NORTH SOUND
MENTAL HEALTH ADMINISTRATION

QUALITY MANAGEMENT OVERSIGHT COMMITTEE

MEETING PACKET

August 28, 2013
1:00 – 3:00 pm

1. Please join my meeting, Wednesday, August 28, 2013 at 1:00 PM Pacific Daylight Time.
https://global.gotomeeting.com/join/573530349

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

Dial +1 (619) 550-0003
Access Code: 573-530-349
Audio PIN: Shown after joining the meeting

Meeting ID: 573-530-349

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: August 28, 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**	*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	• **More Motivational Interviewing Training** • **NSMHA Training next week, Administrative Training on 9/5, Clinical Training on 9/6, 9/10 and 9/23** • **Medicaid Sign-up will become very important.** • **EQRO 9/11 & 9/12 plus calls to providers to be scheduled**						*15 min*
Update on Regional Healthcare Alliance	Brief update	Inform /discuss	Chair/ Greg				*5 min*
	Quality Topics						
Policy 1706 Approval	NSMHA is seeking approval of its revision of its policy on protecting property when a person is involuntarily committed	Discussion & Approval	Sandy Whitcutt	x		**3**	*10 min*
Policy 1721 Approval	NSMHA is seeking approval of the revision of its policy on criteria for medical clearance for voluntary and ITA assessments in hospitals	Discussion & Approval	Sandy Whitcutt	x		**4**	*10 min*
Emergency Department Information Exchange (EDIE)	Brief discussion on the implementation of the EDIE in the North Sound Region.	Discussion	Greg Long	x		**5**	*15 min*
Proposals to DBHR ITA Expansion Mitigation	Brief discussion on the proposals that NSMHA is submitting to DBHR for the ITA Expansion Mitigation Funding	Discussion	Greg Long	x		**6**	*10 min*
2012 NSMHA Quality Management Summary	This is a summary of NSMHA's Quality Management Activities in 2012	Discussion	Greg Long	x		**7**	*20 min*
Other issues							*5 min*
***Review of Meeting**	Were objectives accomplished? How could this meeting be improved? Evaluation forms: Review and complete						*5 min*
Date and Agenda for Next Meeting	Ensure meeting date, time and agenda are planned						

Next meeting: September 25, 2013 - 1:00-3:00 PM **Potential Future Agenda Items:**

North Sound Mental Health Administration (NSMHA)
Quality Management Oversight Committee (QMOC)
NSMHA Conference Room
July 24, 2013
1:00 – 3:00 pm
MEETING SUMMARY

PRESENT: Marie Jubie, Mark McDonald, Candy Trautman and Joan Lubbe, NSMHA Advisory Board; Dan Bilson, Whatcom Co. Ad Brd Representative; Rebecca Clark, Skagit County Community Services; Larry Van Dyke, Skagit Co. Crisis Center; Kim Olander Mayer, Ombuds; Stacey Alles, Compass Health; Kathy McNaughton, Catholic Community Services.
BY PHONE: Cammy Prince, Sunrise Services; Kay Burbidge, Lake Whatcom Center; Jaculine Mitchell, Whatcom Co; Richard Sprague, Interfaith and Kate Scott, Sea Mar.
STAFF: Greg Long, Tom Yost, Sandy Whitcutt, Julie de Losada and Barbara Jacobson.
OTHERS PRESENT: Eric Chambers, NWESD and Jody DesBiens, NWESD;

TOPIC	DISCUSSION	ACTION
1. **Introductions, Review of Agenda – Chair**	The meeting was called to order at 1:00 pm and introductions were made.	
2. **Previous Meeting Summary – Chair**	The minutes were approved as submitted.	Approved
3. **Announcements and Updates – All**	• **IMR Consultation Process Update** Greg noted that the consultations have been going on about 3.5 months and he and Catherine checked in with the trainer Susan Generich and the group leads. All seems to be going really well; the consultations are one hour phone calls and the groups send a progress report after each to Susan. • **Implementation of new behavioral health WACs** Policies that need major changes will be brought to QMOC. Changes in just reference and source will be sent out in a memo. Please notify NSMHA of policies that you are aware of needing changes due to WAC revision. • **DSM V** The state is setting up a statewide workgroup but there is no timeline yet on when it will be implemented; the ICD 10 deadline is October 2014. Michael W and Terry M are participants on the workgroup. • **Letter from (CMS) Centers for Medicare & Medicaid Services** Greg noted the RSNs received a letter from the Centers for Medicare and Medicaid Services (CMS), a federal entity. They are asserting that the states method for contracting with the RSNs did not meet federal requirements. The state has the attorney general and a law firm reviewing this and this may have to go to the legislature. The state may need to submit a corrective action plan within 90 days This is coming up now because of the Affordable Care Act and the changes it brought. There is more than one state affected by this. RSN	Informational

	administrators meet with DBHR tomorrow and if an update to this is made we will notify the group. Solutions could be an open bidding process or the state could revert to a fee for service vs. a capitated system. • **Provider One Listing** Stacey gave an update on the request from last month to update all location/program information for the –find a provider- in Provider One. She noted that Provider One has an issue with all locations showing up and that Provider One IT will work on this. Greg will talk with Joe and Michael to see if NSMHA needs to contact Provider One about this issue.	
4. Identifying chronic illness in those enrolled in mental health services	Tom noted that NSMHA started looking at chronic illness as knowing all conditions can affect treatment and symptoms can mimic mental health symptoms. On regional level we want to look at where more dollars or supports may be needed. Tom briefly reviewed the data in the report that was gathered from Axis 3 on the diagnostic summaries; this data is for 2012. Compared to the rest of the country our system does not capture this information very well. With the elimination of the 5 axis diagnostic system and the move to integrated care a way to capture this data needs to be sought; and the intake assessment is the best opportunity. Discussion showed that provider agencies have some sort of checklist or way to track some of this already. Stacey noted that chronic pain is not shown on this report and is often checked on form and it is agreed that it should go on any checklist. It was also discussed how many of the psychiatric medications impact overall health and this could help with education of individuals in self-care. Kate S stated she will send the piece of the checklist from Sea Mar to Tom. Greg noted for integration of mental health and physical health we need to have a more constructive dialog around medical symptoms consumers struggle with. Dale Jarvis a consultant suggested a "boot camp" for clinicians and case managers on how to communicate with healthcare providers to better help individuals. Larry noted mental health should take the lead by gathering the data on medical concerns to take back to medical providers to start. Kathy M. noted that the UW offers online training modules around integration and she will send the website link. Julie d. noted the Acumentra/EQRO website has some best practices on coordinating/collaborating with primary care. Stacey A. suggested we standardize the information going into Axis 3 and go forward that way until the changeover so we aren't trying to create something new.	
5. Clinical Improvement Project (PIP) update	Julie d. gave a brief update on this clinical PIP that was started in 2010 and has had two interventions thus far. It asks if a decision tree is implemented at the first ongoing appointment does it decrease the time to get a medication evaluation. The region is not showing any improvement with an average of 68 days of wait time. Julie d. noted the need to review the data further and discussed perhaps looking at the available prescriber hours and the need for services. Another intervention will be needed and NSMHA recommends focusing	Motion carried

	on improving communication/coordination between behavioral health and primary care by sending a form to the PCP with information on behavioral health and a follow up phone call. Kathy M. noted the difference between the child and adult populations; that with children you should be going more slowly toward a medication intervention for many reasons and this doesn't appear to be taken into account in this data. Julie d. noted some of the reasons kids are slower to get medication services. Kathy M. noted that for kids it should be measured from request instead of access point. Dan B. introduced a motion on improving communication/coordination between behavioral health and primary care; seconded by Marie J, motion carried. This will be taken back to the workgroup to work on.	
6. Policy on Evaluation & Treatment (E&T) Facility	Sandy W. stated that policy 1555 was due for revision and also needed to be updated as one of the E&Ts closed. This was reviewed by ICRS as well and is being recommended for approval. Stacey A introduced a motion to accept this policy as revised; seconded by Larry V. and motion carried.	Motion carried
7. Less Restrictive Alternative (LRA) workgroup	Sandy noted that a workgroup was formed after chart reviews showed improvements were needed in documentation around less restrictive orders. Chart reviews showed documentation wasn't clear when there was a violation of an order, though overall it is going well with communication and monitoring. The workgroup developed a decision tree to aid the thought process for documentation so that every violation is charted whether or not it ends in revocation. Discussion around the use of decision tree as it is not really a decision tree but more of a prompt for documentation. Sandy stated that the workgroup recommends the use of the decision tree for every violation and placing in the progress notes and she would like input on how to get the information out as well. QMOC agreed to have this go out in a numbered memo as a policy module and to include an addendum of this to the ICRS training module.	Informational
8. Eating disorders and other diagnoses	Greg noted that NSMHA recently had a challenge in getting a consumer with an eating disorder into treatment. He stated that the eating disorder diagnosis was not in the assessment or CIS; overall there is a low number in our data with this diagnosis. The concern is that people are not having all their covered diagnoses assessed and documented. Kathy noted that some diagnoses may come after some time not right away or not revealed up front. Jody noted that in regard to an eating disorder many times an individual won't admit until it is too late and is a medical problem. Greg stated that NSMHA will have the prevalence of diagnoses in our system for next month; how diagnoses match against national prevalence; broken out by Medicaid population and age group.	Informational Information on prevalence of diagnoses for next meeting
9. Out of network services	Greg noted this is a follow up of the eating disorder issue as NSMHA wants to ensure that providers understand the out of network services system. Policy 1522 is attached for review of the process. It is mentioned that an update of the specialty provider list is called for	Informational

	that NSMHA had sent out. Stacey noted that at Compass there is a review process and if we can't meet the need than we subcontract; we have some subcontractors that are "standing by" as needed. Greg noted that NSMHA can contract for out of state treatment or residential treatment, if needed. If your clinicians think they may be getting into a situation where residential or out of state treatment is needed, don't promise the client anything. Clinicians should consult with supervisor sooner rather than later. Supervisors or managers of the providers may need to consult with NSMHA's Out of Network Coordinator, currently Terry McDonough.	
10. Other issues	None mentioned.	Informational
11. Date and Agenda for Next Meeting	The meeting was adjourned at 3:00 pm. The next meeting is scheduled for August 28, 2013.	

NSMHA COMMITTEE DISCUSSION FORM

AGENDA ITEM: ICRS Policy 1706, Safeguarding of Property

PRESENTER: Sandy Whitcutt of Greg Long

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

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:

NSMHA providers of crisis services and providers who operate psychiatric inpatient Evaluation and Treatment (E&T) facilities need to ensure that reasonable precautions are taken to safeguard an individual's property. This policy addresses the processes needed to ensure the property is safeguarded for the Designated Mental Health Professional (DMHP) when an individual has been taken into custody to be evaluated and for providers at the E and T when an individual has been detained to the E&T.

This policy was due for minor revision to include the new WAC source. It has been approved by ICRS sub policy and ICRS.

CONCLUSIONS/RECOMMENDATIONS:
Approve the policy with revisions

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

ATTACHMENTS:
Policy 1706

Effective Date: 3/3/2008; ~~8/30/2007~~
Revised Date: ~~7/30/2007~~1/324/13
Review Date: 1/324/13

North Sound Mental Health Administration

Section1700 – Crisis Services: Safeguarding of Property

Authorizing Source: WAC 388-8~~7765~~-028~~045~~(3) & RCW 71.05.220, 71.05.700-71.05.715
Cancels:
See Also:
Providers must "comply" with this policy
Responsible Staff: Deputy Director

Approved by: Executive Director
Signature:

Date: ~~3/3/2008~~

POLICY #1706.00

SUBJECT: SAFEGUARDING OF PROPERTY

PURPOSE~~POLICY~~

NSMHA ~~shall ensure that its~~ providers of crisis services and providers who operate ~~e~~p~~P~~sychiatric i~~I~~npatient Evaluation and ~~t~~Treatment (E&T) facilities shall have appropriate policies and processes to ensure that reasonable precautions are taken to safeguard an individual's~~consumers'~~ property.

POLICY~~PURPOSE~~

When a Peace Officer or Designated Mental Health Professional (DMHP) ~~or Designated Crisis Responder (DCR)~~ escorts an individual~~consumer~~ to a facility to be evaluated, the DMHP~~/DCR~~ must take reasonable precautions to safeguard the individual's~~consumer's~~ property.

Providers who operate ~~eEvaluation and tTreatment~~E&T facilities shall take~~will ensure that~~ reasonable precautions ~~are taken~~ to inventory and ~~to~~ safeguard the ~~consumer~~'s property of the individual detained to that facility.

PROCEDURE

1. Agencies employing DMHPs ~~/DCR~~s shall~~will~~ provide adequate training and have protocols regarding:

    a. ~~Make reasonable attempts to S~~sSafeguarding the individual's~~consumer's~~ property in the immediate vicinity, ~~f~~ if involved, at the point of apprehension;
    b. ~~Safeguarding Make reasonable attempts to s~~Safeguarding belongings not in the immediate vicinity, if made aware that there may be possible danger to those belongings; the DMHP may coordinate with law enforcement and/or other available collateral supports to address these needs;
    c. Taking reasonable precautions, if made aware, to lock and otherwise secure the individual's~~consumer's~~ home or other property as soon as possible after the individual's~~consumer's~~ initial detention; the DMHP may coordinate with law enforcement and/or other available collateral supports to address these needs;
    ~~c.~~d. Ensuring that requirements for crisis outreaches to home visits (RCW.71.05.700 through 71.05.715) are met; and
    ~~d.~~e. Documenting~~ing, that during the course of the investigation, the steps that were~~, if made aware, the actions taken to safeguard the individual's~~consumer's~~ property~~. on the crisis contact sheet~~.

2. At the time an individual is involuntarily admitted to an E&T facility, a copy of the inventory, signed by the E&T facilities' staff member completing it, shall be given to the individual~~person~~ detained. ~~and shall, i~~In addition, the inventory contents shall be open to inspection to any

responsible relative, subject to limitations, if any, specifically imposed by the detained individual.~~person~~. For purposes of this section, "responsible relative" includes the guardian, conservator, attorney, spouse, parent, adult child, or adult brother or sister of the individual. The facility shall not disclose the contents of the inventory to any other person without the consent of the individual~~patient~~ or order of the court.

3. NSMHA will monitor providers' policies and ~~is~~ practices through the auditing process.

ATTACHMENTS

None

NSMHA COMMITTEE DISCUSSION FORM

AGENDA ITEM:
Policy 1721 Medical Status Criteria for Voluntary and Involuntary Crisis Assessment

PRESENTER: Sandy Whitcutt or Greg Long

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

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:
Individuals in need of voluntary and involuntary treatment crisis assessments need to be medically able to be interviewed to assure accurate mental health assessments. Individuals need to be medically evaluated by the hospital professional, prior to contacting the CCRS Clinician at the Care Crisis Line with the referral, and requesting a dispatch.
The policy was revised to further clarify when the hospitals need to call for a mental health assessment.
The policy was revised at ICRS sub-policy, and approved by ICRS.

CONCLUSIONS/RECOMMENDATIONS:
Approve the policy with revisions.

TIMELINES:
If approved, this revised policy will go into 60 days after the posting on the web.

ATTACHMENTS: Policy 1721

Effective Date: 2/3/2010; 10/9/2008
Revised Date: 6/27/2013
Review Date:

North Sound Mental Health Administration

Section 1700 – ICRS: Medical Status Criteria for ~~Crisis~~Voluntary and Involuntary Treatment Act (ITA) Crisis Assessment

Authorizing Source: Per NSMHA and DMHP Protocols
Cancels:
See Also:
Providers must "comply with" this policy
Responsible Party: Deputy Director

Approved by: Executive Director
Signature:

Date:

POLICY #1721.00

SUBJECT: MEDICAL STATUS CRITERIA FOR VOLUNTARY~~CRISIS~~ AND ITA CRISIS ASSESSMENT IN EMERGENCY DEPARTMENTS AND COMMUNITY HOSPITALS

PURPOSE

To outline a process that assures medical stability of the individual, prior to screening for ~~crisis~~ voluntary and involuntary treatment (ITA) crisis assessment at community hospitals (emergency departments, general medical floor, Intensive Care Unit, etc). Such criteria are essential to provide a consistent and basic medical status for the assessment process.

POLICY

Individuals in need of voluntary and ~~crisis~~ ~~and~~ involuntary treatment crisis ~~assessments~~~~involuntary assessments~~ ~~ITA~~~~should need to~~assessments shall be medically ready for discharge from the hospital and able to be interviewed to assure accurate mental health assessments. **Exceptions can be made on a case-by-case basis when, in the professional judgment of the ~~hospital~~~~emergency department~~ ~~Medical~~**hospital Medical **Doctor (MD), Advanced Register Nurse Practitioner (ARNP), or Physician~~'s~~ Assistant (PA), specific diagnostic/medical clearance procedures are not warranted or are not in the best interest of the individual.** Exceptions and rationale ~~should~~ shall be documented and communicated to Volunteers of America (VOA) Care Crisis Response (CCR) Clinician when the referral is made.

PROCEDURES

1. Individuals ~~shouldneed to d~~shall be evaluated by a MD, ARNP, or PA, and the individual's presenting problem(s), to the hospital~~ED~~, should be addressed by the hospital~~ED~~ professional, prior to contacting the CCRS Clinician at the Care Crisis Line with the referral.
2. All potential referrals to voluntary ~~crisis~~ and ~~Involuntary Treatment Act (~~ITA~~)~~ crisis services ~~shouldneed to~~shall have a full, documented body systems examination by a MD, ARNP, or PA, to include wounds or trauma, cardiac and respiratory status, evidence of acute nutritional/hydration issues, acute etiologies ruled out and complaints of pain addressed.
3. The following vitals parameters shall~~need to should~~ be met prior to evaluation for crisis and ITA services:

    a. Resting pulse no greater than 120 and no lower than 50
    b. Systolic blood pressure no greater than 200
    c. Diastolic blood pressure no less than 50, no greater than 110
    d. Temperature no greater than 101.5 degrees Fahrenheit

4. A urine toxicology screen is needed if any signs of intoxication or substance abuse are present.

a. For individuals with alcohol intoxication, a level below .08 is required prior to an evaluation.
b. Individuals who present with substances in their system and are not able to be interviewed due to the effects of the substances require medical intervention/observation to address detoxification. The individual should be re-examined by the medical~~ED~~ professional after the individual is medically ready for discharge and able to be interviewed to determine if the initial presenting problem has resolved or is still in need of an evaluation for crisis and ITA services.

5. A blood level of measurable psychotropic medications (e.g., lithium, tegretol, depakote) shall be done.
~~4.~~6. If psychiatric hospitalization is deemed likely, other routine laboratory screens (e.g., chemical 7 panel, complete metabolical panel, urinalysis and urine toxicology) ~~should~~shall be completed in order to facilitate the individual's rapid ~~patient~~ transfer.
~~5.~~7. For individuals presenting with psychosis and no mental health or drug use history, a brief screening neurological exam is needed to rule out focal neurological symptoms that may indicate a primary medical concern.
~~6.~~8. A constellation of confusion, agitation, incoherence and elevated vital signs should be assumed to be delirium until proven otherwise. This would include delirium secondary to substance withdrawal.
~~7.~~9. A brief Mental Status Exam ~~should needs to~~ shall be completed.

ATTACHMENTS

None

NORTH SOUND MENTAL HEALTH ADMINISTRATION

Quality Management Oversight Committee
August 28, 2013

AGENDA ITEM: Emergency Department (ED) Information Exchange (EDIE)

REVIEW PROCESS: Quality Management Oversight Committee **(X)** Advisory Board ( ) Board of Directors ( )

PRESENTER: Greg Long

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

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:

OBJECTIVE:
- To assure optimum coordination of care and thus quality of care for people in the mental health system.
- To assure rapid access for the EDs to information on the mental health crisis lines.
- To reduce unnecessary use of EDs.

BACKGROUND:
A health information exchange was set up by the state to link all the EDs in the State. This exchange allows the EDs to check on a person's ED usage anywhere in the State. The system is designed to assist with the problems of people seeking drugs at multiple EDs and people repeatedly going to the EDs unnecessarily. EDs users of the system can add information and recommendations on individuals entered into the system. All but one ED in the State of Washington is now on this system. The EDIE system is operated by Collective Medical Technologies Inc.

At the request initially of Whidbey General Hospital and now with the support of the other EDs, NSMHA is proposing downloading of all mental health crisis plans into this system. This information could only be accessed when a patient goes to an ED. All of the EDs in the North Sound Region have enthusiastically supported this plan.

NSMHA will also be able to get notifications from the EDIE system if any of our consumers tracked by the system use EDs excessively.

PREVIOUS ACTION(S) TAKEN:
Crisis Plan information has been available to EDs and crisis workers/DMHPs through VOA for years. This is moving to a more modern approach to making this information available.

CONCLUSIONS/ACTION REQUESTED:
- The purchasing of access and use of the EDIE System has been approved by the Board of Directors.
- NSMHA will now have to explore the accessing and uploading of information from EDIE
- NSMHA will now have to explore the downloading of crisis plans into EDIE.
- The accuracy, detail, and currency of crisis plans will become more important with this new interface with EDs.
- After this system gets set up, providers will want to inform consumers that their crisis plans will be available to EDs to better coordinate their crisis care.
- Eventually, providers will be getting alerts from NSMHA when one of their authorized consumers receives ED services. Details on this have to be worked out.
- If this system works well, NSMHA and providers may want to consider whether crisis plans should be developed for more people in the mental health system.

FISCAL IMPACT:
The anticipated cost of access and use of this system is no more than $25,000/yr. The RSNs will be charged $.05 per member per month for crisis plans that we download into the system.

ATTACHMENTS:
None

NORTH SOUND MENTAL HEALTH ADMINISTRATION

Quality Management Oversight COMMITTEE

August 23, 2013

AGENDA ITEM: Expansion of Involuntary Commitment Act (ITA) Update

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

PRESENTER: Greg Long/Joe Valentine

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

OBJECTIVE:

To update the Quality Management Oversight Committee on the development of NSMHA's proposal to apply for state funding to address the impact of the accelerated implementation of the ITA Expansion Law.

BACKGROUND:

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:

- The Legislation to move up the date for the expanded ITA Commitment Criteria to July, 2014 [HB 1777/SB 5480] was passed by the Legislature and signed into law by the Governor.
- A DMHP who conducts an evaluation for imminent likelihood of serious harm or imminent danger because of being gravely disabled under RCW 71.05.153 (Emergent Detentions) must also evaluate the person under RCW 71.05.150 (Detention of persons with mental disorders for evaluation and treatment-Procedure) for likelihood of serious harm or grave disability that does not meet the imminent standard for emergency detention.
- The State estimated that this change will cost $28,000,000 plus some funding for diversion options. This funding was included in the budget passed by the Legislature.
- The Division of Behavioral Health and Recovery (DBHR) will be inviting proposals for E&Ts and other community programs which might mitigate the impact of the increased number of involuntary commitments.

PREVIOUS ACTION(S) TAKEN:

NSMHA has received input from its committees and talked to key stakeholders, including Hospitals, HCS, CMHAs, etc. Four strategies in particular received wide support to include in NSMHA's proposal for funding:

- Increase funding to triage centers to add capacity and the ability to do on-site medical assessments. Move all Crisis Centers towards meeting the Triage Center WAC requirements.
- Develop a Care Transition Program to provide transition and brief treatment services (60 days) to older adults who are difficult to place from hospitals due to their behaviors and medical needs.
- Provide 3-5 slots for Enhanced Service Facilities to take direct admits from community hospitals to avoid them having to go to WSH.
- Hire three more DMHPs across the Region.

CONCLUSIONS/ACTION REQUESTED:

- NSMHA will submit a proposal covering these strategies by August 30th to DBHR.

FISCAL IMPACT:

Uncertain. The additional number of people who will be involuntarily committed is difficult to predict.

ATTACHMENTS:

None

NORTH SOUND MENTAL HEALTH ADMINISTRATION

QUALITY MANAGEMENT OVERSIGHT COMMITTEE (QMOC)

August 28, 2013

AGENDA ITEM: 2012 NSMHA Quality Management Plan

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

PRESENTER: Greg Long

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

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:
Please be aware that this document in done in landscape format on 8.5 x 14 paper. This may be better viewed on your computer. If you need a hard copy version and you printer does not produce these types of documents, please contact NSMHA.

OBJECTIVE:
To provide a broad summary of NSMHA Quality Management Activities.
To meet EQRO Recommendation.

BACKGROUND:
NSMHA use to do a bi-annual Quality Management Plan. This has been dropped as a requirement for several years, but is now a requirement again. EQRO requested that we develop a yearly quality management program summary.

This document contains nothing new that was not reported in 2012 or 2013. All of these reports and findings were presented to QMOC or other committees. It is a summary of NSMHA's Quality Management Activities for 2012. Since a major portion of NSMHA's responsibility is quality management, especially if this is defined broadly, this becomes a large and complex document. Only a brief summary is provided in this document. More detailed information is contained in the specific document reporting on that QM process.

PREVIOUS ACTION(S) TAKEN: None

CONCLUSIONS/ACTION REQUESTED:
- NSMHA wants QMOC to be aware of this document and the many QM activities it summarizes.
- NSMHA would like approval of this summary of 2012 QM Activities
- In future years, NSMHA will attempt to have this summary out by April of the following year. Hence the 2013 QM Summary would be presented to QMOC in April 2014.

FISCAL IMPACT: None

ATTACHMENTS: **2012 NSMHA Quality Management Plan**

2012 Quality Management Summary

This report summarizes many of the 2012 Quality Management Activities conducted by the North Sound Mental Health Administration. Greater details and a full report are available on request for any of these quality management processes which gives the goal, methodology, tools, findings, actions and corrective actions. This summary report covers the following areas: EQRO Recommendations and Findings, NSMHA Strategic Plan, NSMHA Administrative Audits, NSMHA Clinical Quality Management Audits, Consumer Grievances, Trainings, Encounter Validation/Service Verification Audit. This summary reports on the activities from NSMHA Strategic Plan and NSMHA Work plan.

Work Plan Task #	Task Name	Task Description	Staff Lead	Abstract of Results	Recommendations/ Future Actions
EQRO Report and Recommendations					
	EQRO Report	All health plans including RSNs are required to have an independent review conducted by an EQRO every year. The Division of Behavioral Health and Recovery (DBHR) contracts with Acumentra Health to perform external quality review (EQR) of managed mental health services provided for Washington Medicaid enrollees. The major EQR activities are: -- review of the RSN's compliance with federal and state regulations and contract provisions governing managed care -- evaluation of the RSN's performance improvement projects (PIPs) -- an Information Systems Capabilities Assessment (ISCA) for each RSN --EQRO conducted an Encounter Validation/Service Verification to assure the encounter validation process that NSMHA conducted.	Lisa Grosso	The compliance review found that in 2011, NSMHA fully met all eight of the compliance protocols with the following scores (1-5 scale with 5 being best score): --Network 5 --Coordination 4.7 -- Authorization 5 -- Provider 5 --Delegation 5 --Guidelines 4.7 --QA/PI 4.8 Acumentra Health reviewed one non-clinical and one clinical Performance Improvement Project (PIP) conducted by NSMHA, both continued from previous years. The RSN scored 96/100 on the non-clinical PIP, Non-clinical—Improved Delivery of Non-Crisis Outpatient Appointments after a Psychiatric Hospitalization. The RSN scored 89/100 on the clinical PIP: Decrease in the Days to Medication Evaluation Appointment after Request for Service. Both scores qualify as fully meeting this standard. ----The EQRO conducted an Information Systems ISCA in 2011 resulting in 13 recommendations. NSMHA had successfully implemented two recommendations related to concluding its contract with Raintree Systems and was in the process of implementing six other recommendations. NSMHA had made no progress in addressing four recommendations related to hardware systems, data security and encounter data auditing. ----EQRO found very high rates of match between RSN and chart data for the encounters and charts reviewed. These findings were similar to what the NSMHA team found for the same 83 encounters.	Numerous strengths were cited and there were no findings. The following compliance recommendations were made: --NSMHA needs to routinely review its practice guidelines to ensure that they still apply to enrollees' needs and include any updated clinical recommendations. --NSMHA needs to perform a more comprehensive annual QA/PI evaluation. --NSMHA needs to continue to closely monitor the timeliness and completeness of enrollees' treatment plans. NSMHA will make these changes. --EQRO recommended that the RSN establish a testing system, including code review, to ensure that EDV systems are working before using those systems in the field.
NSMHA Strategic Plan					
	Strategic Plan	NSMHA developed a new strategic plan in 2012	Joe Valentine	With the hiring of a new Executive Director in 2012, NSMHA developed a new 3 year Strategic Plan. The plan was approved by the Planning Committee, the Advisory Board and NSMHA Board of Directors. The plan lays out 4 strategic goals which NSMHA is committed to accomplish. These include: Organizational Structure and Health Care Reform, improving access to services, increase peer support and consumer involvement and workforce development. In addition, the following three goals were set as important priorities: improve NSMHA's information technology capabilities, implement a NSMHA Communications and Marketing Plan and 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.	Since the Strategic Plan was approved in late 2012, implementation will begin in 2013. These goals will be divided into strategies and objectives in the coming years.

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Performance Measures					
	Regional Performance Measures	NSMHA has three Regional Performance Measures: -Increasing the diversion rate from inpatient care -Increasing the crisis bed utilization rate -Increasing the rate of identification of co-occurring disorders	Diana Striplin	The Region exceeded its target for diversion from inpatient for 10/1/2011-9/30/2012. NSMHA was forced to change the crisis bed utilization measure, baseline and targets due to changes in the crisis system. For 10/1.2011 -9/30/2012 NSMHA also exceeded its target for the identification of co-occurring disorders.	NSMHA will continue these performance measures for the next year.
	State-Wide Performance Measures	NSMHA has two State-Wide performance measures. -A Medicaid enrollee will be seen for non-crisis services with 7 days of discharge from inpatient care. -Encounter Validation-for encounter validation see section on encounter validation	Diana Striplin/ Michael White	NSMHA did not meet performance for the 7 day measure and has designed a special intervention to improve performance on this measure.	NSMHA will implement this intervention for the 7-day measure.
NSMHA Administrative Audits					
	Administrative Audits	During 2012 the following audits were conducted: All outpatient Contractors, all Mental Health Block Grant Contractors, Crisis Center/Triage Facilities, Evaluation & Treatment Center and County Jail Services.	Margaret Rojas	The following Contractors were placed in Remedial Action or were given recommendations during the 2012 audit: CCSNW-Recommendations were made to the Wraparound program, there were no findings during this audit. NSMHA will review for the incorporation of recommendations during the next audit cycle. Compass Health-Placed in Remedial Action in the following programs, DD Crisis, Crisis Triage and PACT services; a corrective action plan was submitted and accepted. Interfaith-Placed in Remedial Action in the following area: Complaint and Grievance; Corrective Action plan was submitted and accepted. Pioneer Human Services-Placed in Remedial Action in the organization's Compliance Plan; Corrective action plan was submitted and accepted. Tulalip (MHBG) Recommendation was made on establishing communication pathways between program and fiscal staff. NSMHA will review for the incorporation of the recommendation during the next audit cycle. VOA Recommendation was made on VOA's complaint and grievance documentation. NSMHA will review for the incorporation of the recommendation during the next audit cycle. WCPC-Placed in Remedial Action in the following area: Supported Employment; corrective action plan was submitted and accepted.	NSMHA is required to audit once per contract cycle. The next audit will take place in 2014.
06.13.01	Conduct Utilization Reviews	A 63 standard tool was utilized to review 415 randomly selected outpatient charts across providers to evaluate the quality of clinical services.	Charissa Westergard	Regionally, 5 standards were below 90%, though 4 of these standards were above 85%. -If during the intake the individual reports having no PCP, a referral to a PCP is offered - 87.3% -The RRP was developed within 30 days of the first ongoing outpatient appointment - 88.3% -Goals for treatment are based upon identified mental health needs - 89.2% -The RRP is strength-based - 72.2% -The clinical/medical record contains documentation that individuals and, as appropriate, family members are informed about the medication prescribed and possible side effects in language that is understandable to the individual - 89.8% All providers had aggregate compliance scores above 90%. The number of standards below 90% by provider ranged between 2 and 14.	Remedial actions were taken with 6 of 8 providers on the standards for which they were below 90%. All of these providers submitted corrective action plans. All providers will be reviewed next year for improvement and compliance.

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06.05.03	Crisis outreach/ensure that crisis dispatch does not exceed two hours	Providers need to ensure that crisis dispatch times to individuals are not exceeding 2 hours or have adequate justification of why there is an exception to 2 hours. Once dispatched, voluntary or involuntary service ICRS providers try to maintain or improve on a 95% standard of under 2 hours both regionally and by agency.	Sandy Whitcutt	All providers are meeting the goal. Regionally at 97% up from 96.9% from 2011. Providers have also been able to stay above the 95% individually.	Continue monitoring looking for any changes at provider sites or in region.
06.05.01	Care Crisis Monthly reports	As part of ICRS, Care Crisis (VOA) is responsible for responding to calls from the community, triaging those calls, dispatching cases to Emergency Services staff in the appropriate counties and monitoring timely response from ES staff within 10 minutes. Care Crisis is also responsible for documenting the disposition of the dispatch from ES/DMHP and recording the time the S worker/DMHP arrived at the outreach location.	Sandy Whitcutt	Total calls for the first 9 months has averaged 6979 a month. The percentage of abandoned calls for the first 9 months has been 3.37%. This percentage is below the national average of 5%.	This will continue to be monitored through the ICRS for any trends.
06.05.02	Crisis calls will be dispatched in a timely manner	Care Crisis (VOA) is responsible for dispatching cases to Emergency Services staff in the appropriate counties and monitoring timely response from ES staff(within 10 minutes). Care Crisis is also responsible for documenting the disposition of the dispatch from the DMHP/ES worker and recording the time the DMHP/ES worker arrived at the outreach location. This is reviewed as part of the annual audit.	Sandy Whitcutt	Care Crisis response continues to reflect consistent response to crisis calls, to include documentation of the nature of the crisis, proper paging of the ES worker in the field, good coordination with the ES worker, law enforcement and the community. Documentation continues to detail the call. Dispatching rationale remains clear. There appears to be improved disposition call back from the ES worker within the two hours. This was a recommendation made to ICRS last year.	Continue to monitor both in the audit, as well as, through ICRS reports.
06.05.07.04	Monitor Crisis stabilization use	Crisis stabilization beds are located in Whatcom, Skagit and Snohomish Counties. These programs continue to work to increase utilization. In addition to reporting to ICRS, the programs are also audited to monitor the utilization and quality requirements through chart reviews at each site. This occurs during the annual audit.	Sandy Whitcutt	WCPC: There was evidence of follow up on some of the 2011 recommendations. There are continued recommendations that have been noted on the audit. Pioneer: the program continues to develop. Utilization remains high; referrals have increased. There are some recommendations for the program noted in the audit results. The Snohomish stabilization/triage facility has continued to work on coordination with law enforcement, marketing and has been working on capacity. The average length-of-stay continues to be closely monitored by the facility. There were recommendations from 2011 not met and corrective action was put in place.	Programs will continue to be reviewed during the audits, corrective actions will be addressed this year and programs will be reviewed in December and January due to recommendations and corrective actions.
06.05.07	Crisis stabilization beds will have full utilization /data	Data reports from WCPC, Pioneer and Compass reported via dashboard to ICRS	Sandy Whitcutt	WCPC: Data for this program was not reported due to the changeover to EMR, but utilization remains an issue due to the structure of the facility. Pioneer: Stabilization has been averaging 56% for first six months. Snohomish: Utilization has been averaging 45% for the first six months.	Continue to closely monitor and address the low usage. Crisis system review will also address the programs and this is part of the performance measures. Requests will be made to providers to look at ways to increase utilization.
03.15.03	Ensuring provider compliance with denial standards	Consistent application of eligibility standards for outpatient services across the region by age, levels of care.	Sandy Whitcutt	During first 9 months there were 247 requests, 126 were adult denial requests, 121 were child denial requests. 235 or 95.7% were upheld. 12 or 4.3% were overturned. There were 94 extensions. The number of upheld requests was 95% reflecting consistency in documentation.	A process for corrective action, as well as, identifying regional excellence needs to be developed for agencies.
05.04.04	Encounter validation review	In order to maintain and improve a robust and accurate data collection and reporting system, encounters were done as part of utilization review during August and September 2012, from a random sample	Sandy Whitcutt	Encounters were reviewed at each provider site. The sample was developed by Michael (see report). The encounter tool was again slightly modified this year to assist in ease of entering the data and ensure completion of data in each field. There were also guideline changes made for 2012. The results were reported to the state. A high degree of validity was found between the data and the clinical records.	Recommendations from the review are reported by Michael White. No actions are needed at this time. This study will be repeated next year. Greg added this.

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06.02.02	Supported employment workgroup	The workgroup, comprised of WCPC and Sunrise fidelity staff, reviews data, addresses ongoing employment issues, shares strategies and works on performance improvement. Both programs are responsible for submitting quarterly reports to NSMHA with employment outcomes.	Sandy Whitcutt	Sunrise Supported program: 38 new enrollees this year; 27 new job starts. Sunrise continues to have full utilization of the program, works actively with DVR and continues to market the program. WCPC does not have cumulative data but reports there have been 18 new enrollees, 10 new job starts. There has not been full utilization of the program but now have two employment specialists and supervisor.	Monitoring of both programs occurs during the audit. Due to the low numbers, another review of WCPC will be completed December 2012 and reported to leadership. Follow up discussion will take place regarding any revisions to the WCPC program.
01.04.04	NSMHA ICRS Meeting	ICRS is a long standing regional committee comprised of NSMHA and supervisors from mental health agencies in the region who provide crisis services (Compass, WCPC, Snohomish County, Pioneer and VOA) who meet bi-monthly to discuss regional crisis issues, address policy with the ultimate goal of maintaining an integrated responsive crisis system.	Sandy Whitcutt	This year ICRS has continued to focus on delivery of services to include law enforcement issues, triage programs and MOT. It has also focused on clarification of IOP/PACT/ICRS/ED roles, Inpatient medical responsibilities, ED/ICRS clarification, single bed certification, parent initiated treatment (PIT). The crisis module was updated. Multiple policies were updated. A new ICRS dashboard was created to chart all of the data and monitor trends.	In 2013, a crisis system review will begin looking at the strengths and areas of improvement needed in the crisis system. The ICRS committee will continue to be integral to this review. Any recommendations will be brought forward to leadership and distributed to ICRS members.
01.14.27	Local crisis oversight meetings	In order to address county specific ICRS issues, Skagit, Snohomish, and recently, Whatcom Counties have developed a local crisis oversight. This meeting is comprised of the county coordinator, hospital representation, law enforcement, interested outpatient providers, crisis providers, VOA and NSMHA. When specific issues arise, other community representation is invited to the meetings. Meetings are generally held every two months at all sites.	Sandy Whitcutt	Skagit oversight has been meeting for a number of years and has well developed relationships; issues this year have been about dementia and boarding. Snohomish oversight has also been meeting a number of years and has increased membership to outpatient providers. This year there has been an increased focus on the role of ED's, as well as, continued focus with Law enforcement. Whatcom has just recently started an oversight meeting; the first meeting taking place in July 2012. The group has expressed an interest in looking at data to look at detention rates, improve relationships with crisis and outpatient programs.	Continued attendance to assist with quality and policy issues
06.02.01	Monitor Fidelity supported employment	WCPC and Sunrise continue to manage these programs in Snohomish, Skagit and Whatcom Counties. The programs are reviewed for fidelity standards. This currently occurs during their audit.	Sandy Whitcutt	Sunrise Fidelity results showed a mean score of 3.7 out of 5, for individual charts and 4.2 out of 5 for organization, a slight drop from 2011, due to the newness of the charts reviewed. There were no recommendations but will be monitored next year for improvement. WCPC scored 3.4 out of 5 for individual charting and 3.9 out of 5 for organization. Due to recommendations last year, a finding was made to increase referrals, as well as, show improvement in employment as an outcome.	Continue monitoring next year for both fidelity compliance and increasing the number of consumers getting employment.
06.05.07.01	Monitoring of the Mobile Outreach Teams (MOT)	The number of interventions per month are reported to ICRS through NSMHA . Additionally, both programs were audited this year.	Sandy Whitcutt	During the audit, there were strengths in chart documentation in assessing the situation, making referrals and providing resources. The areas needing improvement were in development of a recovery plan, offering follow up care and reporting data. For Pioneer during the audit, strengths were seen in documentation, in consultation to caretakers, stabilizing the crisis, responding rapidly making referrals and follow up care. Areas needing improvement were in development of a recovery plan and completion of a plan.	Continue to monitor during the audit. A crisis review will take place in 2013, and the effectiveness of the program should be reviewed, with revisions to follow.
06.05.07.02	Monitor MOT advisory workgroup	A workgroup was created with participation from the MOT providers, ICRS representation, county coordinators, and NSMHA to address issues associated with the program.	Sandy Whitcutt	WCPC has not been able to generate a report to NSMHA but indicates they have provided services to 169 individuals from January to September and has done marketing. Pioneer reports serving 98 individuals to September 2012. Both programs did a customer satisfaction survey; with low numbers of return but both programs are seeing good satisfaction.	Continue to do a quarterly workgroup. WCPC data will need to be reported to see if the data presented for 2012 is reliable.
06.07.01	Monitor use of Seclusion and Restraints at the E and T	The regional Evaluation and Treatment Program (E &T) provides needed care for individuals requiring involuntary treatment. This facility program makes a concerted effort to attempt less restrictive options prior to use of seclusion and restraint. The effort is to minimize the use. When there is the need to use seclusion and restraint, it is monitored closely for appropriateness. This area has been monitored by NSMHA for many years. It is done through daily reporting and review of charts. It is also discussed at ICRS on a routine basis.	Sandy Whitcutt	Data is submitted daily to NSMHA, and a report is generated monthly, then reviewed by NSMHA and ICRS. This area is also a focus during the audit. The average census for 9 months was 14.99. The number of seclusions during this timeframe was 101, comparing to 136 for 10 months in 2011. The number of restraints was 15 during this period, comparing to 33 for 10 months in 2011. The numbers have been trending down. The E and T reports they have been doing more training, as a recommendation of the 2011 audit requesting charting reflect better rationale and has improved this year.	This area is monitored and will continue to be monitored closely for any inconsistencies or sudden increase in the use of seclusion and restraints. This is done through reports and the audit.

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01.07.06	Conduct focused review of special populations	This review is done to ensure individuals receive culturally competent services. A random sample was pulled for all providers. The review is looking to see: 1) if the documentation reflects that the consult was done within the required timeline and 2) that the consultant's recommendations were incorporated into the care plan.	Sandy Whitcutt	The review was conducted in September and October 2012. Regional compliance on question 1 was 69%, comparing to 66% for 2011. Regional compliance for question 2 was 63%, comparing to 79% in 2011. Providers were in corrective action in 2011. The results of the 2012 review will be brought to QMOC for review and recommendations for improvement in December 2012.	Providers were put in corrective actions in the areas that they fell below. Providers have sent NSMHA responses. Another review will be conducted in the fall of 2013.
06.09.01	WSH census management	The NSMHA Adult Care Coordinator works with inpatient psychiatric facilities, Western State Hospital (WSH), and the Western State Hospital liaisons to ensure that individuals receive care in the least restrictive environment possible. Individuals referred to WSH from the North Sound region are screened by NSMHA to review the admission with the inpatient facilities as the individual moves to the 90 MR. The review with the facilities addresses other diversion strategies attempted and the current status of the individual prior to going to WSH.	Sandy Whitcutt	NSMHA by contract is currently allocated 101 slots at Western State Hospital (WSH). In 2011, NSMHA had an average of 12 approved referrals per month. 2011 continued to have the region be at or under the census cap for most of the year. For 2012, for the first six months, the average has been 6.6 approved referrals, but there were 17 referrals in May. NSMHA did briefly go over the cap, but the liaisons and community hospitals worked hard at other discharge options. Additionally, due to critical incidents at WSH, admissions were slowed and again liaisons and the community hospitals worked on other options. NSMHA continues to screen all referrals and provide liaison discharge services.	Continue the current screening process for referrals in 2013. This continues to appear to assist with addressing less restrictive options.
02.01.08.02	Report Customer Satisfaction Survey to LT & QMOC	Complete 2011 report and present findings to LT & QMOC.	Kurt Aemmer	Report completed Feb. 4, 2012; Presented to LT Feb. 7, 2012; Presented to QMOC Feb. 22, 2012. Key findings: 1. The positive response rates were very similar, per provider, per question across the region. 2. Consumers across the region are very satisfied with the services they are receiving. 3. The majority of consumers' surveyed reported services have changed their lives for the positive, though the positive response rate in these 6 questions was lower than the positive response rate in the 8 questions that measured satisfaction. 4. Data was gathered and analyzed region-wide. However, the raw data (completed questionnaires) will be forwarded to the providers to augment their quality improvement efforts. 5. 29% (N=1,459) of adults who responded to the "Interest in Peer Support Services" question expressed interest. Only 7% (N=360) of youth expressed interest. 6. *Overall participation rate was 45%, significantly lower than the range of rates published in the 2009 Clark County RSN Customer Satisfaction Report (75% - 77%, 2007, 08 & 09).	Develop strategies to increase participation rates in 2013 survey. NSMHA will look at strategy to focus more on evaluating outcomes.
03.15.04	Maintain effective incident reporting process	Update P&P per 2012 contract language requirements; screen all provider reports; synthesize and forward all applicable reports to DBHR; facilitate CIRC meetings as scheduled; send all required follow-up reports to DBHR; Complete 3rd & 4th qtr. 2011 and 1st & 2nd qtr. semi-annual reports, present reports to LT & QMOC according to schedule.	Kurt Aemmer	Fast-track P&P update implemented in time for required Oct. 1 implementation date; subsequent requirements added, and final P&P approved at Nov. 28th QMOC. All CI were screened & forwarded to DBHR where indicated. 3rd & 4th qtr. 2011 and 1st & 2nd qtr. 2012 semi-annual reports were completed and reported to LT on Feb. 28th & July 14th; to QMOC on Apr. 25th & Aug. 22nd. 3rd & 4th qtr. 2011 key findings - 21 investigated CI; 1st & 2nd qtr. 2012 key findings - 14 CI investigated. As the nature of CI categories has progressively shifted from being Quality Improvement focused to Risk Management focused, and the applicable operational definitions of these categories have narrowed since 2010, the volume of reported CI has continued to decrease.	Continue process.

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3.15.09	Monitor & process MHP Waivers & Exceptions process	Screen provider exception & waiver requests, sign RSN's support where indicated, & submit to DSHS for approval.	Kurt Aemmer	DSHS has tightened up documentation of supervised experience requirements in an effort to reduce the volume of clinicians without advanced degrees being employed as MHPs throughout the state. Currently, there remains only two clinicians who do not hold advanced degrees functioning as MHPs in the North Sound Region. Both hold MHP waivers which are current. There are only four more clinicians who hold waivers or exceptions because they are either receiving there master's degree soon, or they have an advanced degree but need to accumulate the required years of experience under the supervision of an MHP.	Continue process.
6.12.01	Second Opinions	Screen 2nd opinion requests, and facilitate second opinions when appropriate.	Kurt Aemmer	After a continuous increase in the avg. number of requests per quarter, per year; from 2009 (3.5), 2010 (5.0), 2011 (5.8), a sudden decrease occurred in the 1st two quarters of 2012 (1). Unless the request was rescinded by the consumer, or the consumer had special schedule request(s) & chose to waive the required 30-day window, 100% of the requested 2nd opinions have been completed in the required 30 days since the 2nd quarter of 2009. There were 10 requests in 2012. Seven were completed. One was initiated, but not completed because the consumer showed up late for the appointment. There were two no-shows. The second no-show was the follow-up appointment for the individual who appeared late for his first appointment, described above. There was a 50% agreement rate (2/4) among prescribers 2nd opinion consultants, and a 100% agreement rate (1/1) among masters level MHPs.	Continue to manage and report on the number and type of second opinion requests.
06.06.01	Residential services	45 charts were reviewed across the four residential facilities utilizing a 19 standard tool to monitor the appropriateness of this level of care and mental healthcare provided to residents.	Charissa Westergard	Aggregate scores -Aurora House 80% -Greenhouse 94% -Haven House 59% -LWC 93% All four facilities struggled with documentation that supported the LOCUS scoring. Other areas that were an issue for more than one of the facilities were: -Having an appropriate plan to address identified drug/alcohol issues. -Provision of recovery oriented treatment services. -Provision of treatment that is likely to assist the individual in meeting their identified goals.	Remedial action was taken in 2011 and will be applied for standards falling below the 90% benchmark in 2013 as well.
06.08.01	Medicaid Personal Care	Service approved/disapproved; semi-annual written report on number of approved/denied MPC requests. Monitor MPC input into CIS	Terry McDonough	Presented report to LT in Nov 2012. Current MPC cases are approx. one quarter of what they were previously. There are currently 24 clients receiving NSMHA-funded MPC payments. NSMHA's MPC expenses for 2012 were approx. $14,000/ month.	Continue review and authorize MPC Services in 2013.
06.08.03	Medicaid Personal Care	Monitor expenses to remain w/in budget and develop semi-annual written report.	Terry McDonough	Presented report to LT in Nov 2012. Verified w/Shari that NSMHA is w/in budget for 2012.	Continue task in 2013.
06.10.01	Provide Out of Network Services	Maintain ongoing spreadsheet on how many get services and provide written report.	Terry McDonough	During 2012 there were four Out of Network requests that NSMHA agreed to fund. All four of these people were clients who had received Out of Network services in 2011.	Continue task in 2013.
06.10.03	Provide Out of Network Services	Maintain spreadsheet data on why we use Out of Network services and need of service; prepare written report.	Terry McDonough	Of the four Out of Network clients that NSMHA funded in 2012, two were receiving Dissociative Identity Disorder services and two were receiving services regarding their hearing impairment.	Continue task in 2013.
01.07.09	VOA Inpatient Utilization Management Review	Review of VOA's Inpatient Utilization Management chart documentation/activities to determine if consistent with NSMHA guidelines.	Charissa Westergard	VOA received 2,086 requests for hospitalization in 2011. 672 of these requests were for voluntary hospitalization and subject to the UM process. 30 Inpatient UM charts were reviewed with all standards scoring above 90%.	This process is stable and functioning well. Will monitor at least every two years in the future.

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01.07.15	CA/LOCUS (Child & Adolescent/Level of Care Utilization System) Review	Chart review to determine if documentation supports CA/LOCUS scoring.	Charissa Westergard	212 charts were reviewed across the region, approx. 66% LOCUS and 34% CALOCUS. Overall reviewer and provider scoring agreement was at or above 90% for all but one provider (Sea Mar at 87%). Scoring of the Co-Morbidity dimension results in the most disagreement between reviewer and provider.	Discontinue task for 2013 in favor of monitoring LOC data and CA/LOCUS inter-rater reliability testing.
01.11.02	Monitor PACT programs	PACT chart review at both programs.	Charissa Westergard	14 charts reviewed at the Whatcom County PACT (50 slot program). Overall score of 3.9 out of 4 with lowest score of 3.6 on standard assessing peer counselor activities. This was primarily related to a change in peer counselors during the period reviewed. 15 charts reviewed at Snohomish County PACT (100 slot program). Overall score of 3.5 with the lowest rating of 3.1 on peer counselor related activities. Remedial action was implemented related to areas that require improvement, including maintaining a fully staffed team and increased admissions.	NSMHA staff will follow-up on the corrective action process with the Snohomish County PACT. Audit both PACTs next year since they are critical and intensive programs.
6.21	Youth Care Coordination	Make care linkages throughout system, assist stakeholders & consumers in navigating the system and monitor for use of medically necessary services beginning with the least restrictive options for all youth with special focus on high utilizing youth.	Angela Fraser-Powell	Care Coordination contacts that required RSN level intervention to resolve the issue/concern, took the form of multiple calls and/or meetings with family, treatment team and other allied systems to develop a plan and hopefully reduce barriers to address the needs, while still receiving medically necessary services. Currently, this information is tracked case by case via spreadsheet format and not yet in CIS although this is in process. It is the hope that once in CIS, more meaningful data might be gathered.	**Continue care coordination to assure access and quality of care for youth and their families. **CIS database for care coordination would replace the spreadsheet method and potentially produce more meaningful data. Parameters TBD by Clinical Oversight team.
6.20.00	Adult Care Coordination	Make care linkages throughout system, assist stakeholders & consumers in navigating the system and monitor for use of medically necessary services beginning with the least restrictive options for all adults with special focus on high utilizing adults.	Angela Fraser-Powell (for 2012 only due to vacant position).	Adult Care Coordination is also tracked case by case via spreadsheet format and is not yet in CIS system. In late October 2011, the Adult Care Coordination position became vacant, precipitating a need for Adult Care Coordination functions to have a primary contact and then be distributed across the remaining staff of the Clinical Oversight team until a replacement could be hired. While the reorganization of duties created less rich spreadsheet data regarding interventions and types of coordinated care for individuals, adult consumer needs remained a priority and were appropriately and thoroughly addressed.	**Continue care coordination to assure access and quality of care for adults. **CIS database for Care Coordination activates; would replace the spreadsheet method and potentially produce more meaningful data. Parameters TBD by Clinical Oversight team. **In mid September of 2012, a new Adult Care Coordinator was hired and has assumed all functions of the role.
6.12.01	CLIP Referrals	Coordinate CLIP referrals, make recommendations and coordinate admissions with CLIP Administration.	Angela Fraser-Powell	Regional CLIP Committee & Coordinator continued to meet the contract expectations with regard to coordinating CLIP referrals and, where appropriate, diverting to less restrictive options or recommending to CLIP Administration . In 2012, a total of 23 youth were screened through various processes for a possible CLIP admit. Of the 23 total, 11 North Sound youth were screened through the RSN Voluntary process, 9 were recommended by the RSN and subsequently certified for a treatment episode by CLIP Administration. The remaining 2 of 11 youth were screened but diverted into more intensive community based services. Of the 23 total screened, 11 were screened and admitted through the Involuntary process between an acute care hospital team and CLIP Administration. And lastly, 1 North Sound youth was admitted to CLIP via an RCW 10.77 court process. While most of the CLIP functions continue as in 2011, CLIP policy updates at the state level and workgroups born out of the CLIP Improvement Team (CLIP IT) have changed some aspects of CLIP such as treatment episodes being reduced to 6 months from the previous 1 year. CLIP IT workgroups have worked on several items including an agreement to have pre-admission meetings involving the community team, CLIP Administration and the receiving CLIP facility to engage the community team more immediately and set goals prior to admit.	Revise local CLIP policy to reflect the changes.

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6.12.02	CLIP Coordination	Coordinate with CLIP facilities and other systems partners from admit to discharge.	Angela Fraser-Powell	CLIP Care Coordinator continued to meet the contract expectations with regard to working with CLIP and community teams to coordinate care for youth from before the admission process through to discharge, and beyond. This mainly involves attending monthly CLIP / other meetings, making contacts with community services based on youth & family needs in a timely manner prior to discharge for every youth who goes in CLIP. Youth who go to CLIP on a voluntary basis remains a slightly smaller number than those that enter through an ITA process.	Some CLIP data is entered into CIS. Determine specific reports that can be run from this data.
6.16.02	EPSDT	Data review regarding physician referral sheet and call log.	Angela Fraser-Powell	EPSDT Program is a federal preventative health care benefit designed to screen consumers under age 21 in order to identify physical and/or mental health/CD problems through screenings and referrals. EPSDT is one doorway a consumer might become engaged in mental health services and receive care coordination. 2010 contract change stipulated that MH providers would contact and log EPSDT referred individuals within 10 working days for the purposes of engagement and loop closing in addition to continuing to send a letter back to the physician from the initial MH assessment with the diagnosis information. EPSDT has been historically difficult to monitor / capture meaningful data as numbers of EPSDT identified youth tend to be very low. The bulk of charts identified as EPSDT tend to come from a single provider mainly due to their sending youth to the PCP after the initial mental health assessment, at which time a youth becomes labeled EPSDT. This is problematic as the contract states the referral should originate from the PCP in order to truly be labeled as an EPSDT referral; it continues to be rare occurrence when a youth is referred directly from the PCP. A review of charts was performed for time period 5/1/2011 through 4/30/2012, a sample of 40 were reviewed region wide and while good care coordination could be noted region wide, it was difficult to obtain accurate data as many charts were inappropriately marked as EPSDT.	Chart pull instructions to be revised for 2013 so only those charts where the referral originated from the PCP will be reviewed.
Training					
	Motivational Interviewing Training	NSMHA provider basic (16 hrs.) and advanced (16 hrs.) of Motivational Interviewing Training for 100 clinical staff from our provider network. This was provided by NW Addiction Transfer LLC. In addition, ongoing webinars were provided focusing on specific motivational interviewing topics.	Greg Long/ Angela Fraser-Powell	The basic and advanced training was well attended and well received by clinical staff and classes were all filled. The webinars on specific topics were only marginally attended with 3-16 participants.	Need to consider strategies for continuing to promote this evidence-based counseling technique in the coming years.
	Illness Management and Recovery	NSMHA provided a 2.5 hour Introduction to Illness Management and Recovery (IMR) and a 16 hour intensive training on IMR.	Greg Long/ Catherine Youngbuck	The Introductory IMR Training was moderately attended with 22 attendees. The two day intensive training was well attended with 27 participants.	Conduct IMR Consultation and Supervision for a year in 2013-2014.

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Consumer Grievances					
	Grievance System	Maintain and Oversee Grievance System. NSMHA continues to maintain a robust grievance system . Maintains system for both provider and RSN level grievances, notices, appeals, and fair hearings. NSMHA anticipates some items considered complaints will be processed and reported as grievances in the future. NSMHA maintains an internal grievance review committee, started a monthly Ombuds meeting, and provides quality management recommendations. Providers also use their data for continuous quality improvement in reports to NSMHA. NSMHA also reports to the Mental Health Division every 6 months. NSMHA also oversaw provider processes in the audit process and highlighted strengths, recommendations, and findings for provider processes.	Diana Striplin	NSMHA makes system recommendations for further review or continuous quality improvement related to grievance system information. One area identified was to review expertise for specialty areas such as DID and Eating Disorders. NSMHAs' plan is to review expertise within the network but not restrict ourselves to the network. Information has also been one factor in development of one of our current PIPs for medication management. NSMHA and providers continued with the Dignity and Respect Initiative and Campaign in 2012. In addition quality improvement may be identified in the Internal Grievance Committee. Each provider also provides a report to NSMHA every 6 months with items they identified for further study and review or quality improvement related to complaints or grievances.	The North Sound Regional Grievance System will have to be significantly redesigned for both policy and reporting requirements as DBHR makes contractual changes, develops reporting processes, grievance system documents, and WAC revisions.
Service Verification and Encounter Validation					
05.04.04	Encounter Validation Review	In order to maintain and improve a robust and accurate data collection and reporting system, encounters were done as part of utilization review during August and September 2012, from a random sample.	Michael White & Sandy Whitcutt	Encounters were reviewed at each provider site. The sample was developed by Michael (see report). The encounter tool was again slightly modified this year to assist in ease of entering the data, and ensure completion of data in each field. There were also guideline changes made for 2012. The results were reported to the state. There were no findings from review.	Recommendations from the review are reported by Michael White. NSMHA continues its iterative process of improving on the reviewing of encounters throughout the system. Lessons learned from EQRO Encounter Data Validation training will be incorporated in future EDV reviews done by NSMHA staff.
NSMHA Compliance Activities					
	Compliance Communication and Training	NSMHA's commitment to compliance includes: communicating to all employees, consultants, independent contractors and subcontractors clear ethical guidelines; provide training and education regarding applicable State and Federal laws, regulations, and policies; and provide monitoring and oversight to help ensure that we meet our compliance commitment. We promote open and free communication regarding our ethical and compliance standards and provide a work environment free from retaliation.	Lisa Grosso	Created separate NSMHA Compliance Exclusions distribution list with tribal and network provider agency Compliance, Quality Management and HR representatives. Created standard E-mail with links and directions to the OIG List of Excluded Individuals and Entities (LEIE) website and the System for Award Management (SAM). Excluded Parties List System (EPLS), is transmitted quarterly. Reviewed and briefed the OIG Health Care Fraud Prevention and Enforcement Action Team (HEAT) Provider Compliance Training initiative resource to Leadership Team and Staff, Planning and Quality Management Oversight Committee, issuing Numbered Memorandum to network provider agencies requiring inclusion in Compliance Plans. Established direct E-mail to Compliance Officer, compliance_officer@nsmha.org, updating website. Compliance Officer attended 2012 Spring and Fall Medicaid Quality Management (MQM) Conference/DBHR RSN Training; Presented Compliance Training module Spring 2012 titled "How to Jump Start Your Compliance Investigation." Subscribed to the National Council Compliance Watch Newsletter, distributed to all Staff by e-mail every two months. Conducted annual Compliance/Program Integrity Training for All Staff, with separate training date for stragglers.	Re-validate distribution list annually. Develop and conduct Compliance/Program Integrity Training for Boards and Committees. Continue to participate in semi-annual MQM Conference/DBHR RSN Training. Research credentialing certification program for Compliance Officer. Conduct Annual Compliance/Program Integrity Training of All Staff and incorporate Compliance Training areas of focus in monthly All Staff meeting.
	Compliance Investigations	Investigate all potential incidents of non-compliance, including reviews of relevant documents and interviews of relevant people.	Lisa Grosso	There were 7 reports of alleged fraud or abuse reported, with 2 cases still pending, 1 investigated by the State with no substantiation found; 3 investigated and no fraud substantiated; and 1 investigated and fraud found at under $5000 with recoupment effected. 4 cases were reported by Staff, 2 by Provider Agency and 1 by State Agency.	Raise awareness in the enrollee community through establishment of a dedicated direct and toll free number and voice mail for reporting to the Compliance Officer and recurring tag-line listing in eNewsletter.

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	Compliance Audits	Detect and prevent fraud and abuse through auditing and monitoring processes and review and oversight activities. Conduct annual Administrative, Fiscal, Quality Assurance/Performance Improvement (QA/PI) and Encounter Data Validation (EDV) on-site provider contract reviews designed to ensure contractor compliance.	Lisa Grosso	Conducted review of Compliance Program, policy and procedures for each network provider agency as part of the administrative audit, with particular emphasis in the relevant risk areas identified by the Office of Inspector General (OIG) in its "Compliance Guidance to Medicare + Choice Organizations."	Complete review of Compliance Program policy and incorporate updates as outlined by change to contracts/regulations. Conduct Biennial review of Compliance Program policy and procedures for network provider agencies.