March is a GoToMeeting month for convenience; meeting will also be in conference room.

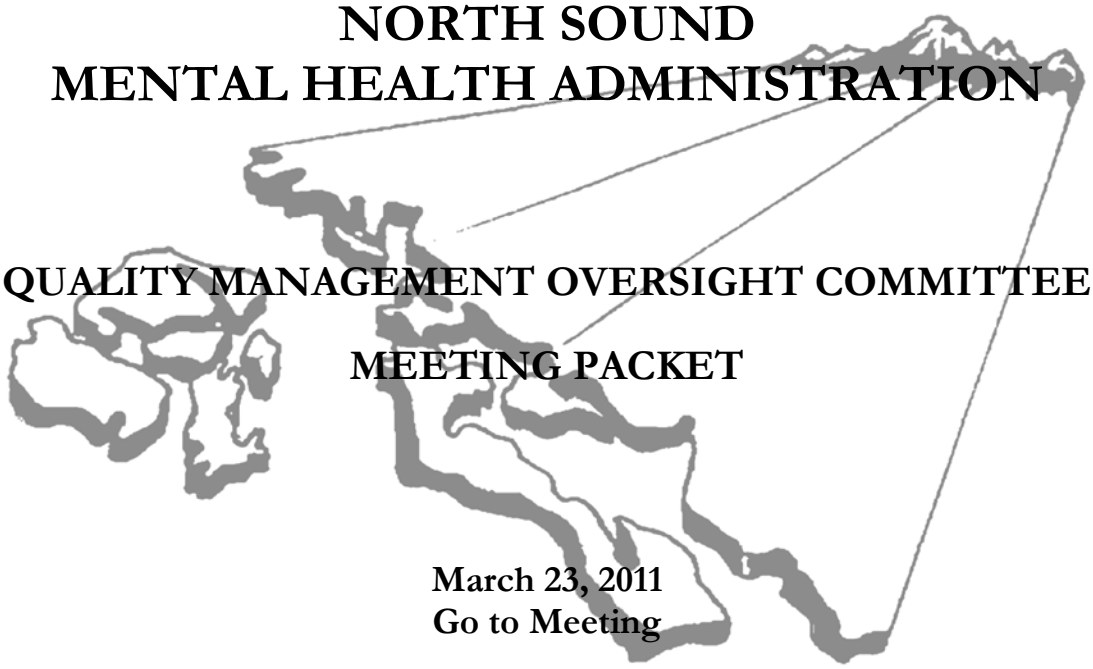
1. Please join my meeting.
https://www3.gotomeeting.com/join/756229526

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

Dial +1 (909) 259-0011
Access Code: 756-229-526
Audio PIN: Shown after joining the meeting

Meeting ID: 756-229-526

NORTH SOUND MENTAL HEALTH ADMINISTRATION



QUALITY MANAGEMENT OVERSIGHT COMMITTEE

MEETING PACKET

March 23, 2011
Go to Meeting

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.**
- **Demonstrate RESPECT and speak with RESPECT toward each other at all times.**
- **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: 01-17-01

NORTH SOUND MENTAL HEALTH ADMINISTRATION
QUALITY MANAGEMENT OVERSIGHT COMMITTEE AGENDA

Date: March 23, 2011 – Go to Meeting **Time: 1:00-3:00 PM**
Location: NSMHA Conference Room
For information Contact Meeting Facilitator: Greg Long, NSMHA, 360-416-7013

Topic	Objective	ACTION NEEDED	Discussion Leader	Handout available pre-mtg	Handout available at mtg	Tab	Time
Introductions	Welcome guests; presenters and new members		Chair				*5 min*
Review and Approval of Agenda	Ensure agenda is complete and accurate; determine if any adjustments to time estimates are needed. Meeting will start and end on time.	Approve Agenda	Chair	Agenda		**1**	*2 min*
Review and Approval of Summary of Previous Meeting	Ensure meeting summary is complete and accurate.	Approve Meeting Summary	Chair	Summary		**2**	*5 min*
Announcements and Updates	Inform QMOC of news, events; Binder Updates, if any; Advisory Board News; Provider One update, if any; ICRS System review; others updates? Quality Management Plan 2010-2013 Update	Inform /discuss	All				*10 min*
Evaluation forms from last meeting, if any	Discuss feedback, if any.		Chair/ Greg				*5 min*
Comments from the Chair			Chair				*3 min*
Using NSMHA Policies Region-Wide	Discuss of how providers can implement utilizing NSMHA Policies and writing implementation guidelines	Discussion	Greg	xxx		**3**	*10 min*
Over Turned Denials due to lack of collateral contacts	Problem solving regarding how to get collateral medical information for assessments recommended for denial.	Discussion	Greg/ Diana	xxx		**4**	*15 min*
Dignity and Respect Workgroup Report and Presentation	Inform/discuss	Discuss/ Educate	Jeannette Anderson				*15 min*
Risk Assessment	Follow-up discussion on better risk assessment of more areas and analysis/summary in the clinical record	Discuss and develop plan of action if needed	Greg	xxx		**5**	*15 min*
Service Level 1 & 2 Monitoring	Follow-up/discussion		Charissa	xxx		**6**	*15min*
Comparisons across RSNs	Follow-up discussion based on request from Advocate		Greg	xxx		**7**	*15 min*
Open Forum	Open for discussion if time is available		Chair				
***Review of Meeting**	Were objectives accomplished? How could this meeting be improved? Eval forms		Chair				10 min
Date and Agenda for Next Meeting	Ensure meeting date, time and agenda are planned						

Next meeting: April 27, 2011 1:00-3:00 PM

<u>Potential Future Agenda Items;</u>

Draft not yet approved

North Sound Mental Health Administration (NSMHA)
Quality Management Oversight Committee (QMOC)
NSMHA Conference Room
February 23, 2011
1:00 – 3:00 pm
MEETING SUMMARY

PRESENT: **Greg Long**, NSMHA; **Charissa Westergard**, NSMHA; **Kay Burbidge**, LWRTC; **Kathy McNaughton,** CCS; **Pat Morris**, VOA; **Susan Ramaglia**, NSMHA Advisory Board; **Pam Benjamin**, WCPC; **Mark McDonald**, NSMHA Advisory Board; **Stacey Alles**, Compass; **Candy Trautman**, NSMHA Advisory Board; **Susan Schoeld**, Snohomish County; **Dan Bilson**, NSMHA Advisory Board; **Richard Sprague**, Interfaith; **Laura Davis**, NSMHA; **Mike Manley**, Sunrise; **Chuck Davis**, ombuds; **Cindy Ainsley**, bridgeways; **Diana Striplin**, NSMHA & **Barbara Jacobson**, recording.

EXCUSED: **Fred Plappert, Joan Lubbe** & **Terry Ann Gallagher,** NSMHA Advisory Board.

ABSENT: **Rebecca Clark**, Skagit County & **David Small**, Sea Mar.

OTHERS PRESENT:

TOPIC	DISCUSSION	ACTION
1. **Introductions, Review of Agenda – Chair**	Anne convened the meeting at 1:05 pm and introductions were made. Greg has an addition under announcements and Dan B. has a topic for the announcements as well. This meeting was to have been an in person meeting, however with the snowy weather it was updated to a Go To Meeting so all could safely attend.	
2. Previous Meeting Summary – Chair	Anne asked for any corrections/amendments to the previous meeting summary; they are approved as submitted.	Summary approved as submitted
3. Announcements and Updates – All	Greg noted that at the last Advisory Board meeting a recommendation to QMOC was made to discuss VOA and the national suicide help line. Susan R. had stated that when she called the number it was forwarded to VOA who is a partner in this system and the phone rang for more than three minutes before anyone answered. Susan R. noted that she has heard from Pat M. at VOA on this already. Pat M. explained that this had been an issue that their IT department had been working on with the main line to try to resolve. It was discovered to be a system glitch in getting the calls transferred to VOA; a routing issue. She stated that the issue has been resolved and she had spoken with Susan R. Dan B. stated that a few meetings ago he had requested information on other RSNs in the State to compare how efficient our RSN is compared to others; and he has yet to receive anything. Greg stated that the best resource for him to look for information would be the yearly External Quality Review Organization (EQRO) audits of RSNs and DBHR; they are an independent auditor.	Informational
4. Evaluation Forms from Last Meeting – Chair	Anne reviewed the forms and noted that two were received and she gave a brief overview.	Informational

5. Comments from the Chair – Anne Deacon	Anne just wanted to say that the snow seems to be subsiding and HI was 50 degrees warmer than here!	Informational
6. Report from Advisory Board	Mark McDonald presented the Advisory Board report.	Informational
7. Services to Level 1 & 2	Greg noted that this is a continuation on this discussion from the last meeting where feedback was requested of providers on the original proposal. NSMHA appreciated all the good feedback and have attached a proposal for discussion based on all the feedback. • Refresher on utilization guidelines. Mike M. asked if there are errors in how people are being evaluated for level. Charissa noted some, but mostly the hours of service prompted us to do the inter-rater reliability training and we will review later to see if it is helping. Level 1 is getting too many hours and level 4 are getting too little. Time will tell if they are appropriately rated or just too much service. • QMOC/other venue discussion. How NSMHA can support providers as they apply limits per the guidelines and how this will impact consumers and how this will be perceived. • Application of limits per utilization guideline. NSMHA has implemented strategy in the routine UR to review these things in the charts chosen prior to the review. Kathy M. would like to see the outcomes of these reviews; some feedback on what is found in chart reviews. Stacey A. would like a review of the UR guidelines themselves; are they realistic, and are the services attached to Level 1-2 appropriate. Such as stabilize in five sessions or less and Level 1 receiving med management when they come into services. Greg noted that these guidelines came from the clinical redesign in 06-07; based on projections on needs and amount of available funding. We have to serve this entire population so how do we allocate those dollars. • Agencies utilizing most effective strategies for assisting consumers. Focus on EBPs; Stacey A. noted that agencies need to be more efficient and perhaps NSMHA could provide more training to provide more efficient services. Greg noted that we don't have much funding for training but he would like feedback on what agencies would suggest. He noted that Compass is providing training in motivational interviewing in mental health settings on March 9-10. This is a SAMHSA program and it encourages a different way of interacting with clients to motivate them to change and move to recovery more rapidly. Greg will send out the link to the SAMHSA PowerPoint about this. • NSMHA review of policies. NSMHA will begin a review of policies to remove barriers to discharge and also what policies providers think put up barriers. • Shorter authorization periods. Greg noted that he took the feedback from the last QMOC meeting to the Leadership Team and this proposal came from that. Mike M. asked if NSMHA had done any study on the fiscal impact of overutilization and if this proposal with its increased workload would save financially. Greg noted that that was identified as somewhat of a problem and as it is one we can impact we	Informational

	are going this route. The pressure to be more efficient is only going to increase with decreased funding. Pam B. stated that clients getting the letter with the shorter authorization period and providers outlining what kind of services they can expect will help. Dan B. stated that we also need to ensure that level 4 consumers are looked at as well, since they are currently underserved. • Process proposals. There are options listed here for discussion to choose what will work best if NSMHA generates the report monthly. Providers agree that the second bullet with supervisors certifying has them overseeing this and helping clinician in discharge planning. They agree that getting the report on the 10th of the month prior to auth period expiration. Kathy M. noted that she will run these ideas past her supervision staff and return the feedback to NSMHA. Ann asks for any additional feedback and Stacey A. asked about the extra review being done on the B diagnosis on Axis 1 and the order they are entered in Raintree. Charissa noted the order they get entered in Raintree is important, any other ideas for criteria would be great. Stacey stated that perhaps if the B diagnosis is the only qualifying diagnosis they go on list and if they have only an A diagnosis we would exclude. Charissa will look at this and see what kind of impact this would make and report back. Greg noted that we want any feedback within the next 2 weeks on policies with barriers and it looks like we have agreement on the process; we will clarify criteria and then we will write up procedure and do a policy or an MOU. Charissa can have this done within the next month.	
8. Exhibit N Report	Diana noted she will give a brief overview of the report. This is for the period of April – September of 2010 and she noted the changes happening in the region. We no longer collect overall complaint data and the Leadership Team now reviews the report as well and makes recommendations. We collect the minimum data sets required by DBHR. She noted that inpatient denials have gone up over time and there was discussion around this.	Informational
9. Expedited Intake Criteria	Greg noted that for several meetings there has been discussion with providers on their concern around the increase in expedited referrals. He noted that if providers go to a rapid access model this could cease to be a problem, though it could be awhile before agencies are able to implement. NSMHA gave a proposal and asked providers for input on how VOA can screen what criteria they use. Stacey A. expressed concern over consumers receiving the expedited appointment expecting to get med management on their first appointment which does not happen. Charissa will address this. Pat noted that their screeners are clear that the med management would not take place at this appointment. Stacey also wanted to have a process in place for the consumer at risk of hospitalization that has the screeners asking about natural supports and other things that may make the client able to wait for the urgent or regular appointment. Pat stated that they do this as well; they factor in if they have strong supports of family and community to help them. Susan R. noted that family members are not caregivers for those that are decompensating and to also consider consumer history when deciding on expedited or not. Pat stated that VOA knows of this concern and the consumer may be able to go urgent instead of expedited. Charissa stated that they can consider if the behavior is	Informational

	baseline or new behavior showing decompensation in their decision making. Stacey also noted the issue of the consumer being offered the expedited and when their scheduler calls they are not available within the three days. Pat noted that they do ask those questions, though the story can change. If the consumer states they don't need the three day we give them their options. Greg asked if Pat will write up the final draft of their procedures from this discussion and Greg will send out to all for feedback.	
10. Risk Assessment	Greg states this topic is from our QS staff about concerns around CI and grievances as it is not clear how serious the risks presented by the consumer were. NSMHA is concerned about the liability for all as most risk is assessed with the current and historic check boxes. There are a lot of other risks that should be considered; the check boxes are marked but there is no summation of how critical the risks are. Greg would like QM departments of providers to review these issues and report back to QMOC any recommendations for improvement from their Quality Management and Risk Management Committees.	Informational
11. IOP & Residential Focused Review Outcomes	Laura noted the focused review she did in 2010; this was the first year for focused reviews so this was the starting point. She gave a brief overview of the report from the reviews. Those that got below 80% will be reviewed again starting in June. For the IOP review, all did well in giving good medication management and getting the correct Locus level client into the program. Crisis planning was below expectations across providers and also weakness seen in addressing drug and alcohol issues. The residential reviews showed medication management was good, crisis planning was found to be weak and areas were found that need to be addressed around providing treatment and planning for treatment and helping clients' rehabilitate and move to lesser care. Starting in June we will revisit the programs and review where they were below 80%; and at that time if still below they may face corrective action. In 2012 when we do reviews we will expect the 90% benchmark to be reached. Laura asked for feedback on the report and Kay B. asked about the data on boarding homes and Laura will call Kay to discuss her agency. She notes that some of the N/A answers can make the data seem skewed but this is being considered as we do no corrective action this year and look at this again. Greg noted the concern that it appears there is not a lot of mental health treatment happening for residential clients. The charts show they are getting med management and daily activity charting but not actual mental health treatment. If the client is a Level 5 and is therefore in residential treatment they should receive some sort of mental health treatment. Stacey noted she has retrained around documenting interventions so that it is clear in the record. Laura noted this could be a documentation issue and thanked Compass for already addressing this. Susan R notes that she was told Haven House is a boarding home not residential when she asked about treatment. Greg stated in either boarding homes or residential treatment there should be mental health services provided. Mental health treatment should happen for all the facilities listed, though what the treatment is will vary by person, and documentation needs to clearly articulate this.	Informational

12. Open Forum	Future agenda items. Stacey would like the packets distributed at least a week early as there is not enough lead time to review prior to meeting. Greg noted this and will work towards this. Greg noted that we want to evaluate each meeting going forward. Mike M. noted this meeting was better than the last go to meeting; not as much cutting out and distortion. Greg will check with IT about these issues.	
13. Date and Agenda for Next Meeting/ Review of Meeting	The meeting was adjourned at 2:50 pm. The next meeting is March 23, 2011 – Go to Meeting.	

NSMHA COMMITTEE DISCUSSION FORM

AGENDA ITEM: Using NSMHA Policies Region-wide

PRESENTER: Greg Long

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

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:
NSMHA has gotten agreement from DBHR that providers may use our policies as their policies. See and retain attached handout for confirmation of DBHR's agreement. If necessary, they can write "Implementation Procedures" to clarify for staff how the policies will be implemented within their particular agencies. Implementation Procedures can not contradict the basic NSMHA Policies.

NSMHA has received no further comments from providers on which of our proposed master list of policies would apply to them.

CONCLUSIONS/RECOMMENDATIONS:
NSMHA will develop a policy on this process and circulate it for review.

TIMELINES: Policy will be circulated in the next month.

ATTACHMENTS: Email chain to Pete Marburger

Documentation of DBHR's Agreement to allow Providers in the North Sound Region use NSMHA Policies

3/10/2011

Pete,
Thanks for your response. I think you covered the points in my proposal well.

I'm not sure why you had difficulty opening my previous attachment. I thought it was a word document in which I pasted in my e-mail. I am forwarding it to you as a clear word document, but in summary including most of my proposal.

Let me know if you have any problems with what I am proposing. I will have you put on our mailing list for all draft policies.
Greg

From: Marburger, Pete (DSHS/HRSA/DBHR) [mailto:MARBUPH@dshs.wa.gov]
Sent: Thursday, February 24, 2011 10:29 AM
To: Greg C. Long
Cc: Roberts, Victoria (DSHS/HRSA/DBHR); Sarno, Mary (DSHS/HRSA/DBHR)
Subject: FW: Policy Change Confirmation
Importance: High

Greetings Greg:
I am unable to open the attached document on my computer. I do not have a confirmation e-mail of NSRSN proposal to use regional policy as bases for CMHA providers' policies.

I do recall our conversation of mutually agreeing with this concept. We also agreed that NSRSN would send me a copy of polices as they went out to the RSN provider network for their review. We mutually agreed to this due to RSNs writing policies based on the RSN contract with DBHR however providers (CMHA) policies for licensure and certification must be based on the Mental Health WAC. To prevent this potential and likely disconnect I would receive the RSN draft policy at the same time as the providers. My comments would be strictly related to WAC concerns. You thought this would be very doable. The turnaround on any RSN policy review was given as 30 days. This would provide the L&C Unit sufficient time to provide comments.

We also agreed that the CMHA will have the latitude to fit/adjust the overall RSN policy to their specific population and services. A current core element of CMHA policy is that the WAC standards are implemented to fit the specific agency organizational structure, staffing and operations.

Without the benefit of being able to read the RSN proposal I am reluctant to express agreement with the written proposal.

Peter M

From: Greg C. Long [mailto:greg_long@nsmha.org]
Sent: Tuesday, February 22, 2011 4:54 PM
To: Marburger, Pete (DSHS/HRSA/DBHR)
Subject: Policy Change Confirmation

Pete,
I thought I had e-mailed you a confirmation of our phone approval of the North Sound Region's proposal to use our Regional Policies as the basic mental health policies that the CMHA providers would comply with.

I can't find the original e-mail I sent, but maybe you have it. I kept an electronic version of it for our records. Our providers asked for a copy of it so I figured I had better e-mail it to you as well.

Let me know if I have not accurately confirmed our understanding.
Greg

From: "Greg C. Long" <greg_long@nsmha.org>
Date: December 13, 2010 10:45:10 AM PST
To: Pete Marburger MARBUPH@dshs.wa.gov
Subject: Confirmation of North Sound Region's change in Policy Development and Management

Pete,

I am writing this e-mail to confirm our phone conversation regarding NSMHA's proposed change in how policies are developed and managed in the Region by the North Sound Mental Health Administration and our providers.

Our proposal is that Regional Policies will be developed by NSMHA in conjunction with our providers. Providers will then be expected to comply with these NSMHA Regional Policies. NSMHA policies will be designed to meet all Federal and State laws, WACs and mental health contract requirements.

Providers can develop additional Implementation Procedures to fit their specific agency needs when necessary. Providers may also develop additional policies to meet their organizational needs.

In our conversation, you cautioned me that the policies must comply with RCWs, WACs and Contracts. NSMHA and our providers are aware of this obligation and we always are aiming to be in compliance with these laws and regulations.

Thanks to you and Victoria Roberts for your review of our proposal. We believe this will work well when DBHR does their reviews.

Greg Long

NSMHA COMMITTEE DISCUSSION FORM

AGENDA ITEM: Over Turned Denials due to lack of collateral information
PRESENTER: Greg Long

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

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:
NSMHA is concerned that one of the reasons NSMHA staff frequently overturn recommended denials is there is a lack of collateral information. Most frequently, there is evidence of psychiatric medications being prescribed and there is no explanation in the denial information of the severity of symptoms that lead the current prescriber to give the medications. This currently leads to people being authorized for a year of service when the severity of their problems is unknown or undocumented.

The short timeline for getting people with complex mental health and medical issues into treatment contributes to this dilemma. If providers go to an open access model, then their staff would have additional time to obtain collateral information before they have to request the authorization for services. Providers can request a 14 day extension to collect the collateral information. NSMHA could give a 30 or 60 day authorization to complete the assessment.

CONCLUSIONS/RECOMMENDATIONS:

TIMELINES:

ATTACHMENTS:

NSMHA COMMITTEE DISCUSSION FORM

AGENDA ITEM: Improving Risk Assessments

PRESENTER: Greg Long

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

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:
At the last QMOC Meeting, NSMHA presented the concern that risk assessments were very limited in clinical records. Typically, most provider risk assessments focus on just suicide, homicide, and violence risk. Risks are usually just checked off in boxes for current risk and historical risk. There are many other types of risk besides these three.

A second concern was there tends to be little or no analysis or summary of the risks. Hence, it is frequently difficult to know from the records the severity of the risk.

NSMHA asked that providers take these concerns back to their provider Quality Management and Risk Management Committees for review and recommendation.

This discussion is follow-up on that request and QMOC will hearing agency recommendations.

CONCLUSIONS/RECOMMENDATIONS:

TIMELINES:

ATTACHMENTS: None

NSMHA COMMITTEE DISCUSSION FORM

AGENDA ITEM: Managing Services to Individuals in Levels of Care 1 & 2

PRESENTER: Charissa Westergard

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

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:
Given funding reductions, NSMHA has been considering ways to manage service utilization in different ways. We have identified one area where we think we can have an impact and that is in the provision of services to individuals in Levels of Care 1 and 2. Presumably individuals in these levels of care have fewer/less severe needs to address and, for some, may be able to get their needs met with a shorter length of stay and within suggested service hours for the specified level of care (LOC).

This is a follow up to one of the previously identified strategies (alternate process for some LOC 1 & 2 reauthorization requests) to manage services to LOC 1 & 2. The identified alternate process is for NSMHA to generate a report of individuals in LOC 1 & 2 that meet specific criteria. This report will be given to providers who will then review the charts and certify which individuals meet medical necessity for continued services.

The previously identified criteria of individuals with a "B" diagnosis as their primary diagnosis was identified as possibly being problematic (i.e., clinicians may not list diagnoses in order of primary, secondary, etc). NSMHA looked at data again to determine how many individuals in LOC 1 & 2 have only a "B" diagnosis/do not have an "A" diagnosis. These criteria accounted for approximately 8% of reauthorizations for adults (app. 18/month region wide) and approximately 12% for children/youth (app. 28/month region wide).

Additional impact could be made by adding an additional category of LOC 1 & 2 for review. The criteria identified below would add an additional 5% (app. 11/month region wide) of reauthorization requests:

- Current LOC 1 ***OR***
- Current LOC 2 that was LOC 2 in previous authorization period
  AND
- No Inpatient, Crisis Services, Jail Services since the last authorization period **AND**
- Current treatment episode open less than two years

CONCLUSIONS/RECOMMENDATIONS: Recommend implementing process

TIMELINES: Request conclusion at this QMOC

ATTACHMENTS: None

NSMHA COMMITTEE DISCUSSION FORM

AGENDA ITEM: EQRO Recommendations to RSNs

PRESENTER: Greg Long

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

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:

The follow recommendations were made by the EQRO to DBHR in 2010 for improvement in services after their reviews of all the RSNs. The full report was sent out under separate cover to QMOC on several occasions. There is no mention of the drastic budget deficits or past and probable future funding reductions.

• ***DBHR needs to work with the RSNs to ensure an adequate number of certified mental health specialists to provide consultations for enrollees in special populations, or revise the mental health specialist certification requirements.***

–RSNs and providers have requested that DBHR change these expectations for several years. DBHR has not taken action.

• ***DBHR needs to work with the RSNs to build capacity for services delivered by minority-specific providers who are bilingual and/or bicultural.***

–NSMHA contracts with Seamar to assure culturally competent services for the Hispanic community. The Cross-Cultural Counseling Center at Compass in Everett has closed due to funding reductions.

• ***DBHR needs to work with the RSNs and community mental health agencies to provide adequate community based services as an alternative to acute care for children in the RSN system.***

-NSMHA has put much funding and effort into developing Wrap-Around Services in four counties. NSMHA started and ended the short-term, high-intensity treatment program due to lack of funding.

• ***DBHR needs to encourage RSNs to develop resources for transition-age youth.***

• ***DBHR needs to coordinate with other state agencies and geriatric facilities to ensure that enrollees discharged from the State Hospital and community hospitals receive long term care.***

-NSMHA meets regularly with Home and Community Services and the Area Agency on Aging. NSMHA was paying nearly $500,000/yr for adult family home or in-home services. Funding reductions are now causing NSMHA to limit this and putting stress on our relationship with these two agencies.

• ***DBHR needs to facilitate discussion between the RSNs and QRTs to determine how to incorporate QRT input into the RSN delivery system.***
-The QRT function has been taken out of NSMHA's contract. The Federal Government now requires the State to do consumer satisfaction studies independently of QRT. NSMHA is proposing to the State that it no longer expect Ombuds to carry out the QRT function.

• ***DBHR needs to work with the RSNs to ensure that RSN advisory boards represent all enrollees and, as needed, represent allied agencies.***
–NSMHA has an Advisory Board.

• ***DBHR needs to work with the RSNs and the Healthy Options MCOs to improve collaboration and ensure that Medicaid enrollees receive mental health care in the least restrictive environment.***

• ***DBHR is encouraged to identify creative solutions, such as cross-system funding, to ensure the availability of supported employment programs and peer-run services.***
-NSMHA has set up two fidelity supported employment programs. NSMHA continues to urge providers to use cross-system funding including DVR funding to provide employment services to people with mental illnesses. NSMHA currently funds three peer centers and is trying to be as creative as possible in continuing funding for them. NSMHA is also requiring peer counselors in its re-designed crisis centers in Snohomish and Skagit Counties and in the new Mobile Outreach Teams.

• ***DBHR needs to work with RSNs to ensure timely assessment of enrollees' skills, strengths, and needs.***
-NSMHA has stressed focusing on recovery and resiliency which includes building upon enrollees' skills, strengths, and needs.

• ***DBHR needs to work with the RSNs to maintain a continuum of community-based services and alternatives to acute care to ensure that enrollees are served in the least restrictive environment.***

CONCLUSIONS/RECOMMENDATIONS:
These proposals make sense and RSNs would like to do many of them. The current funding realities are making these more difficult to accomplish than ever.

TIMELINES:

ATTACHMENTS: None