NORTH SOUND
MENTAL HEALTH ADMINISTRATION

QUALITY MANAGEMENT OVERSIGHT COMMITTEE

MEETING PACKET

June 24, 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: June 24, 2015 **Time: 1:00-3:00 PM**
Location: NSMHA Conference Room **Chair: Anji Jorstad, Snohomish County Human Services**
For information Contact Meeting Facilitator: Betsy Kruse, 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. • March 25, 2015 • May 27, 2015	Approve Meeting Summary	Chair	Summary		**2**	*5 min*
Announcements and Updates	• July QMOC Meeting Date – Anji Jorstad •	Inform/ Discuss	All				*5 min*
Quality Topics							
Routine Utilization Review (UR) Data	Presentation of 2015 Routine Utilization Review data	Inform/ Discuss	Kurt Aemmer	Discussion Form & Report		**3**	*15 min*
Roads to Community Living (RCL) Policy	Review of new policy on Roads to Community Living	Action	Angela Fraser-Powell	Discussion Form & Policy		**4**	*15 min*
Intensive Programs Policy	Review of new policy for Intensive Programs	Action	Jessie Ellis	Discussion Form & Policy		**5**	*15 min*
Policy 1726	Review of new policy - Involuntary Treatment Program Court Liaison Role and Responsibilities	Action	Sandy Whitcutt	Discussion Form & Policy		**6**	*15 min*
SOCI Report	Review of conference	Information	Eric Chambers				*15 min*
State Licensing Reviews	Begin discussion to identify issues BHAs are encountering via State licensing reviews especially for those BHAs licensed for both mental health and substance use services.	Discuss	Betsy Kruse				*15 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: July 22, 2015- 1:00-3:00 PM

North Sound Mental Health Administration (NSMHA)
Quality Management Oversight Committee (QMOC)
NSMHA Conference Room
March 25, 2015
1:00 – 3:00 pm
MEETING SUMMARY

PRESENT: Mark McDonald, Greg Wennerberg, Candy Trautman and Jennifer Yuen, NSMHA Advisory Board; Anji Jorstad, Snohomish County; Eric Chambers, NWESD; Kate Scott, Sea Mar; Richard Sprague, Interfaith; Stacey Alles, Compass Health; Chuck Davis, Ombuds; Kathy McNaughton, CCS and Robert Sullivan, Pioneer H.S.
BY PHONE: Cammy Prince, Sunrise, Kay Burbidge, LWC; Pat Morris, VOA and Kim Olander, Ombuds.
STAFF: Charissa Westergard, Sandy Whitcutt, Jessie Ellis, Julie de Losada and Barbara Jacobson.
OTHERS PRESENT: Rachelle McCarty, NSMHA consultant and Heather Fennell, Compass Health.

TOPIC	DISCUSSION	ACTION
1. **Introductions, Review of Agenda – Chair**	Chair, AnjiJ convened the meeting; introductions made. No revisions or additions to the agenda mentioned.	
2. Previous Meeting Summary – Chair	ChuckD presented a motion to accept the previous meeting summary as submitted, seconded by EricC; motion carried.	Approved
3. Announcements and Updates – All	• The Regional Training Community will be meeting at 3:00 pm directly after this meeting. • The Integrated Provider Meeting is this Friday at 10:30 am at Skagit Publishing. • The Medical Directors meeting is April 2, 2015 at 2:30 pm. • Concept paper proposals for the Co-occurring Pilot are due by March 31. The timeline will be driven by the proposals received, looking at 9-12 month pilot projects.	Informational
4. Evaluation Forms from Last Meeting – Chair	Briefly reviewed.	Informational
5. Evidence-Based Practice (EBP) Reporting	Julie noted the 2012 legislation that requires increased utilization and practice of EBPs in children under 21 in the juvenile justice, child welfare and mental health systems. Julie gave brief overview of some of the barriers to practicing at fidelity also noting this is an unfunded mandate. Julie briefly reviewed some of the barriers that have occurred and noted the attached report has an update coming out in the next few weeks. She noted that the state would like to move toward tracking in real time using the clinicians National Providers Identifier (NPI) number. We need to make decisions on where it is best to focus on what practices for this region that will channel forward to the training committee. StaceyA noted that CBT+ is one to consider as it has board applicability across multiple diagnoses. Barriers discussed with the largest seeming to be accountability so it does	Julie to arrange presentation from UW

	not come back on the agency as a liability as guidance from the State is vague. On the list of EBPs for mental health, some are not able to be billed to Medicaid. Turnover is a barrier to keeping up on training; we want to keep training local and accessible. How will we capture data and how will we monitor need to be considered. The goal of the mandate is that by 2019, 45% of youth are treated with EBPs. Julie recommended a time limited workgroup to develop strategies and come up with guidance or mapping around EBPs able to bill to Medicaid and be compliant with the law. Agencies should keep moving forward as they are comfortable until the workgroup comes up with guidance. Charissa stated we should develop strategies for all ages as it will likely transfer to all in the future. Julie inquired of the group if they would like a presentation from the EBP Institute at UW to review the report of the geo-mapping of EBPs. She will arrange a webinar to occur before a QMOC meeting for this.	
6. EBP Training Priorities	Jessie gave a brief overview of the training committees work on promoting EBPs in the region. Illness Management Recovery (IMR) and Motivational Interviewing (MI) are scheduled. These will be trainings with consultation afterward to ensure that they will be used going forward. Coming from agency feedback CBT+ and Common Elements Treatment Approach (CETA) are two we are looking to do this year.	Informational
7. Performance Improvement Project (PIP)	Julie and RachelleM reported on the Non-Clinical PIP of transition age youth (TAY - 16-20) that looked at workforce development to improve outcomes. Rachelle reviewed the three measures; provider pre and post self-tests, followed by training modules, another self-test and 4 months of extended follow up that showed that overall the improvements were maintained. She gave a brief overview of the barriers encountered and successes. Julie requested recommendations on continuing the PIP or retiring; agency specific breakout of data was called for. It is felt that it is important because some youth do not connect with services once they become adults; this needs to be looked at to identify patterns. We do not have any specialized programs for TAY; there is an opportunity to develop a TAY program specific to WISe. If we retire this PIP a new one could focus on increased care coordination. Julie noted the included survey from Portland State University and that Youth N Action has submitted a proposal for youth to survey youth. A focus group of clinicians and supervisors is recommended to determine if this PIP will be continued or retired and what will work going forward, she will send an email to get those interested. Julie noted that NSMHA is hiring a QI that will work on the PIPs as part of their job.	
8. Distance Standards	Charissa addressed the issue from the contract amendment brought up last month regarding distance from agencies. She noted that each provider does not have to comply; it is a region wide standard. NSMHA will be looking at this as we go forward to make sure the region still	

	meets the standard.	
9. Crisis Plans	These were due for an update and needed some revision as they are now transmitted to ERs. She reviewed some of the changes; it incorporates both child and adult aspects and is more recovery based. The workgroup kept in mind the cost to the data systems when reviewing; it will entail a cost. The clinical crisis recommendation form will transmit the client form does not. The form goes to IT next to see if it will transmit to the ERs through their EDIE system. Suggested edits to the clinical crisis plan: • Add a co-occurring checkbox • Revise medication non-compliance checkbox to something more recovery oriented such as medication adherence. • Remove can we contact, yes or no • Check box for allergies • Complete the last question to read "What intervention strategies prior to inpatient care have been investigated?" The client crisis plan that is not transmitted can be formatted to agency or program as long as the required elements are there. The clinical plan that is transmitted is standardized for the region. QMOC would like to see this again after CIS feedback.	Informational
10. Medication Formularies	In January 2014 medications started going through the health plan formularies and Charissa is checking in to see if there have been any issues such as when an exception is needed. No issues were noted after the initial transition, let Charissa know of anything that comes up.	Informational
11. Rural King Co Residents	NSMHA has received requests for service from some rural King County residents that reside closer to our providers. NSMHA has been doing this when requested and involves a small number of individuals on Hwy 2. King County will not reimburse NSMHA for these rare occasions and is expected to have a minimal fiscal impact. NSMHA will review yearly to see if it is having any impact.	Informational
12. Open Forum		Discussion
13. Date and Agenda for Next Meeting	The meeting was adjourned at 2:50 pm. The next meeting is April 22, 2015.	

North Sound Mental Health Administration (NSMHA)
Quality Management Oversight Committee (QMOC)
NSMHA Conference Room
May 27, 2015
1:00 – 3:00 pm
MEETING SUMMARY

PRESENT: Marie Jubie, Greg Wennerberg, Candy Trautman, Mark McDonald and Jennifer Yuen, NSMHA Advisory Board; Chuck Davis, Ombuds, Richard Sprague, Interfaith; Randy Polidan, Sunrise Services; Stacey Alles, Compass Health; Heather Waters, CHS; Kathy McNaughton, CCS; Eric Chambers, NWESD and Anji Jorstad, Snohomish Co.
BY PHONE: Karryn Dean, Sunrise Services, Kate Scott, Sea Mar; Kim Olander, Ombuds, Kay Burbidge, LWC, and Pat Morris, VOA.
STAFF: Betsy Kruse, Lisa Grosso, Julie de Losada, Sandy Whitcutt, Irene Richards and Barbara Jacobson.
OTHERS PRESENT: Heather Fennell, Compass Health; Stephanie McDonald, Interfaith, Holly Morgan, Sunrise and Shelly Kjos, Ombuds Practicum Student.

TOPIC	DISCUSSION	ACTION
1. **Introductions, Review of Agenda – Chair**	Julied convened meeting with introductions and additions to the agenda called for with none mentioned.	
2. Previous Meeting Summary – Chair	AnjiJ called for review of the May Minutes approved as amended; March minutes to be presented at June meeting for approval.	Approved - Bring March minutes forward to June for approval
3. Announcements and Updates – All	• Crisis Plan Update: SandyW noted that MichaelW is working on transaction codes for the client and clinician crisis plan forms and there is a template of the clinician crisis plan online to review under the data dictionary tab. This will be going to the Consumer Information System (CIS) workgroup for review. • Provider Contact List-Julie noted that the list is being passed around and to review and update with your agencies contacts by program. • Policies that AngelaF and JessieE were to present on will be postponed until next meeting. • CandyT and MarieJ noted that the Advisory Board schedules two site visits a year in the region and last month they toured the WSH hospital grounds and enjoyed the tour.	Informational
4. Evaluation Forms from Last Meeting – Chair	Anji briefly reviewed the evaluation forms from the April meeting.	Informational
5. Ombuds Report	Chuck reviewed the 2015 Spring report noting some great success stories over the period. He noted that as things move to the Behavioral Health Organization (BHO) they are not sure what may change but they are funded to exist and grow. Ombuds will also be available to clients of managed care plans that are BHOs.	Informational

	Chuck noted that they assisted 88 clients this period which is a low number and Chuck stated that providers are resolving issues quickly and they are not recurring. Also NSMHA has started or expanded several programs over the last several years that are positively impacting recovery.	
6. WISe Data Report	Julie noted the work being done in the state as part of the TR settlement agreement quality management plan and described the data reports that will be produced from the WISe program. The reports are to understand the outcomes of key service processes to continually improve services to children and are available online. Julie described some of the issues being worked on such as addressing data lag, which doesn't meet state expectations and also that some of the data needs correction. She briefly reviewed some elements of the report and noted that she will be bringing data forward at least quarterly and working closely with program managers. Please let Julie know of any data needs or other suggestions.	Informational
7. Changes to Access to Care (ACS)/ Diagnostic & Statistical Manual (DSM)/ International Classification of Diseases (ICD)	Julie noted that the new diagnostic coding is still set to be implemented on October 1, 2015; feedback has been sent to and reviewed by the State. We will continue to use the old criteria up to the October 1st deadline. The Access to Care Standards (last updated 2006) have been revised by the State in relation to these changes; however a final version has not yet been distributed. Julie will send out the draft for review. NSMHA is asking what providers need for training to prepare staff; Serious Emotional Disorder (SED)/Serious Mental Illness (SMI) are requested as well as training for DSM/ACS before the October kick off. Julie noted that Relias has some training on DSM and there is a lot out there; the ACS is where the training need will be. RichardS noted that with the new ACS many more people will be eligible for services with the B diagnosis removed. ChuckD stated that this change will help DDA clients with mental illness as it is a struggle to get them help now. StaceyA requested that a train the trainer approach be used to have a core group that can continue this. It was recommended to have a workgroup look at train the trainer approach.	Informational Draft of the ACS to be sent out.
8. RCL Policy	Postponed to next meeting.	Postponed
9. Intensive Programs Policy	Postponed to next meeting.	Postponed
10. Less Restrictive (LR) Review	Sandy gave a brief overview of the chart review done in March for clients on LRs. The review looked at strengths and areas for improvement in documentation, also when there is an LR violation; the review was not scored. The attached tool used for the chart reviews will now go back to the workgroup to look at the outcomes of the review for recommended changes.	Informational

11. Compliance Presentation	Lisa noted that she recently gave this report to the Board of Directors to give them an overview of their responsibility under the Compliance Program. The compliance report for 2012-2014 was presented with the 2014 cases briefly reviewed. Lisa noted that compliance training modules will be added to Relias along with privacy training.	Informational
12. Open Forum	Anji stated that at the last County Coordinator meeting discussion occurred that QMOC would be evolving to add the CD providers. EricC noted that the SOCI conference report will be ready to present next month and could be added to the agenda.	Discussion
13. Date and Agenda for Next Meeting	The meeting was adjourned at 2:45 pm. The next meeting is June 24, 2015.	

NSMHA COMMITTEE DISCUSSION FORM

AGENDA ITEM: 2015 NSMHA Provider Routine Utilization Review Report

PRESENTER: Kurt Aemmer

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

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:

I. The NSMHA Utilization Review (UR) Team conducted clinical record audits for each of the contracted outpatient providers in the region. The reviews were conducted at designated provider sites.

II. Records for review were selected in numbers calculated to insure at least a 90% confidence level.

III. Teams consisting of 1 - 3 NSMHA Quality Specialists site visited the designated provider locations monthly, during February and March.

IV. In 2014 each record was reviewed against 45 standards derived from WAC and NSMHA QMOC policies/protocols. This year only those standards were reviewed that did not meet the 90% compliance threshold at each given provider. *Note: The two newest providers, CHS & NWESD were again reviewed under all 45 standards to help them develop further as a NSMHA provider. LWC was not reviewed as they had no standards scored less than 90% in 2014.*

V. To be consistent with the historic DBHR audit compliance benchmark, each standard is determined to be in compliance when final analysis reveals that the standard was met 90% of the time.

VI. Request For Change - When a standard is identified as not being met in an individual record, a Request for Change (RFC) letter is generated which identifies the specific standard(s) noted as not being met. This letter is sent to the provider with the expectation that within 60 days the record will be updated (brought up to standard), and the RFC will be returned to NSMHA with supporting documentation that verifies the change. When no response to an RFC is received after 60 days, that RFC is deemed "outstanding," meaning the response is overdue.

VII. Key findings:

A. As of 6/1/15 there were still 80 outstanding RFC. *Note: All 25 RFC from NWESD have been responded to, but were received by NSMHA while this report was being written. Schedule conflicts for the two involved NSMHA reviewers did not allow for a determination as to whether or not these responses will be accepted. Once the responses can be evaluated, it is expected that the number of outstanding RFC will be reduced by up to 25.* See TABLE I

B. In 2015 the aggregate data from the reviews revealed that each provider reviewed successfully reduced the number of standards found to be less than 90% in 2014. (See TABLE II)

C. In 2014, as a region, only 3 standards were found to be in <90% compliance (See ATTACHMENT III):

1. Q10 - *When required (LOC 4 and above), requested or clinically indicated, a crisis plan exists (83.6%)*
2. Q26 - *The RRP is strengths-based (71.2%)*
3. Q35 - *The clinical record contains documentation of coordination with the individual's current external health care provider(s) (77.7%)*

In 2015 the region-wide scores for Q10 dropped by only 1.4% to 81.2%. However, the score for Q26 increased 9.9% to 81.1%, and the score for Q35 by 8.9% to 86.6%. See TABLE 3.

VIII. Requirement of corrective actions:

A. Later in June tables will be sent to each provider showing standards that did not meet the 90% threshold in 2014 or 2015. Corrective action plans pertaining to each of these standards will be required by NSMHA in the following months.

CONCLUSIONS:

1. At least 55 RFC remain outstanding and need responses no later than 8/1/15
2. All providers that underwent focused reviews in 2015 showed a reduction of the number of standards scoring less than 90% in 2014.
3. There was a marked improvement in region-wide compliance rates in 2 of the 3 standards that scored less than 90% in 2015. All three were within 10% of the 90% threshold.

RECOMMENDATIONS:

1. Providers need to account for their remaining RFC, and send responses to NSMHA as soon as possible, but no later than 8/1/15.
2. Remedial action will be forthcoming for any standards that were below 90% in the 2015 review.

2015

NORTH SOUND MENTAL HEALTH ADMINISTRATION

ANNUAL ROUTINE UTILIZATION REVIEW REPORT

Background - North Sound Mental health Administration (NSMHA) conducts the Routine Utilization Review (UR) annually. This is a review of clinical charts that uses a 45-standard review tool to evaluate the appropriateness of services, i.e., is the individual what they need when they need it, and in the most efficient way. In 2014, all standards were reviewed at all providers. The focus of this year's review, conducted in February and March, was a follow-up on standards that providers scored below the 90% benchmark in 2014 (i.e., not all 45 standards were reviewed at every provider in the 2015 review). There are some specific notations for the 2015 review:

- NSMHA's two newest providers received a full review on all 45 questions to assist them in their ongoing development as a NSMHA provider.
- Lake Whatcom Center was not reviewed in 2015 because they scored at least 90% for every standard in 2014
- The exact number of standards reviewed in 2015 for all other providers can be found in the left number column of TABLE II, below.

Process - NSMHA uses two mechanisms to facilitate improvements for standards identified as below 90%; chart specific requests for change, and analysis and reporting of aggregate data:

- Request For Change - When a standard is identified as not being met in an individual record, a Request for Change (RFC) letter is generated, which identifies the specific standard(s) noted as not being met. This letter is sent to the provider with the expectation that within 60 days the record will be updated (brought up to standard), and the RFC will be returned to NSMHA with supporting documentation that verifies the change. When no response to an RFC is received after 60 days, that RFC is deemed "outstanding," meaning the response is overdue.

- Aggregate Data – Each provider is given a report that reflects the compliance rate for each standard for their agency.
    - Historically chart review lists were generated randomly, and in numbers that would allow for 90% statistical confidence that the pull is reflective of each of the provider's overall quality of documentation. In 2015 data issues resulted in some pull lists not being totally randomly selected. However, the charts were still selected in sufficient number, per provider, to allow for confidence in the results.

Key Findings

- RFC
  - As of June 1, 2015 there were 80 outstanding RFCs in the region. Table I, below, reflects the number of RFCs still outstanding from the 2015 review, by provider
    - Analysis - The effectiveness of the process for receiving, distributing and responding to RFC vary from provider to provider.
    - Recommendations
      - By June 30, 2015 NSMHA will send a list of individuals' names for whom RFC remain outstanding, to each provider
      - Providers will be asked to send responses to NSMHA no later than August 1, 2015.

TABLE I: Number of Outstanding RFC by Provider	**As of 6/1/15**
Bridgeways	0
Lake Whatcom Center	0
Interfaith	2
Sunrise Services	3
Compass Health Whatcom	4
Compass Health North	5
Sea Mar	6
Catholic Community Services	8
Compass Health South	11
Center for Human Services	16
Northwest Educational Service District	25*

**Note: As this report was being written, NSMHA received responses for each of the 25 NWESD RFC. However, schedule conflicts for the two NSMHA reviewers did not allow for determination of whether or not any of the RFC could be accepted before the final draft of this report could be completed.*

- Aggregate Data
  - Except for LWC, who was not reviewed in 2015, all providers had fewer standards scored less than 90% in 2015. Table II, below, shows the number of standards scoring less than 90% in 2014 (left number column) and 2015 (center number column). The right number column reflects improvement indicated by the difference between the 2014 numbers and the 2015 numbers, e.g. +6 indicates that the provider had 6 fewer standards scoring less than 90% than in 2014.
    - Analysis - In general, the steps that providers have taken to improve their documentation appears to have been effective, at least to the extent that they increased the scope of standards for which they met the 90% compliance threshold. There are still some areas that require continued attention by providers.

TABLE II: Number of Standards Scored Less Than 90%, by Year			
Provider	2014	2015	Improvement
Lake Whatcom Center (adult)	0	0	NA
Bridgeways (adult)	7	1	+6
Interfaith (adult)	6	1	+5
Compass Health North (child)	4	1	+3
Sunrise Services (adult)	3	2	+1
Compass Health Whatcom (adult)	6	2	+4
Sea Mar (adult)	5	3	+3
Compass Health North (adult)	7	4	+3
Catholic Community Services (child)	6	5	+1
Compass Health South (child)	11	5	+6
Compass Health South (adult)	8	5	+3
Sea Mar (child)	13	6	+7
Compass Health Whatcom (child)	15	8	+7
Center for Human Services (child)	23	14	+9
Northwest Educational Service District (child)	18	15	+3

- In 2014 there were three standards for which the regional compliance rate was less than 90%. For those providers who were scored on these standards in 2015 (i.e., they were below 90% in 2014), there was overall improvement in two of the three standards. TABLE III, below, shows the three standards, and compares the 2014 and 2015 data.
  - Analysis 1 - The 2015 aggregate compliance rates for each of the three standards are within 9% of reaching the 90% threshold. The greatest improvement was seen in standards #26 & 35. And though the compliance rate for standard #10 decreased slightly, it remained within less than 9% of the 90% threshold.
  - Analysis 2 - Though overall improvement was made per these three standards, there were at least 5 providers whose scores were less than 90%. This suggests there is still a regional issue for these areas.

  For each standard that continued below the 90% benchmark in 2015, NSMHA will be requiring a Corrective Action Plan from the provider. Formal remedial action letters will be forthcoming.

TABLE III: Standards scoring less than 90% in 2014 Comparing the 2014 & 2015 Data			
Standard	2014	2015	Difference
Q10 - When required (LOC 4 and above), requested or clinically indicated, a crisis plan exists	83.6%	81.2%	-1.4
Q26 - The RRP is strength-based	71.2%	81.1%	+9.9%
Q35 - The clinical record contains documentation of coordination with the individual's current external health care provider(s)	77.7%	86.6%	+8.9%

- Congratulations to the following providers who were scored on standard #10 and met the 90% threshold in 2015!
    - Compass Health South (adult) - 97.4%
    - Sea Mar (child) – 100%

- Congratulations to the following providers who were scored on standard #26 and met the 90% threshold in 2015!
    - Sunrise Services (adult) - 91.2%
    - Interfaith (adult) - 91.8%
    - Compass Health Whatcom (adult) - 94.7%
    - Compass Health North (child) - 100%

- Congratulations to the following providers who were scored on standard #35 and met the 90% threshold in 2015!
    - Compass Health South (child) - 91.7%
    - Compass Health North (adult) - 92.1%
    - Bridgeways (adult) - 95.8%
    - Compass Health North (child) - 100%
    - Compass Health Whatcom (child) - 100%
    - Compass Health Whatcom (adult) - 100%

NORTH SOUND MENTAL HEALTH ADMINISTRATION
COMMITTEE DISCUSSION FORM

AGENDA ITEM: Roads to Community Living (RCL) Policy

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

PRESENTER: Angela Fraser-Powell

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

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY: None

OBJECTIVE: A new policy to outline the procedure for Medicaid consumers discharging from qualifying institutional settings to access RCL funding.

BACKGROUND: RCL contract was signed in 2013. The purpose of utilizing these funds is to bridge gaps in services for consumers discharging from qualifying institutional settings and help ensure sustainability in the community. Due to the process of how funds are requested, contracts are developed and expectations of care coordinated efforts, policy development was necessary.

PREVIOUS ACTION(S) TAKEN: None

CONCLUSIONS/ACTION REQUESTED: Policy approval

FISCAL IMPACT:

ATTACHMENTS: Draft policy

Effective Date:
Revised Date: Rev D
Review Date:

North Sound Mental Health Administration

Section 1500 – Clinical: Roads to Community Living (RCL)

Authorizing Source: WAC 388-106, DSHS / NSMHA RCL Contract
Cancels:
See Also: Approved by: Executive Director Date:
Responsible Staff:: Signature:

POLICY #

SUBJECT: ROADS TO COMMUNITY LIVING (RCL)

PURPOSE
To provide guidance on accessing the Roads to Community Living (RCL) funds for community based services / supports which help consumers meet their treatment goals when discharging from qualified institutional settings back into the community.

DEFINITIONS
Roads to Community Living (RCL) – are a mix of federal and state funds provided to Medicaid eligible consumers discharging from qualified institutional settings. These funds are designed to fund services / supports to ameliorate symptoms, prevent the need for future hospitalizations and/or residential treatment and are not funded by any other system or resource.

Qualified Institutional Setting – Children's Long-Term Inpatient Program (CLIP – youth under age 18), state psychiatric hospital, nursing home or residential habilitation center.

Qualified Community Setting – home, apartment, licensed residential setting with 4 or less unrelated individuals.

POLICY
The North Sound Mental Health Administration (NSMHA) will authorize RCL for individuals who meet the eligibility criteria and have identified, qualifying unmet needs stated in the transition care plan, not otherwise provided by Medicaid or a more appropriate system / provider.

PROCEDURE

Eligibility Criteria:

RCL funding **may** be accessed while the consumer is in a qualified institutional setting provided the eligibility criteria are met. From the date of discharge, the benefit period for each consumer is a maximum of 365 days beginning the date of discharge into a qualified community setting. No extensions shall be granted for RCL funding.

In order to be eligible to access RCL funding, consumers:

- Must be under age 21 or over age 65

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- Must be residing in a qualified institutional setting, receiving services for more than 90 consecutive days, and are not admitted for the sole purpose of short-term rehabilitative services.

- Must be receiving Medicaid benefits for services in a qualified institutional setting for at least one day prior to transitioning into the community.

- Must sign the Participation Form prior to the date of discharge from a qualified institutional setting and be preauthorized to participate in the program by the Department of Behavioral Health and Recovery (DBHR) RCL Administrator.

Process

- Qualified institution will fill out the provided NSMHA request for RCL funding form, outlining the needs to be supported by RCL. NSMHA care coordinator and outpatient providers will work with facilities and families to help identify the appropriate resources in the family's local community.

- Consumer, and where appropriate the legal guardian, shall consent to participate in the RCL program by signing the Participation Form prior to the date of discharge from a qualified institutional setting. The signed Participation Form must be sent to NSMHA care coordinator prior to the discharge date.

- NSMHA care coordinator will send the signed participation form to the appropriate DBHR RCL Administrator for preauthorization.

- NSMHA care coordinator will work with NSMHA contracts, NSMHA providers and the identified RCL community provider to develop a contract for the requested services. A copy will be sent to the fiscal department in order to facilitate payment.

- NSMHA care coordinator will review deliverables from the contracted RCL providers.

Transition Planning

From the date of discharge, the benefit period for each consumer is a maximum of 365 days beginning the date of discharge into a qualified community setting. No extensions shall be granted for RCL funding.

- The benefit period will end for the follow reasons:

    - 365 days have been completed
    - The consumer returns to an institutional setting for longer than 30 days. In this case, a consumer may reapply when discharging from the qualified institutional setting after the 90 consecutive day mark has been satisfied.
    - The consumer moves out of state
    - The consumer no longer wants the service
    - The consumer passes away

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If the consumer is dis-enrolled from the RCL for any reason during the contract period, the Disenrollment Form shall be completed and turned into the DBHR RCL Administrator.
Prior to the end of the benefit period, the RCL contracted provider shall collaborate with other community providers (e.g. NSMHA providers) to develop and implement a sustainable discharge plan that continues to address the identified needs.

The Transition Plan shall include at least:

- The services / supports provided by the RCL funding are stable and sustainable after the end of the benefit period.

- The RCL service provider, in conjunction with other community providers, will ensure the consumer is residing in stable sustainable housing and have the necessary supports in place to continue placement in the community.

- If a consumer is enrolled with a NSMHA provider, the NSMHA provider will coordinate with the RCL contracted provider to ensure that the consumer has all the necessary supports in place to continue placement in the community

ATTACHMENTS
RCL NSMHA Request Form

Draft

North Sound Mental Health Administration
Regional Support Network for Island, San Juan, Skagit, Snohomish, and Whatcom Counties
Improving the mental health and well being of individuals and families in our communities
117 North First Street, Suite 8 • Mount Vernon, WA 98273
360.416.7013 • 800.684.3555 • Fax 360.416.7017 • Email nsmha@nsmha.org • Web Site http://nsmha.org

North Sound Mental Health Administration (NSMHA)
Request for Roads to Community Living (RCL) Resources

RCL funds are for supports provided to Medicaid eligible consumers discharging from qualified institutional settings to support recovery by ameliorating symptoms, prevent the need for future hospitalizations and/or residential treatment and are not funded by a more appropriate / any other system or resource. The North Sound Mental Health Administration (NSMHA) will authorize RCL for individuals who meet the eligibility criteria, have identified, qualifying unmet needs stated in the transition care plan and are not otherwise provided for by Medicaid or a more appropriate system / provider.

Please fill out and submit this form to NSHMA ***prior*** to having youth / family sign the RCL Participation Form.

Today's date:	**Expected date of discharge:**	
Youth Name:	**DOB:**	**Gender (circle)**: M F
Youth Discharge Address (city, state, zip):		
Youth SSN #:	**Youth Provider One #:**	

Parent / Legal Guardian Name(s):		
Parent / Legal Guardian Address (city, state, zip):		
Home Phone:	**Cell Phone:**	**Other:**

It is important to establish providers, programs or services a youth is or will be engaged in after discharge in order to identify gaps. ***Please indicate this by placing a check mark in the applicable boxes***.

Type of Provider / Program / Service

	Mental Health & Psychiatry		**Residential / Children's Administration**
	Outpatient Mental Health Provider / Therapist		Home / Relative Care
	Psychiatrist		Foster Care
	Intensive Outpatient Mental Health Provider / Program		Group Home
	Other:		BRS
	Other:		Other:
	Medical		**Educational**
	Primary Care Physician (PCP)		School
	Other:		IEP or 504
	Other:		Other:

Legal Involvement	
	Probation
	Other:
	Other:

The following requested information is to determine the specific service / item being requested.

Please type responses to the following questions in the space provided. Do not leave blanks.

Please provide clinical rationale for how the requested service / item will support the treatment goals and identified needs?
Have all resources to fund the requested service / item (e.g. scholarships, other system funding responsibility, etc.) been explored and exhausted?
Does the family already have a provider in mind in their local community to deliver the requested service? *(If so, please give name, credentials and contact information)*
Please outline the specific costs of the requested service / item.

NORTH SOUND MENTAL HEALTH ADMINISTRATION
COMMITTEE DISCUSSION FORM

AGENDA ITEM: Intensive Programs Crisis Response Policy

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

PRESENTER: Jessie Ellis

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

BACKGROUND: In 2010, NSMHA released a numbered memo providing guidance for how the adult intensive programs, ICRS, and hospital EDs can work together to respond to crisis situations.

Adult intensive programs include Intensive Outpatient, PACT, and Geriatric Transitions Program.

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:
This new policy provides guidance on how adult intensive programs, ICRS, and hospital EDs should work together when an individual enrolled in an intensive program experiences a crisis. It is very similar to the original memo. Intensive programs are responsible for all voluntary crisis response for individuals enrolled in these programs.

Changes from the numbered memo include:

- Greater specificity about roles, including phone responses, facilitation of voluntary hospitalization, requests for DMHP dispatch.
- Timelines for phone and in-person response by intensive programs.

OBJECTIVE: Provide increased clarity around expectations for crisis response by adult intensive programs.

PREVIOUS ACTION(S) TAKEN: Numbered memo; 30 day review period for this policy.

CONCLUSIONS/ACTION REQUESTED: Approve the intensive programs crisis response policy.

FISCAL IMPACT: None

ATTACHMENTS: Intensive Programs Crisis Response Policy

Effective Date:
Revised Date:
Review Date:

North Sound Mental Health Administration

Section 1500: Intensive programs crisis response

Authorizing Source: NSMHA
See Also: Approved by: Executive Director Date:
Providers must comply with this policy and may develop individualized implementation guidelines as needed.
Responsible Staff:: Deputy Director Signature:

POLICY #15xx

SUBJECT: INTENSIVE PROGRAMS CRISIS RESPONSE

PURPOSE

This policy addresses roles and responsibilities of North Sound Mental Health Administration's Behavioral Health Agencies' adult intensive programs in responding to crises for individuals enrolled in those programs. It provides guidance for the collaboration of the adult intensive programs, Integrated Crisis Response Services (ICRS), and hospital emergency departments (EDs).

DEFINITIONS

- **Adult intensive program** – a program that serves adults, and has a contractual or policy based expectation of 24/7 service availability for outreach. This includes but is not limited to Programs for Assertive Community Treatment, Adult Intensive Outpatient, and Geriatric Transitions Program.

POLICY

Intensive program clinicians know the individuals enrolled in these programs very well, including their baseline functioning and the individualized supports available to them. Program staff members are well-equipped, and expected, to assist these individuals in stabilizing during a crisis, and to prevent hospitalization when possible. Voluntary ICRS should not be necessary in most crisis situations for individuals in an intensive program.

PROCEDURES

<u>General procedures</u>

Outreach should be performed when

- It is clinically indicated, for example, when
  - the clinician determines that his or her presence will provide support to the individual, or
  - the clinician can assist in diverting a hospitalization, and
  - presence of the clinician is not contra-indicated for the individual's treatment.
    - When community outreach is contra-indicated for a specific individual, this should be clearly indicated in their crisis plan. The crisis plan should also clearly outline alternative strategies for dealing with crisis.

- It can be performed safely. If safety concerns cannot be effectively addressed, the team will work to coordinate an alternative plan to meet the individual's needs.
- It is within the program's home county, or an adjacent county along the I-5 corridor.

DRAFT

- If the drive time is more than 45 minutes from the intensive program's office, outreach is not expected, but can be provided at the program's discretion.
- For programs that encompass multiple counties, outreach is expected when it is within a 45-minute drive from the program office to which the enrolled individual is assigned.
- When outreach cannot be performed due to distance, geographical limitations (such as ferry schedules), or other factors, the clinician should provide as much assistance as possible via phone and/or other available means.

The following timelines are expected for phone and in-person responses:

- Telephone response should be within 10 minutes of the initial page or contact.
- In-person outreach should occur within two hours of the initial page or contact.
- Whenever VOA contacts an intensive services clinician, the intensive services program should call in a disposition to VOA within 1 hour of completion of their response to the crisis situation.

<u>Crisis situations in the community (other than hospital emergency departments)</u>

- If an individual in intensive services experiences a crisis and contacts VOA Care Crisis, VOA Care Crisis will contact a clinician from the intensive program and the clinician will determine what follow-up is needed. The clinician will call in the disposition to VOA Care Crisis after response to the crisis situation.
  - VOA Care Crisis may choose not to contact an intensive program clinician when:
    - They are able to successfully help the individual through the crisis and no additional follow up is needed; and
    - The client is not requesting to speak to a clinician from their intensive program.
  - If VOA is able to resolve the crisis and chooses not to contact the intensive program, the primary clinician will be notified of the call the following business day.

- The intensive program should coordinate any voluntary crisis response, including community outreach, referral to crisis stabilization, voluntary hospitalization, and any other options less restrictive than evaluation by a Designated Mental Health Professional (DMHP). When voluntary hospitalization is required, the clinician should facilitate the hospitalization, including locating the bed, contacting VOA for certification/authorization, and communicating with the admitting hospital.

- If the intensive services clinician believes an involuntary evaluation is needed, the clinician will contact VOA Care Crisis to request dispatch of a DMHP, and will indicate to VOA that this is the disposition of their involvement in the crisis situation. The clinician should provide any necessary information to the DMHP and VOA. The DMHP will call in their disposition to VOA Care Crisis after completion of their response to the crisis situation.
  - Prior to requesting a DMHP evaluation, the expectation is that a program clinician will have had face-to-face contact with the individual within the 12 hours prior to the request for an ITA evaluation. Face-to-face contact does not have to be conducted by the same individual requesting evaluation, but the requester should be able to discuss relevant clinical details.
    - Exceptions to this standard are made on a case-by-case basis if both the referring clinician and the VOA staff are in agreement. For example, if the individual is unwilling to see the intensive program or participate in less restrictive options, the intensive program may request DMHP dispatch without having recently evaluated the individual.

- Only DMHPs are able to write custody authorizations (pick-up orders) allowing law enforcement to involuntarily transport individuals. Therefore, in cases where evaluation for involuntary detention is warranted, but DMHP dispatch is deemed unsafe, DMHPs should consult with intensive program staff to determine a course of action, which if appropriate may include a pick-up order.

Responding to crisis situations at hospital emergency departments (EDs)

- If an individual enrolled with an intensive program arrives at an ED, hospital ED staff are requested to contact VOA at 1-800-747-8654 after they have evaluated the individual. VOA will contact the intensive program and communicate the hospital's information to the clinician. Follow up will be coordinated between the intensive program clinician and the hospital ED staff. The intensive program clinician will call in the disposition to VOA Care Crisis after responding to the crisis situation.
  - Intensive programs clinical staff responding to crisis situations are considered to have sufficient educational and professional experience to respond to crisis situations by providing community support services.
  - Intensive program staff involvement is not intended to supplant ED staff duties, although there may be some overlap in the rare circumstances noted below.
  - After phone consultation with the hospital ED staff, the clinician will perform an outreach to the hospital if it is determined by the clinician to be clinically warranted.
  - The clinician will clearly indicate to the ED staff whether they intend to perform an outreach, and if so, the approximate time they will arrive at the ED.
  - If all less restrictive options have been attempted, and the individual is determined to need voluntary hospitalization, the hospital staff should facilitate the hospitalization, including locating the bed, contacting VOA for certification/authorization, and communicating with the admitting hospital.
    - In some circumstances, the hospital may not have a social worker on duty at the emergency department. If this is the case, the intensive program clinician should facilitate the hospitalization. This can be expected to occur at some of the region's smaller hospitals.
    - If there is disagreement between the hospital and the intensive program about who should facilitate the hospitalization, the intensive program clinician should perform these duties. The intensive program can contact NSMHA after the crisis situation is resolved with any concerns about this process.
  - If all voluntary options have been deemed inappropriate, and an involuntary evaluation is needed following a hospital emergency department intervention, the hospital staff should contact VOA Care Crisis to request dispatch of a DMHP.
    - The intensive program clinician should provide any necessary information to the DMHP and VOA.
    - In circumstances where the hospital has no social worker on duty, the clinician will contact VOA Care Crisis to request dispatch of a DMHP.
    - As above, if there is disagreement about who should perform these duties, the intensive program clinician should do so.

Disputes

- In the case of dispute, please reference policy #1707, Crisis System Clinical Dispute Resolution.
- The emphasis should always be on providing the best service possible to the individual.

NSMHA COMMITTEE DISCUSSION FORM

AGENDA ITEM:
Policy 1726 Involuntary Treatment Program Court Liaison Role and Responsibilities

PRESENTER: Sandy Whitcutt

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

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:
The North Sound Mental Health Administration (NSMHA) region has developed a process that facilitates the interaction between the Designated Mental Health Professional (DMHP) teams, the inpatient facilities and court systems when an individual (respondent) is detained; identified as the role of Court Liaison. This role supports the legal processes of the courts during the inpatient stay.

This policy provides elements and expectations for NSMHA provider agencies contracted to provide the Court Liaison function. This is a new policy, developed by the ICRS sub-committee. It has been reviewed and approved by the committee.

CONCLUSIONS/RECOMMENDATIONS:
The recommendation is to pass this new policy. If passed, it will go into effect 60 days after posting on the web

TIMELINES:

ATTACHMENTS:
Policy 1726 clean version (new policy)

Effective Date: **DRAFT**
Revised Date: 5/28/2015
Reviewed Date: 5/28/2015

North Sound Mental Health Administration

Section 1700 – ICRS: Involuntary Treatment Program Court Liaison Role and Responsibilities

Authorizing Source: WAC 388-865-0245(1); RCW 71.05, 71.34, and 70.96 B
Cancels:
See Also: Approved by: Executive Director Date:
Provider must "comply with this policy and may develop individualized implementation guidelines as needed"
Responsible Staff:: Deputy Director Signature:

POLICY #1726.00

SUBJECT: INVOLUNTARY TREATMENT PROGRAM COURT LIAISON ROLE AND RESPONSIBILITIES

PURPOSE

To ensure the duties of court liaisons provided under Involuntary Treatment Services are administered by professionals knowledgeable in the Involuntary Treatment Act (ITA) court process in accordance with RCWs 71.05, 71.34 and 70.96B (refer to Policy 1720.00 – Administration on Involuntary Treatment for definitions).

POLICY

The North Sound Mental Health Administration (NSMHA) has developed a region-wide process that facilitates the interaction between the Designated Mental Health Professional (DMHP) teams, the inpatient facilities and court systems when an individual (respondent) is detained, identified as the role of court liaison. This role supports the legal processes of the courts during the inpatient stay.

This role has generally been an adjunct to the DMHP teams but can also be a function of hospital professionals assigned the court work who is knowledgeable of the ITA court process.

There are variations in the duties based on workload and the size of the counties but there are core elements specific to the functions of this role.

This policy provides elements and expectations for NSMHA provider agencies contracted to provide court liaison function.

PROCEDURE

A. Individuals performing this function will:

1. Have a thorough understanding of all applicable laws and procedures;
2. Have excellent clinical assessment skills and a solid understanding of the court process;
3. Act as an expert contact regarding the process and workflows.

B. Upon direction of the attending physician/psychiatric ARNP/designee, the court liaison will initiate the process of pursuing further involuntary treatment and if applicable, file the appropriate petition.

C. The court liaison will prepare, file and make all court documents available to public defense, prosecution, the inpatient unit and respondent within expected timeframes.

D. The court liaison is prepared to testify at the discretion of the court.

E. They will document their activities with and on behalf of respondents; these activities will be retained in the clinical record.
F. The court liaison will provide coordination, communication and collaboration between the court system and clinical system throughout the involuntary inpatient stay.
G. NSMHA provider agencies contracted to perform the court liaison role will have the ability to provide liaison support throughout their contracted county(ies).
H. NSMHA provider agencies contracted to perform the court liaison role will provide training and administrative oversight to this position, including any changes in policies relevant to this position.
I. NSMHA will monitor this function through the typical auditing and oversight process.

ATTACHMENTS

None