*		
American Indian or Alaskan Native	*5,150*	*$164,302.89*	*3.5%*	*4.6%*	*3.48%*	*Sum of NativeAmer*
Asian or Pacific Islander	*4,773*	*$78,529.35*	*3.2%*	*2.2%*	*2.12%*	*Sum of Asian Ap*
Black	*4,062*	*$109,110.55*	*2.8%*	*3.0%*	*3.27%*	*Sum of AfricanAmer*
Caucasian	*76,742*	*$2,326,225.78*	*52.1%*	*64.8%*	*65.12%*	*Sum of White*
Hispanic	*23,541*	*$339,438.72*	*16.0%*	*9.4%*	*4.78%*	*Sum of Hispanic*
Native Hawaiian	*210*	*$3,865.98*	*0.1%*	*0.1%*	*21.23%*	*Sum of other*
Not Applicable	4	$265.26	0.0%	0.0%		
Not Provided	22,821	$408,154.82	15.5%	11.4%		
Other Race or Ethnicity	7,855	$127,381.20	5.3%	3.5%		
Pacific Islander	2,022	$34,983.89	1.4%	1.0%		

NSMHA Counts of Mental Health Specialties and Languages in currently open staff episodes

Values	Agency													
	bridgeways	Catholic Community Services	Compass - Mukilteo E&T	Compass Health	Compass North	Interfaith	Lake Whatcom Center (Treatment)	Pioneer Human Services	Sea Mar	Skagit County Community Services	Snohomish County ICRS	Sunrise Services	Whatcom Counseling & Psychiatric Clinic	Grand Total
Sum of NPICount	37	126	22	303	113	13	67	4	58	1	21	51	95	911
Sum of childMHS	0	29	0	26	15	0	0	0	3	0	0	0	5	78
Sum of geriatricMHS	0	0	0	5	4	0	0	0	0	0	0	0	4	13
Sum of deafMHS	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Sum of DDMHS	0	1	0	1	2	0	0	0	0	0	0	0	1	5
Sum of HispanicMHS	0	1	0	1	1	0	0	0	4	0	0	0	0	7
Sum of AfricanAmericanMHS	0	0	0	0	0	0	0	0	0	0	0	0	2	2
Sum of NativeAmericanMHS	0	1	0	0	0	0	0	0	0	0	0	0	2	3
Sum of AsianAPIMHS	0	0	0	0	1	0	0	0	0	0	0	0	1	2
Sum of MHP	2	10	4	77	49	5	3	1	39	0	0	9	42	241
Sum of EthnicMinorityMHS	0	0	0	1	0	0	0	0	0	0	0	0	0	1
Sum of Japanese	0	0	0	1	0	0	0	0	0	0	0	1	0	2
Sum of Korean	0	0	0	0	0	0	0	0	2	0	0	0	0	2
Sum of Spanish	1	0	0	3	1	0	0	0	9	0	0	0	0	14
Sum of Cambodian	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Sum of Mandarin	0	0	0	2	0	0	0	0	0	0	0	1	0	3
Sum of Tagalog	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Sum of French	0	0	0	8	1	1	0	0	0	0	0	1	0	11
Sum of English	32	60	19	277	109	5	51	4	40	0	9	49	42	697
Sum of German	0	0	0	3	1	0	0	0	0	0	0	2	0	6
Sum of AmericanSignLanguage	1	0	0	6	0	0	0	0	0	0	0	1	0	8
Sum of Russian	1	0	1	1	0	0	0	0	0	0	0	0	0	3
Sum of Romanian	1	0	0	0	0	0	0	0	0	0	0	0	0	1
Sum of OtherLanguage	0	0	0	4	0	0	0	0	1	0	0	0	0	5

Snapshot

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NORTH SOUND MENTAL HEALTH ADMINISTRATION

QUALITY MANAGEMENT OVERSIGHT COMMITTEE (QMOC)

March 27, 2013

AGENDA ITEM: Conversion of the North Sound Regional System to DSM V

REVIEW PROCESS: Planning Committee ( ) QMOC (**X**) Advisory Board ( ) Board of Directors ( )

PRESENTER: Greg Long/Stacy Alles

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

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:

OBJECTIVE:

To begin planning the conversion of the North Sound Regional System to the Diagnostic and Statistical Manual V (DSM V)

BACKGROUND:

The new DSM V will become publically available in May 2013 after nearly a decade in the planning. A two year conversion period is allowed by the American Psychiatric Association. As of the writing of this discussion form, NSMHA has no clear information from the Center for Medicaid and Medicare Services (CMS), Health Care Authority of Washington State (HCA) or Division of Behavioral Health and Recovery (DBHR) on the timelines for this conversion. NSMHA has asked DBHR for directions on this conversion process on several occasions. Other payors may start requiring the new codes after May 2013. This could become very confusing for clinical staff to be using two different versions of the DSM.

It should be remembered that DSM codes only flow to NSMHA. NSMHA translates DSM codes to International Classification of Diseases (ICD) and transmits ICD Codes to DBHR/HCA. ICD 9 is scheduled to change to ICD 10 in October 2014. Thus, this conversion might be meaningful at the State and Federal levels after October 2014. A cross-walk from DSM V and ICD 10 will presumably be developed on a national basis. NSMHA will have to change/update its data dictionary and computer software to translate DSM V and transmit the new ICD 10.

The DSM V builds upon DSM IV, but there are significant changes. Clinicians are going to be encouraged to take more time in diagnosing clients to be more accurate; so many people will be given a more general diagnosis which needs to be refined within six months. Axis 4 & 5 are gone in DSM V. They are coded to each specific diagnosis in DSM V. Some personality disorders are being eliminated and it is going to take a year before personality disorders diagnoses should be designated. Hence, the State-wide Access to Care Standards will have to be updated. For this and many other reasons, training for clinical staff is going to be necessary.

PREVIOUS ACTION(S) TAKEN:

When DSM IV was introduced there was some Regional Training. A few staff have sought out training on DSM V, but no Region-wide organized approach has been taken as of this time. Specific agencies may want to discuss their plans to train staff.

CONCLUSIONS/ACTION REQUESTED:

There is a need to develop a coordinated plan to make this shift to the DSM V and the ICD 10. Since hundreds of staff need to be trained, a plan to do this efficiently and cost-effectively makes sense.

FISCAL IMPACT:

DSM V costs $200/copy. Many of those will need to be purchased. Most clinical staff will need to be trained on DSM V.

ATTACHMENTS: None

NORTH SOUND MENTAL HEALTH ADMINISTRATION

QUALITY MANAGEMENT OVERSIGHT COMMITTEE (QMOC)

March 27, 2013

AGENDA ITEM: Adequacy of Western State Hospital Discharge Options

REVIEW PROCESS: Planning Committee ( ) QMOC (**X**) Advisory Board ( ) Board of Directors ( )

PRESENTER: Greg Long/Mike Manley

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

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:

OBJECTIVE:

To clarify issues around the adequacy of Western State Hospital (WSH) Discharge Options

BACKGROUND:

Current Recovery-Oriented Philosophy and services are aimed at encouraging and supporting people with serious and persistent mental illnesses to live as independently as possible in the community and not in institutions. The State and CMS view state hospitals as long-term, acute care facilities. They believe that if a person does not meet medical necessity for hospital level of care they should not remain there and they should not be paying these costs. State hospitals are trying not to provide custodial care or placements to assure public/community safety. This has placed increasing pressures on RSNs, CMHAs and Home and Community Services to place people with serious mental illnesses back into the community, even though they may still have significant psychiatric symptoms.

NSMHA's current census cap at WSH is 101 beds. The North Sound Regional census cap is scheduled to go up to 108 in April 2013. However, this number will include the WMIP people at WSH which averaged between 5 and 6 during 2012. NSMHA has been very near its cap for the last 6 months and over the cap for a few days. This costs $550/day per bed over the cap.

NSMHA averages around 12 admission and discharges per month. However, there can be considerable variation. NSMHA has 1.6 FTE employees working at discharge planning at WSH.

The principal placements for people coming out of WSH are:

- Lake Whatcom Center
- Green House
- Aurora House
- Snohomish PACT
- Whatcom PACT
- IOP programs
- ARTFs *(for people with medical disabilities as well as serious and persistent mental illnesses)*
- Nursing Homes
- New Program-Skagit PACT
- New Program-Skagit Integrated Dual Disorder Program (IDDT)

Transition Placements: *(Used for people who need to be discharged, but benefits or permanent housing is not immediately available.)*

- Alkire House
- LWC Apartments
- Skagit Transitional Housing
- Sun House in Bellingham
- Motel rooms

PREVIOUS ACTION(S) TAKEN:
The entire public mental health system has been adjusting to this philosophical shift for the last 20 years. This is part of why ECS, PACT, and IOP were started by NSMHA. HCS has now expanded its Expanded Community Support program to more than 40 people in our Region.

CONCLUSIONS/ACTION REQUESTED:
- Communities, RSNs, providers and other system need to continue to develop more and better community support programs.
- More housing options are needed.
- Accurate and on-going risk assessments are important.

FISCAL IMPACT:
While it is much less expensive and more humane to treat people in the community than in institutional setting, it is still expensive. It costs approximately $150,000/yr. to have someone in WSH. It costs approximately $15,000/yr. to have someone in a PACT program. However, there are additional costs for public assistance payments, Medicaid medical costs, and housing. These costs do not accrue to the same entities and budgets.

ATTACHMENTS: None