

EXECUTIVE SUMMARY

CUMBERLAND COUNTY

MH/DD/SAS

April 1, 2003

Cumberland Area MH/DD/SA Authority
Updated Strategic Plan for the Local Business Plan

EXECUTIVE SUMMARY: All Sections

The Cumberland Area Mental Health, Developmental Disabilities and Substance Abuse Authority (Area Authority) has provided services to the citizens Cumberland County since the 1960s. The program has operated as a single county area program and the wishes of our County Management are that we continue to do this under the new mental health reform. Historically the area program has provided and/or facilitated access to a wide array of services. Although our funding from the State and County have been limited, through grants, partnerships with other human services agencies and revenue generation, we have developed a fairly comprehensive array of treatment, rehabilitation, education and prevention services for children and adults that have allowed our consumers to be served in their home communities the majority of the time. Many of the guiding principles of the Area Authority are the same as those of the reform bill, with the primary difference being that the Area Authority may no longer be a primary provider of services. Instead, in response to House Bill 381 and the State Plan as developed by the Division of MH/DD/SAS, the Area Authority will become a Local Management Entity. In order to provide services to consumers and families, it will be necessary to develop a larger and more comprehensive qualified provider network.

Another change will be developing more natural supports for individuals who no longer will qualify for services using public monies. Historically funds over earned in one area could be used to develop other medically necessary and clinically appropriate services for consumers. Under the State Plan, as well as the Integrated Payment and Reporting System (IPRS), an individual must qualify in a target population in order to receive services using State or Medicaid monies. Also, services must be a part of the benefit package as defined by the State. This plan will cause some services that were developed based on community needs to no longer be available unless alternative funding can be found. (One critical example is a comprehensive array of services to adult sex offenders. The majority of these individuals do not meet the diagnostic criteria for Severely and Persistently Mentally Ill (SPMI) or Severely Mentally Ill (SMI) and as a result, can no longer receive services with public monies).

There have been partnerships between human services agencies and many community, faith based and non-profit organizations in our County for quite some time. The Department of Social Services, Juvenile Justice and the Mental Health Center have partnered for over 20 years to ensure an array of services are available to children and youth and their families. Through this partnership, we were able to develop a continuum of services for non-Willie M. children before the eligibility criteria was changed to allow other seriously emotionally disturbed children to qualify for services. We have had staff in the courthouse to facilitate access to services for those needing DWI services. Our Treatment Alternatives to Street Crimes (TASC) program is housed in the Community Corrections Center and substance abuse staff working with DSS families are located at DSS. The Community Foundation and the Florence Rogers Trust have funded summer

programs for children and adolescents, and other groups, such as the Fayetteville Metropolitan Golf Association and God's Outreach Ministries have provided funds and opportunities for enrichment activities.

Our Agency has long emphasized the importance of families and consumer choice in service delivery. We have worked hard to serve individuals in the community whenever possible in the least restrictive but most clinically appropriate setting. As a result, our County is a low utilizer of State institutions for all disability areas. It is recognized that there are many facets to true person centered planning and we will strive to learn from the consumers and family members how better to allow them to be in charge of their lives. In some areas it is known that what a person or his/her family wants is not going to be considered Best Practices. When these situations occur, the goal will be to ensure that there is a win-win situation.

Because there are so many different funding sources for our Area Program, there has been an emphasis on outcomes, both for the consumers and families as well as the System, for many years. There also has been a review and authorization process to ensure services were medically necessary, least restrictive and in compliance with accepted levels of care for different ages and disabilities. Because of the review process, the length of stay in intensive services is decreasing while not compromising goals for the consumer and family. Our planning process will build on these successes as the public behavioral health system moves into an outcomes mode with other providers currently in our community, though most are serving consumers from other catchment areas. There have been some stressors between the Area Authority and some providers because their standards are not comparable to those implemented by the Area Authority. The State Plan has fostered better communication between existing providers and the Area Authority as they participate as full partners in the implementation of mental health reform. The same providers that historically expressed concerns about standards being too high are now developing partnerships with other providers and developing protocols, similar to those of the Area Authority, that will embrace Best Practices, demonstrate efficiency and effectiveness as well as allow reporting of data for performance indicators. Many of these providers have never reported nor tracked outcomes for consumers. Now they realize the importance of this and have started some data management activities. This will certainly enhance the availability of quality choices for consumers and families.

The State Plan mandates that the Local Management Entity (LME) provide or facilitate access to core services. We are working to modify our system to allow this to occur. The State has three phases for implementation of the State Plan. The first phase will begin in 2003 and Phase III will begin in 2004, with full implementation for all aspects of mental health reform by July 1, 2007. Our County and Area Authority have requested and been approved to be a Phase III program, which begins July 1, 2004 with completion by July 1, 2007. Our community partners support Phase III implementation to allow the community to develop more supports and services to non-target populations, enhance person centered planning skills, assist providers in being able to meet performance indicators outlined in the Plan and to learn from Phase I and II programs as they have divested themselves of services and become a management entity.

Individuals representative of the populations in the catchment area have worked jointly with staff in developing the strategic plan. This is an evolving document representative of the combined efforts of all concerned parties. Major areas of emphasis include the creation of a mechanism to gather consumer and family input, enhancing data reporting, promoting a qualified provider network that matches our community, the divestiture of services and provision of services during the implementation process.

The Local Business Plan (LBP) is an outline comprised of ten sections that identify the transition requirements that we must address as the Area Authority moves toward becoming the LME. This Plan currently contains sections: I. Planning, III. Qualified Provider Network Development, VI. Service Monitoring and Oversight, VII. Evaluation and X. Collaboration, were submitted to the State January 1, 2003. We have received a verbal approval of those sections, with some modifications being recommended.

Sections II. Governance, Management & Administration, IV. Service Management, V. Access to Care, VIII. Financial Management & Accountability and IX. Information Systems & Data Management are submitted April 1, 2003.

This Local Business Plan is an outline of how the Area Authority will move forward with implementation. It is a strategic plan and as such will be undergoing changes constantly as our community changes in response to reform. Input and changes will be ongoing as we move forward in the process of complying with the State Reform Plan. We continue to solicit input and involvement from consumers, family members, citizens, stakeholders and staff as we work to establish an efficient and effective community based system of mental health, developmental disabilities and substance abuse services.

I. PLANNING

The Planning section of the Strategic Plan submitted by the Area Authority describes the process that will be utilized to address the needs of the community. This process will address the needs identified for the service array for those meeting target population criteria well as those individuals who will be considered “non-target population” for state and Medicaid funds. The Planning process will further outline the strategies and collaborative relationships that will need to be developed as the Area Authority changes from a service provider in many areas to management entity and provider of only designated services when no other qualified providers exist and/or to ensure there is a safety net for consumers.

The Planning Committee has been meeting with the Collaboration Committee since August 2002. There has been a broad representation from the community in this group with each individual playing an active and vital role in determining directions for the LME and the community. There has been a very active subcommittee working on

identifying and consolidating resources for all individuals, particularly those who will fall outside of the covered population for services. There have also been attempts to blend efforts of the Planning and Collaboration Committees with activities undertaken by the Area Authority as part of their COA Reaccreditation. Both groups have worked on reviewing the mission, vision, core values and guiding principles of not just Cumberland County Area Authority but also those of other programs.

The following outlines some of the tasks that have been addressed and others that will be a focus for the future.

1. Adopt a mission statement for the LME that will blend information from the State Plan with that of the Area Authority and other stakeholders.
2. Complete a needs assessment that will focus on strengths and weaknesses of the entire service delivery system for our community, focusing particularly on those areas that are outlined in the State Plan array of services. Review information from providers and other stakeholders as well as other community initiatives to blend LME planning efforts with those in the community in order to avoid duplication of efforts as much as possible.
3. Establish a Consumer Family Advisory Committee (CFAC) that is representative of adult and child consumers and the three disability areas. Attempts will be made to also match the demographics of the community whenever possible.
- 4 Identify strategies to increase involvement of CFAC members and other stakeholders in the overall planning process, consistent with the State Plan.
- 5 Develop a strategic plan for the 1st, 2nd and 3rd years to ensure full operation as an LME by July 2007.
6. Complete training for key stakeholders and continue community education on a regular basis, with the frequency being determined by the Planning Committee and other relevant stakeholders.

Review of the Planning information will demonstrate that strides have been made in many of these areas already, particularly relative to training and education of the community. Public forums have been held as well as individualized trainings for target groups, focusing on their issues and concerns (Fayetteville United, District Court Judges, Cumberland County Providers' Association, Community Collaborative, County Management staff to name some of the specialized trainings held.) We will continue work on the Needs Assessment and Community Profile and refine ways to interpret data to build on the strengths of the entire community.

II. GOVERNANCE, MANAGEMENT & ADMINISTRATION

This section focuses on the Area Board composition, governing structure for the public behavioral health system in the community, demographic composition of the catchment area, policy formulation, consumer involvement, etc. This section further details the relationship between the Area Authority and the County as well as looks into possibilities for consolidation, collaboration and partnerships with surrounding area programs to meet the needs of consumers and their families.

The State Plan mandates that a certain population exist within an area in order for the area to continue operating under its current structure, as either a single county program or a multi-county program or that a program cover a minimum of five counties.. For those areas that do not meet the population threshold there is a mandate to consider consolidation with other programs. For Cumberland County, the population exceeds 300,000, which exceeds the minimum requirements for an area program to continue its current governance structure. The Board of County Commissioners and the Area Board expressed their desire to continue to operate as an area authority with the catchment area being Cumberland County. This has been approved by the Secretary of Health and Human Services. Our plan does note that we will look at economies of scale and enhancement of services to consumers, which could include additional partnering possibilities with Lee-Harnett Mental Health Center in service delivery. Other opportunities will arise as we look at how to ensure accessibility and availability of services to consumers who reside at the county line and in which services from another county may in fact be more accessible to them than traveling into Cumberland County.

The Area Authority will have to change its organizational structure in order to assume the duties of an LME. A tentative organizational chart is being considered that includes the Area Director and the following areas: Financial/Operations Management, Access and Service Operations, Management and Program Support, Network Management, Clinical Services and Management Information Systems. It will be critical to allow time to facilitate a smooth transition for the consumers and family members from the Area Authority as a primary service provider to seeing the Area Authority as primarily a management entity entrusted with developing, monitoring and maintaining a network of qualified providers. This entire process will include significant involvement from consumers, family members, advocates, community agencies and providers.

III. QUALIFIED PROVIDER NETWORK DEVELOPMENT

Providers attending meetings have identified significant training, policy/procedure development and implementation deficits within our community. Other providers, who have been aware of the importance of managing services, complying with medical necessity and level of care criteria, data management and reporting, satisfaction surveys, outcomes and best practices are serving as leaders within the existing provider community to facilitate as many as possible meeting the standards

for inclusion in a qualified provider network. Although the State Plan and legislation dictate how certain things need to be done, there are still those providers who insist that they can maintain their status quo, regardless of whether the consumers being served meet target population criteria and regardless of whether the services being provided are part of the service array defined by the State. We will continue to work with the providers collectively, using provider to provider mentoring when possible, to enhance our overall pool of resources. Our community is committed to having a truly “Qualified” provider network that embraces person centered planning and values the involvement of consumers and family members at all stages.

The Area Authority has been working on identifying individuals currently in service that may fall out of the target population definitions in the future. Subcommittees have been analyzing data and again focusing on how to meet the needs of those who need some support and services, but for whom public monies can only fund very brief interventions. The Planning and Collaboration Committees have worked diligently with the community to identify resources available and those that can be developed. This information will be factored into the development of the comprehensive service array for the community.

The Provider Network Committee has solicited feedback from public and private providers as we are developing the Qualified Provider Network Development Plan. The LBP Committees have identified needs and gaps in services, not just for behavioral health but in other areas that impact on a person being able to live successfully in his/her community and to achieve the highest quality of life possible. We will be analyzing the trends and priorities as identified by various groups. Any area identified as a need or gap is considered a priority but the stakeholders understand the need to focus on all ages and disabilities in order to have a total plan. As other areas are identified, they will be added to the list and analyzed by community partners.

Another subcommittee has been addressing training and technical assistance that will be needed by providers from the LME. This group is composed of providers across age and disability areas and is representative of the demographics of the community. They are proposing quarterly meetings and trainings with other information being disseminated in writing, on the web and through monthly consultations.

The Provider Network Development has proposed policies on use of independent practitioners, consumer choice, and assurance of service array and divestiture of services. These will be presented to the Area Board for approval and procedures for implementation will be created where appropriate.

IV. SERVICE MANAGEMENT

This Committee has been combined with the Evaluation Committee of the Local Business Plan process. This section outlines many of the duties and responsibilities of the LME from a quality improvement and quality management perspective. Our

strategic plan outlines how Cumberland County LME will manage services, supports and treatments, particularly as it relates to ensuring that the appropriate level and intensity of services is provided to the right individual, in compliance with state standards. The LME will be responsible for managing the use of state hospitals and facilities in addition to developing an internal utilization management system that covers all services. The LME will be responsible for provision of or facilitating access to Core Services, which includes screening, assessment and referral, service coordination, emergency services, consultation, education and prevention services. Collaboration is occurring with the hospital in development of a comprehensive emergency / crisis services component for the community. This section will also address service authorization, oversight of the service delivery system to target populations and all aspects of compliance to best practice models. Included here will be provisions to ensure consumer choice, appropriate care management and service coordination, case management, protocols for consumers re: their right to grievance and appeals and mandates to facilitate smooth transitions from one service or provider to another. Our plan also addresses the need for a safety net for consumers should there be a circumstance in which they are abandoned by a provider for some reason. The Area Program currently has a system in place to monitor and manage services to Medicaid eligible consumers. The existing system is being enhanced to manage all state funded services as we transition to the Integrated Payment Reporting System (IPRS).

V. ACCESS TO CARE

The Area Authority has already started to modify its existing access to care system based on feedback from consumers, family members and other stakeholders. It has been determined that all disabilities need to be assessed by staff qualified in all disability areas. Persons have identified frustrations with having to go to a disability specific section for assessment and eligibility determination because of the way the Agency is currently structured. As we implement these changes to access, we will also focus on the elements identified in the State Plan. It will be critical that persons obtain services in a timely, efficient and consumer/family friendly manner. Points of entry into the system will also be increased based on needs and desires stated by stakeholders. Significant coordination will need to occur if there are multiple access points, particularly with those outside of the Area Authority to ensure that there is consistency in eligibility determination, timely access and reporting of data and availability of sufficient crisis stabilization services. This section addresses consumer choice as well as cultural and accessibility barriers to care.

VI. SERVICE MONITORING & OVERSIGHT: QUALITY MANAGEMENT

The entire quality management section of the Local Business Plan process matches up well with many of the components of the Continuous Quality Improvement standards

for COA. There is a mandate to report and analyze performance indicators, not just for the LME but for the provider network. There must be report cards available to consumers and family members as they are making choices about the service provider to select. There must be a commitment to quality and best practices. The quality management system must include monitoring protocols for risk management and health and safety issues including incident and death reporting, consumer safety, the use of restrictive interventions, privileging and credentialing of staff, training involving identified staff core competencies, consumer satisfaction, a comprehensive and effective client rights program and a grievance complaint process. Many of these protocols currently exist within the area program policies and procedures. However, it has been seen that many providers do not adhere to the standards nor do they have the data to report. It is also seen that within the area program, some areas are stronger than others in analysis and reporting of data. It will be critical that our overall service monitoring protocols address each of these areas.

The Area Authority has drafted a policy that states there will be compliance to best practices as identified by the State. Various disability groups have already been reviewing information on proposed best practice models and comparing these to adopted practices within the current service delivery system. Within child mental health, benchmarks established for the implementation of the System of Care have been exceeded. These same principals will be globally instituted where appropriate to ensure our total service delivery system operates as a system of care.

This section also describes the reporting requirements of the LME for federal and state data. In all four areas identified in the business plan-NC-TOPPS- (Treatment Outcomes and Program Performance System),SAMSHA (Substance Abuse and Mental Health Services Administration), CSAP (Center for Substance Abuse Policy), and Developmental Disabilities Wait List Database, the Area Authority has demonstrated or is currently providing this information to the State as required. As we become an LME, the commitment to meeting all reporting requirements mandated by state and federal regulations, will continue.

VII. EVALUATION

The Evaluation Committee has been meeting with the Service Management Committee of the Business Plan. The Evaluation Manager for the Partnership for Children is chairing a subcommittee to develop a comprehensive evaluation program for the LME and the community as it relates to behavioral health services. Meetings are occurring with the CFAC, inviting other consumers and family members to attend, to obtain their views on how to evaluate the system. Separate meetings are occurring with providers and the LME. All groups will be brought together as appropriate. Components of the evaluation plan will include, but not be limited to access to care, quality of care, consumer outcomes, emergency and crisis services,

satisfaction with services, service coordination, referral services, quality improvement and quality management, cultural competency, provider services and respite services, consumer rights, grievances and complain processes, person centered planning protocols and compliance to best practices.

Many of the generic standards for COA reaccreditation focus on evaluation of services not just from a person specific basis but also from a systems perspective. It will be critical as we become an LME that evaluation protocols remain strong. Cumberland Area Authority will be well poised to meet the requirements of another accrediting body, should one be mandated by the State, due to the COA process. Self evaluation is critical and the process will be expanded to our other stakeholders. Providers participating in the process are committed to evaluating themselves in order to report information to the LME and meet monitoring standards.

Effectiveness and efficiency of service delivery will be critical. The overall CQI process is being revisited with the revised plan being designed to be more inclusive of all stakeholders, establishing performance indicators to evaluate quality, continuity of care, access to care, penetration rates, administrative processes, timeliness of receipt of service and adequacy of qualified providers.

Implementation of our enhanced quality improvement and management process will take time and will be continuously modified based on data and feedback, particularly from consumers and family members. Our MIS staff will continue to work hand in hand with members of the Evaluation Committee to ensure the integrity of the data and the process.

VIII. FINANCIAL MANAGEMENT & ACCOUNTABILITY

Many aspects of this section have already been addressed by the Financial Management Committee. The area program has a financial management plan that assures proper internal controls throughout the operation in accordance with state, federal and licensure/professional requirements. Policies have been adopted that assure that the LME is sharing budget information with the community collaborative as appropriate and processing claims, including denied and disputed claims, in a timely manner.

Consultation is occurring with those involved in provider network development of the business planning process to ensure that the LME and providers understand and are willing to comply with applicable federal and state fiscal requirements. The area program has historically met these requirements as a provider of services; however, many providers acknowledge that they have not been aware of the type and volume of reporting that is required by the state or other funding sources. Policies address the

mandate for all contracts and provider network agreements to include audit compliance requirements.

The final component of the financial management section addresses real assets of the LME. Our County Finance Director has been involved in developing this section to ensure that all aspects are appropriately addresses.

IX. INFORMATION SYSTEMS AND DATA MANAGEMENT

This section addresses issues related to our information systems and data management. The area program began the Integrated Payment Reporting System in February 2003 as a Phase III program. MIS staff are working diligently to ensure that we are using HIPAA compliant transaction sets. Our ANSIX12N834 (reporting of client eligibility enrollment) and ANSIX12N837 (professional claim format) have been accepted and work is continuing on the ANSIX12N835, for receiving remittance advice information electronically from IPRS.

Our business plan will adhere to the state technology standards and all security procedures established by the Division of MH/DD/SAS for protection and safeguarding of electronic data, financial assets and material resources will be followed. MIS staff are consulting with our software vendors with Unicare on a regular basis to ensure that as we transition to an LME, all MIS requirements are met. Information is also shared with the other community stakeholders to ensure that they are aware of changes and requirements.

X. COLLABORATION

Collaboration has been a strength of Cumberland County for a long time. Agencies have shared resources, collaborated in the delivery of services and networked on behalf of consumers, family members and the community to ensure that in spite of limited financial resources, we have a quality and comprehensive array of services for consumers and their families. Because of our involvement with the Partnership for Children, the Families Helping Families initiative with DSS and the Juvenile Crime Prevention Council, all three of which have emphasized and at times mandated that agencies demonstrate they are collaborating with others, we are far ahead of some communities in this area.

Our business plan will include a description of our role in the community in working with those identified as qualifying for a target population. The Needs Assessment will include an analysis of the strengths and weaknesses of collaboration across stakeholders with recommendations being made on how to build on strengths and address weaknesses. At times the Area Authority may need to assume the lead role in certain areas. At other times, it will be important for us to be a part of the team but not the leader. All of these roles and clarifications will be developed as part of the sharing of information with

stakeholders.

We have seen a great outpouring from our community as we have solicited feedback on who is willing to provide what to individuals who may not qualify for services under the target population definitions. Outreach has occurred with over 300 churches via surveys. Meetings have been held with the ministers from various religions by one of our partners from the non-profit world to identify what the faith based community is doing and will do in the future. The media is supporting the initiative by doing an article about the importance of the faith-based community in implementing mental health reform.

It is known that there will be a need for ongoing education and training for all stakeholders in our community on mh/dd/sa issues. Some of the training will be formal and other information will be disseminated in more informal ways. A multitude of ways to get the word out will be developed through networking with those involved to learn “how can we give you information that will mean something to you now and in the future?”

A community profile has been developed through analysis of data from a multitude of sources: the Chamber of Commerce Metro Visions Report, Juvenile Crime Prevention Council juvenile justice indicators, and DSS child abuse and neglect reports. Child Fatality data, Child Advocacy Institute Kids Count reports, census data, Council on Aging data, Analysis of information housing and health insurance, poverty indicators, County demographics as well as Medicaid data and the Client Statistical Profile from the Division of MH/DD/SAS. Unmet needs have already been identified from this information and attempts are being made to solicit involvement from those individuals who can better meet the needs of the unmet citizens.

The Area Authority will serve as a leader in community collaboration through integrating and coordinating the services with other state, local agencies and private providers. A written policy will demonstrate the LME's investment in this plan. A letter from the CFAC endorsing the LME as a leader in the collaborative effort will be presented. Issues and concerns on collaboration will be addressed by sub-committees of the CFAC, at stakeholders' meetings and brought before the CFAC to be discussed and solutions identified.

The LBP must meet all state requirements regarding collaborative relationships. The LME will develop a system of care for children's funding involving community partners, stakeholders, private providers and the CFAC, which will be monitored by an Annual Report. It will also ensure compliance to all existing guidelines and rules for adult, child and adolescent substance abuse services through new or existing community partners. We will enhance this process through involvement of members from the CFAC.

The current Synar activities outlined in our action plan for substance abuse services, will ensure the Federal Synar Amendment is being met. These activities will be addressed under the guidance of our supervisor for Consultation and Education Services in our

substance abuse program.

Cumberland County will submit a full business plan in January 2004, based on updates of the Strategic Plan that is submitted in 2003. We will begin many of the operations of an LME in July 2004 as a Phase III program, using the experience from Phase I programs, the knowledge from the State and feedback from all stakeholders, particularly consumers and family members, to ensure that our plan will meet the needs of our community.

