NORTH SOUND
MENTAL HEALTH ADMINISTRATION

QUALITY MANAGEMENT OVERSIGHT COMMITTEE

MEETING PACKET

January 28, 2015
1:00 – 3:00 pm

1. Please join my meeting.
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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

Date: January 28, 2015 **Time: 1:00-3:00 PM**
Location: NSMHA Conference Room **Chair: Anji Jorstad, Snohomish County Human Services**
For information Contact Meeting Facilitator: Charissa Westergard, NSMHA, 360-416-7013

Topic	Objective	ACTION NEEDED	Discussion Leader	Handout available pre-mtg	Handout available at mtg	Tab	Time
Introductions	Welcome guests; presenters and new members		Chair				*5 min*
Review and Approval of Agenda	Ensure agenda is complete and accurate; determine if any adjustments to time estimates are needed. Meeting will start and end on time.	Approve Agenda	Chair	Agenda		**1**	*5 min*
Review and Approval of Summary of Previous Meeting	Ensure meeting summary is complete and accurate.	Approve Meeting Summary	Chair	Summary		**2**	*5 min*
Announcements and Updates		Inform/ Discuss	All				*5 min*
Quality Topics							
Policy 1549 Disaster Preparedness		Discuss/ Approve	Sandy Whitcutt			**3**	*10 min*
Policy 1559 Co-occurring Disorder Screen		Discuss/ Approve	Sandy Whitcutt			**4**	*10 min*
Individuals Difficult to Serve	Discussion about policy & procedure for serving and transfer, if appropriate, of individuals with behaviors identified as dangerous	Discuss	Charissa Westergard				*20 min*
Consent for Intake	Review of policy on obtaining consent for intake prior to scheduling	Discuss	Charissa Westergard			**5**	*15 min*
Child/Youth MH Update		Discuss	Julie de Losada				*20 min*
Other issues							*5 min*
***Review of Meeting**	Were objectives accomplished? How could this meeting be improved? Eval forms						
Date and Agenda for Next Meeting	Ensure meeting date, time and agenda are planned						

Next meeting: February 25, 2015- 1:00-3:00 PM

North Sound Mental Health Administration (NSMHA)
Quality Management Oversight Committee (QMOC)
NSMHA Conference Room
December 10, 2014
1:00 – 3:00 pm
MEETING SUMMARY

PRESENT: Chuck Davis, Ombuds, Eric Chambers, NWESD; Richard Sprague, Interfaith; Cindy Ferraro, Bridgeways; Laura Yen, Compass; Miriam Hunt, CHS; Anji Jorstad, Snohomish County; Mike Manley, Sunrise; Kate Scott, Sea Mar; Mark McDonald, Greg Wennerberg, Fred Plappert, Candy Trautman and Marie Jubie, NSMHA Advisory Board.
BY PHONE: Kay Burbidge, LWC; Camilla Prince, Sunrise; Pat Morris, VOA; Rob Sullivan, Skagit Triage and Kathy McNaughton, CCS.
STAFF: Greg Long, Julie de Losada, Jessie Ellis, Charissa Westergard and Barbara Jacobson**.**
OTHERS PRESENT: Heather Waters, CHS.

TOPIC	DISCUSSION	ACTION
1. **Introductions, Review of Agenda – Chair**	AnjiJ convened the meeting and introductions made. Agenda revisions called for; items will be presented out of order. Future agenda item; EHR implementation, it is a requirement in 2014 for a portal process for client access which brings up issues.	
2. Previous Meeting Summary – Chair	Previous meeting summary up for review; EricC presented motion to approve as submitted, second by ChuckD; motion carried.	Approved
3. Announcements and Updates – All	• GregL noted with the WA state requirement around suicide training the enclosed SAMHSA printout is similar to what the state is laying out to follow. • SBC update-State says there will be 145 new beds by December 26 deadline that includes the 30 bed Fairfax Everett and a new E&T on the WSH campus. NSMHA is on hold with the E&T as the State will decide in two weeks on granting a short-term lease. This will still not provide adequate beds. • State wrote into emergency WACs that a hospital can certify that they are able to provide adequate psychiatric services to hold. DBHR would like to see CMHAs contract with hospitals to provide this.	Informational
4. Evaluation Forms from Last Meeting – Chair/Greg	Anji gave a brief overview of the evaluation forms.	Informational
Quality Topics		
5. Internal Changes at NSMHA	Greg noted that with the development of the Behavioral Healthcare Org (BHO) and Medicaid expansion changes at NSMHA are ongoing. CharissaW has been promoted to Adult Services Manager; Julied has been promoted to the Children Services Manager and SandyW has been promoted to Crisis Services Coordinator. Greg noted that he is retiring as the Deputy Director; his last day is January 9th. There is additional hiring planned in 2015 and 2016. Looking to hire a CD Manager and also to hire someone with background in statistics and	Informational

	things to oversee Performance Improvement Projects (PIPs) and other processes.	
6. Out of Network policy 1522	JessieE noted that this policy was approved, but there were substantial edits that needed to be made so she brought it back with these changes for review. The main change is that all out of network services except for services out of state must be subcontracted through CMHAs. Subcontracting is outlined with a process for how to fund. Copies of all your subcontracts should come to NSMHA. These cases are complex and need coordination; it is suggested there be a point person at each agency to oversee the process. We audit for out of network services that will be in the audit next year. MikeM noted agency is mostly just an agent in the process and is stuck between the two, negotiating on behalf of NSMHA. Greg noted that a joint phone call should cover that. The agency has the clinical responsibility that is separate from the financial/contract issue. CIS data entry is another issue; subcontractor would give information to the CMHA that has the burden for the data portion.	Informational
7. IOP audit results	Jessie gave a brief report on the adult IOP audit recently done. High scores were given on coordination around hospitalization and other coordination and on recovery oriented treatment plans. There were several scores below the 90% benchmark; there will be corrective actions on these lower scores for established agencies.	Informational
8. Policy 1505 Authorization for Outpatient services	CharissaW noted the change to remove the alternate process on review of reauthorization for levels of care 1 and 2; there will be up to six months authorized. MarieJ presented a motion to approve the policy as presented, second by ChuckD; motion carried.	Motion carried
9. Children & Youth Mental Health	Julie noted she will bring forward children's issues on a regular basis and is looking for input on what information is most helpful for this group. Youth are up to age 21 for Medicaid and the State wants to make sure we are addressing EPDST and other issues. MiriamH noted the need for training around youth services in school for cutting for example. EricC noted the lack of data that is relevant for trends to address issues that would be good to see here. MarkM suggested a monthly summary of children's data be presented. A workgroup to address larger issues would be convened. Julie noted a meeting from noon to 4:00 pm this Saturday at the Fairhaven Library in Bellingham facilitated by Dads Move for family run systems. • SERI changes for youth under 21; there were a few codes that needed clarification and it was requested to change the name of one code to care coordination. More work still needs to be done in this area. • Under HB2536 for EBPs some codes were removed from SERI and the state will work to put back in. • For serving transition age youth-there is no real system and Julie recommends a workgroup to address the shortfall. • RFP for children's IOP-the state is now requesting WISe capacity double and with the payments to us only being half of what the provider spends, more discussion needs to occur around this.	Informational

10. Review of Notices Implementation	Charissa noted that the policies on notices were approved in August and the templates went out in October; NSMHA is checking in on implementation. Heather noted that managers and directors have been trained at Compass and they are beginning to use the forms now. KathyM noted that supervisors are trained at CCS and were ready to go by November 1. KateS noted that Sea Mar has trained and will use starting Monday. Charissa will email all for an update with a deadline for implementation. Charissa inquired if there are more languages needed other than English and Spanish; Russian requested.	Informational Charissa will email for update with deadline. Notices in Russian requested.
11. Behavioral Health Organization (BHO) Preparations	Greg gave update on the BHO with the RFP expected to come out in July from the State. Counties have right of first refusal and our counties want to go the BHO route; we have retained Dale Jarvis for the financial model and Dr. Reis for the clinical model. There will be stakeholder meetings in early 2015 for clinical and financial planning. We would actually have co-occurring services in this new system. Mike noted a recent audit on CD that the state wanted to audit both CD and mental health and wondered what the timeline is. Greg noted the state has workgroup to reconcile the three WACs out there, for CD, behavioral health and mental health and asked if Sunrise could send their audit results for Charissa to review as we go forward. Charissa noted there are still two separate WACs that have not been reconciled yet. IT will need to be addressed as well for data elements.	Informational
12. Decentralized Access	Greg noted that in BHO planning the region is looking at an additional path to access services directly through provider agencies. Charissa noted that from the data stand point VOA tracks it now and VOA can see more data than agencies; provider agencies would need to add some capability to their data set for this. PatM noted that VOA also gets calls all day for those not eligible for services; VOA does a warm transfer to 211; offers other resources and follows up with them, which is time consuming. Providers note concerns with the larger workload and with all agencies using different data systems this will add difficulties and expense. Give further feedback to Charissa on IT impacts and other issues.	Informational
13. Policies regarding use of Interpreters	Greg noted that NSMHA has been asked to clarify the need for interpreter services for intensive or residential services; where there are many hours of contact, many not of a clinical nature. The WACs are not completely clear around this. PatM noted they contract with Optimal Phone Interpreters that works very well and has many languages available. LauraY noted that is often not a simple matter of language but the cultural barriers that come up. Anji noted this should be added to agenda again for further discussion.	Informational Add to agenda again at some point.
14. Open Forum	None.	Discussion
15. Date and Agenda for Next Meeting	The meeting adjourned at 3:00 pm. The next meeting is January 28, 2015.	

NSMHA COMMITTEE DISCUSSION FORM

AGENDA ITEM: Policy 1549 Disaster Preparedness

PRESENTER: Sandy Whitcutt

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

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:

There is an expectation that NSMHA participate in all disaster preparedness activities and respond to emergency/disaster events (e.g., natural disasters, acts of terrorism) when requested by DBHR. NSMHA has complied with this policy through its subcontracts with providers. This response was provided during Oso in 2014, through a subcontract with Volunteers of America. When requested, NSMHA and its providers are expected to:

- Attend DBHR-sponsored training regarding the role of the public mental health system in disaster preparedness and response.
- Participate in local emergency/disaster planning activities when county Emergency Operation Centers and local public health jurisdictions request collaboration.
- Provide Disaster Outreach Services, required in the State Mental Health Contract (SMHC), in NSMHA's service area in the event of a disaster/emergency.

The policy was due for review and revision. There have been small revisions to the policy. It has been sent to QMOC for comments. There were none given.

CONCLUSIONS/RECOMMENDATIONS:
Pass Policy 1549 with revisions.

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

ATTACHMENTS:
Policy 1549, clean version and revised version

Effective Date: 1/10/2008; 11/21/2005
Revised Date: 7/3/14
Review Date: 7/3/14

North Sound Mental Health Administration

Section 1500 – Clinical: Disaster Preparedness

Authorizing Source: NSMHA contract
Cancels:
See Also:
Providers contracted to provide crisis and outpatient services should have policies that comply with NSMHA policies
Approved by: Executive Director
Date:
Responsible Staff: Deputy Director
Signature:

POLICY #1549.00

SUBJECT: DISASTER PREPAREDNESS

PURPOSE

To ensure the North Sound Mental Health Administration (NSMHA) complies with all state and federal requirements regarding disaster preparedness.

NSMHA is committed to meeting the needs of its enrolled individuals and all residents of our Region during disasters. Resources will be prioritized first to those with the greatest need.

POLICY

NSMHA must participate in all disaster preparedness activities and respond to emergency/disaster events (e.g., natural disasters, acts of terrorism) when requested by DBHR. NSMHA will comply with this policy through its subcontracts with providers.

PROCEDURE

NSMHA shall:

1. Attend DBHR-sponsored training regarding the role of the public mental health system in disaster preparedness and response.
2. Participate in local emergency/disaster planning activities when county Emergency Operation Centers and local public health jurisdictions request collaboration.
3. Provide Disaster Outreach Services, required in the State Mental Health Contract (SMHC), in NSMHA's service area in the event of a disaster/emergency.

    a. Disaster Outreach Services means contacting persons in their place of residence or in non-traditional settings for the purpose of assessing their mental health and social functioning following a disaster or increasing the utilization of human services and resources.
    b. There are two basic approaches to outreach: mobile (going person to person) and community settings (e.g., temporary shelters, disaster assistance sites, disaster information forums) The outreach process must include the following:

        i. Locating persons in need of disaster relief services;
        ii. Assessing their needs;
        iii. Engaging or linking persons to an appropriate level of support or disaster relief services;
        iv. Providing follow-up mental health services when clinically indicated.

4. Disaster Outreach can be performed by trained volunteers, peers and /or persons hired under Federal Emergency Management Agency (FEMA) Crisis Counseling Grant. These persons should be trained in disaster crisis outreach which is different than traditional mental health crisis intervention.
5. Conduct post-disaster outreach to determine the need for disaster related crisis counseling and assess the availability of local resources in meeting those needs.
6. Provide the name and contact information to DBHR for person(s) coordinating the NSMHA disaster/emergency preparedness and response plan upon request.
7. Provide information and preliminary disaster response plans to DBHR within 7 days following a disaster/emergency or upon request.
8. Partner in disaster preparedness and response activities with DBHR and other DSHS entities, the State Emergency Management Division, FEMA, the American Red Cross and other volunteer organizations.

    a. This must include participation when requested in local and regional disaster planning and preparedness activities and coordination of disaster outreach activities following an event.
    b. Disaster outreach crisis services for enrolled NSMHA individuals will be coordinated between NSMHA, NSMHA's Integrated Crisis Response Services (ICRS) and outpatient providers.

ATTACHMENTS

None

Effective Date: 1/10/2008; 11/21/2005
Revised Date: 7/3/14~~12/26/12~~
Review Date: 7/3/14

North Sound Mental Health Administration

Section 1500 – Clinical: Disaster Preparedness

Authorizing Source: NSMHA contract
Cancels:
See Also:
Providers contracted to provide crisis and outpatient services should have policies that comply with NSMHA policies
Responsible Staff: Deputy Director~~Quality Manager~~

Approved by: Executive Director Date: ~~1/10/2008~~
Signature:

POLICY #1549.00

SUBJECT: DISASTER PREPAREDNESS

PURPOSE

To ensure ~~that~~ the North Sound Mental Health Administration (NSMHA) complies with all state and federal requirements regarding disaster preparedness.

NSMHA is committed to meeting the needs of its enrolled individuals~~consumers~~ and all residents of our Region during disasters. Resources will be prioritized first to those with the greatest need.

POLICY

NSMHA must participate in all disaster preparedness activities and respond to emergency/disaster events (e.g., natural disasters, acts of terrorism) when requested by DBHR~~MHD~~. NSMHA will comply with this policy through its subcontracts with providers.

PROCEDURE

NSMHA shall:

1. Attend DBHR~~MHD~~-sponsored training regarding the role of the public mental health system in disaster preparedness and response.
2. Participate in local emergency/disaster planning activities when county Emergency Operation Centers and local public health jurisdictions request collaboration.
3. Provide Disaster Outreach Services, required in the State Mental Health Contract (SMHC), in NSMHA's service area in the event of a disaster/emergency.

    a. Disaster Outreach Services means contacting persons in their place of residence or in non-traditional settings for the purpose of assessing their mental health and social functioning following a disaster or increasing the utilization of human services and resources.
    b. There are two basic approaches to outreach: mobile (going person to person) and community settings (e.g., temporary shelters, disaster assistance sites, disaster information forums) The outreach process must include the following:

        i. ~~I~~Locating persons in need of disaster relief services;
        ii. ~~assessing~~ Assessing their needs;
        iii. ~~engaging~~ Engaging or linking persons to an appropriate level of support or disaster relief services;
        ~~iii.~~iv. ~~providing~~ Providing follow-up mental health services when clinically indicated.

4. Disaster Outreach can be performed by trained volunteers, peers and /or persons hired under Federal Emergency Management Agency (FEMA)~~a federal~~ Crisis Counseling Grant. These persons should be trained in disaster crisis outreach which is different than traditional mental health crisis intervention.
5. Conduct post-disaster outreach to determine the need for disaster related crisis counseling and assess the availability of local resources in meeting those needs.
6. Provide the name and contact information to ~~MHD~~DBHR for person(s) coordinating the NSMHA disaster/emergency preparedness and response plan upon request.
7. Provide information and preliminary disaster response plans to ~~MHD~~DBHR within 7 days following a disaster/emergency or upon request.
8. Partner in disaster preparedness and response activities with ~~MHD~~DBHR and other DSHS entities, the State Emergency Management Division, FEMA, the American Red Cross and other volunteer organizations.

    a. This must include participation when requested in local and regional disaster planning and preparedness activities and coordination of disaster outreach activities following an event.
    b. Disaster outreach crisis services for enrolled NSMHA individuals~~consumers~~ will be coordinated between NSMHA, NSMHA's Integrated Crisis Response Services (ICRS)~~Emergency Services,~~ and outpatient providers.

ATTACHMENTS

None

NSMHA COMMITTEE DISCUSSION FORM

AGENDA ITEM: Policy 1559 Co-Occurring Disorder Screen

PRESENTER: Sandy Whitcutt

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

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:
This policy addresses procedures for ensuring consumers age thirteen (13) and above at admission are asked to perform a Global Appraisal of Individual Needs-Short Screener
(GAIN-SS screening) at intake in outpatient setting, at the initial evaluation at an Evaluation and Treatment facility, and during the provision of a crisis episode of care.

This policy was due for review and revision. There were only small changes made. The policy was sent to QMOC for review, and there were no comments.

CONCLUSIONS/RECOMMENDATIONS:
Pass Policy 1559 with revisions.

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

ATTACHMENTS:
Policy 1559, clean version and revised version

Effective Date: -11/30/2012; 12/3/2007, 9/27/2007
Revised Date: 10/22/12
Review Date: 7/1/2014

North Sound Mental Health Administration

Section 1500 – CLINICAL: Co-Occurring Disorder Screening and Assessment

Authorizing Source: RCW 70.96A and C, 71.05, 71.34, WAC 388-877-0610, NSMHA contract
Cancels:
See Also:
Providers must comply with this policy and individualized implementation guidelines may be developed by BHAs
Responsible Staff:: Deputy Director
Approved by: Executive Director
Signature:
Date:

POLICY#1559.00

SUBJECT: CO-OCCURRING DISORDER SCREENING AND ASSESSMENT

PURPOSE

To provide an integrated, comprehensive and routine screening and assessment process for chemical dependency and mental health disorders throughout the North Sound Region.

POLICY

Providers will ensure all consumers age thirteen (13) and above at admission are asked to complete the statewide approved screening and assessment tool, GAIN-SS (Global Appraisal of Individual Needs-Short Screener).

PROCEDURE

1. The Provider must attempt to screen all individuals aged 13 and above through the use of the Department of Social and Health Services (DSHS) provided GAIN-SS during:
    a. All new intakes and re-admits at Behavioral Health Agencies (BHA) for individuals including children who turn 13 (between 13th birthday and the next recovery plan review).
    b. The initial evaluation at free-standing, non-hospital evaluation and treatment facilities.
    c. The provision of each crisis episode of care including Involuntary Treatment Act (ITA) investigations services, except when:
        i. The service results in a referral for an intake assessment.
        ii. The service results in an involuntary detention under RCW 71.05, 71.34
        iii. The contact is by telephone only.
        iv. The clinician conducting the crisis intervention or ITA investigation has information that the individual has completed a GAIN-SS screening within the previous 12 months.
2. The GAIN-SS screening must be completed as self-report by the individual and signed by the individual on the DSHS-GAIN-SS form located at: http://www.dshs.wa.gov/pdf/ms/forms/14_485.pdf . If the individual refuses to complete the GAIN-SS screening, or if the clinician determines the individual is unable to complete the screening for any reason, this must be documented on the GAIN-SS form.
3. The results of the GAIN-SS screening, including refusals and unable-to-complete, must be reported to DBHR through the Consumer Information System (CIS).
4. The Provider must complete a co-occurring mental health and chemical dependency disorder assessment, consistent with training provided by DBHR and outlined in the Substance Abuse and Mental Health Services Administration (SAMHSA) Treatment Protocol 42, to determine a quadrant placement for the individual when the individual scores a two (2) or higher on either of

the first two scales (Internalizing Disorder Screener & Externalizing Disorder Screener) and a two (2) or higher on the third scale (Substance Disorder Screener).

The assessment, to include quadrant placement, shall be completed as part of the initial intake evaluation process at BHAs and free-standing, non-hospital evaluation and treatment facilities. The assessment is not required during crisis episodes of care including ITA investigations. The quadrant placements are defined as:

a. Less severe mental health disorder/less severe substance disorder
b. More severe mental health disorder/less severe substance disorder
c. Less severe mental health disorder/more severe substance disorder
d. More severe mental health disorder/more severe substance disorder

5. The quadrant placement must be reported to DBHR through the CIS system.

ATTACHMENTS

None

Effective Date: -11/30/2012; 12/3/2007, 9/27/2007
Revised Date: 10/22/12
Review Date: ~~11/29/2012~~7/1/2014

North Sound Mental Health Administration

Section 1500 – CLINICAL: Co-Occurring Disorder Screening and Assessment

Authorizing Source: RCW 70.96A and C, 71.05, 71.34, WAC 388-8~~65~~77-0610, NSMHA contract ~~0420 (d)(iii)~~
Cancels:
See Also:
Providers must comply with this policy and individualized implementation guidelines may be developed by ~~CMHAs~~BHAs
Approved by: Executive Director
Date: ~~11/30/2012~~
Responsible Staff: Deputy Director
Signature:

POLICY#1559.00

SUBJECT: CO-OCCURRING DISORDER SCREENING AND ASSESSMENT

PURPOSE

To provide an integrated, comprehensive and routine screening and assessment process for chemical dependency and mental health disorders throughout the North Sound Region.

POLICY

Providers will ~~assure~~ ensure ~~that~~ all consumers age thirteen (13) and above at admission are asked to complete the statewide approved screening and assessment tool, GAIN-SS (Global Appraisal of Individual Needs-Short Screener).

PROCEDURE

1. The Provider must attempt to screen all individuals aged 13 and above through the use of the Department of Social and Health Services (DSHS) provided GAIN-SS during:
    a. All new intakes and re-admits at ~~CMHAs~~ Behavioral Health Agencies (BHA) for individuals including children who turn 13 (between 13th birthday and the next recovery plan review).
    b. The initial evaluation at free-standing, non-hospital evaluation and treatment facilities.
    c. The provision of each crisis episode of care including Involuntary Treatment Act (ITA) investigations services~~,~~, except when:
        i. The service results in a referral for an intake assessment.
        ii. The service results in an involuntary detention under RCW 71.05, 71.34~~, or 70.96B.~~
        iii. The contact is by telephone only.
        iv. The clinician conducting the crisis intervention or ITA investigation has information that the individual has completed a GAIN-SS screening within the previous 12 months.
2. The GAIN-SS screening must be completed as self-report by the individual and signed by the individual on the DSHS-GAIN-SS form located at: http://www.dshs.wa.gov/pdf/ms/forms/14_485.pdf ~~http://www1.dshs.wa.gov~~. If the individual refuses to complete the GAIN-SS screening, or if the clinician determines the individual is unable to complete the screening for any reason, this must be documented on the GAIN-SS form.
3. The results of the GAIN-SS screening, including refusals and unable-to-complete, must be reported to DBHR~~SHS~~ through the Consumer Information System (CIS).
4. The Provider must complete a co-occurring mental health and chemical dependency disorder assessment, consistent with training provided by DBHR~~SHS~~ and outlined in the Substance Abuse and Mental Health Services Administration (SAMHSA) Treatment Protocol 42, to determine a quadrant placement for the individual when the individual scores a two (2) or higher on either of

the first two scales (Internalizing Disorder Screener & Externalizing Disorder Screener) and a two (2) or higher on the third scale (Substance Disorder Screener).

The assessment, to include quadrant placement, shall be completed as part of the initial intake evaluation process at ~~CMHAs~~ BHAs and free-standing, non-hospital evaluation and treatment facilities. The assessment is not required during crisis episodes of care including ITA investigations. The quadrant placements are defined as:

a. Less severe mental health disorder/less severe substance disorder
b. More severe mental health disorder/less severe substance disorder
c. Less severe mental health disorder/more severe substance disorder
d. More severe mental health disorder/more severe substance disorder

~~4.~~5. The quadrant placement must be reported to DBHR~~SHS~~ through the CIS system.

ATTACHMENTS

None

NSMHA COMMITTEE DISCUSSION FORM

AGENDA ITEM: Serving Individuals Identified as Difficult to Serve

PRESENTER: Charissa Westergard

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

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:
NSMHA's contract with the provider agencies indicates, "Contractor shall not discriminate against enrolled individuals who are considered difficult to serve. Examples include: a refusal to treat an individual because the individual is deemed too dangerous, because housing is not available in the community, or that a particular type of residential placement is not currently available."

There have been a number of instances where providers have identified an individual as dangerous and have refused to conduct an intake or have taken steps to effectively end services at the particular agency (e.g., lifetime no trespass order). While there may be circumstances when transfer to another agency may be appropriate, there have also been instances when the agency actions do not seem to be in accordance with contract (e.g., alternatives for serving the individual at a particular agency have not been fully explored prior to ending services and/or planned transfer does not occur).

CONCLUSIONS/RECOMMENDATIONS:
NSMHA policy will be updated to reflect:

- NSMHA must be notified in writing when an agency requests not to serve a particular individual due to being identified as difficult to serve, prior to any action that would end the individuals services at the agency (e.g., close of treatment episode, obtaining a no trespass order, etc).
- The notification shall identify why no alternative is available to continue to serve the individual at the agency and plan for transfer.
- Transfers follow usual transfer process as identified in Policy 1510, most notably that receiving agency must complete an intake, refusal to accept the individual requires a discussion with the transferring provider and NSMHA, and the transferring agency retains responsibility for care until the transfer is complete.
- Other issues?

TIMELINES:
N/A

ATTACHMENTS:
None

NSMHA COMMITTEE DISCUSSION FORM

AGENDA ITEM: Consent for Intake

PRESENTER: Charissa Westergard

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

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:
When an intake for mental health services is requested, VOA Access staff currently obtain consent for the intake from the individual/legal representative prior to transferring the individual to an agency to schedule an intake. The primary reasons for doing this are to protect the individual's privacy and to ensure that the individual actually wants services.

The Access Line has been receiving requests from managed care plan care coordinators and PCPs to schedule an intake without a signed consent from the individual/legal representative, which we don't usually allow. At the point that the caller is making the call, they (care coordinator, etc) may not be able to easily obtain signed consent. Allowing certain professionals to make the intake appointment for an individual seems to be an improvement in care coordination processes across systems. The impact on attendance of the intake appointment is less clear (i.e., will the individual be more or less likely to attend the appointment?).

CONCLUSIONS/RECOMMENDATIONS:
What are other possible issues related to allowing some professionals to make intake appointments without signed consent? Are there other professionals that should be included for consideration?

TIMELINES:
N/A

ATTACHMENTS:

NSMHA COMMITTEE DISCUSSION FORM

AGENDA ITEM: Children's Mental Health

PRESENTER: Julie de Losada

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

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:

Systems of Care Institute

- Back after 2 yr hiatus. May 5-6, 2015 Everett, WA
- Please participate in and/or ask your staff to participate in planning survey (email will go to QMOC today).
- Call for Proposals went out today
- Cost for 2 day package with CEUs
    - Early Bird $175 (Feb 2 – Mar 2)
    - Reg $190 (Mar 2 – May 2)
    - Late $210 (May 3- Onsite $210)
    - NSMHA can pay for 50% of cost for first 50 NSMHA network employees
    - A Single Point of Contact will need to coordinate your list and contact Julie for coupon code
    - Registration opens February 2; managed by NWESD

Non-Clinical PIP

Please see Basecamp. Discussion and presentation in Feb. QMOC

First Episode Psychosis Pilot

- DBHR has released a grant – due Feb 10th.
- NSMHA has not made formal decision yet; but Julie is included to not apply
- Data, funding, staffing model and target population are tricky to work with.

CONCLUSIONS/RECOMMENDATIONS:
n/a

TIMELINES:
n/a

ATTACHMENTS:
None