

**North Sound
Mental Health Administration**

**Public Mental Health System
Review**

March 13, 2003

North Sound Mental Health Administration

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Consumers/Advocates

NSMHA Regional Mental Health Advisory Board	Whatcom Co. Mental Health Advisory Board
Island Co. Mental Health Advisory Board	NAMI of Island County
San Juan Co. Mental Health Advisory Board	NAMI of Skagit County
Skagit Co. Mental Health Advisory Board	NAMI of Snohomish County
Snohomish Co. Mental Health Advisory Board	NAMI of Whatcom County

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Everyone's cooperation and calm attitudes assisted with the accomplishment of the overwhelming charge to review a very complex system. We would also like to acknowledge that within our public mental health system, there are many highly dedicated and passionate people committed to providing quality mental health services to the people within the North Sound Region.

EXECUTIVE SUMMARY

This North Sound public mental health system review is conducted for the following reasons:

- Our current system has been in place for six years and it is time to step back and assess our accomplishments and limitations.
- Numerous audits/surveys have identified a lot of confusion as to what the respective roles and responsibilities are between the North Sound Mental Health Administration (NSMHA) and Associated Provider Network (APN).
- The Mental Health Division's Administrative and Medical Audit of NSMHA has raised the concern of potential duplication/overlap of administrative and quality management functions between the NSMHA and APN for the past five years.
- The potential loss of revenues from the State of Washington is on the horizon.
- NSMHA contract negotiations with service providers will begin later this year.

We made the decision to conduct a thorough and timely review of the entire public mental health system. This review includes the following:

- To spend a little time on the background that led the NSMHA to the decision of issuing a Request for Proposal (RFP)
- To review APN's submission to the RFP.
- Discuss the following: over the past few years:
 - ✓ NSMHA sources of revenue
 - ✓ NSMHA Expenditures
 - ✓ Distribution of funds to providers
 - ✓ People served and average hours of service
 - ✓ Recognize our successes as well as our limitations.
- To seize this opportunity to recommend to the Board Directors recommendations for quality improvements and,
- To maximize resources going to enhance direct client services.

Therefore, we are making the recommendations in the following areas:

- Since we have limited resources, and future funding at current levels appears to be in jeopardy, it is incumbent on all of us to hold our administrative costs to a minimum and to maximize resources to direct consumer services.
- Our public mental health system needs to improve its quality management capabilities and that will be a single integrated model at the NSMHA.
- The NSMHA Executive Director is responsible for establishing a NSMHA Transition Committee to meet the above two objectives.
 - ✓ Have a final implementation plan to accomplish Phase One to the Executive Committee and Board of Directors' in April 2003.
 - ✓ Have a final implementation plan to accomplish Phase Two to the Executive Committee and Board of Directors' in June 2003.

- Assess resource needs to fulfill QA/QM responsibilities at NSMHA and occur at the direct service providers of the NSMHA public mental health system.
- Ensure that any system change will:
 - ✓ Maintain or enhance the identified current accomplishments/strengths and to
 - ✓ Improve our limitations
- NSMHA needs to develop policies that give incentives to the providers who are in or come into substantial compliance.
 - ✓ Submit a recommendation to the Executive Committee by July 2003.
- NSMHA needs to implement another effort to reduce paper work that involves all stakeholder groups and provider clinicians.
 - ✓ Report progress to the Executive Committee monthly.
 - ✓ Submit a final report to the Executive Committee by August 2003.

It is also important to recognize that there are many highly dedicated and passionate people committed to providing quality mental health services to the people within our North Sound Region public mental health. We have the advantage of also having a collegial, professional and collaborative working relationship among the numerous stakeholders in our system.

NSMHA continues to support a collaborative approach to assuring that quality services are being provided to our consumers. This report is submitted in conjunction with the NSMHA's Mission Statement, Vision of Hope and Path to Recovery.

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Section A:

INTRODUCTION

A. INTRODUCTION

First, it is important to note that the North Sound Regional Support Network (NSRSN) is currently doing business as the North Sound Mental Health Administration (NSMHA). For the purposes of consistency, all references in this report, except quotations, will be NSMHA.

In response to growing concern regarding possible duplication of effort in some areas of our public mental health system and to address questions being raised regarding the effectiveness of our system, the NSMHA Board of Directors passed the following resolution:

“In light of the MHD Integrated Audit and taking into consideration potential fiscal hardships that lie ahead, the Executive Committee recommends that the NSRSN Executive Director working with the Executive Committee perform an NSRSN system review to include:

- Historical clinical review
- Assessment of administrative structure
- Assessment of quality management oversight

This system review will include input from stakeholders, consumers, and advocates. The NSRSN Executive Director will work with the Executive Committee and come back to the Board of Directors at their March 2003 meeting with his recommendation for the most efficient and effective method to deliver high quality culturally competent services.”

It is the intent of this report to evaluate our current strengths and limitations so that we can turn some limitations into strengths. This really should be an on-going process and conducted at some determined frequency.

During this North Sound Region public mental health system review, it is imperative that we take time to recognize and celebrate our successes as well as identifying our limitations.

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Section B:

BACKGROUND

B. BACKGROUND

The NSMHA, formerly the North Sound Regional Support Network (NSRSN), was formed by an interlocal agreement between Island, San Juan, Skagit, Snohomish and Whatcom counties that define the geographic service area of the North Sound Region. The NSMHA began operations on January 1, 1991. NSMHA contracts with the Mental Health Division (MHD) of the State of Washington to provide public mental health services for these five counties (North Sound Region). NSMHA is governed by a Board of Directors comprised of elected officials or their designated alternates, the President and Vice-President of the regional Advisory Board, and representatives of the 8 Tribal sovereign nations within the North Sound Region. According to the terms of the Interlocal Agreement, Board of Director votes are divided as follows:

- Snohomish County - 4
- Whatcom County - 2
- Island County - 1
- San Juan County - 1
- Skagit County - 1
- Tribes - 1

In 1997, the NSMHA issued a Request for Proposals (RFP) to provide crisis services and capitated mental health services for all Medicaid eligible people across the North Sound Region. Prior to that time, the NSMHA had contracted with 16 mental health providers to provide services. The payment for services was based on a combination of carve-outs for specific services (i.e. Evaluation & Treatment Facilities operating costs, Crisis Services, Children's Hospitalization Alternative Program [CHAP], Residential Services), and a 3-tier system, that was intended to make the most resources available to the people most in need of service. The theory behind creating a system-wide alignment of resources matched to service need was that providers could manage care for all the consumers by moving resources. A broad population of consumers of various need levels in an agency would generate adequate funding to meet agency operational needs. Unfortunately, some providers engaged in what has since become known as "tier wars", where each provider vied to open the maximum number of high-tier clients, even if they didn't have the capacity to serve them immediately. The effect of "tier wars" was a raid on the common resources of the system, resulting in what is historically known as "the tragedy of the commons" where a few members of a community accumulated a disproportionate share of the common assets of the community. Available information suggests that services were not adequately indexed to clinical need during this phase.

In addition to the problems of the tiered system of payment, the NSMHA was holding large amounts of funding in reserve accounts. It is important to acknowledge that the reserve accounts were a necessary evil because DSHS could not determine the number of eligibles and therefore could not guarantee stable funding; and could not guarantee stable per member per month) PMPM) payments to the RSNs. Some providers routinely attended the NSMHA Board of Directors' meetings demanding access to those reserve dollars. This environment encouraged local interest and anti regional debates that undermined efforts towards cooperative and collaborative regional efforts.

A major need at this point in the history of NSMHA was to create a public mental health system that integrated outpatient, inpatient and crisis services. The RFP issued by NSMHA

sought mental health provider agency that could deliver innovative, effective mental health services, be accountable to the public and demonstrate the ability to coordinate with other social service agencies. In addition, the Board of Directors required a minimum of 85% of all dollars awarded to service providers be expended on direct client services. Another need was to create a public mental health system that integrated outpatient, inpatient and crisis services.

To respond to the RFP, a number of local mental health providers formed a Limited Liability Company (LLC) named the Associated Provider Network (APN), to act as an agent for its participating providers and affiliates. Member agencies and affiliates included:

- Catholic Community Services
- Community Mental Health Services
- Counter Point
- Family Counseling
- Homestead
- Island County Mental Health
- Lake Whatcom Treatment Center
- LifeNet
- North Islands Mental Health
- Rainbow Resources (bridgeways)
- Sun Community Services
- Whatcom Counseling & Psychiatric Clinic

Per the APN’s Operating Agreement adopted April 1, 1997; “The purpose of the Company (a.k.a. APN) shall be to do all things lawful, necessary or desirable to contract on behalf of its Members and its Contract Affiliates with the North Sound Regional Support Network and to engage in other activities designed to strengthen and enhance the cost-effective delivery of quality behavioral healthcare services in the area...” The APN is governed, managed and supervised by the Operating Council. The Operating Council is comprised of the CEO of each APN member agency and one CEO from the APN’s affiliates. Initial voting rights were one vote per member. As mergers and acquisitions have occurred subsequent to the formation of APN, the voting rights also merged. As a result, APN’s current voting rights are:

- Catholic Community Services 1
- Compass Health 5
- Whatcom Counseling & Psychiatric Clinic 1
- Affiliates (LWTC, bridge ways) 1

The APN was the sole bidder and their bid was not initially accepted. The APN bid proposed provision of services beyond the scope of the RFP, including quality management, hospital discharge planning, and resource management. After intensive negotiations, a contract was signed in November 1997 between NSMHA and APN. The contract provisions required APN to develop, fund, manage, and oversee care across the North Sound Region through the use of its provider network. The NSMHA has subsequently re-contracted with the APN for three additional contracts extending to December 2003.

Over the past five years, the Mental Health Division’s (MHD) Integrated Audits have raised questions about a lack of clarity around NSMHA and APN roles and functions. In the NSMHA's most recent Integrated Audit, MHD cited duplication between NSMHA and APN in the areas of administration and quality management. In addition, NSMHA clinical chart reviews and administrative audits have raised persistent questions about whether the

system as a whole is rising to provide an acceptable level of care at an acceptable rate. Because it is NSMHA's responsibility to provide oversight and management of our region's publicly funded mental health system, it is incumbent upon NSMHA to take a serious and thorough look at the organizational structure of our system.

Our current system has been in place for over five years and it has grown and changed over time. It is time to step back, re-evaluate where we are and determine where we would like to go in the short and long term future of public mental health services in the North Sound Region. In order to do so, it is important to look at what our system has accomplished and to identify work that is yet to be done.

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Section C:

DOCUMENTS USED TO DETERMINE ACCOMPLISHMENTS/ LIMITATIONS

C. DOCUMENTS USED TO DETERMINE ACCOMPLISHMENTS/ LIMITATIONS

We had to develop some mechanism to identify our public mental health system's accomplishments and limitations. In order to do that, we decided to utilize NSMHA's approved guiding principles and numerous reports as follows:

- NSMHA's RFP for outpatient and inpatient services
- APN's response to the RFP
- NSMHA/APN contracts from 1998 – 2003
- MHD's Annual Medical and Administrative Audits of NSMHA
- NSMHA's Quality Management Plan
- Concurrent Reviews from 1997 – 2002
- Ombuds' reports
- Quality Review Team reports
- NSMHA Critical Incident Review Process
- NSMHA Certification as a Coordinated Quality Improvement Program by DOH
- NSMHA's Mission Statement
- NSMHA's Value Statements
- NSMHA's Principles and Framework for all NSMHA's activities
- NSMHA's movement toward the Recovery concept
- NSMHA's Board of Directors 2002 Retreat
- APN's System Review Documents
- Washington State DSHS State-Wide Publicly Funded Mental Health Performance Indicators, Fiscal Year 2001

In 2002, the Board of Directors' Planning Committee re-evaluated NSMHA's Mission Statement and whether a name change should be considered for the North Sound Regional Support Network. The name change was discussed earlier.

The revised Mission Statement is:

“We join together to enhance our community’s mental health and support recovery for people with mental illness served in the North Sound region through high quality, culturally competent services.”

The NSMHA adopted the following core values, principles and key elements of consumer care. This framework will be the basis for all NSMHA activities and contracts. It is also intended that all NSMHA activities and contracts will be in compliance with the regulatory requirements of WAC, MHD Contract, and Clinical Eligibility and Care Standards. These assumptions are based on a consumer driven mental health services model focusing on strength-based concepts and the provision of responsive, effective, and improved services throughout the region.

EXCERPTS FROM CORE VALUES AND PRINCIPLES – KEY ELEMENTS OF CONSUMER CARE

Eligibility/Access shall be a single point of entry that is timely and provided on a 24 hour, 365-day basis.

Consumer Services/Consumer Rights deal with being treated with dignity, respect, courtesy, fairness, consumer participation, voice, and satisfaction with services.

There shall be an **integrated inpatient/outpatient** system with active provider outreach and engagement for enrolled or unserved consumers.

Mental Health crisis workers shall have **access** to current **crisis plans** and **individual treatment plans** at all times. The NSRSN supports a meaningful information system for all mental health professionals that provide ready access to information regarding the specific consumer's crisis plans and individualized treatment plans.

There shall be comprehensive **complaint and grievance** service made available (and tracked) at all levels of the system.

Strength Based Services developed on consumers' skills, capabilities, strengths, and assets will be recognized and utilized in the individual service plan. Services will be provided as a partnership between consumer, provider and other systems.

Families, communities, and natural supports will be valued and utilized in serving the needs of consumers.

A range of **residential** services and **housing supports** shall be provided, emphasizing least restrictive, stable living options that are age, culturally, and linguistically appropriate. "Housing" is defined in WAC 275-57-140.

The NSRSN and its providers are committed to the **safety** of:

- Consumer
- Staff
- Community

Collaboration is a key element of NSMHA and its contractors in meeting the needs of the whole person. Mentally ill consumers in the justice system shall have access to mental health services.

Educating the community about mental health issues is a core value. NSMHA and its providers will educate the public about the scope of available services, service locations, crisis response services, client rights and responsibilities. The NSRSN and its providers shall actively promote public education regarding mental health and stigma reduction.

Consumers, family members, NSRSN and its contractors shall advocate for consumer rights, funding for services, and quality.

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Section D:

ACCOMPLISHMENTS

AREA	ACCOMPLISHMENT
Consumer Satisfaction	<ul style="list-style-type: none"> • “Generally speaking, consumers appeared to be very satisfied with the mental health services they received.” The state consumer satisfaction survey found that 70% (69.8%) of North Sound consumers were very satisfied or mostly satisfied with mental health services. • Quality Review team found <ul style="list-style-type: none"> ✓ 82% of consumers are satisfied with access ✓ 78% of consumers were satisfied with case management • APN found <ul style="list-style-type: none"> ✓ 76% of consumers perceived services to be helpful in the 2000 study ✓ 76 % of consumers said they would return again if they needed help
Crisis Services	<ul style="list-style-type: none"> • Better integrated • Luther Children’s Crisis Center <ul style="list-style-type: none"> ✓ Resulted from a number of factors: <ul style="list-style-type: none"> ▪ APN Children’s Acute Care Study ▪ APN/NSMHA Utilization Management Information ▪ NSMHA Inpatient Cost Data ▪ APN clinical review of high utilizer charts ▪ Start-up funds and RFP from NSMHA • North Sound is a leader in the use of crisis beds around the state. <ul style="list-style-type: none"> ✓ North Sound has 39 of 52 crisis beds in the entire state ✓ 25 crisis beds in Snohomish County operate at 75% capacity • VOA now provides crisis and care telephone services for the entire region • VOA is directly linked with APN Access and other agencies • Crisis phone services are provided by professional staff 24/7 • There is always a Master’s level clinical coordinating services at the VOA care/crisis line • NSMHA has implemented the ability for Volunteers of America to issue a “no decline” dispatch for CDMHPs • APN is conducting monthly Regional Crisis Management Team meetings
Financial Management	<ul style="list-style-type: none"> • APN has a rational basis for fund distribution to their providers • Fewer financial conflicts between counties, BOD and providers • NSMHA funding is maximized to direct consumer services; administration our public mental health system is limited within state administrative limits <ul style="list-style-type: none"> ✓ Excludes funds in the required risk reserves • State Auditors have revealed NO FINDINGS in the last 5 years • Improved and more meaningful financial reports to Advisory Board and Board of Directors • A single integrated contract negotiation process between providers and NSMHA results in reduced administrative costs.

AREA	ACCOMPLISHMENT
Service Delivery	<ul style="list-style-type: none"> • Access <ul style="list-style-type: none"> ✓ Centralized access (APN) ✓ No waiting lists ✓ Decreased time entering services from 19.4 days to below 10 days • Outpatient services <ul style="list-style-type: none"> ✓ Increased access to services with regional mental health/developmental disabilities program ✓ Cross-system effort provides on-site mental health support to high need children in schools ✓ On-going expansion of housing opportunities for mentally ill consumers throughout the region ✓ Major providers are offering Dialectical Behavioral Therapy (DBT) in each county • Inpatient services <ul style="list-style-type: none"> ✓ Children's crisis services enhanced • Community hospital discharge coordination improved • Flex funds are being used to support children's inpatient services and housing • Children's Hospital Alternative Program (CHAP) <ul style="list-style-type: none"> ✓ Corrective actions resulted in: <ul style="list-style-type: none"> ▪ Utilization and quality have increased: ▪ Utilization has increased to nearly 85% and has gone over on several occasions ▪ Out-of-Home CHAP placements and services are occurring ▪ Use of respite care is above 90% <ul style="list-style-type: none"> • Significant decrease in unplanned discharges from CHAP • Expanded Community Support (ECS) • NSMHA and Providers are first to pilot this program • 15 very difficult to place consumers from WSH have been successfully placed and living in our communities • Only 2 of the 18 people placed in this program have returned to WSH • ECS direct service provider participants are: <ul style="list-style-type: none"> ✓ Compass Health ✓ Lake Whatcom Residential Center ✓ Community Mental Health Services ✓ Whatcom Counseling and Psychiatric Clinic ✓ These mental health providers also partnered with other community agencies to create the ECS program
MHD Licensing Reviews	<ul style="list-style-type: none"> • Are now performed in collaboration with NSMHA's administrative and clinical record reviews. This decreases the number of provider reviews from three to one. • MHD modeled state review tool after NSMHA's concurrent review tool • All Non-APN providers and some APN Providers are passing their minimum licensing reviews by MHD

AREA	ACCOMPLISHMENT
Trainings	<ul style="list-style-type: none"> • Annual NSMHA Recovery Conference <ul style="list-style-type: none"> ✓ Promoted Recovery Concept ✓ BOD approved Recovery movement ✓ Of over 250 participants, over 50% are consumers/advocates • NSMHA is now taking the lead with provider participation in developing a region-wide training plan • Post Traumatic Stress Disorder (3 trainings, 345 participants) • Regional Disaster Management Training (1 trainings, 31 participants) • Co-occurring Disorders (COD) <ul style="list-style-type: none"> ✓ Coordination with MHD to sponsor trainings for Mental health staff regarding substance abuse • Gay, Lesbian, Bisexual and Transgender trainings for administrative and clinical staff GLBT (3 trainings, 120 participants) • Annual Tribal Conferences • NSMHA's monthly training provided to Advisory Board • APN/DDD conducted DD trainings • APN and providers conducted considerable training in Dialectic Behavioral Therapy (DBT)
Tribes	<ul style="list-style-type: none"> • On Board of Directors • Monthly Tribal meetings • On numerous committees <ul style="list-style-type: none"> ✓ Planning ✓ Quality Management and Oversight Committee ✓ Annual Tribal conferences ✓ 7.01 Plan Board of Directors' approved • Increased participation and leadership from the tribes has contributed significantly to the quality and health of our system as a whole
Information Services	<ul style="list-style-type: none"> • NSMHA and providers will have the same Raintree software • This new software will expand capacities to utilize management system information for planning, program/system development, and evaluation.

AREA	ACCOMPLISHMENT
Service Coordination Development and Integration	<ul style="list-style-type: none"> • Board of Directors and County Coordinators have evolved into reviewing and making decisions based on a regional basis • NSMHA has established collaborative relationships with: <ul style="list-style-type: none"> ✓ Home & Community Services ✓ Division of Alcohol & Substance Abuse <ul style="list-style-type: none"> ▪ Regional Co-occurring Disorders Committee ✓ Division of Developmental Disabilities ✓ Children's Administration ✓ Schools ✓ Juvenile Rehabilitation Administration • APN has regular meetings of its Management Council, Clinical, Fiscal and QM Committees: <ul style="list-style-type: none"> ✓ Better communication among member agencies ✓ Improved coordination of services between member agencies ✓ Patient transfers between member agencies easier • All non-APN providers and some APN providers have improved in the areas of: <ul style="list-style-type: none"> ✓ Treatment Plans ✓ Crisis Plans ✓ Building consumer strengths into treatment plans • A-Team <ul style="list-style-type: none"> ✓ Multi-systems Case Planning Teams <ul style="list-style-type: none"> ▪ Established in Snohomish County ▪ Expanded into Skagit , Whatcom, and Island Counties • APN standardized a number of forms, such as <ul style="list-style-type: none"> ✓ Intake ✓ 180 day reviews • Public mental health system and the Department of Corrections has improved post-released discharge planning for people with a mental illness • DMIO project is a direct MHD/APN contract • Atypical individual case management/coordination <ul style="list-style-type: none"> ✓ DDD Crisis services • Public mental health system is involved in many of the cross-system coordination and collaboration efforts • Western State Hospital Liaison <ul style="list-style-type: none"> ✓ North Sound Region's liaisons to WSH and the outpatient system of care in the region have been successful in maintaining our census at one of the lowest per capita rates in the state. <ul style="list-style-type: none"> ▪ Average census was 84 for 2002 and 80 for the last six months of 2002. ✓ Useful clinical reviews that vastly improves the possibilities for successful and appropriate levels of consumer placement in the Expanded Community Service Program • NSMHA and provider efforts with NAMI have included participating in a variety of trainings, such as Family to Family, and Provider to Consumer

AREA	ACCOMPLISHMENT
Resource Management	<ul style="list-style-type: none"> • Mental health providers have improved their ability to find resources for atypical/high utilization consumers • Three residential reviews have consistently found appropriate placements, quality assessments, and consumer voice. NSMHA will recommend that focused reviews only be conducted on a biennial basis and not yearly due to consistent quality in this area. • APN has developed good working relationship with DOC and in discharge planning and community coordination.
Planning	<ul style="list-style-type: none"> • NSMHA and the County Coordinators have conducted the following planning processes: <ul style="list-style-type: none"> • Strategic Plan 2003 • E & T Planning • Inpatient Savings Distribution Plan • Children's Service Recommendations • Older Adult Mental Health Report • Homeless and Mental Illness in the North Sound Region • Housing for People with Mental Illnesses in the North Sound Region • Consumer-oriented Projects • APN & NSRSN collaboratively conducted the: <ul style="list-style-type: none"> • Children's Acute Care Services Study <ul style="list-style-type: none"> ✓ Addressed service gaps that lead to the development of the Luther Children's Crisis Center • APN conducted the following planning studies: <ul style="list-style-type: none"> • Study of 30 high utilizing children and 30 high utilizing adults • Study and selection of new MIS system • Associated Providers Network Integrated Contract Plan & Associated provider Network Long-Term Integrated Residential and Inpatient Plan • Case Manager Caseload Size Study
Consumer Outreach/ Stigma Reduction	<ul style="list-style-type: none"> • Ombuds annual Consumer poster context • NSMHA's annual Exemplary Service Awards • Consumer participation and voice at all levels of NSMHA • 18 Consumer Oriented Projects were approved and funded by the Board of Directors (\$458,482) • NSMHA's Annual Recovery Conference (noted above) • Routine face-to-face surveys with consumers at their agencies by QRT • Consumer oriented funding is now allocated to each NSMHA member counties to implement programs locally.

AREA	ACCOMPLISHMENT
Quality Management	<ul style="list-style-type: none"> • Continued to enhance NSMHA’s Quality Management Plan that has been approved by MHD • NSMHA has streamlined and consolidated all clinical monitoring and improvement activities • NSMHA has combined the Administrative and Clinical Record reviews at provider agencies • MHD licensing reviews are performed in collaboration with NSMHA staff, rolling three audits into one at each provider agency • The Standard of Care Manual (previous Level of Care Manual) was created by NSMHA clinical staff <ul style="list-style-type: none"> ✓ The SOC identifies eligibility criteria, array of services and service intensity and has been copied by other RSN’s. • NSMHA's certification by Department of Health as a Coordinated Quality Improvement Program (CQIP). • Clinical Reviews and Oversight <ul style="list-style-type: none"> ✓ NSMHA clinical reviews of providers have documented the particular areas in which the providers are performing well, as well as what areas need improvement ✓ NSMHA is now utilizing the MHD Outpatient Record Review Tool ✓ APN has developed some region-wide standardized forms ✓ Providers have initiated internal peer reviews • Complaints and Grievances <ul style="list-style-type: none"> ✓ NSMHA has developed and implemented a BOD approved complaint/grievance policy region-wide ✓ NSMHA is promoting a “no blame” culture so reports of complaints are seen as opportunities for improvement ✓ New policy has built in a role for APN to resolve complaints at a lower level which is preventing some grievances from coming to the NSMHA level for resolution • Critical Incidents <ul style="list-style-type: none"> ✓ Revised critical incident policy approved by BOD ✓ Added clarity and definition to reportable incidents ✓ Expanded to include incidents at Evaluation & Treatment Centers ✓ Improved system of reporting • Quality Review Team has been able to increase their sample sizes at the provider agencies • MHD has given deemed status to SeaMar, Catholic Community Services and Volunteers of America

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Section E: LIMITATIONS

AREA	LIMITATION
Service Delivery	<ul style="list-style-type: none"> • Available data for numbers of clients served and the number of client hours between 1999-2001 has only increased slightly. <ul style="list-style-type: none"> ✓ See Section F: Funding and People Served for details. • Access <ul style="list-style-type: none"> ✓ Some allied systems have expressed their dissatisfaction access regarding facilitated referrals. • Inpatient Services <ul style="list-style-type: none"> ✓ Inpatient services are increasing for adults and decreasing for children <ul style="list-style-type: none"> ▪ Reasons for this trend should be investigated for possible program/policy implications ✓ Inpatient savings dollars are disappearing • Certification Team <ul style="list-style-type: none"> ✓ Changes in the APN process for inpatient certifications were fully implemented last November • Community Hospital Discharge Coordination <ul style="list-style-type: none"> ✓ Changing level of care adequately before and after hospitalizations needs improvement ✓ Rapid follow-up after hospitalizations needs to be enhanced ✓ Discharge of difficult cases in need of improvement • Luther Children's Crisis Center <ul style="list-style-type: none"> ✓ No utilization data is available yet. The data has been requested and we promise to add data once we receive it. ✓ The other 6 bed unit needs to be opened • We are providing out-patient services for people with higher acuities of mentally illnesses and will likely be dually diagnosed due to a decrease in Western State Hospital beds <ul style="list-style-type: none"> ✓ This is a substantial drain on our funds supporting outpatient services • Expanded Community Services (ECS) <ul style="list-style-type: none"> ✓ Since these people are very difficult to serve, we must maintain our efforts in this area as a top priority ✓ ECS is now expanding to the geriatric population that will provide additional challenges. ✓ Main funding for geriatric population is with HCS
Financial Management	<ul style="list-style-type: none"> • The number of covered lives and consequently available resources or funding is unpredictable because of inadequate information from the Mental Health Division and Medical Assistance Administration of DSHS. <ul style="list-style-type: none"> ✓ Thereby potentially increasing the numbers to be served while simultaneously reducing available funding.

AREA	LIMITATION
Service Coordination Development and Integration	<ul style="list-style-type: none"> • While APN has developed many protocols and trainings for use by APN providers, APN does not have authority to mandate the implementation of those protocols. APN must rely upon consensus and voluntary implementation.
Training	<ul style="list-style-type: none"> • Consumers/Advocates were unable to get region-wide case manager training with a standard curriculum, which was by consumers/advocates and the regional advisory board.
MHD Licensing Reviews	<ul style="list-style-type: none"> • APN has not demonstrated its ability to oversee and effect change in its members regarding compliance with Contract and State WAC regulations, despite APN assurances over several years that positive change will occur in its member providers • Some agencies have failed their minimum licensing requirements
Quality Management	<ul style="list-style-type: none"> • We are incapable of doing effective and proactive utilization management due to a lack of reliable and timely data • NSMHA clinical record reviews have consistently indicated that some APN providers have shown a pattern of being below acceptable standards. There have been little or no significant improvements between 1997-2002 by some APN providers. • Both NSMHA and APN share the responsibility for this area • Clarification of roles and responsibilities between NSMHA and APN remain a question. • Most reported complaints are coming through the NSMHA's Ombuds program. • QRT sample sizes remain fairly small • APN staff does not monitor for quality assurance with its members or affiliates which partially explains their inability to effect change in contract compliance in their member providers.
Consumer Outreach/ Stigma Reduction	<ul style="list-style-type: none"> • We are not doing enough to educate the general public on mental illness.
Information System	<ul style="list-style-type: none"> • Provider implementation of Raintree has been delayed repeatedly. • Consequently, NSMHA's implementation is delayed. • Reliable and timely management data remains unavailable

AREA	LIMITATION
Resource Management	<ul style="list-style-type: none"> • NSMHA staff still spending time to assist with resources to serve atypical/high utilization consumers. The reasons for this duplication should be examined for purposes of identifying potential contractual changes. • Residential authorization lacks independent review to assure consumer choice and assure due consideration of less restrictive alternatives • No independent authorization or re-authorization for level of care for outpatient services • No independent re-authorization for residential services • APN just implementing inpatient certification process

North Sound Mental Health Administration

Public Mental Health System Review

Section F:

FUNDING AND PEOPLE SERVED

F. FUNDING AND PEOPLE SERVED

Funding:

First, it is important to have an understanding of our funding sources and how those financial resources are utilized in the North Sound public mental health system. Please refer to **Attachment 1 NSMHA Revenue**. As you can see, our major funding source is 95% Title IX (Medicaid which is 50% Federal and 50% State). The other 5% of funding is from Federal Block Grant, Division of Developmental Disabilities, Expanded Community Services, Interest earned and conference revenues. All of these revenue sources total just over \$43 million.

See **Attachment 2 NSMHA Expenditures** for how those financial resources are utilized in the following manner:

It is our understanding that NSMHA is the only public mental health region that actually appropriates funds to the regional advisory board. We fully support that funding since it mainly supports the travel, education and participation of advisory board members and other consumers and advocates within our region. This also supports public education, stigma reduction, our Vision of Hope and Path to Recovery philosophy.

Total funding annualized for NSMHA and all direct service providers have increased from \$30,717,825 in 97/98 to \$42,662,122 in 02/03. This is an increase of \$11,944,297 or 38.9%.

Please refer to **Attachment 3 Outpatient Cost Allocation Plan 2003**. Outpatient funds are used to support the following:

There are many factors that come into play that has lead to our increased funding. The major areas are:

- Integration of inpatient/outpatient funding
- Phase in of funding formula over six years
- Increases in Medicaid eligibles.
- Increase in Medicaid eligible rates

Since administrative costs for NSMHA and Providers appear to be a major concern, we will take a look at those figures. The intent is to keep administrative costs at a minimum to maximize resources going to direct services. We will focus on administrative costs between NSMHA and Providers for calendar years 2001 and 2002.

- APN administrative costs between 2001 and 2002:
 - ✓ Increased from \$ 5,151,016 to \$ 5,443,377
 - ✓ This is a 5.7% increase or \$ 292,331
 - ✓ Administrative cost as a percentage of expense decreased from 14.8% to 14.57%
- NSMHA total costs between 2001 and 2002:
 - ✓ NSMHA increased from \$ 1,532,462 to 1,654,115
 - ✓ This is a 7.9% increase or \$ 121,653
 - ✓ NSMHA decreased its percentage of cost to total expense from 3.77% to 3.75%
- NSMHA administrative cost increases over the past four years are due to the following circumstances:
 - ✓ In past years the NSMHA experienced a number of vacancies.
 - Five in 1998
 - ✓ NSMHA has switched from contracting for services to NSMHA staff:
 - Contract manager
 - Ombuds
 - Office of Consumer Affairs/Tribal Liaison Manager
 - Information System Person
 - ✓ NSMHA has increased Ombuds and Quality Review Team FTEs from 1.5 to 4
 - ✓ In 2003, NSMHA has increased expenditures in:
 - Medical Director costs increased over 500%
 - HIPAA legal costs
 - Health Benefits increased 26%
 - Salary increases of 1%
 - Liability Insurance increased 50%
 - Workers Compensation increased 33%

Even with the above administrative increases, NSMHA has maintained its funding to 4% of revenues. Over the years 2001 and 2002, the amount of revenues has been disbursed in the following manner: Consequently, 84.9% of revenues go to direct services or activities to support direct services.

- NSMHA Administration 2%
- NSMHA Direct Service 2%
- Provider Administration 13.1%
- Direct Services 82.9%

In addition, NSMHA has under spent its approved operating budget by the following amounts:

1997	\$ 194,789
1998	29,163
1999	87,735
2000	86,057
2001	168,869
2002	<u>87,806</u>
TOTAL =	654,419

Most of the above NSMHA administrative savings, by contract have been disbursed to the APN. The other NSMHA administrative savings went to special projects such as consumer oriented projects like: Cookie Creations, Supported Education, etc. as approved by the Board of Directors.

Since we have a shared at-risk contract with the APN, our contract directs that all revenues except those that are “carve outs” at the NSMHA level go directly to APN.

Please reference **Attachment 4 Annual Contract Payment Analysis** for an historical illustration of the funding to all parts of our public mental health system since 1997. As you can see, the funding to our providers can be summarized as follows:

- Tulalip Tribe funding is **static** (Federal Block Grant funds) 0%
- SeaMar has **increased slightly** 4%
- Snohomish County has **decreased** (some services delegated to providers) -55%
- NSMHA has **increased 37%**
- APN has **increased** by (see paragraph below)

The annualized payments to APN have increased from \$26,107,952 in 97/98 to \$38,062,241 in 02/03. This is an increase of \$11,954,289 or 45.8%. In addition, when comparing total funds received by APN over time please note that their percent of the total funds received by NSMHA has increased from 85.27% in 97/98 to 88.84% in 02/03.

People Served:

We have reviewed the available data from 1999 through 2001 See **Attachment 5 People Served Analysis.** That annual data provides information regarding the total number of clients served and the sum and average of standardized service hours for the following entities:

- **Outpatient services provided by:** Associated Provider Network
 - ✓ Sea Mar
- **Involuntary Treatment Act services provided by:**
 - ✓ Snohomish County
 - ✓ APN
- **Inpatient services provided by:**
 - ✓ Mukilteo E&T
 - ✓ North Sound E&T
- **Care/Crisis Calls provided by:**
 - ✓ Volunteers of America

As you can see, the number of clients served has not significantly increased except for Snohomish County ITA, Mukilteo E&T and Volunteers of America Care Crisis Line.

North Sound Mental Health Administration

Public Mental Health System Review

Section G:

ADMINISTRATIVE & QUALITY MANAGEMENT STRUCTURES

G. ADMINISTRATIVE & QUALITY MANAGEMENT STRUCTURES

Administration:

It is important to note that NSMHA has entities other than APN under direct contract for services. A listing of all NSMHA providers is as follows:

<u>Entities</u>	<u>Services</u>
Associated Provider Network	Outpatient/Inpatient services/Acute Care Services/Involuntary Treatment Act Administration/Residential Service/Operation of Evaluation & Treatment Facilities
Sea Mar	Outpatient for Hispanic and other ethnic populations
Volunteers of America	Care Crisis Line
Snohomish County	Involuntary Treatment Act (ITA), Quality Management
Tulalip Tribe	Traditional Healing

See **Attachment 6 NSMHA System Structure** for an overview of our public mental health system as required by the MHD/NSMHA contract and NSMHA contracts with the above service providers.

As you can see, all contracts, except for APN, are with the provider of direct services. For the most part, these arrangements work fairly well and we have seen system improvements that have been identified earlier in this report.

Please see **Attachment 7 NSMHA, APN and APN Members Structures**. This is where we believe the alleged areas of overlap or duplication can occur. While there does seem to be overlap or duplication, it is important to review the purpose of the areas for administration and quality management.

We also need to take into consideration the following reports:

- Access Review 2002
- QRT Survey of NSMHA 2002
- QRT Survey of APN 2003
- MHD PHP Audit of NSMHA 2002

The common message in all of the above reports is that throughout our system and among all of our stakeholders there is confusion as to who NSMHA and APN are and with what their roles and responsibilities are within the public mental health system. After reviewing the RFP, APN's response to the RFP, public mental health structure and our contracts with APN it is understandable why there is so much confusion.

It is apparent that our system could be streamlined to reduce administrative and quality management overlap, duplication and costs. It is important to note that WAC 388-865-0320 and Code of Federal Regulations 42 C.F.R. 440 requires utilization management be conducted by an independent entity from providers.

Quality Management

Attachment 8 Historical Summary of Oversight Activities illustrates quality improvements by the different service providers and NSMHA over three years (2000-2002). Here is a brief explanation of each of the areas that conduct audits/surveys:

- Quality Review Team
 - ✓ Conducts face to face interviews with consumers at provider locations
 - ✓ Conducts system-wide mail surveys to gather satisfaction with public mental health services from other stakeholders (hospital, law enforcement, schools and other human service agencies).
- Concurrent, Focused and Selective Reviews
 - ✓ NSMHA has Quality Specialists that conduct clinical reviews of providers' consumer charts for compliance with WACs, RCWs, CMS Waiver and NSMHA Contract requirements.
 - ✓ This information is utilized in our quality improvement, critical incident management, and resolution of consumer complaints.
 - ✓ Concurrent Reviews are aimed at system performance.
 - ✓ Focused and Selective reviews are case specific reviews.
- Administrative Reviews
 - ✓ NSMHA conducts administrative reviews of providers' fiscal records, personnel charts and policies/procedures for compliance with generally accepted accounting practices, WACs, RCWs, CMS Waiver and NSMHA Contract requirements.
- MHD Licensing Reviews of Providers
 - ✓ NSMHA teams with MHD to conduct administrative and medical reviews of providers' for compliance with WACs, RCWs, CMS Waiver and NSMHA Contract requirements.
 - ✓ The results are used to certify providers are / are not complying with the minimum licensing standards.
- MHD Audit of NSMHA
 - ✓ MHD conducts an administrative and medical audit of NSMHA to assure compliance with WACs, RCWs, CMS Waiver and MHD Contract requirements.

Special Note: As a streamlining effort to minimize the impact on providers with the above audits, NSMHA and MHD have combined the NSMHA Administrative and Concurrent Reviews with MHD's direct service provider licensing reviews. What this means to providers is that instead of three reviews totaling about six weeks per year; there is now one audit totaling about two weeks per year. This is also a benefit to NSMHA and MHD by integrating the results of these surveys into one report.

As you can see:

- NSMHA, SeaMar, and Volunteers of America have achieved substantial compliance
- APN
 - ✓ Catholic Community Services, Lake Whatcom Treatment Center, Whatcom Counseling and Psychiatric Clinic and bridgeways have achieved substantial compliance.
 - ✓ Compass Health, Community Mental Health Services, and have not achieved substantial compliance.

Please refer to **Attachment 9 NSMHA and APN Quality Management Structures**. As you can see, NSMHA has a Board of Directors' Quality Management Oversight Committee (QMOC) that provides input to the NSMHA Board of Directors on quality improvement recommendations. Consumers, Advocates, APN Providers and other providers are members of the NSMHA's QMOC. In addition, there is the NSMHA Regional Advisory Board who provides recommendations on all Board action items and service improvements.

The APN has six major committees:

- APN Management Council
 - ✓ Comprised of the Chief Executives of each member agency.
 - ✓ Full and complete authority to manage and control the business of APN.
 - ✓ Provides direction, approves contracts and policies.
- Delivery Systems Operation Committee (DSOC)
 - ✓ Comprised of clinical directors and other key clinical staff from each of the agencies.
 - ✓ Develops, implements, and oversees the quality management program.
 - ✓ Provides a framework through which APN can improve the quality of clinical care for its enrolled population
- Quality Management Committee (QMC)
 - ✓ Comprised of quality managers from each of the agencies.
 - ✓ Implements system-wide policies and procedures regarding the APN care delivery system.
 - ✓ Assesses the deployment of resources within the region.
- Regional Crisis Management Team
 - ✓ Clinical review and oversight for services provided through the Integrated Crisis Response System (ICRS).
 - ✓ Identifies and corrects problems related to coordination of services.
 - ✓ Responsible for ensuring the appropriateness and consistent application of standards of care protocols, which assure that high quality services are provided in a timely, consistent, and clinically appropriate manner throughout the region.
- Chief Financial Officers/Management Information System Committee.
 - ✓ Comprised of the chief financial officers from each of the agencies.

- ✓ Addresses APN issues related to NSRSN contract reimbursement for services.
- ✓ Distribution of contract funds to members and affiliates.
- Quality Management Advisory Committee
 - ✓ APN started this in 2002.
 - ✓ Comprised of consumers from their agencies.
 - ✓ Chaired by APN's Quality Manager.
 - ✓ Make recommendations to improve services.

North Sound Mental Health Administration

Public Mental Health System Review

Section H:

CONCLUDING REMARKS

H. CONCLUDING REMARKS

Although we have a number of public mental health consumer services system improvements to celebrate, this is not the time to rest on our laurels. We also have some significant areas in need of improvement, especially in regard to clinical record reviews and overlapping roles and responsibilities in the areas of quality assurance and quality management. We need to continually challenge ourselves for system improvements and it is NSMHA's responsibility to ensure that we utilize this opportunity to implement an efficient and effective quality improvement process into our public mental health system.

We believe that our current system design has created an added layer of bureaucracy in the areas of some administration and quality management responsibilities. This is evident when considering the past and most recent MHD/PHP audit of NSMHA, Quality Review Teams satisfaction surveys of NSMHA and APN, the NSMHA Access Study and the limitations identified earlier in this report.

These conclusions are also consistent with findings in the following reports:

- New Freedom Commissions Preliminary Report to the President
 - ✓ “The efforts of countless skilled and caring professionals are frustrated by the system’s fragmentation.”
 - ✓ “The system is fragmented and in disarray –not from lack of commitment and skill of those who deliver care, but from underlying structural, financing, and organizational problems.”
- DSHS’s Facing the Future document
 - ✓ “Today’s public mental health system consists of many layers:
 - The federal Medicaid program
 - The Mental Health Division of DSHS
 - Regional Support Networks
 - Contracted Managed Care Agencies (in some, but not all RSNs), and
 - Contracted providers of mental health services.”
 - ✓ “There is no consensus on how the organization of mental health services might be improved, or how tensions within the system might be reduced.”
- Blueprints for an Effective Mental Health System in Washington State; NAMI Washington
 - ✓ “Clarify and align roles and functions at all structural levels of the system, reducing duplication and replication of tasks and effort.” Today’s public mental health system consists of many layers:

It is also important to consider what different stakeholders within the North Sound Region is stating regarding our public mental health system. The following information is a summarization of thoughts from the Board of Directors Retreat in December 2002:

- Unified support for Mission and Direct Services
- We need to maximize our resources to direct consumer services.
- Our system is complex and fragmentation of roles and responsibilities needs to be reviewed and appropriate solutions implemented.
- Treatment modalities need to be philosophically accepted by all parts of the system and be based on best practices.
- There is a lot of concern about who will be served and ability to access medications with our state's fiscal dilemma.
- There is a concern regarding Mental Health Professionals leaving the public mental health system.
- Very important to have consumer input regarding policy decisions, treatment plans, crisis plans, etc.
- Clear expectations in Quality Management Plan, Standards of Care and Contract are critical.
 - ✓ Must avoid meaningless and burdensome administrative requirements
- Utilization Management needs to be improved.
- Public education using all available tools is needed to educate the public and combat stigma.

North Sound Mental Health Administration

Public Mental Health System Review

Section I: FUTURE ISSUES/TRENDS

I. FUTURE ISSUES/TRENDS

There are a number of future issues and trends that must be considered during this public mental health system review. We will attempt to capture as many as possible, but this should not be considered to be an exhaustive list of everything:

Outpatient Services

- NSMHA and consumers/advocates would like to see more clubhouses (like Rainbow Center) and consumer-oriented projects.
- Enhancement of trauma training of clinicians and trauma services to consumers is needed.
- Maximizing resources going to support direct consumer services.

Children's Services

- Children's Administration is about to reduce their Behavioral Rehabilitation Services (BRS) beds by 100 in the North Sound. This lowers this resource in our region by 50%!

State Budget Deficit of 2.4 Billion

- The potential of decreasing revenues is evident thereby potentially increasing the numbers to be served while simultaneously reducing available funding.
- Concerned with potential of increased Medicaid eligibility criteria
- As other human service agencies lose funding, we need to be aware of cost shifting

Potential of Fairfax Hospital denying Medicaid patients

NSMHA needs to play a more important role in impacting positive change and oversight

Western State Hospital (WSH)

- WA continues its efforts to decrease beds due to budget constraints.
- WA has not provided sufficient funds for a continuum of residential services to enhance hospital diversion efforts or to safely and adequately place people back into our communities from WSH.
- Potential for liquidated damages is much greater with the above trends of decreasing WSH capacity and then adding a liquidated damage for "ready for discharge."

Integration of MHD licensing, NSMHA Administrative and Concurrent Reviews

- Greater coordination and planning is needed to conduct these combined audits.

There remains confusion by all stakeholders as to what the NSMHA and APN roles and responsibilities are in our public mental health system.

- More significant delineation of roles and responsibilities needs to happen or
- A clear separation of respective responsibilities needs to take place.

FUTURE ISSUES/TRENDS (Continued)

Health Insurance Protection and Portability Act (HIPAA)

- These regulations have no funds for implementation, thus is an unfunded federal mandate.
- MHD is requesting funds to offset the impact of BBA on them, but not to assist the RSNs.
- DSHS position on HIPAA- they will not assist providers or other health plans in developing compliance for the Privacy Rule. Providers and health plans are directed to national websites for HIPAA for assistance.
- CMS has just started offering technical assistance to aid in compliance for the Privacy Rule. It is predicted that many covered entities will have difficulty meeting the April 14, 2003 deadline.
- Following the April 14, 2003 deadline there will need to be ongoing efforts to ensure compliance through monitoring, auditing and other activities both internal and external that will continue to require a substantial commitment of resources and time. (Privacy)
- Security regulations have not yet been finalized but will be soon. We will then need to address these as well.

Balanced Budget Act - 97 (BBA)

- These regulations become 100% effective August 2003.
- There are no funds for implementation, thus an unfounded federal mandate.
- MHD has requested funds to offset the impact of BBA on them, but not to assist the RSN's.

Though the BBA was designed to regulate and safeguard clients receiving federally funded medical care from managed care organizations, mental health falls under the umbrella and must be in compliance. The regulations address requirements in the following areas:

- | | |
|---------------------------------------|--------------------------------|
| • Beneficiary Protection | • Contracting - Subcontracting |
| • Eligibility | • Enrollment |
| • Encounter Data–Performance Measures | • Financial Solvency |
| • Fraud and Abuse | • Information to Beneficiaries |

These regulations become effective August 2003 without any federal or state funds to offset this unfunded mandate.

North Sound Mental Health Administration

Public Mental Health System Review

Section J:

RECOMMENDATIONS

J. RECOMMENDATIONS

It is our observation that the North Sound public mental health system has been functioning very well. Our successes are evident in our list of Accomplishments. We also believe that a lot of our work sets a model for the state. In addition, we must take more time to celebrate our successes as well as identify quality improvements within our public mental health system.

It is also important to recognize that there are many highly dedicated and passionate people committed to providing quality mental health services to the people within our North Sound Region public mental health. We have the advantage of also having a collegial, professional and collaborative working relationship among the numerous stakeholders in our system.

It is imperative that we continually make every effort to seek quality improvements, efficiencies, effectiveness, and maximize resources to direct consumer services. In doing so, we must preserve our accomplishments, consider the limitations and the future trends/issues in order to become more effective. Considering all of the above, it is apparent that there is a lack of clarity of quality management and quality assurance roles and responsibilities. There are overlapping responsibilities in the North Sound public mental health system in administration, quality management and quality assurance. Specific roles related to quality assurance and quality management need to be assessed and clarified.

With quality improvement in mind, we make the following observations regarding our public mental health system's limitations:

- Funding to the providers:
 - ✓ APN has increased by \$ 11,954,289 or 45.8%.
 - ✓ NSMHA has increased by \$ 476,887 or 37.1%
 - ✓ SeaMar has increased slightly, or 4%
 - ✓ Tulalip Tribe has been static
 - ✓ Snohomish County decreased or 55%
- Services provided:
 - ✓ People served and Average hours of service :
 - APN has increased by 7.5 and 0.2%
 - SeaMar has increased by 0.2% and decreased by 0.06%
 - Snohomish County has increased by 110 and 59%
- Our public mental health system needs to improve quality management and that should be a single integrated model at NSMHA.
- Quality Management needs to be simplified and streamlined in the following areas (but not limited to):
 - ✓ Quality Assurance
 - ✓ Quality Improvement
 - ✓ Utilization Management
- Some areas of our system need to strengthen their client's clinical records in the following areas:
 - ✓ Treatment Plans
 - ✓ Crisis Plans

- ✓ Case Management
- ✓ Consumer strengths and consumer voice
- Our public mental health system needs to improve in the following areas:
 - ✓ Satisfaction with allied systems
 - ✓ Management of inpatient utilization (children and adults)
 - ✓ Development and implementation of system protocols
 - ✓ Community hospital discharge planning
 - ✓ Continue to streamline and clarify contract deliverables, roles and responsibilities
 - ✓ Oversight and monitoring of direct service providers for contract, WAC and licensing requirements
 - ✓ Managing complex, multi-system cases at the provider level
 - ✓ Enhancing Utilization Management in both Out-Patient and In-Patient for appropriate levels of service for our consumers

Based on the above observations, our recommendations to the Board of Directors are as follows:

- Since we have limited resources, and future funding at current levels appears to be in jeopardy, it is incumbent on all of us to hold our administrative costs to a minimum to maximize resources to direct consumer services.
- Our public mental health system needs to improve its quality management capabilities and that will be a single integrated model at the NSMHA.
- The NSMHA Executive Director is responsible for establishing a NSMHA Transition Committee to meet the above two objectives.
 - ✓ **Phase One**
 - Form a Transition Committee with APN to accomplish the following charge:
 - Identify the current roles and responsibilities and available resources in the areas of quality assurance (QA) and quality management (QM).
 - Assess what QA/QM activities need to occur only at the NSMHA in the integrated model.
 - Assess what QA/QM activities need to occur the direct service provider levels of the NSMHA public mental health system.
 - Assess resource needs to fulfill QA/QM responsibilities at NSMHA and at the direct service providers of the NSMHA public mental health system.
 - Ensure that current accomplishments/strengths are maintained or enhanced.
 - Ensure that current limitations in quality assurance and quality management will become accomplishments/strengths
 - Have a final implementation plan to accomplish Phase One to the Executive Committee and Board of Directors' in April 2003.

- ✓ **Phase Two**
 - Executive Director will expand the Transition Committee to include all other service providers (Snohomish County, Volunteers of America and SeaMar.
 - Quality Management is a regional responsibility that crosses all of our system's providers and they all need to be represented.
 - Assess what QA/QM activities need to occur at the direct service providers of the NSMHA public mental health system.
 - Assess resource needs to fulfill QA/QM responsibilities at NSMHA and occur at the direct service providers of the NSMHA public mental health system.
 - Ensure that current accomplishments/strengths are maintained or enhanced.
 - Ensure that current limitations in quality assurance and quality management will become accomplishments/strengths.
 - We need to implement the new software (Raintree) at our providers to move toward more timely and reliable management information.
 - NSMHA should continue to maintain a single contract with APN and it's provider members/affiliates.
 - NSMHA needs to implement another effort to reduce paper work that involves all stakeholder groups and provider clinicians.
 - ✓ Report progress to the Executive Committee monthly.
 - ✓ Submit a final report to the Executive Committee by August 2003.
 - NSMHA needs to develop policies that give incentives to the providers who are in or come into substantial compliance.
 - ✓ Submit a recommendation to the Executive Committee by July 2003.

Respectfully submitted,

Board of Directors' Executive Committee:

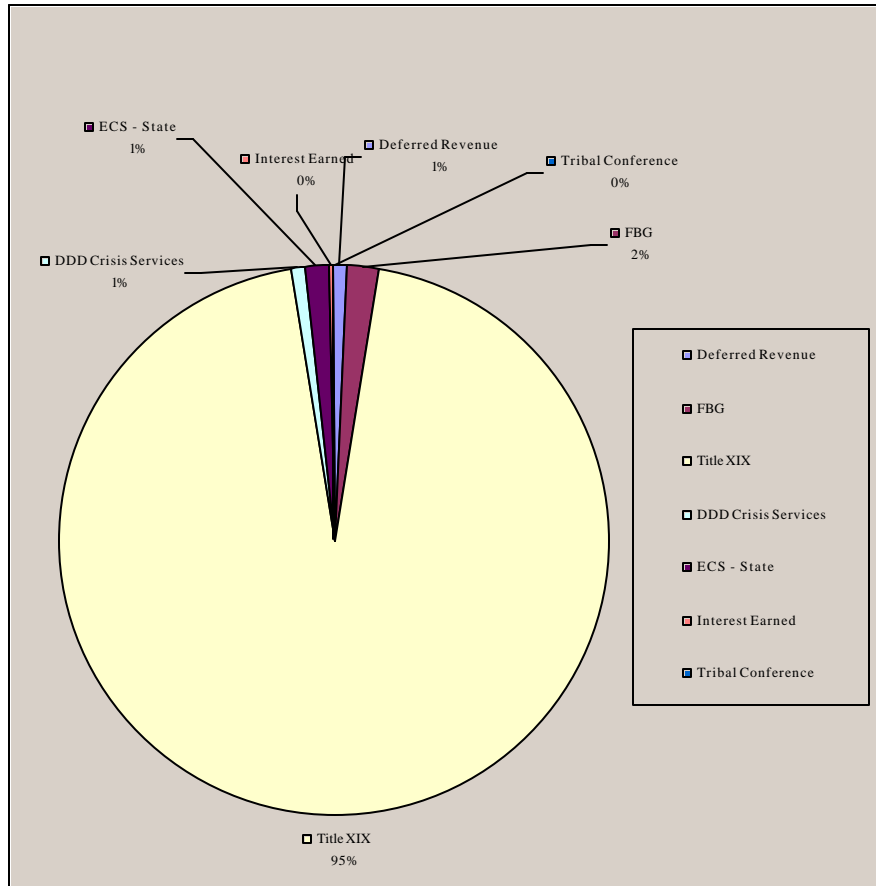
- Snohomish County Commissioner Dave Gossett, Chair
- San Juan Commissioner Rhea Miller
- Whatcom County Councilmember L. Ward Nelson

NSMHA Executive Director

- Charles R. Benjamin

North Sound Mental Health Administration 2003 Projected Revenues

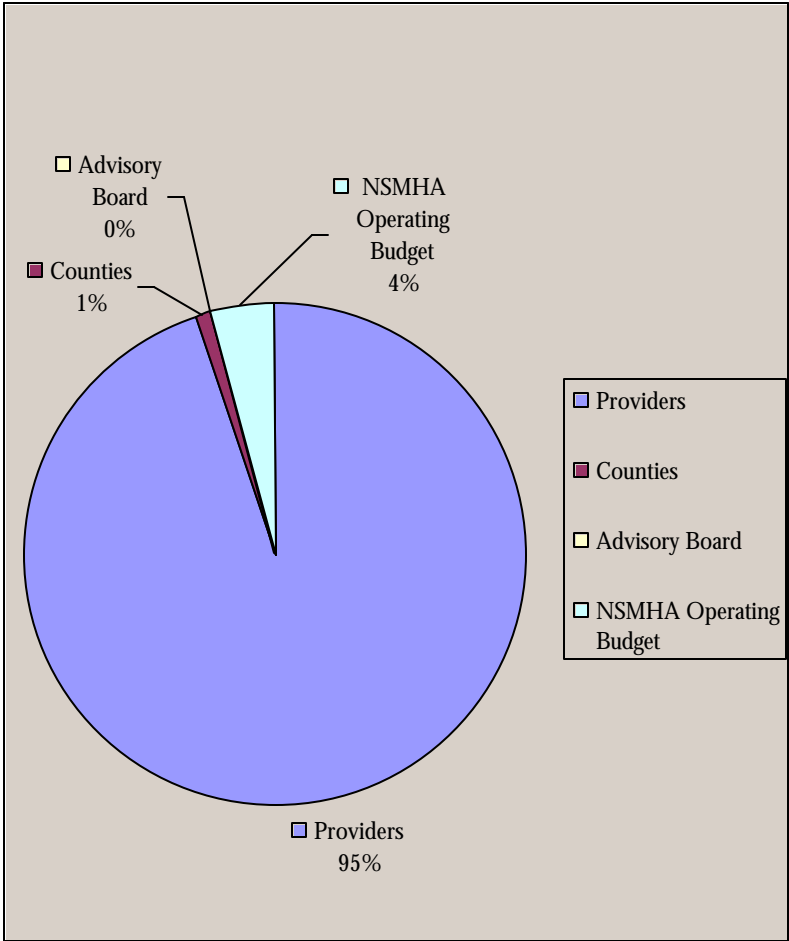
Attachment 1



Revenue Budget 2003	
Deferred Revenue	\$372,017
FBG	881,369
Title XIX	40,690,276
DDD Crisis Services	368,370
ECS - State	627,820
Interest Earned	50,000
Tribal Conference	20,000
Total Revenue	\$43,009,852

North Sound Mental Health Administration 2003 Budgeted Expenditures

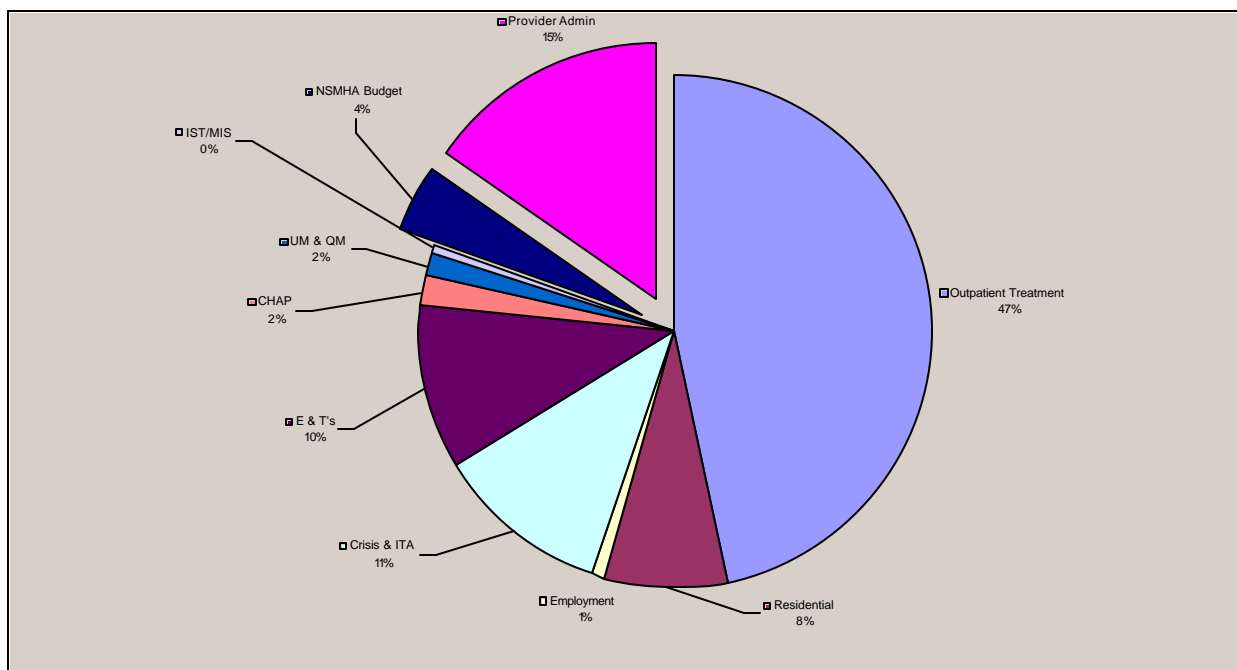
Attachment 2



Expenditure Budget 2003	
Providers	\$40,885,687
Counties	295,010
Advisory Board	25,000
NSMHA Operating Budget	1,804,155
Total	\$43,009,852

* Snohomish County portion in Providers and Counties

North Sound Mental Health Administration CY 2003 Outpatient Cost Allocation Plan



Attachment 3

Direct Services:	
Outpatient Treatment	20,121,590
Residential	3,261,931
Employment	385,000
Crisis & ITA	4,754,716
E & T's	4,503,073
CHAP	780,326
Total	33,806,636

Direct Service Support:	
UM & QM	\$660,406
IST/MIS	146,800
Total	\$807,206

Administration:	
NSMHA Budget	\$1,804,155
Provider Admin	6,591,855
Total	\$8,396,010

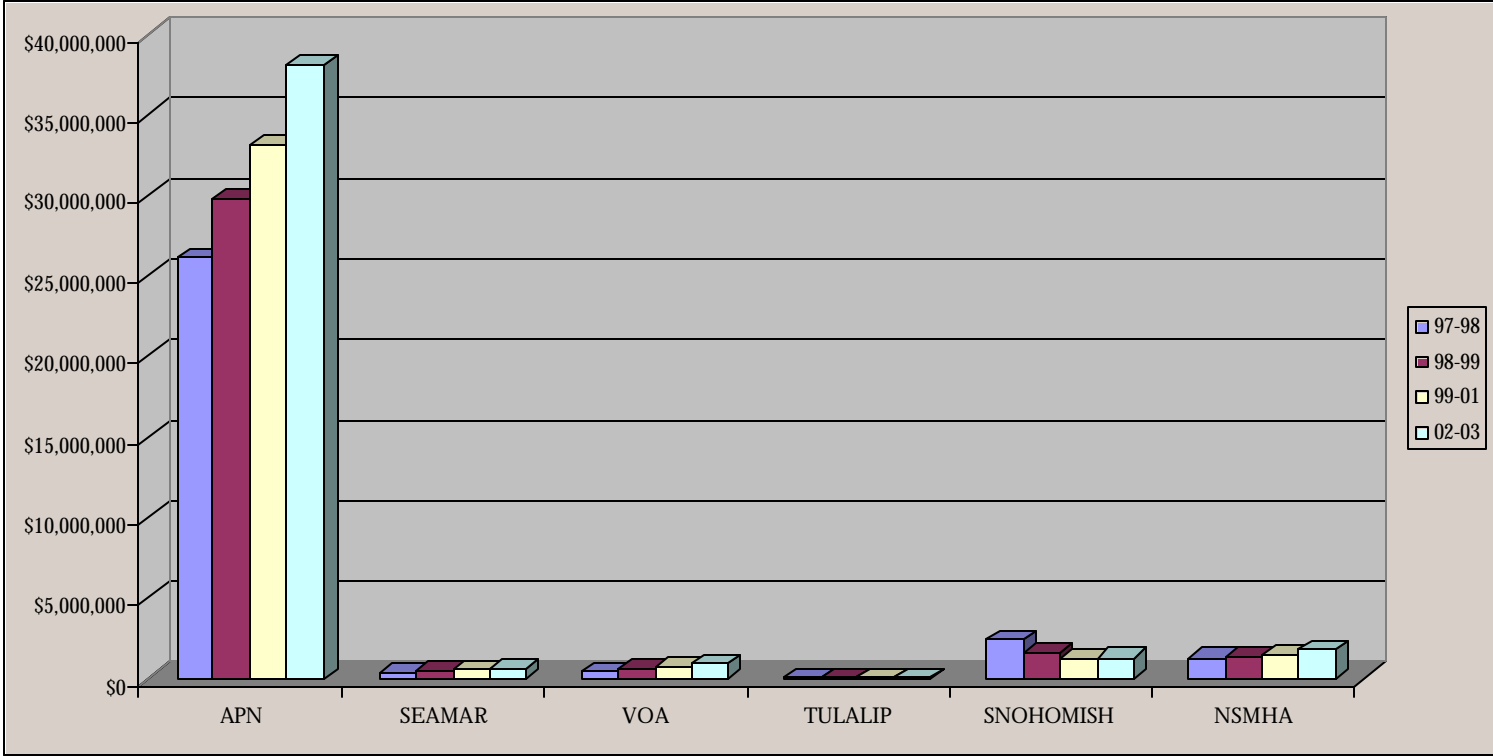
TOTAL COST ALLOCATION PLAN - \$43,009,852

Assumptions -: 2003 Outpatient Cost Allocation Plan data was calculated from the following sources:

1. NSMHA Budget = 2003 Operating Budget less Allocation from Budget to Counties
2. IST\MIS = Annual PHP Carveout
3. CHAP = Annual PHP Carveout
4. Provider Admin, E & T's, Crisis & ITA, Employment, Residential and Outpatient Treatment = Based on historical Biennial Quarterly Reports from Providers

North Sound Mental Health Administration Annual Contract Analysis

Attachment 4



PROVIDER	97-98	98-99	99-01	02-03
APN	\$26,107,952	\$29,847,427	\$33,179,851	\$38,062,241
SEAMAR	366,741	488,984	509,880	534,880
VOA	398,892	561,208	774,654	920,029
TULALIP	81,840	81,840	81,840	81,840
SNOHOMISH	2,377,430	1,611,149	1,186,128	1,311,294
NSMHA	1,284,971	1,357,470	1,490,536	1,761,858
TOTALS	\$30,617,825	\$33,948,078	\$37,222,889	\$42,672,142

Seamar increase in funding over time due to negotiated contracts, MIS allocation and in 01-02 Vision program allocation with payment in 02-03.

VOA Increases over time due to expanded services, MIS allocation, DDD crisis services and renegotiating from 10% Inpatient Savings to all PHP carveout.

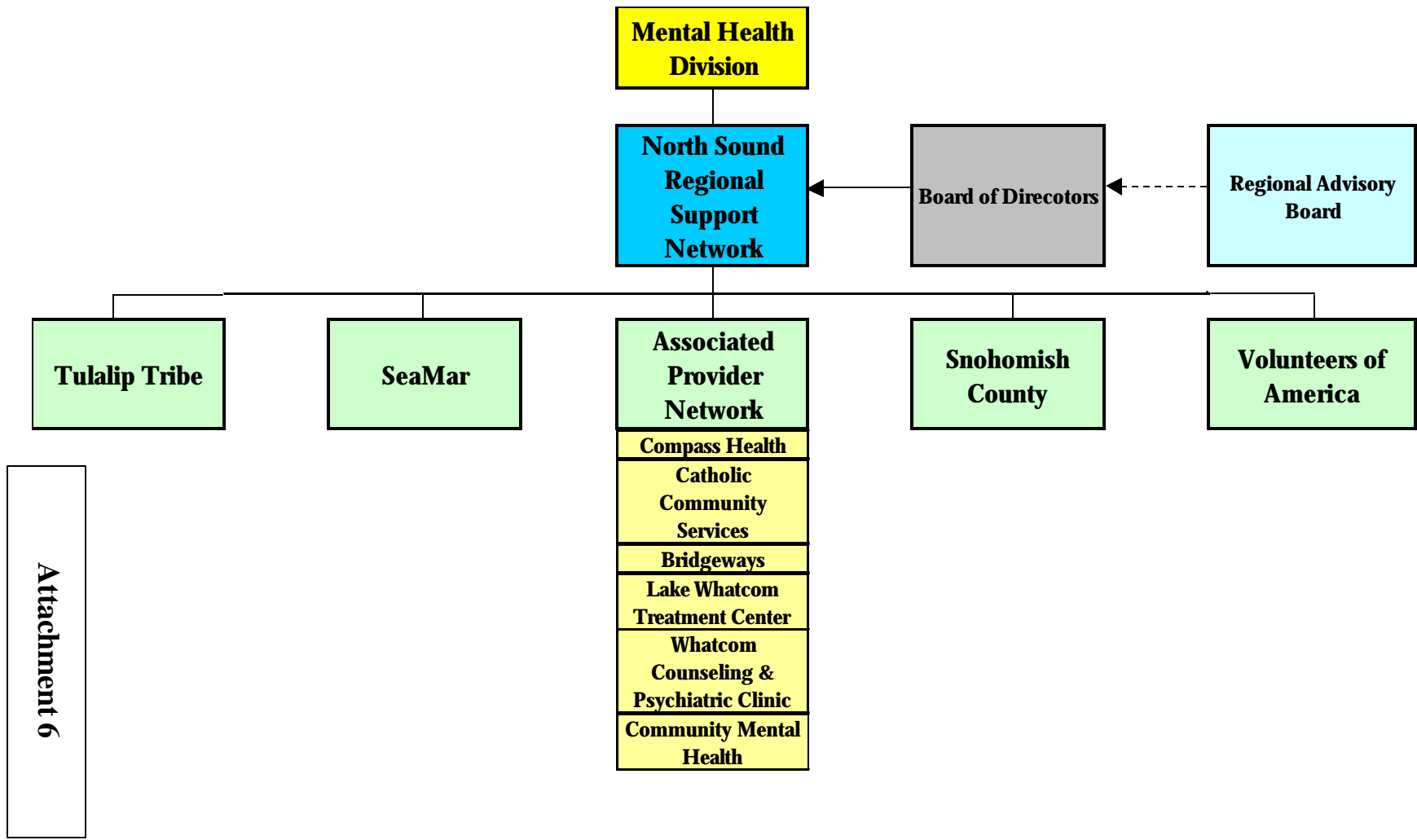
Snohomish changes due to: 1) reduction in funding from 97-98 to 98-99 realized due to crisis response funding (other than ITA) and Flex funds to APN 11/97, 2) reduction in funding from 98-99 to 99-01 realized due to CHAP enhancement funds to APN with 99-01 contract and 1-time only inpatient savings dollars received in 98-99, 3) increase in funding from 99-01 to 02-03 due to increase in ITA funding and consumer projects dollars

**North Sound Mental Health Administration
People Served**

AGENCY	1999	2000	2001	1999 - 2001 % Inc/Dec
<u>APN</u>				
Outpatient Services:				
Monthly Avg. of Clients	5,559	5,948	5,974	7.5%
Avg. Hours of Service/Month	14,749	16,446	17,266	17.1%
Avg. Hours/Consumer	2.65	2.76	2.89	8.9%
Involuntary Treatment Act Services:				
Number of Clients	1,340	1,282	1,264	-5.7%
Avg. Hours of Service/Month	432	459	489	13.2%
Avg. Hours/Consumer	0.32	0.36	0.39	20.0%
<u>SeaMar Outpatient Services:</u>				
Number of Clients	1,587	1,808	1,622	2.2%
Avg. Hours of Service/Month	297	307	280	-5.8%
Avg. Hours/Consumer	2.25	2.04	2.07	-7.8%
<u>Snohomish County Involuntary Treatment Act Services:</u>				
Number of Clients	1,056*	1,694	2,218	40.0%
Avg. Hours of Service/Month	265	262	270	2.1%
Avg. Hours/Consumer	2.00	1.86	1.46	-27.1%
<u>Mukilteo E & T:</u>				
	454	513	515	13.4%
<u>North Sound E & T:</u>				
	460	481	476	3.5%
<u>Volunteers of America Care Crisis Line Services:</u>				
Number of Clients	9,890	11,699	10,874	10.0%
Total Calls	107,049	116,802	119,326	11.5%

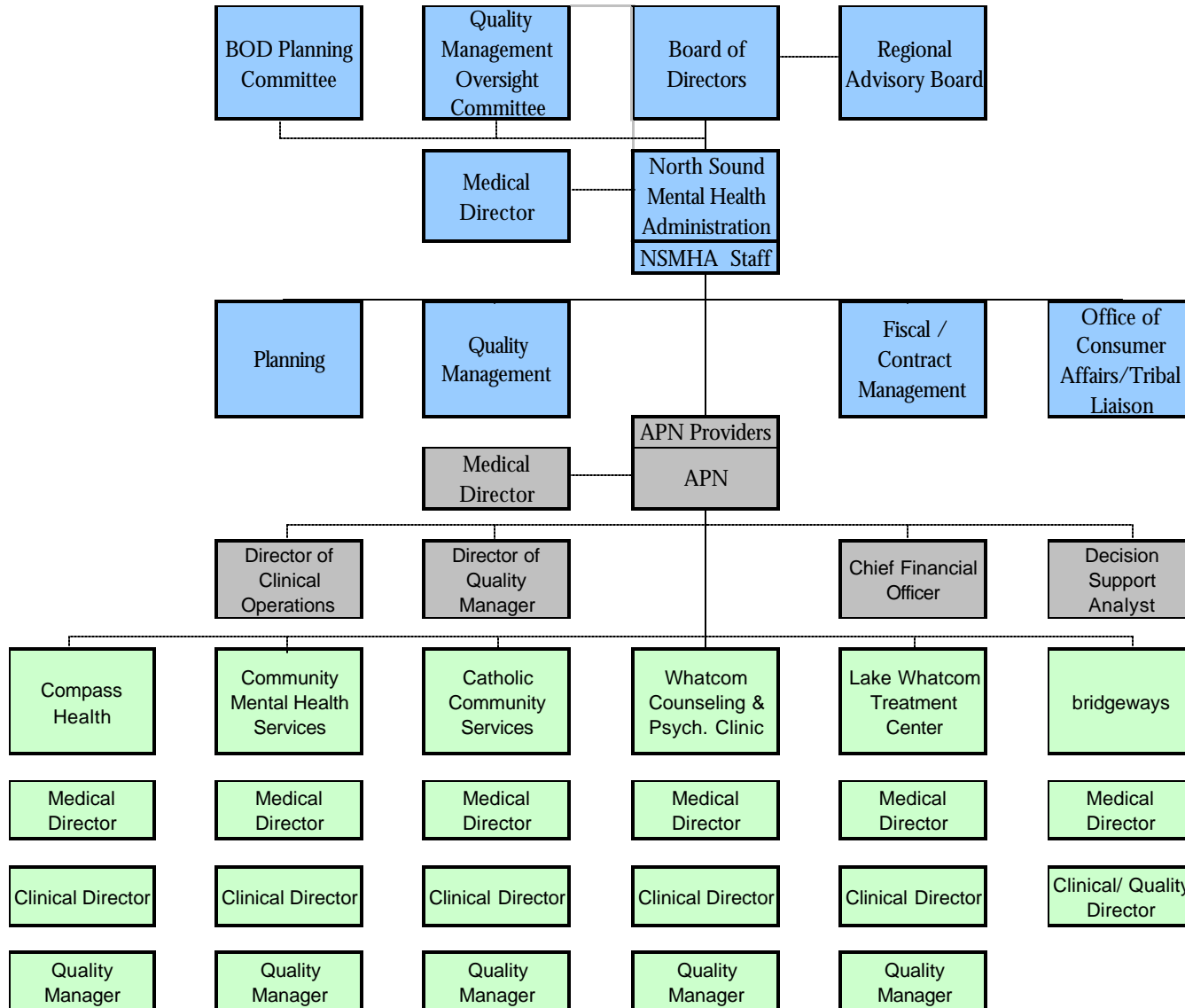
* First full month of services reported was in May 1999.

**North Sound Mental Health Administration
(Island, San Juan, Skagit, Snohomish and Whatcom Counties)**



Attachment 6

NSMHA – APN – APN Member Structures



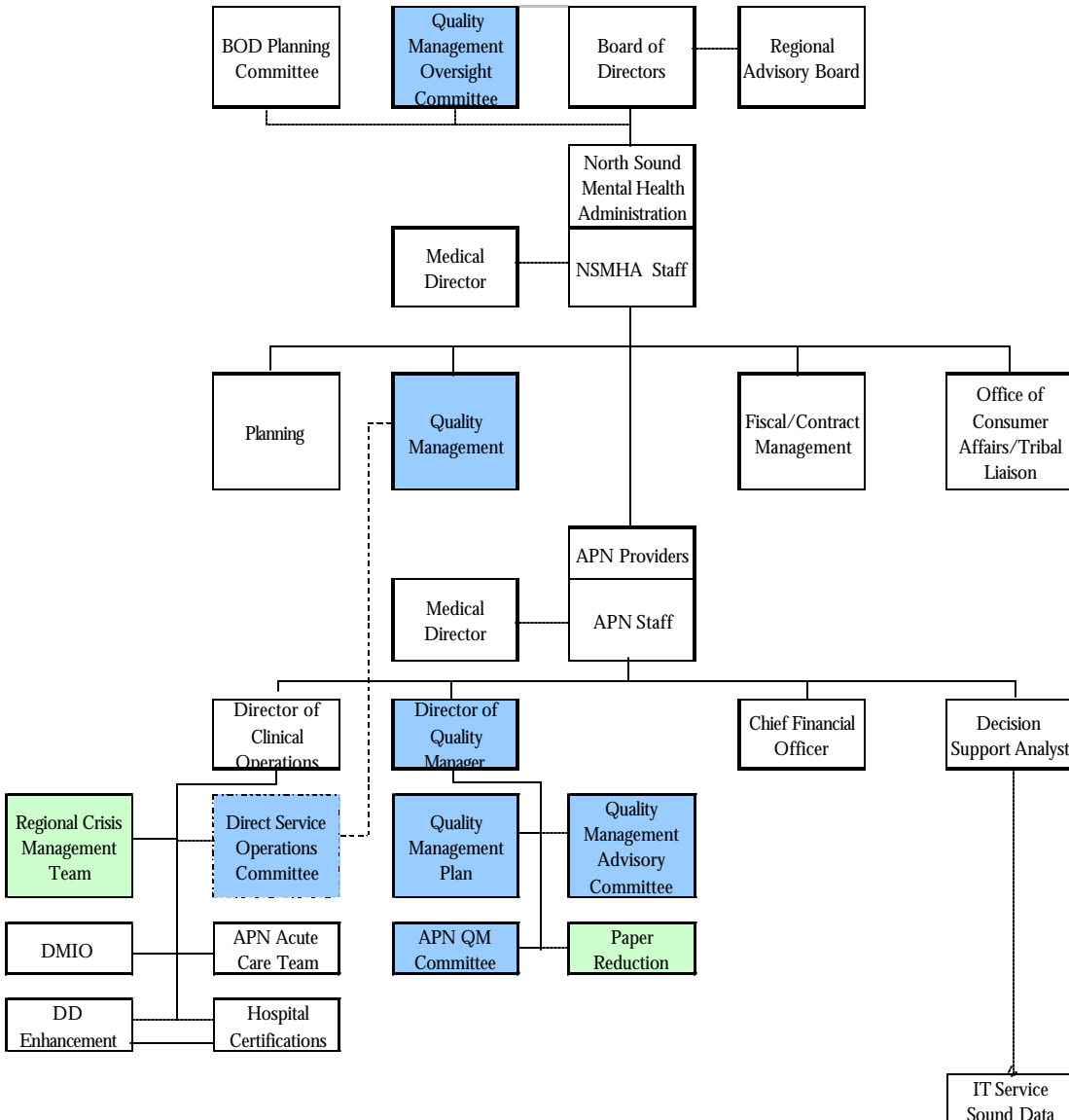
Attachment 7

Oversight Activities

	Accreditation	Quality Review Team			Concurrent Review			Administrative Review			MHD Licensing Review			PHP Certification			
		2000	2001	2002	2000	2001	2002	99-00	2001	2002	2000	2001	2002	2000	2001	2002	
		Attachment															
NSMHA	APN	N	Attachment			n/a	n/a	n/a	-19		-28	n/a	n/a	n/a	n/a	n/a	n/a
	Compass	N	-	-	+	-	-	-	-30		-7	-		-	n/a	n/a	n/a
	Catholic	Y	+	+	+	-	-	+		-11				+	n/a	n/a	n/a
	WCPC	N	+	-	-	-	-	-	-13			-			n/a	n/a	n/a
	bridgeways	N	-	-	+	n/a	+	n/a	-20					+	n/a	n/a	n/a
	LWRTC	N	-	-	+	n/a	n/a	+	-10		-1			+	n/a	n/a	n/a
	CMHS	N	-	-	+		-	-	-33			-		-	n/a	n/a	n/a
	VOA	Y	n/a			n/a	n/a	n/a	-9					+	n/a	n/a	n/a
	SeaMar	Y	+	-	+	n/a	+	+	-24	-5				+	n/a	n/a	n/a
	Sno Cty	N	n/a			n/a	n/a	n/a			-7	+		+	n/a	n/a	n/a
	Tulalip	N	n/a			n/a	n/a	n/a		+	+	n/a	n/a	n/a	n/a	n/a	n/a
	NSMHA	N	Attachment			n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	+		+

Attachment 8

NSMHA/APN Quality Management Structure



Attachment 9

NOTE: Indicates an overlap and confusion to roles and responsibilities
 Indicates a region-wide function