NORTH SOUND
MENTAL HEALTH ADMINISTRATION

QUALITY MANAGEMENT OVERSIGHT COMMITTEE

MEETING PACKET

December 11, 2013
1:00 – 3:00 pm

1. Please join my meeting.
https://global.gotomeeting.com/join/846513261

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

Dial +1 (773) 897-3000
Access Code: 846-513-261
Audio PIN: Shown after joining the meeting

Meeting ID: 846-513-261

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: December 11, 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							*5 min*
Update on Regional Healthcare Alliance	Discuss feedback, if any.	Inform /discuss	Chair/ Greg				*5 min*
Quality Topics							
Draft State Quality Assurance Plan for Wraparound with Intensive Services	This is a discussion regarding the new Quality Assurance Committee and Plan being set up by DBHR for the new Wraparound Services established by the class-action law suit.	Inform/ discuss	Eric Chambers	Committee Discussion Form		**3**	*15 min*
2013 Discharge Planning Focused Review (UR) Report	This is a discussion of the findings of the 2013 Discharge Planning Review	Inform/ discuss	Kurt Aemmer	Committee Discussion Form		**4**	*10 min*
2013 Special Populations Focused Review (UR) Report	This is a presentation on the 2013 Special Populations Review.	Inform/ discuss	Kurt Aemmer	Committee Discussion Form		**5**	*10 min*
ICRS policy 1703 Duration of Crisis Services	This is a request for approval of Policy 1703, Duration of Crisis Services. There are not substantive changes.	Discuss and Act	Sandy Whitcutt	Committee Discussion Form		**6**	*10 min*
Recovery/ Resiliency Plan Reviews	Discussion of strategies for ensuring review of Recovery/Resiliency Plan review and updates	Discuss and Act	Charissa Westergard	Committee Discussion Form		**7**	*10 min*
Planning for Upcoming Reductions in State Funding	This is a draft proposal outlining the reduction in the use of State Funds, the need to get people on to Medicaid, and an approach to reducing State Funds by having providers manage State Funds on a capitated basis.	Inform/ Discuss	Greg Long	Committee Discussion Form		**8**	*20 min*
A Regional approach to Training?	This is a discussion about taking a more regional approach to coordinating, providing and tracking of professional training	Inform/ Discuss	Heather Fennell/ Greg Long	Committee Discussion Form		**9**	*20 min*
Other issues							
***Review of Meeting**	Were objectives accomplished? How could this meeting be improved? Eval forms						
Date and Agenda for Next Meeting	Ensure meeting date, time and agenda are planned						

Next meeting: January 22, 2014 - 1:00-3:00 PM **Potential Future Agenda Items:**

North Sound Mental Health Administration (NSMHA)
Quality Management Oversight Committee (QMOC)
NSMHA Conference Room
October 23, 2013
1:00 – 3:00 pm
MEETING SUMMARY

PRESENT: Marie Jubie, Mark McDonald, Candy Trautman and David Kincheloe, NSMHA Advisory Board; Larry VanDyke, Pioneer Human Services; Rebecca Clark, Skagit Co.; Eric Chambers, NWESD; Stacey Alles, Compass Health and Chuck Davis, Ombuds.
BY PHONE: Anji Jorstad, Snohomish Co.; Danae Bergman, CHS; Cindy Ferraro, Bridgeways; Kathy McNaughton, CCS; Richard Sprague, Interfaith; Kate Scott, Sea Mar; Mike Manley, Sunrise Services and Pam Benjamin, WCPC.
STAFF: Charissa Westergard, Diana Striplin, Kurt Aemmer and Barbara Jacobson.
OTHERS PRESENT:

TOPIC	DISCUSSION	ACTION
1. **Introductions, Review of Agenda – Chair**	Rebecca C. convened the meeting at 1:03 pm and introductions were made. Revisions to the agenda were called for and Charissa noted that in the Ombuds report under Tab 3 the new definitions for grievance and appeals is to be disregarded; it is coming from the change in WACs and is not accurate at this point.	
2. Previous Meeting Summary – Chair	Rebecca called for a review of the previous meeting summary for approval; the summary was approved as submitted.	Approved
3. Announcements and Updates – All	• Charissa noted the letter the state recently received from Centers for Medicare & Medicaid Services (CMS) has to do with the procurement process and the state is holding public meetings. It appears the state may not challenge the letter and may do a procurement process; though this is only a guess at this point. • Charissa noted the recent public meeting on the 75 bed psychiatric hospital in Marysville proposed by US HealthVest. Marie J. noted that she and Joan B. attended that meeting. • Providers are working on going live with Electronic Health Records (EHR); providers noted that it is challenging but moving along. • A subcommittee of the Regional Health Alliance is meeting on October 31st to discuss the inpatient boarding issue. • Marie J. noted that tomorrow is the mental health and aging forum at Merrill Garden and she will be a speaker.	Informational
4. Evaluation Forms from Last Meeting – Chair/Greg	The evaluations were reviewed and Charissa noted that adding a statement about why your number is low is helpful. David noted that many topics have no history or context and some may not understand the importance of a topic. Evaluations need to be sent out to phone participants as well.	Informational
5. Ombuds Report	Chuck D. reviewed his report and touched on key points. The full report is available in the packet. He noted that Ombuds has relocated to this building upstairs in Suite 42.	Informational

6. Grievance Report to DBHR	Diana reported on the period covering October 2012 through March 2013 and noted that the state is making changes to this system and NSMHA will update its processes as we go along. Her report contains recommendations that come from quality improvement arrived at from this system. Some of the changes coming include the elimination of complaints; to be replaced by grievances at the provider level and at the RSN level. Notices will be changing; some new areas will need a notice such as disagreement with the treatment plan. NSMHA is working on how to implement the changes and update policies around this; most of these changes will come about with the new contracts from the state starting in January 2014.	Informational
7. Dropping the Clinical Performance Improvement Project (PIP)	Charissa noted that recently NSMHA was reviewed by the External Quality Review Organization (EQRO) and they looked at our PIPs. The clinical PIP is to reduce the time between the request for service to the medication appointment. This has been worked on for a few years and has not been highly successful. We still want to improve in this area and we will continue working on this; but EQRO recommended we drop this and pick a new clinical PIP. NSMHA plans to look for a consultant to help with the PIP process. A replacement has not been identified and a workgroup will convene on this soon. There was a motion to discontinue the current clinical PIP; seconded and motion carried.	Motion carried
8. Non-clinical PIP	The new non-clinical PIP for the region is Improving the Quality of Care Coordination for High Risk Transition Age Youth (16-21 yrs). This is very new and still in the design process. One of the things that came out of the TR lawsuit is the need to focus on gaps in service to transition age youth. Some of the interventions being considered include workforce development and improving care coordination processes. The workgroup for this PIP starts in December.	Informational
9. Clinical Guidelines	Kurt noted that NSMHA reviews and revises the Clinical Guidelines periodically and 8 diagnoses have been added this year; along with child and adult suicidal behaviors guidelines. Adding the suicidal behaviors addresses the need identified by utilization reviews and the critical incident program at NSMHA. This would mean 27 guidelines overall with three non-diagnostic guidelines. Links to the appropriate websites are listed with each guideline for ease of access. The bullet points under each diagnostic guideline are the core elements that were developed by Dr. Brown to ensure services are being provided in accordance with the guidelines. Stacey suggested on page 7 under Child & Youth Psychotic Disorder, second bullet, the word exhaustive should be appropriate instead; Kurt will follow up with Dr. Brown. Kurt will update the document to include the correct links as discussed. There is a motion to approve the revisions and new guidelines; seconded and motion carried.	Motion carried
10. 2012 QM Plan	EQRO recommended we have both a Quality Management Plan and a Work Plan. The plan was reviewed and corrections noted will be incorporated. NSMHA recommended that this Plan be adopted. There was a motion to approve as amended; seconded and motion carried.	Motion carried

11. Adult & Child Diagnoses in Region	Charissa noted that there was a request from QMOC for a look at the diagnoses of those served around the region. This report is for April through June 2013 and is broken out by adult (21 and up) and child/youth. One item noted was that children receive more services than adults and Stacey A. noted that the high no show rate of adults may account for some of that. The report was discussed and the group liked the way the data was broken out.	Informational
12. Report on New WAC	Charissa noted the concerns that were brought forward at the last meeting on the WAC changes and that she attended the recent DBHR training. The special population consults has been taken out of the WACs but will be put in contract; though in what form is still unknown. Related to the 15 hours of supervision; Department of Health (DOH) doesn't approve hours or anything; the need to clearly document was noted. The old individual service plans, intake and definition WACs have not yet been repealed; so follow the new ones and the old will be repealed at a later date. Licensure and certification will likely be revised. The 180 day review requirement has been dropped but NSMHA needs to look at this as the requirements it covered are still there. NSMHA will look at tying this in with the authorization process in some way. At the next QMOC we will look at the 180 day review so get ideas to Charissa.	Informational
13. Open Forum		Discussion
14. Date and Agenda for Next Meeting	The meeting was adjourned at 2:50 pm. The next meeting is scheduled for November 27, 2013; it is decided to combine the November and December meetings into an early December meeting. A Doodle Poll will go out with one suggested date being December 11, 2013.	

NORTH SOUND MENTAL HEALTH ADMINISTRATION

QUALITY MANAGEMENT OVERSIGHT COMMITTEE (QMOC)

AGENDA ITEM: Draft State Quality Assurance Plan for Wraparound with Intensive Services

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

PRESENTER: Eric Chambers (NWESD)

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

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:

OBJECTIVE:
To share relevant work from the state-wide quality assurance team that may impact the work of the NSMHA Quality Management Oversight Committee.

BACKGROUND:
Driven by the T.R. v. Dryfuss Settlement, the State restructured their quality improvement process to include an Executive Team, Family, Youth, System Partner Roundtables (FYSPRTs), a Data and Quality Team, and the DBHR Quality Improvement Program.

The Data and Quality Team is responsible for the "development, refinement, and execution" of the State Quality Assurance Plan. On November 15, 2013 Kathy Smith-DiJulio, System of Care Research Manager for the Behavioral Health and Service Integration Administration convened the first meeting of a subcommittee to draft the quality assurance plan. Dr. Smith-DiJulio presented a draft plan (see attached) for discussion. The subcommittee expressed appreciation for the effort but agreed that a different approach was necessary—especially since no one on the team has seen the WISe implementation plan. Thus, Dr. Smith-DiJulio and Dr. Eric Bruns from the University of Washington agreed to draft a template that would refocus the work on accountability, based on what we know now. The team agreed to "fill in the blanks" on the template prior to the next meeting on January 17, 2014.

PREVIOUS ACTION(S) TAKEN:
None.

CONCLUSIONS/ACTION REQUESTED:
None.

FISCAL IMPACT:
Unknown.

ATTACHMENTS:
Draft Quality Assurance Plan.

Quality Assurance Plan

Wraparound with Intensive Services

I. PURPOSE

The Washington State Division of Behavioral Health and Recovery Wraparound with Intensive Services (WISe) program is designed to provide comprehensive behavioral health services and supports to children, youth and families with intensive behavioral health needs. The program outlines the treatment and support activities that care providers undertake; governs how services are coordinated among systems and providers; prescribes the means to measure and account for outcomes; provides relevant feedback to managers and clinicians so as to continuously improve system and service quality; and ensures cost-effective use of resources. Washington State's Children's Mental Health Principles inform and guide the management and delivery of mental health services and supports.

II. ORGANIZATIONAL STRUCTURE

Executive Team: The Children's Mental Health Executive Team will oversee and guide the implementation of the *T.R. Settlement Agreement and* WISe and monitor outcomes. The role of the Executive Team is to provide leadership, problem-solving, and decision-making regarding progress in implementing system-wide practice improvements, fiscal accountability, and quality oversight.

Family, Youth, System Partner Roundtables (FYSPRTs): Statewide, Regional and Local FYSPRTs provide oversight for program planning, coordination, service delivery and evaluation.

Data and Quality Team: Development, refinement, and execution of the Quality Assurance Plan (QAP) is led by the Children's Behavioral Health Data and Quality (DQ) Team which reports to the statewide FYSPRT. The mission of the DQ Team is to provide a cross-system forum for developing performance measures and refining data collection and management strategies related to screening, assessment and quality improvement relevant to children's behavioral health in Washington State. The Measures of Statewide Performance list goals, outcomes and indicators relevant to all children and youth with emotional and behavioral health needs served by DSHS and HCA. The DQ Team will review the QAP annually and make revisions to assure ongoing improvement monitoring capabilities.

Division of Behavioral Health and Recovery (DBHR) Quality Management Program (QMP): The DBHR's QMP provides a structure for system-wide quality improvement (QI) efforts and on-going evaluation of those efforts. The DBHR Quality Improvement Committee (QIC) provides the forum to systematically review data to assess the performance of behavioral health services and systems, improve contract performance, programs and services and efficiently manage resources. Progress toward goals is reported throughout DBHR. The QIC works in an inclusive and transparent manner to facilitate integration of improvement activities within DBHR and throughout the state's behavioral health system. The QIC coordinates the division's quality goals, outcomes and performance measures. The Chief of Decision Support and Evaluation (DBHR) serves as co-chair on both the QIC and the Children's Behavioral Health Data and Quality Team. The Children's System of Care Research Manager also serves

on both committees. The QIC provides regular progress reports on improvement efforts to DBHR leadership.

DBHR contracts with Regional Support Networks (RSNs) to provide care to children/youth with emotional disturbances and their families. Competency of staff providing services is assured through licensing and certification by DBHR as well as regular site visits completed by Quality Review Teams.

• Provider-level certification and licensing o Degree level o Experience level o Training and certifications o Licenses	• Periodic licensing and certification reviews of community mental health agencies	• These site visits consist of a review of personnel files, clinical records, and updated policies and procedures to ensure compliance with state minimum standards	• Do providers meet standards and possess the appropriate qualifications for WISe service delivery?

Expectations for Quality Assurance and Performance Improvement are included in RSN contracts and include an annual External Quality Review Organization (EQRO) monitoring review to assess compliance with regulatory requirements, adherence to quality outcomes and timeliness and access to services. A DBHR Committee, the Performance Indicator Workgroup (PIWG), monitors Regional Performance Measures against the established improvement targets throughout the year. DBHR staff co-chairs this committee and one serves on the QIC.

Data reported at the RSN level and rolled up to DBHR includes:

• Caregiver and youth ratings of fidelity and quality	• WISe-specific MHSIP phone survey	• WISe-specific MHSIP phone interview conducted by WIMHRT with WISe enrolled caregivers and youths o Includes 6-8 items from WFI-EZ	• Does intensive care coordination as delivered adhere to the WISe program model? • Are supervisors or managers using data to inform supervision and coaching? • What resources or policy changes need to be brought to bear to improve adherence and fidelity?
• Adherence and fidelity ratings from Plan of care and document review	• Plan of Care, documentation (progress notes, meeting notes, team members, etc)	• POC and documentation reviewed by external quality review team	
• Adherence and fidelity ratings from observation of team meetings	• Team meeting observation form	• ?? Supervisors (also use data for staff coaching)?? • External quality review for sample of youths?	

III. GOALS AND OBJECTIVES – *required per agreement….will need to develop….Could structure it like the BHSIA Strategic Plan – however we do it, needs to be OUTCOME focused. We say what we are hoping to achieve and then describe the underlying accountabilities related to that outcome – data elements recorded, reported and evaluated.*

WISe Access and Service Delivery

Goals:

1. Measure and report annually the number of youth who are identified, screened, assessed and receive WISe, reported by PIHP.
2. Each PIHP will have at least one annual Performance Improvement Project (PIP) focused on improving mental health services to Medicaid funded children and youth.
3. Update Children's Behavioral Health Measures of Statewide Performance and post in a publicly accessible location *(add specific location when know).*
4. Compare outcomes of youth who received WISe with those who were screened out on Children's Behavioral Health Measures of Statewide Performance and other indicators as developed.

Objectives:

1. Identify, screen, refer and enroll eligible youth to the WISe program in a timely fashion *(TBD).*
2. Provide needs and strengths based individualized home and community-based services and supports.
3. Coordinate delivery of services and supports across child-serving agencies and providers through the use of child/family teams and other opportunities for collaboration

IV. TOOLS/RESOURCES - *also required per agreement….will need to develop*

Social marketing: Descriptions and explanations of WISe program and services to youth, family and other stakeholders including eligibility, access, identification and referral, e.g., posting on DBHR website, public service announcements, community meetings.

WISe screening algorithm (including out-of home placements for mental health treatment, functional indicators that lead to out of home placement) to identify youth eligible for the WISe program – to be phased in beginning January 1, 2014 with capacity progressively increased to achieve statewide penetration through _____ 2018. See attached implementation plan.

CANS screen and assessment

Implemented a service code for WISe

WISe Quality Monitoring tool

Workforce Development Collaborative to create a plan for implementation of statewide education, training, coaching, mentoring and TA to support child-serving agencies across the system in providing WISe to fidelity standards.

PIHP capacity

Quality Review Activities, including Quality Service Reviews

EQRO

V. PERFORMANCE MEASUREMENT/EVALUATION - *To be fully developed once implementation plan is complete…when we know completely what we're doing and how we're doing it we can fill in how to monitor the process and what outcomes to look for. Much of this detail will be in the WISe implementation manual – specific accountabilities for desired outcomes at various levels to be outlined here….*

PROCESSES (Performance Measurement)

Data element	Data source(s)	Data collection	Data reporting and use
• Youths identified and referred as possible WISe youths	• CANS screen	• DSHS referring agencies (see Figure 1) complete referral form	• Are referral sources identifying and referring expected numbers of youths? • Are referred youths appropriate for WISe? • Are WISe providers and RSNs enrolling adequate numbers of youths? • Do WISe-enrolled youths meet eligibility requirements for WISe (characteristics, level of need)
• Youths screened	• CANS screening tool	•	
• Youths enrolled in WISe if eligible – referred to other care if not	• CANS full screen completed • RDA administrative records	• CANS full screen entered into database or submitted to DBHR (prior to operational database) • Information on WISe youths compiled by DSHS RDA and available to QA Team	
• Youths characteristics	• Full CANS evaluation • NOMS on subsample	• Referral and enrollment forms and CANS data submitted to MHP and managed administratively by RDA	
• Date of WISe referral	• WISe Referral form	• DSHS referring agencies (see Figure 1) complete referral form	• Are referred youths receiving initial intake and screen within XX days? • Are youths screened as indicated for WISe being enrolled (or referred for other services) within XX days? • Are youths enrolled in WISe having Plans of Care developed within XX days? • Ongoing CFT meetings occur every 30 days until discharge. • Are CANS screens being
• Date of intake and screen	• CANS Screener • RDA administrative records	• CANS screener completed by WISe provider and submitted to DBHR	
• Date of WISe enrollment	• WISe Enrollment form • RDA administrative records	• WISe enrollment form submitted to DBHR • Information on WISe youths compiled by DSHS RDA and available to QA Team	
• Date of initial Plan of Care	• Plan of Care	• WISe provider submits initial POC to RSN/DBHR	

• Date of CANS assessments with information on needs and strengths, multisystem involvement	• CANS (initial and quarterly)	• CANS entered into database and managed administratively by RDA	completed in a timely manner? I.e.: o Initial within XX days of enrollment o Follow-up CANS within XX days of 3 month deadline.
• Strategies and services in Plan of Care	• Plan of Care	• WISe provider submits initial POC to RSN/DBHR • POC reviewed by external quality review team	• Are services and strategies in the POC aligned with needs and strengths as identified in the most recent CANS? • Are services and strategies in the POC aligned with the family and team's priority needs? • Are services in the plan of care actually delivered/received? Is a Crisis and Safety Plan in place? • Do families and youths report that services and strategies meet priority needs? For youths who are showing no progress on the CANS, are services and strategies in the POC revised? • Are services being provided consistent with the WISe program? • Are enrolled youths receiving o Intensive Care Coordination o Mobile Crisis o "Intensive In-home" services? To what degree are WISe services being delivered across RSNs and providers?
• Family- and team-identified needs in plan of care	• Plan of Care	• WISe provider submits initial POC to RSN/DBHR • POC reviewed by external quality review team	
• Caregiver and youth ratings of adequacy of plan elements and CFT	• MHSIP survey	• MHSIP Phone interview with WISe enrolled youths	
• Services delivered/received	• SERI	• Providers report services delivered by unit into SERI	

OUTCOMES (Evaluation)

• Change in CANS strengths and needs scores	• CANS	• CANS collected at baseline and every 3 months; reliable change calculated for each youth and summarized	• Are WISe-enrolled youths improving with respect to their behavioral health? • Are strengths increasing and needs being addressed? • Are WISe-enrolled youths at home, in school, and out of trouble? • Is WISe achieving better outcomes than services as usual? • Is WISe achieving better outcomes for youths with SED than the system was able to achieve in previous years? • Is the overall children's behavioral health system showing better outcomes as a result of WISe implementation?
• Critical functional outcomes, e.g.: o Res Placement; o School attendance/ achievement; o ER/crisis use o Justice contacts; o Welfare involvement	• DSHS RDA integrated client database	• Info for WISe enrolled youths regularly submitted to RDA and reports run o Comparisons to matched or historical comparison group of similar non-WISe youths	
• Statewide children's behavioral health outcomes • WISe implementation progress; CANS data reports	• Measures of statewide performance for children's behavioral health • TBD	• DQ team oversees regular review and annual update of the Statewide Performance Measures • Quarterly Review • Reports to statewide FYSPRT	
• WISe service costs data	• ???	• Regular compilation of costs of WISe and other behavioral health services for WISe youths	• Is WISe implementation cost-effective compared to services as usual? • Is WISe implementation cost-neutral compared to previous approach to serving youths with SED?
• Costs of critical outcomes, e.g.: o Residential Placement; o ER/crisis use o Justice contacts/ detention; o Child welfare involvement	• DSHS RDA integrated client database	• Info for WISe enrolled youths regularly submitted to RDA and reports run o Comparisons to matched or historical comparison group of similar non-WISe youths	
• Caregiver ratings and satisfaction and quality	• WISe-specific MHSIP phone survey	• WISe-specific MHSIP phone interview conducted by WIMHRT with WISe enrolled caregivers and youths	• Are WISe-enrolled youths and caregivers satisfied with their services? • Are WISe-enrolled youths and caregivers satisfied with progress toward meeting their needs? • What strengths and needs for improvement do youths and caregivers perceive? What recommendations do youths and caregivers have?
• Youth ratings and satisfaction and quality	• WISe-specific MHSIP phone survey	• WISe-specific MHSIP phone interview conducted by WIMHRT with WISe enrolled caregivers and youths	

DBHR Quality Improvement Structure and Reporting

Child/ Youth & Family	Provider/ Agency	RSN	DBHR	Statewide FYSPRT*
CANS				
WISe Fidelity tools	Other Fidelity tools			
	SCOPE			
	EQRO Report			
	Behavioral Health Dashboard			
		DBHR Quality Report(s)		
	Certification/ Licensing Reports			
	Satisfaction Surveys			

*Family, Youth, System Partner Roundtable

NSMHA COMMITTEE DISCUSSION FORM

AGENDA ITEM: 2013 Discharge Planning Focused Review (UR) Report

PRESENTER: Kurt Aemmer

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

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:

- In October of 2013 NSMHA utilization review Quality Specialists performed a UR at each of the provider flagship sites, which focused on Discharge Planning.
- Fifteen discharged consumer records were selected by the providers for review by the UR team.
- The charts were reviewed against nine questions which had been developed by the review team to measure compliance with the NSMHA discharge P&P.
- No scientific method was utilized, yielding no statistically significant confidence. Rather, the review was an attempt to give the review team an idea of how closely providers are meeting the requirements in the policy. These findings are intended to help determine whether or not future formal D/C planning reviews are needed, and if so provide baseline data.
- This presentation is intended to communicate the 2013 provider and regional rates to QMOC.

Regional Level

- Six of the nine questions scored a compliance rate of 90% or greater; one scored between 80% & 90%; & two scored less than 80%.
- Questions number 6. (42%) & 8. (54%) showed the greatest opportunity for improvement (See attached table). These questions pertained to actual discharge plan documents & post-discharge correspondence.

Provider Level

- Aside from questions # 6 & 8, only one provider showed challenges in one or more other questions.
- Only two providers (CH North & Sunrise Services) showed overall compliance rates of over 90%.

CONCLUSIONS/RECOMMENDATIONS:

- We need NSMHA IT to develop an electronic chart pull mechanism, like the one used in routine UR.
- We need NSMHA IT to develop an electronic database, like the one used in routine UR.
- Providers may want to consider NSMHA developing a standardized Discharge Plan (not transition summary) form for easier & more complete documentation of NSMHA consumers' post-discharge plans.

ATTACHMENTS:

2013 Discharge focused UR Table of Provider Compliance Rates

QUESTION	PROVIDER								
	Region	LWC	Interfaith	CCS	WCPC	CH No.	Sea Mar	Sunrise	CH So.
1) Discharge planning was initiated on admission	86%	68.8%	40.0%	100%	95.0%	100.0%	80.0%	100.0%	100.0%
2) The transition phase was initiated at the point that any of the six circumstances (delineated in NSMHA P&P #1540.00) were identified and only under circumstances permitted by policy	97%	100.0%	100.0%	93%	100.0%	100.0%	90.0%	100.0%	92.9%
3) If the individual entered WSH or CLIP, the individual's chart was kept open or closed per policy.	100%	100.0%	NA	NA	NA	NA	NA	NA	NA
4) The reason for discharge is documented in the record and is supported by the documentation	98%	93.8%	100.0%	93%	100.0%	100.0%	93.3%	100.0%	100.0%
5) For planned discharges, there are goals/objectives on the RRP that were implemented during the transition phase with sufficient time to ensure adequate resources & supports were in place prior to discharge	93%	44.4%	100.0%	100%	100.0%	100.0%	100.0%	100.0%	100.0%
6) For planned discharges, the discharge plan identifies the continuum of services & type & frequency of follow-up contacts recommended by the provider to assist in the successful transition to the next appropriate level of care or phase of recovery	42%	11.1%	100.0%	13%	0.0%	61.5%	40.0%	100.0%	80.0%
7) For unplanned discharges, re-engagement efforts were appropriate to the individual's need	90%	50.0%	100.0%	71%	100.0%	100.0%	90.0%	100.0%	100.0%
8) Written correspondence from the CMHA (e.g., re-engagement letters) shall be written in terminology understandable to the individual and include consumer rights, how to access routine services and how to access emergency services. A copy of the written correspondence shall be retained in the individual's clinical record.	54%	0.0%	86.7%	71%	100.0%	80.0%	0.0%	50.0%	38.5%
9) There is a discharge summary that summarizes the consumer's demonstrated progress toward their recovery goals	90%	31.3%	100.0%	93%	100.0%	100.0%	100.0%	93.3%	100.0%
TOTAL	83%	56.1%	88.3%	84%	88.3%	92.2%	73.3%	93.2%	88.6%

NSMHA COMMITTEE DISCUSSION FORM

AGENDA ITEM: 2013 Special Populations Focused Review (UR) Report

PRESENTER: Kurt Aemmer

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

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:

1. The Special Populations Consultations (SPCs) process is one of many ways we can demonstrate cultural competence in services delivery.
2. In 2012 NSMHA developed & presented an updated roster of special pops specialists/consultants including names and contact numbers for specialists in each of the required populations, and sent it to providers.
3. This focused review looked at two key questions:
    a. At what rate are SPCs being completed on time (within 90 days of the 1st ongoing), when indicated?
    b. At what rate are the consultant's treatment recommendations brought forward to the Recovery & Resiliency Plans (RRPs)?
4. As a region, there has been steady improvement in timely completion of SPCs. Six of eight providers improved from 2012 or maintained a compliance rate of 100%.
    a. The regional compliance rate was **82%**
5. In 2013 treatment recommendations from consultants were carried over to the RRP at a rate of **84%**, a 21% improvement over 2012, and the highest regional rate since 2010.

CONCLUSIONS/RECOMMENDATIONS:

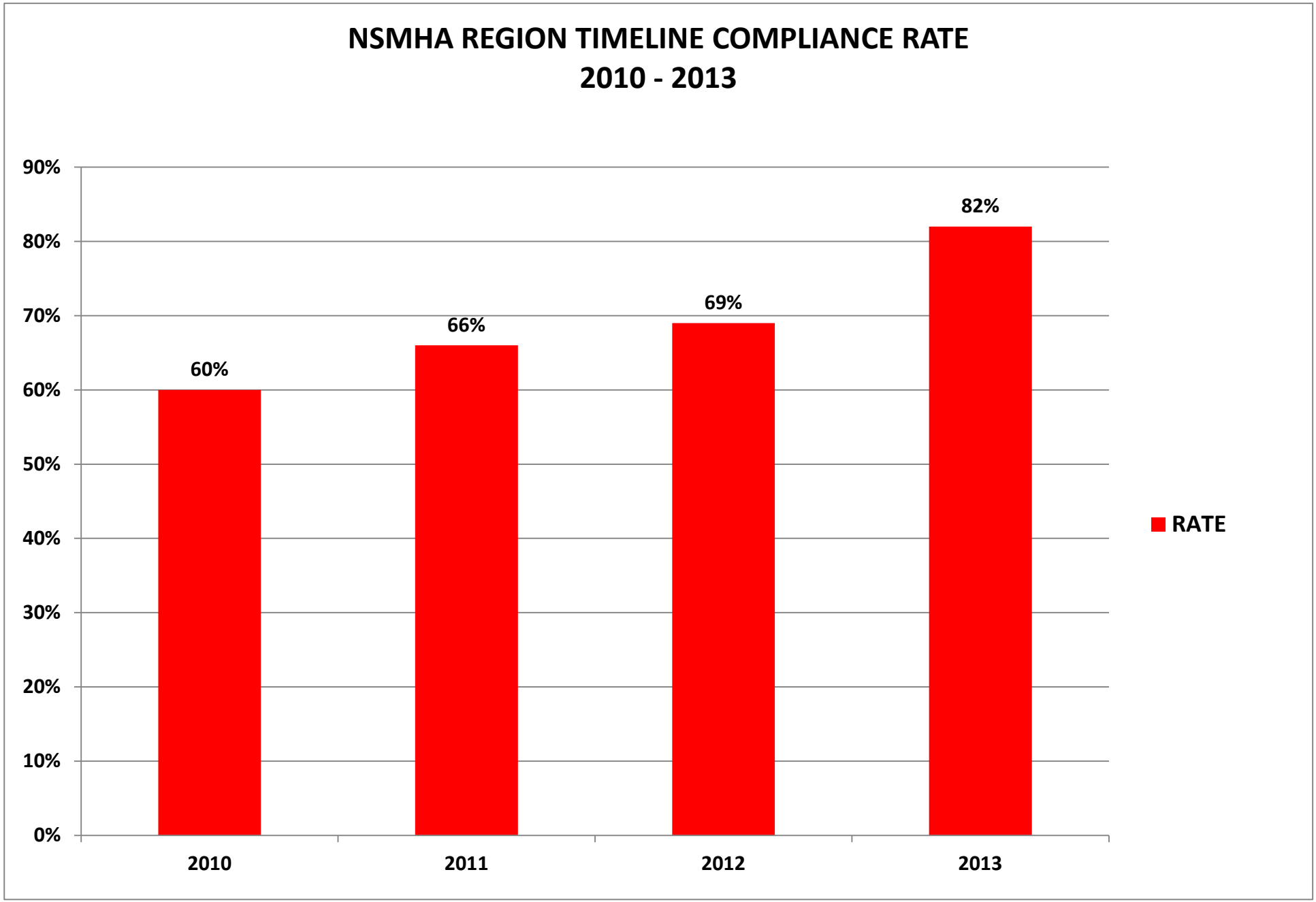
- Though some providers have heard state surveyors comment that the most recent WACs will no longer require Special Populations Consultations in the future, NSMHA has been informed they may remain as a contractual requirement. We are moving ahead as if they will be required until/unless we hear otherwise.
- NSMHA Clinical Oversight is suggesting that QMOC members bring new ideas of how we can increase cultural competency (and how we can oversee it in the region) to present at January QMOC. We are currently researching ideas, and would like QMOC input.

TIMELINES:

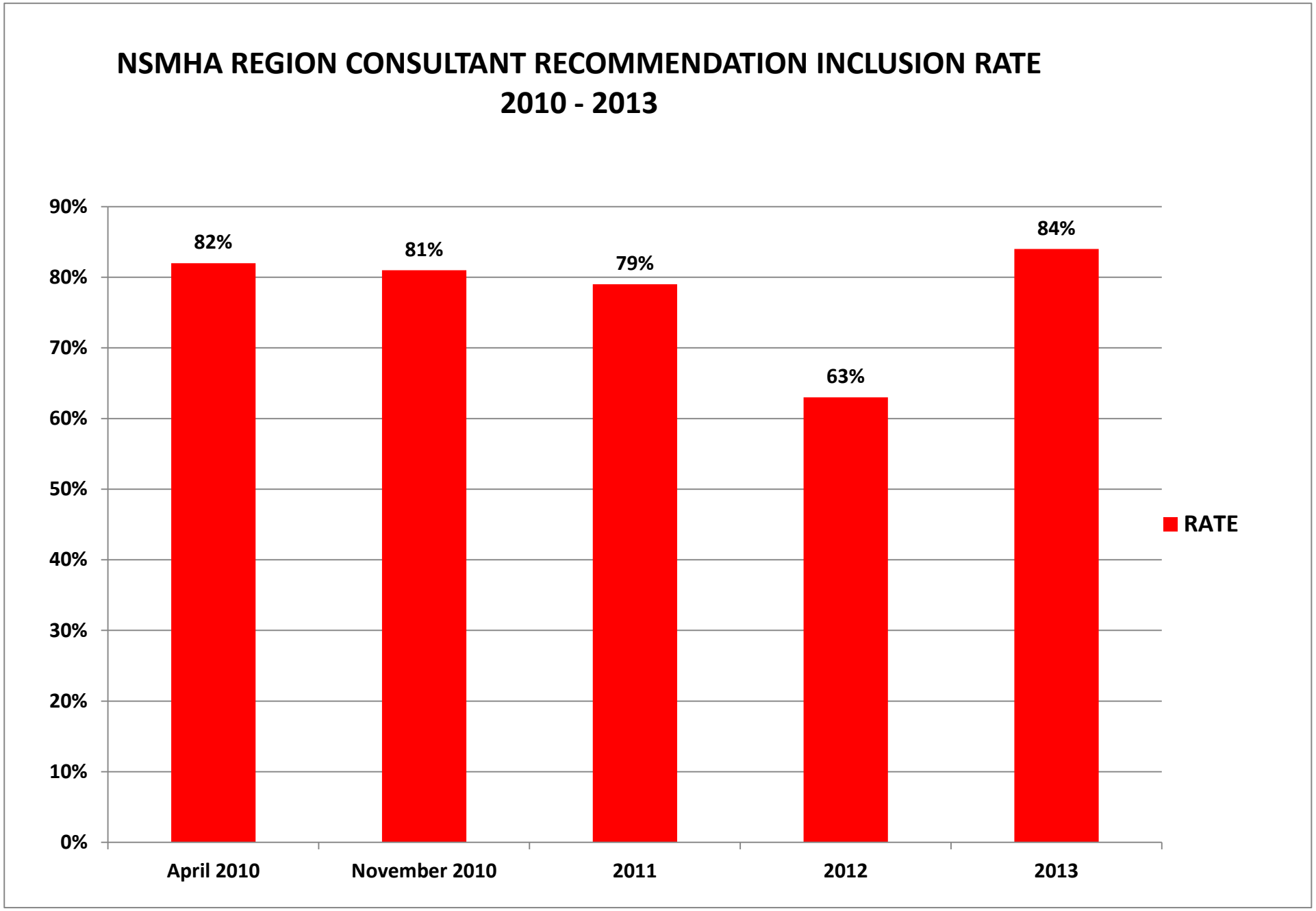
- NSMHA is expecting a draft of the new contract by the end of November 2013, which should indicate whether or not SPCs will remain a requirement in 2014. We hope to report that decision by the 12/11/13 meeting.
- If SPCs are still required, the Clinical Oversight UR team will likely repeat this focused review in the fall of 2014.

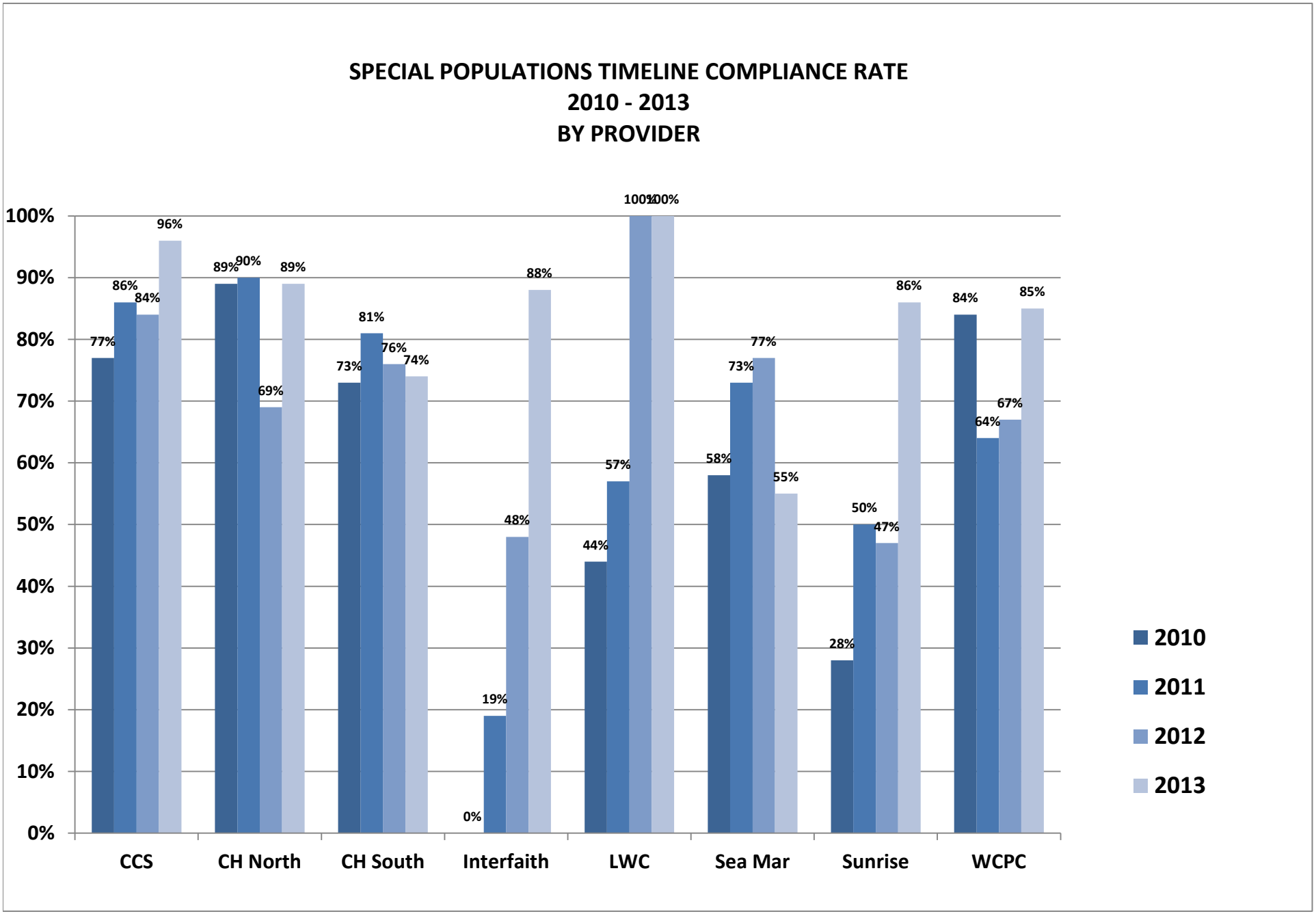
ATTACHMENTS:

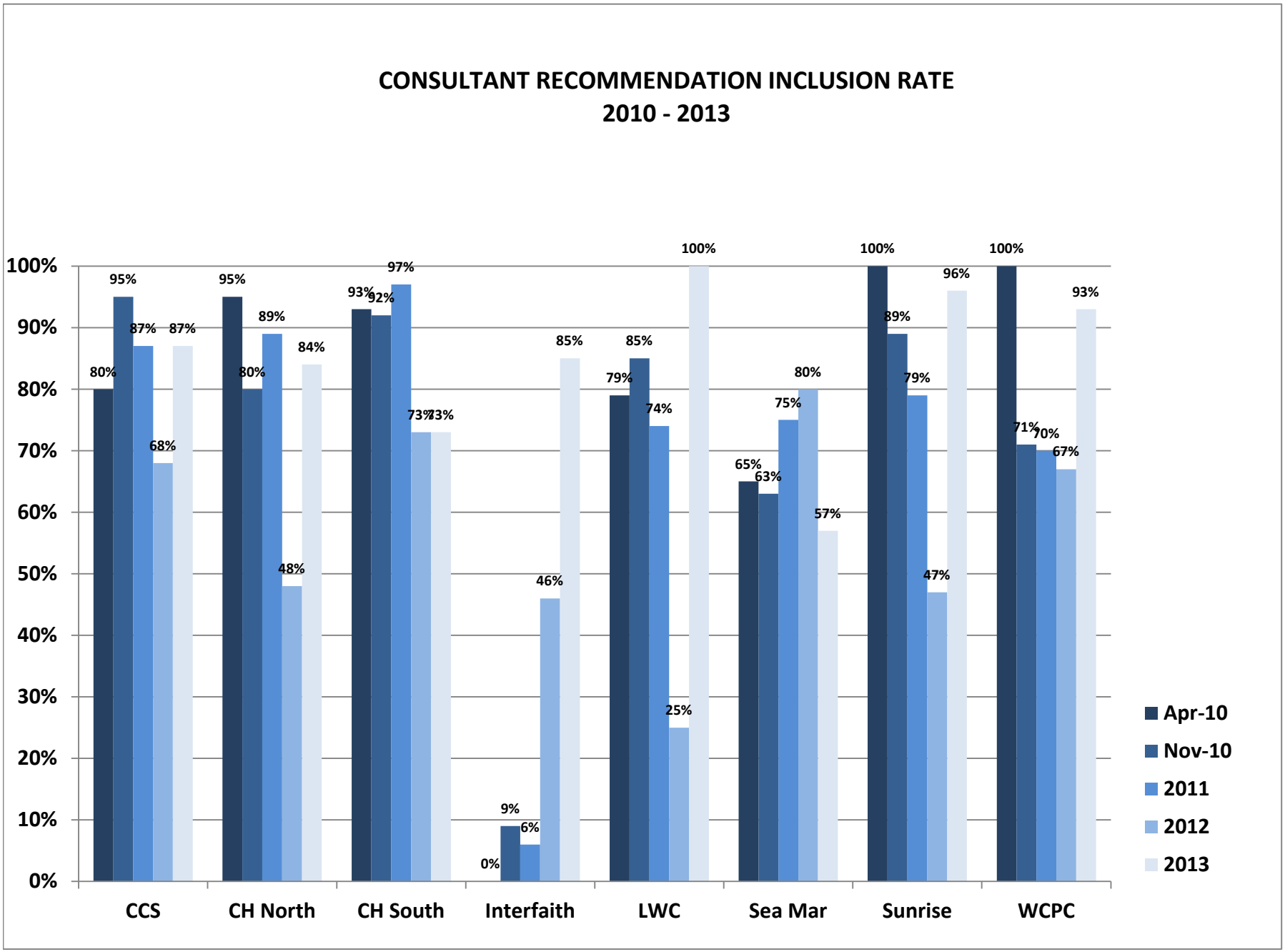
- 2013 NSMHA Regional Compliance Bar Charts; one for each of the two questions.
- 2013 NSMHA Provider Compliance Bar Charts; one for each of the two questions.


NSMHA REGION TIMELINE COMPLIANCE RATE
2010 - 2013
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
60%
66%
69%
82%
2010
2011
2012
2013
RATE

NSMHA REGION CONSULTANT RECOMMENDATION INCLUSION RATE
2010 - 2013




SPECIAL POPULATIONS TIMELINE COMPLIANCE RATE
2010 - 2013
BY PROVIDER
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
77%
86%
84%
96%
89%
90%
69%
89%
73%
81%
76%
74%
0%
19%
48%
88%
44%
57%
100%
100%
58%
73%
77%
55%
28%
50%
47%
86%
84%
64%
67%
85%
CCS
CH North
CH South
Interfaith
LWC
Sea Mar
Sunrise
WCPC
2010
2011
2012
2013


CONSULTANT RECOMMENDATION INCLUSION RATE
2010 - 2013
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
80%
95%
87%
68%
87%
95%
80%
89%
48%
84%
93%
92%
97%
73%
73%
0%
9%
6%
46%
85%
79%
85%
74%
25%
100%
65%
63%
75%
80%
57%
100%
89%
79%
47%
96%
100%
71%
70%
67%
93%
CCS
CH North
CH South
Interfaith
LWC
Sea Mar
Sunrise
WCPC
Apr-10
Nov-10
2011
2012
2013

NSMHA COMMITTEE DISCUSSION FORM

AGENDA ITEM: ICRS policy 1703 Duration of Crisis Services

PRESENTER: Sandy Whitcutt or Greg Long

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

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:

Policy 1703 describes the nature and duration of crisis services as well as procedures that are followed by Crisis and Crisis stabilization services providers.
The policy was last revised in 2008. It has been reviewed, revised and approved by ICRS. It only required small revisions.

CONCLUSIONS/RECOMMENDATIONS:
ICRS recommends approval of this policy by QMOC.

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

ATTACHMENTS:
Policy 1703 (clean version and policy with revisions)

Effective Date: 6/17/2008; 1/28/2008; 11/29/2005
Revised Date: 11/26/2013
Review Date: 11/26/2013

North Sound Mental Health Administration

Section 1700 – Integrated Crisis Response Services: Duration of Crisis Services

Authorizing Source: NSMHA and ICRS Management
Cancels:
See Also:
Providers contracted for Crisis Services must have "policy consistent with NSMHA policies"

Responsible Staff: Deputy Director | Approved by: Executive Director | Date:

Signature:

POLICY #1703.00

SUBJECT: DURATION OF CRISIS SERVICES

POLICY

Crisis Service and Crisis Stabilization Services are provided until the assessor has determined that the individual is stabilized and no longer presents an immediate, acute, or heightened risk of harm to self, others, or grave disability. Crisis Service and Crisis Stabilization Services also may end when the individual is referred to other services.

Crisis Services and Crisis Stabilization Services are short-term (less than two weeks per episode) in nature and are intended to last for a few hours or days and in unusual cases, a few weeks. Individuals may re-enter crisis services if a new crisis arises or the individual's functioning deteriorates.

PROCEDURES

I. Appropriate and timely discharge from Crisis Service and Crisis Stabilization Services are a consideration from the beginning of each crisis intervention.
II. When discharge from crisis services is being planned, the following shall occur:

a. The risk of harm to self or others shall be assessed and documented in the clinical record and any substantial risks have been addressed.
b. The action plan for the continued resolution of the crisis and stability has been developed. This means the following:

1. The action plan has been agreed to by the individual who was in crisis;
2. The action plan has been coordinated with significant others and other professionals; as appropriate.
3. If the individual is being referred to another service, the individual has the referral contact information and alternative plans, if this referral does not work out;
4. The individual and significant others have a plan to respond if the issues of concern become more acute again and
5. The action plan has been documented in the clinical record.

ATTACHMENTS

None

Effective Date: 6/17/2008; 1/28/2008; 11/29/2005
Revised Date: ~~1/4/2006~~9/26/2013
Review Date: ~~5/28/2008~~9/26/2013

North Sound Mental Health Administration

Section 1700 – Integrated Crisis Response Services: Duration of Crisis Services

Authorizing Source: NSMHA and ICRS Management
Cancels:
See Also: Approved by: Executive Director Date: ~~6/17/2008~~
Providers contracted for Crisis Services must have "policy consistent with NSMHA policies"
Responsible Staff: Deputy Director Signature:

POLICY #1703.00

SUBJECT: DURATION OF CRISIS SERVICES

POLICY

Crisis ~~Outreach~~ Service and Crisis Stabilization Services are provided until the assessor has determined that the individual is stabilized ~~to that their individual's normal, pre-crisis, functioning or~~ and no longer presents an immediate, acute, or heightened risk of harm to self, others, or grave~~ly~~ disability~~led~~. Crisis ~~Outreach~~ Services and Crisis Stabilization Services also ~~will~~ may end when ~~it seems reasonably likely~~ the individual ~~will not need to be re-admitted for further crisis services or more restrictive services to remain stable for at least the next 48 hours. Crisis outreach and stabilization services also will end when the individual~~ is referred to other services.

~~—~~Crisis Service and Crisis Stabilization Services are short-term (less than two weeks per episode) in nature and are intended to last for a few hours or days and in unusual cases, a few weeks. Individuals may re-enter crisis services if a new crisis arises or the individual's~~a~~ ~~person's~~ functioning deteriorates.

PROCEDURES

I. Appropriate and timely discharge from ~~crisis~~ Crisis ~~outreach~~ Service and Crisis ~~stabilization~~ Stabilization ~~services~~ Services are a consideration from the beginning of each crisis intervention.

II. When discharge from crisis services is being planned, the following shall occur:

a. The risk of harm to self or others shall be ~~re-~~assessed and documented in the clinical record and ~~these risks are of an acceptable level so the consumer will be safe and not need services again for at least 48 hours.~~~~and~~ any substantial risks have been addressed.

b. A plan(The Action Plan) for the continued resolution of the crisis and stability has been developed. This means the following:

1. The action plan has been agreed to by the ~~consumer~~ individual who was in crisis;
2. The action plan has been coordinated with significant others and other professionals; as appropriate.
3. If the ~~consumer~~ individual is being referred to another service, the ~~consumer~~ individual has the referral contact information and alternative plans, if this referral does not work out;
4. The ~~consumer~~ individual and significant others have a plan to respond if the issues of concern become more acute again and
5. The action plan has been documented in the clinical record.

ATTACHMENTS

None

NSMHA COMMITTEE DISCUSSION FORM

AGENDA ITEM: Recovery/Resiliency Plan Reviews

PRESENTER: Charissa Westergard

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

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:
With the recent Washington Administrative Code (WAC) revision, the requirement to review the Recovery/Resiliency Plan (aka Individual Service Plan or Treatment Plan) at a minimum of every 180 days was eliminated.

At the October QMOC meeting, NSMHA requested members to consider strategies for ensuring review and updating of Recovery/Resiliency Plans to discuss further at this QMOC meeting.

Some of the ideas NSMHA is considering:

- Continue with the current standard of reviewing the plan at least every 180 days and, as necessary, updated sooner to reflect any changes in the individual's treatment needs or as requested by the individual or their parent or other legal representative, if applicable.
- Review the plan at least every "x" number of service hours (e.g., every 15 hours of service).
- Review the plan at least every "x" number of service hours based on level of care (e.g., every 5 hours for Level 1, every 10 hours for Level 2, etc).

CONCLUSIONS/RECOMMENDATIONS:
We would like to hear and discuss recommendations from QMOC as well and identify the preferred 2-3 strategies.

TIMELINES:
Once preferred strategies are reviewed, policy will be revised and sent out to QMOC for the 30-day comment period.

ATTACHMENTS:
None

NORTH SOUND MENTAL HEALTH ADMINISTRATION

QUALITY MANAGEMENT OVERSIGHT COMMITTEE (QMOC)

December 11, 2013

AGENDA ITEM: Planning for Upcoming Reductions in State Funding

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

PRESENTER: Greg Long

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

OBJECTIVE:

To continue preparations for upcoming reductions in State Funding.

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:

BACKGROUND:

With health care reform being implemented starting in January 2014, the State projects there will be a substantial increase in the number of people who are currently funded for mental health services by the State who will qualify for Medicaid. Based on the State's projections for the increased number of people on Medicaid, the State has reduced the amount of State Funding coming to the North Sound Region by around $4,000,000/yr. There will be an increase in Medicaid funding, but it cannot be used to fund many of the programs that the State Funds have covered in the past.

NSMHA has been going over its Medicaid and State Fund allocations to determine how to bring this into balance.

PREVIOUS ACTION(S) TAKEN:

- NSMHA continues to study this issue internally.
- NSMHA outlined this issue at QMOC last month.

CONCLUSIONS/ACTION REQUESTED:

- NSMHA believes it is crucial to get every individual in our system qualified for Medicaid possible. This will provide better access to all types of treatment for the individuals and will readjust the balance between Medicaid and State funds by reducing the demands for State funds. Be prepared to discuss what actions are being taken to assure that everyone eligible for Medicaid is applying.
- NSMHA believes there are only minor adjustments in many of our specialized programs such as crisis services, residential services, inpatient services, court costs and flex funds that can be made to reduce State Funds.
- The major reductions will have to occur in Outpatient Services. NSMHA is purposing the following:
    - Putting a cap on the amount of State Funds allocated to each agency and give/allow the providers to manage State Funded Clients and Services to stay under that cap. Providers would have to decide on a case by case basis if they want to use their allocated State Funds by requesting a re-authorization based on the severity of the specific individual's needs.
    - Initial and Re-Authorization would be for three months for State Funded individuals.
    - Re-adjusting the Authorization Processes and Policy so people on State Funds would have a shorter authorization time if they lose Medicaid, perhaps a month. The Policy on the Use of State Funds would also have to be revised.

FISCAL IMPACT:

These changes would reduce the expenditure of State Funds. However, this is a very dynamic situation so the caps and practices would have to be adjusted on a quarterly basis reflecting the actual utilization of State Funds. Further measures to reduce the use of State Funds might be necessary or these rules might be loosened up if the reduction in use of State Funds is large enough.

ATTACHMENTS:

None

NORTH SOUND MENTAL HEALTH ADMINISTRATION

QUALITY MANAGEMENT OVERSIGHT COMMITTEE (QMOC)

December 11, 2013

AGENDA ITEM: A Regional approach to Training?

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

PRESENTER: Heather Fennell/Greg Long

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

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:

OBJECTIVE:

To ensure consistent quality training of staff region-wide.
To provide ongoing staff development opportunities.
To be able to document and analyze the training that our provider clinicians have obtained.

BACKGROUND:

Heather Fennell states "I am in the midst of updating our Training Plan at Compass Health to be current with our practice and thinking about the WAC changes. I would really love a place at a regional level where we could discuss trainings, especially those that may make the most sense to offer regionally on a regular basis, such as Clinical Supervisor Training, Suicide Assessment & Treatment, MI, and Cultural Competency. These are the ones that come to the fore-front of my mind right now…but it seems like an area we could get the most bang for our buck to coordinate. I am very happy to offer our training team for logistics and our venue."

There is also a need for DSM V Training, understanding and working with people with chronic conditions and NSMHA is getting more requests for Motivational Interviewing Training and IMR Training.

PREVIOUS ACTION(S) TAKEN:

NSMHA has provided a variety of trainings for years to address specific needs such as Recovery and evidence-based practices. These training and consultations have included Wraparound, Motivational Interviewing, Illness Management and Recovery, Wellness Recovery Action Plan (WRAP), Eating Disorder Treatment and Dialectical Behavioral Therapy for children.

Compass Health and other agencies have also sponsored wide varieties of trainings.

CONCLUSIONS/ACTION REQUESTED:

- Many Trainings could be provided more effectively and less expensively if they were coordinated.
- A wide variety of trainings are available on the web or DVDs.
- Providers and NSMHA are being expected to document, certify and recertify training and competencies that clinical staffs in our Region have. A better system to track this information for reporting and planning is needed.

FISCAL IMPACT:

NSMHA itself currently spends over $100,000/yr. on Training. Our estimate is that an online Regional Training System might cost $60,000-$100,000/yr.

ATTACHMENTS:

None