SECTION I.

PLANNING

CUMBERLAND COUNTY MH/DD/SAS

April 1, 2003

Local Business Plan: Strategic Plan Matrix

Area Program(s)/County Program	Cumberland County Mental Health, Developmental Disabilities and Substance Abuse Center
Contact	Hank Debnam, Phone 910-323-0601, Fax 910-323-0096, areadirector@mail.ccmentalhealth.org
Submission Date	April 1, 2003

Item: I. Planning

Goal: 1. The Local Business Plan demonstrates congruence with the mission and principles of the State Plan. (non-weighted)

Effective Date: December 2002 and ongoing

Steps Taken	Steps Planned	Barriers
a) The mission statement of Cumberland County Area Authority has been modified to reflect changes. b) Business Plan Committees and CFAC continue to review mission statement, core values and guiding principles to ensure congruence with State Plan. c) The Area Authority is providing information and education to providers and community partners on system of care and person centered/family centered service delivery. d) Child mental health collaboration in the community has followed system of care philosophy for many years, as a best	Mission statement, core values and guiding principles will be reviewed on an ongoing basis by LBP committees and the CFAC to determine enhancements and modifications that need to be made. Education and technical assistance to other stakeholders will continue on person centered, family focused services.	

practice, before this was undertaken by the State with pilot programs. These ideas are being shared across other age and disability areas.	System of care components will be incorporated into all services and included as a part of best practices models of intervention.	
e) Cumberland County has a track record of working collaboratively with consumers, family members and other stakeholders to serve consumers in the least restrictive, most clinically appropriate and closest to home service. Planning committees and others have committed to continuing this practice.	Data of individuals served by private providers will be analyzed to determine compliance to least restrictive but most clinically appropriate setting.	Because the mental health center does not have to be included in ongoing authorizations for residential care, we do not always have access to complete information on individuals served by private providers, to assess whether a consumer could be stepped down to a less restrictive setting. This makes it difficult to determine strengths and weaknesses in the service delivery system. Monitoring rules developed in the future may allow access to full consumer data.
f) The LBP process has documented that public behavioral health monies have been spent primarily on those individuals who are included in the target population. Those falling out of the target population appear to be in the adult mental health area (adults with sex offending behaviors) and adult substance abuse ("functional substance abusers" , those involved in the criminal justice system who fall outside of TASC (i.e. unsupervised probation, etc.) and those advanced in their substance abuse disease but who do not have documented treatment failures.		
g) Training has been provided to multiple community partners and stakeholders on changes occurring in the public behavioral health system. Specialized training has been conducted with the Community Collaborative, Fayetteville United, Cumberland County Provider's Association, the Autism Society, NAMI, District Court Judges, County Management and the JCPC.		

h) Training with others has included information on those who will no longer qualify under target population definitions. Other stakeholders are looking at their systems and resources to determine alternative ways to ensure services needed by the community can be provided through other funding or providers. i) Demographics on the community have been analyzed to determine community profile and needs. The community has not been successful in providing comprehensive services to Latino and Native Americans in our community. Reasons for this are not completely clear but they are being studied. *j) Focus group coordinated by the Bureau of Indian Affairs held in March 2003.* *Attachment I.1: Mission Statement, Core Values, Guiding Principles*	Data analysis will continue. Thus far, the community has not identified comprehensive resources for those who will fall out of services because there are no funds available to serve them or providers willing to work with the population. Need for services by Native Americans and Latinos in our communities will be determined based on information from focus groups coordinated by leaders for these groups in the community. This information will be incorporated into the planning process to ensure that needs are addressed. *Two focus groups for Hispanic community are scheduled in April, one in English and one in Spanish. Data obtained on needs, values, barriers, weaknesses, etc. will be incorporated into planning process.*	

Reviewers Comments:

Local Business Plan: Strategic Plan Matrix

Area Program(s)/County Program	Cumberland County MH/DD/SAS
Contact	Hank Debnam, Phone 910-323-0601, Fax 910-323-0096, adirector@mail.ccmentalhealth.org
Submission Date	April 1, 2003

Item: I. Planning

Goal 2: The Local Business Plan planning process meets State Plan requirements. (Weighted)

Effective Date: July 2002 – June 2007

Steps Taken	Steps Planned	Barriers
a) Strengths and weaknesses analysis has been started with the following information being identified: Strengths (1) Low utilization of state facilities (2) Community public agencies have a long track record of pooling resources on behalf of consumers. (3) Some MHC staff are co-located with staff in other human services agencies. (4) Community has many initiatives currently addressing needs of families, particularly those with high risk factors. (5) Population in the community is very diverse and there are some providers already	(1) All business plan committees will continue to identify strengths and weaknesses in the planning process and have this information routed back to the Planning Committee to be addressed. (2) Needs assessment will continue to be refined. (3) Military will be encouraged to participate more in the mental health reform efforts. (4) Community groups are addressing how to blend initiatives so there are not so many meetings to attend.	

trained and competent to work with culturally diverse populations. (6) Some consumers and family members have been on area board for many years and are strong advocates for persons with disabilities. (7) The Area Authority has been utilizing a review process for level of care for several years, particularly in children's services. (8) Out of home placements are utilized only when less intensive alternatives have failed or are not clinically appropriate. (9) The Area Authority has been tracking outcomes in many areas, both system outcomes and personal outcomes for consumers. The person centered planning process has been emphasized. (10) The Area Authority has a strong track record re: documentation, financial audits, blending financial resources, contract monitoring. (11) There are providers available in the community in different service areas. Several of them have established a provider network to implement standardization among their procedures that mirrors standards within the area authority. (12) Consumers and family members on the CFAC are strong advocates and are committed to the LBP process. (13) The majority of consumers who need out of home placement are served within the community and not out of county, unless the resources do not exist or are not available in the county. (14) The community has identified services needed to enhance the quality of life and	.	

address some risk factors. Weaknesses: (1) Many providers are serving out of county clients and do not want to coordinate service delivery with the area authority. Having the out of county consumers served here, without adequate supports or monitoring from their home counties, leads to more pressure on the community to step in and fill the gaps. (2) There are many providers who, although licensed or accredited, do not maintain sufficient standards of quality in service delivery. Many have ongoing staffing issues, compliance, abuse/neglect/client rights issues and training issues. Without state adopted best practices, those who are resistant continue to verbalize that requirements discussed are just coming from the County. *(3)* There is a higher percentage of Native Americans and Hispanics residing in our community, compared to other areas in the state; however, few are accessing services in developmental disabilities and substance abuse services. Representatives from the Hispanic community are participating in the LBP process but we have no representation for the Native Americans. *Focus group with Native Americans occurred the end of March.* (4) There are many risk factors for the community, particularly when compared to the protective factors, which make it even more difficult to serve the	Encourage support of SB 163 and adequate monitoring by communities of consumers sent to our area. If the home communities do not monitor, advocate for adequate funding if the LME is to do this. Have other providers continue to encourage resistant providers to participate, along with ongoing outreach efforts from the area program. Work with provider network to enforce minimum standards. Advocate for State to adopt Best Practices ASAP. QPN Training Committee to develop training protocols and standards to be available within the community. Conduct more outreach with the Native American and Hispanic Populations to identify reasons services are not accessed and utilized. Planned meetings with staff from the Latino Center and other Hispanic leaders. *Focus groups for Hispanics are planned the first of April.* Identify strategies to include Native Americans, including outreach from Native American staff. Concerns about some services (adult sex offender tx.) not continuing due to funding constraints and consumers not being target populations. Other community agencies also	The Hispanic representatives have identified that some do not access services because they are illegal aliens and are afraid of being deported. Cultural issues may impede access to care.

population identified with the finite resources provided.	have limited funds and have no means to continue services developed.	Without knowing the funding for certain services and having a clearly defined array of services for target populations, providers have been hesitant to branch out into new areas. There is also some fear that current funding will be cut even more.
(5) There are services needed in the continuum that do not exist. List has been identified and is being updated on an ongoing basis.	Review list of needs and gaps in services on a regular basis with committees and the CFAC. Continue prioritization process. Continue to analyze data on service utilization and LOS.	
(6) There are many military dependents in the area due to Fort Bragg and Pope Air Force Base, which leads to a transient population in many sections of the community.		
(7) There is a need for more training and competencies being demonstrated in the areas of person centered planning.	Training committee and MHC staff development office to work together.	
(8) Many persons in the community are still unaware of the mental health reform efforts.	Quarterly community meetings.	
(9) The military personnel have participated only minimally in community initiatives at this time, including mental health reform, due to concerns being addressed within the Army, particularly re: domestic violence.	Coordinate meeting with relevant leaders at Fort Bragg and Pope Air Force Base to ensure information is being made available, even if they are not able to participate at this time.	
(10) There are no detailed State adopted best practices at this time.	Distribute best practices information already identified in relevant meetings and adopt standards until State gives information.	
(11) The Quality Improvement process for the Area Authority does not meet all of the standards outlined for a QI/QM process. The Area Authority will need to develop more abilities to measure performance outcomes for all providers		

See Attachment I. 2 (a) Demographic Analysis and Prevalence (b) Policy establishing Consumer Family Advisory Committee has been proposed and meets requirements. Policy outlines that there will equal representation of ages and disabilities. *See Attachment I.2(b): CFAC Policy* (c) There is a statement attesting to consumer/stakeholder involvement consistent with the State Plan, which is representative of the broader population of the locality with the confirmation by the CFAC. The CFAC has been meeting and reviewing information on the LBP process. Consumers and family members as well as board members, representatives from key community partners and over 120 providers have participated in the process so far. *See Attachment I. 2 ©: Statement from CFAC Chair re: involvement in Strategic Planning Process* (*d) Resolution of the governing body accepting/approving the local business plan was approved.* (*e) There is a separate report submitted by the CFAC.*	Obtain Area Board Approval. . CFAC will submit updates on local business planning process.	

Reviewers Comments:

Local Business Plan: Strategic Plan Matrix

Area Program(s)/County Program	Cumberland County MH/DD/SAS
Contact	Hank Debnam, Phone 910-323-0601, Fax 910-323-0096, adirector@mail.ccmentalhealth.org
Submission Date	April 1, 2003

Item: I. Planning

Goal: 3. The Local Business Plan incorporates a 3-year strategic plan (no more than 10 pages) for initial implementation that meets all identified State requirements. (W)

Effective Date: January 2003 and ongoing

Steps Taken	Steps Planned	Barriers
The Area Authority has assessed consumers currently in services and compared them to target population criteria. This process began in the early fall and has continued until we went live with IPRS on March 21, 2003. *Analysis of the data shows that there are only 35 consumers who are falling outside of the target population range and who are not Medicaid. 21 of these are in Adult Substance Abuse Services and 14 are in Adult Mental Health Services.* *Staff working with these consumers are continuing the assessment of needs and to determine other resources that may be available*	Continue to refine Strategic Planning document with input from all stakeholders. Obtain Area Board approval.	

in the community. It is also seen that proposed changes to target populations being discussed with the State may allow them to be in a target population in the future. *Staff have been assessing individuals presenting for services based on target population eligibility and referring, successfully to other community resources, as seen by the low number of consumers in the transitional non-covered population.* *See Attachment I.3: Strategic Planning Goals and Objectives* *See Proposed Policy on Long Range Planning (Section No. 74)*		

Reviewers Comments:

MISSION STATEMENT

THE CUMBERLAND COUNTY MENTAL HEALTH CENTER IS COMMITTED TO ASSURING HIGH QUALITY COMPREHENSIVE SERVICES TO CHILDREN AND ADULTS WITH MENTAL ILLNESS, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE PROBLEMS.

SERVICES ARE RENDERED IN A CULTURALLY SENSITIVE MANNER AND ARE DESIGNED TO EMPOWER PERSONS TOWARD BECOMING INDEPENDENT IN THE COMMUNITY AND TO MAXIMIZE THEIR QUALITY OF LIFE.

VALUES AND PRINCIPLES FOR THE MENTAL HEALTH CENTER'S SYSTEM OF CARE

CORE VALUES

1. The Mental Health Center's system of care should be person centered and family focused, with the needs of the individual and family dictating the types and mix of services provided.

2. The Mental Health Center's system of care should be community based, with the focus of services as well as management and decision-making responsibility resting at the community level.

3. The Mental Health Center's system of care should be culturally competent, with agencies, programs, and services that are responsive to the cultural, racial, and ethnic differences of the populations they serve.

GUIDING PRINCIPLES

Persons with or at risk for mental illness, developmental disabilities and substance abuse problems and their families…

…should have access to a community-based, comprehensive array of services that address their physical, emotional, social, and educational needs.

…should receive individualized services in accordance with the unique needs and potentials of each person and guided by an individualized service plan.

…should receive services within the least restrictive environment that is clinically appropriate.

…should be full participants in all aspects of the planning and delivery of services.

…should receive services that are integrated, with linkages with all stakeholders between human services agencies and programs and mechanisms for planning, developing, and coordinating services.

…should be provided with case management/care coordination or similar mechanisms to ensure that multiple services are delivered in a coordinated and therapeutic manner and that they can move through the system of services in accordance with their changing needs.

…should receive early identification and intervention as promoted by the system of care in order to enhance the likelihood of positive, measurable outcomes.

…should be afforded smooth transition and aftercare planning to meet their needs, either directly or by referral, as appropriate.

…should have rights protected, and effective advocacy efforts promoted.

…should be encouraged and supported to participate in community-based activities of their choice.

Demographic Analysis and Prevalence

The Client Profile Statistical Report produced by the Division of MH/DD/SAS estimates the total 2002 population for Cumberland County to be 310,436. This appears to be fairly consistent when compared to the U.S. Census Bureau 2000 data of 302,963. Our community has a higher percentage of Asians (2.2% compared to State figures of 1.5% of the population), Hispanic/Latino (6.9% versus 4.7% for the State), African Americans (34.9% versus 21.6%) and a slightly higher percentage of Native Americans (1.5% compared to 1.2% for the State).The overall population growth for the area, however, is much below the state average (9.7% compared to 21.2% for 1992 to 2002 and expected population growth between 2002 to 2012 of 9.8% compared to 16.9% for the State).

The 2002 Community Benchmarks Report compiled by Metro Visions (CQI Team of the Chamber of Commerce) indicates that Cumberland County lags behind other counties in the state in home ownership, which is seen as defining in some aspects the stability of a community. There is an extremely high rental housing phenomenon that is reflective of our transient population brought on in large part by the military presence (Fort Bragg). This issue is more concerning when comparing our community to others on the poverty benchmarks. 13.3% of the population in the United States lives below the poverty index and 19.9% of the children. In North Carolina 12.6% of the population live below the poverty index and 18.6% of the children. For Cumberland County 15.5% of our citizens live below the poverty index and 21.2% of our children. We are below the median Family Income for the State as a whole and the U.S. in general (N.C.: $35,320; U.S.: $37,005 and Cumberland County: $33,836).

In virtually all areas of Social and Human Services, Cumberland County is above the state average.

- Food Stamp Recipients as percent of population:(2000) 8.1 versus 6.3
- Children in DSS custody per 1000 children (2000) 8.9 versus 6.1
- Substantiated cases of abuse and neglect per 1000 children 18.2 versus 15.3
- Percent of population without Health Insurance (1999) 17%versus 16.3%
    - 20.7% versus19% for individuals age 18-64)

It is positive to note that in areas of child abuse and neglect, strides are being made in the community to improve our statistics. Even though we are above the State average in substantiations, the overall numbers are decreasing. We had 94.06 per 1000 in 1999, when we led the state in reports (7222 children reported abused and/or neglected) to 72.47 per 1000 in F.Y. 2001. We also are seeing improvements in the area of juvenile crime but we are still above the State average (Juvenile offenses before Court per 1000 children: 23.3 compared to 21.5) and Youth Development Center Admissions (1999-2000) 13.7 per 1000 compared to the State average of 11.4.

% Population with Food Stamps

Year	Percentage
1990	7.6
1991	8.4
1992	9.8
1993	10.2
1994	10.4
1995	10.2
1996	10.1
1997	9.9
1998	9.7
1999	8.8
2000	7.9

% Public School Dropout Rate- Grades 7-12

Year	Percentage
1992	2.2
1993	2.3
1994	2.3
1995	2.0
1996	3.7
1997	3.8
1998	4.33
1999	3.46
2000	3.12

Neglect and Abuse

Year	Abuse and/or neglect rate per 1000 children	% reports substantiated
1991	47	45.5
1992	48.5	39.9
1993	66.20	41.2
1994	71.90	36.5
1995	63.25	36.1
1996	53.34	35.1
1997	71.16	32.9
1998	72.52	33.1
1999	94.06	34.9
2000	83.97	33.7
2001	72.47	27.9

Analysis of the behavioral health state institution utilization reveals that overall Cumberland County is doing a good job of serving individuals in the community:

- Persons in State Psychiatric Hospitals per 1000 1.02 versus 2.03
- Persons in State MR Centers per 1000 .16 versus .28
- Persons in ADATC per 1000 .05 versus .49

The under age 18 population for Cumberland County was 82,633 in 1999 or 28.3% of the total population (N.C. Child Advocacy Institute data- N.C. Children's Index 2000). There is a higher percentage of children under the age of 18 (27.9% compared to State 24.4%) and a higher percentage of persons under 5 years of age (8.2% compared to 6.7%). Looking at the other end of the age spectrum reveals that although the percentage of persons over the age of 65 is increasing, the rate of increase is below the State average (7.7% compared to 12%). This information must be factored into our planning process for service delivery in our community.

Looking at these figures, and using estimates from the North Carolina Division of MH/DD/SAS on prevalence rates, 10-12 percent of the children under the age of 18 would experience some type of serious emotional disturbance or 8263 -9915 children. Review of reported CAFAS scores for Cumberland County MHC for Fiscal year 2000-2001 shows that only 24% of the clients seen had CAFAS scores of 30 or below. The majority of those served had CAFAS scores of 50 and above. Again, this suggests that the population that was seen in 2000-2001 are those in the target population range, based on clinical data reported. Diagnostically, this is also true with a higher percentage of children and youth seeking treatment having serious diagnostic profiles when compared to the State average (i.e. 7.7% of children in Cumberland County reported with diagnosis of Adjustment Disorder compared to State average of 21.9%)

For adults, using the Federal Center for Mental Health Services data that 20% of adults could have a mental health problem that would warrant treatment, approximately 62,000 adults in Cumberland County could be in need of services. This number is compared to the prevalence rates as identified in the *National Household Survey on Drug Abuse-2001: SAMHSA)* that reported 7.3% of adults aged 18 or older are classified as having some type of Serious Mental Illness. For Cumberland County this would total 16,340. Analysis of the data from the Client Profile Statistical Report for Fiscal Year 2000-2001 prepared by the Division of MH/DD/SAS, Cumberland County area authority had 3226 active clients in the adult mental health program, 1674 in the adult substance abuse program for a combined total of all MH/SA adults of 4900. GAF scores reported for this population documented that approximately 60% of those served had GAF scores below 50 with only 15% in the mild symptoms range and 26% in the moderate symptoms range. This would suggest that the majority of clients being served will qualify for the target population. As the area authority has begun the process of studying case loads and comparing individuals to the criteria for target populations, the data also seems congruent, with 5-10% of the population not appearing, based on current documentation, to qualify in the

adult mental health world as a target population. Some of these are adults served through a partnership with the Community Corrections Program and the court system. There is an extensive program to work with adult sex offenders in our Adult Mental Health program. The majority of these do not meet the SPMI or SMI diagnostic constructs; however, these individuals clearly need mental health treatment and without the needed treatment, the health, safety and well-begin of our community is compromised. Through collaboration and planning with other stakeholders involved with this population, the community is seeking alternative resources for treatment for this population.

Prevalence of Mental Illness in Adults

Mental Illness	Estimated Prevalence Rate	Base Population for Cumberland County	Estimated number of persons affected
SMI and SPMI	7.3% of population age 18 and older	223,843	16,340
SMI and SPMI-geriatric population	3.9% of total population over age of 65	23,905	932
SPMI	2.6% of total population 18+	233,843	5820

Estimated population: 310,436
71.9% over the age of 18
7.7% over the age of 65

Prevalence of Serious Emotional Disturbance in Children

Mental Illness	Estimated Prevalence Rate	Base Population for Cumberland County	Estimated number of persons affected
Serious Emotional Disturbance (SED) with substantial functional impairment	10-12% of children ages 5-17	86,612	8661-10,393
Serious Emotional Disturbance (SED) with extreme functional impairment (subset of above)	6-8% of children ages 5-17	86,612	4330-6929

27.9% of population age 0-17

(Sources of information: U.S. Census Bureau
Substance Abuse and Mental Health Services Administration (SAMSHA) survey- 2001

Comparative Analysis of Consumer Data

For Fiscal year 2000-2001, Cumberland County MH/DD/SAS provided or purchased services for 7290 individuals. Of that number 1848 were children under the age of 18, 5441 were adults and 1 was listed as age unknown. 48% were females and 52% were males. There is a more even distribution of races served by Cumberland County when compared to other area programs with a high of 46.7 per 1000 for Native Americans, 31.1 for African Americans, 19.6 for White 10.5 for Hispanic and 12.7 for "other." Review of the State data reveals that 61.1 per 1000 were African American, 32.6 white, 49.6 Native American. 11.5 Hispanic and 9.5 for "other." Census data on race is as follows:
African American: 34.9%, white 55.2%, Native American 1.5%, Hispanic 6.9%.

In Cumberland County female adults were served at the highest rate per 1000 population with a primary disability of mental health with a rate of 18.8 per 1000. Statewide the highest rate per group is male children (32.4 per 1000).

Age of Active Clients

Children made up 25.3% of clients served in Cumberland County compared to 27.2% statewide. Young adults ages 18-44 were 52.1% of the client base compared to 49.1% statewide. Older adults (defined by the State as 45 and older) were 22.6% of clients served in Cumberland County compared to 23.7% statewide.

Children age 15-17 were served at the highest rate relative to their respective population, a rate of 34.2 per 1000 population. This was also the group statewide with the highest penetration rate per 1000 population.

	Cumberland County			State		
Age group	Numbers	Percentage of Total	Rate/1000 population	Numbers	Percentage of Total	Rate/1000 population
0-4	320	4.4%	12.9	11,676	3.7%	21.6
5-9	424	5.8%	17.4	21,311	6.8%	37.9
10-14	677	9.3%	29.5	31,162	9.9%	56.5
15-17	427	5.8%	34.2	21,225	6.8%	68.3
18-24	833	11.4%	20.1	35,358	11.3%	43.8%
25-34	1,381	18.9%	26.3	53,884	17.2%	44.4
35-44	1,581	21.7%	33.5	65,043	20.7%	50.5
45-54	1,007	13.8%	30.4	42,266	13.5%	38.9
55-64	423	5.8%	20.5	18,097	5.8%	25
65 and older	216	3%	9.2	14,039	4.5%	14.5
Unk	1	.01%		112	.04%	
All Ages	7,290	100%	24.1	314,173	100%	39

It is important to look across all disability areas as well as age categories of below 18 and 18 and older and to look at the presentation at admission from a diagnostic perspective. For children, according to the *Client Profile Statistical Report, Fiscal Year 2000-2001,* the most prevalent diagnosis for children admitted for mental health services was Conduct Disorder (35% compared to State average of 22.3%). Second most common was Attention Deficit Disorder (27.2% vs. 22.8%) followed by Adjustment Disorders (7.7% vs. State average of 21.9%) and Anxiety Disorders (7% vs. 5.5%). For youth admitted for substance abuse problems, 61.8% were given a principal or admitting diagnosis of drug abuse compared to 27.1% for the State. 22.4% had no mental health diagnosis (State average 26.1%). These youth would have been served in prevention activities. 7.2% were documented as having alcohol abuse as the initial diagnosis compared to 4.4% for the State. It should also be noted that in the adolescent substance abuse report the State has 27.5% of clients with an unknown diagnosis, which suggests gaps in information documented/reported.

Analysis of the child data shows that there are fewer children presenting to the public sector with an Adjustment Disorder diagnosis in Cumberland County. For adolescent substance abuse, clearly the primary concern for the community is drug abuse. Activities will need to be geared toward this information in future planning for services based on target population definitions.

In the Child Developmental Disabilities information it is seen that 52.7% of children had a diagnosis of Other Childhood Disorders. The majority of children in this area would have received services through the Early Childhood Intervention program. This compares to 41.3% for the State. Other diagnostic categories reported are 17.2% for Autism and Pervasive Developmental Disorder (5.3% State average), 14.4% Mental Retardation (11.7% State) and 6.5% of the children with a Specific Developmental Disability noted (19.8% State). Clearly in the DD population our community is serving very young children and those with autism and pervasive disorders. An analysis with providers, advocates and family members will assist in determining if these are the directions to focus interventions in the future or if the data suggests alternative populations are not appropriately served.

For those individuals 18 years and older, the most prevalent diagnosis at admission was Major Depression (27.6% vs. 27.8% State) which will fall into the Seriously Mentally Ill or Target Population two category for consideration in the future. Cumberland County served a higher percentage of adults with Schizophrenia and other psychotic disorders (23.6% vs. 16.8%) and Bipolar Disorder (10.1% vs. 7.6% State). As with children, in adult mental health Cumberland County is serving a lower percentage of persons with mild impairment as evidenced by only 3.8% of the population with an Adjustment Disorder compared to 10.4% for the State average.

In substance abuse, as with youth under 18, drug abuse is again the primary problem (50.8% vs. 38.4% State). However, unlike in the adolescent world, alcohol abuse is not as prevalent for adults when compared to the State (34.7% vs. 43.8%).

Our community showed a higher percentage of adults presenting for services through the Developmental Disabilities Program with a diagnosis of Mental Retardation (71% compared to 67.1% State) and Autism and Pervasive Developmental Disorder (7% vs. 2.4%). It is interesting to note that there were 5.7% (Cumberland County) and 5.9% (State) of adults presenting to the Developmental Disabilities Programs with an initial diagnosis of Schizophrenia and other Psychotic Disorders. This is probably due to the former Thomas S. program in which dually diagnosed individuals, MR/MI, were identified for specialized services. As the lawsuit has been dismissed, it is seen that those dually diagnosed individuals are still presenting for services and will need special attention in the future.

Not only is it important to see what diagnostic categories have received services, it is equally important to analyze the services that have been reimbursed with Medicaid funds. According to the *Medicaid Expenditures and Services Report for MH/DD/SAS for Fiscal Year 2000-2001 for Cumberland Service Area*, it is seen that the majority of the Medicaid funds are spent for CAP-MR services (33.7% of total expenditures compared to State average of 23.3%) and ICF-MR services (37% compared to a slightly higher State figure of 40.8%). Area Program billed services accounted for 20.5% compared to the State average of 25.4% and included services contracted out by the area program but billed against the area program Medicaid number. The remaining Medicaid receipts were for other community services and inpatient care.

The average cost per person in Cumberland County is below the state-wide average ($4665 with a median cost per person of $277 compared to the State $5930 and a median cost of $293). Analysis of the race/ethnicity and gender of persons served shows a fairly equitable distribution for African American and White males and females but a substantially higher percentage of Hispanic and Native Americans served. This data matches that of the community demographics as reported by the Census Bureau. The data does not show many Native Americans or Hispanics receiving services for Developmental Disabilities. Reasons for this will need to be further analyzed but may represent an underserved group in our community. The same phenomenon appears to be present for Substance Abuse, particularly for Hispanics, with only 6 adults receiving services reimbursed by Medicaid for Substance Abuse Treatment and only 17 Native Americans. There were only 3 Native Americans under the age of 18 receiving services and no Hispanic adolescents. Again, with the community profile indicating we have a higher percentage than the State average of these two groups in our community and with the numbers increasing each year, it will be critical that outreach and education activities be conducted to identify and appropriately serve these individuals.

Costs per consumer for Cumberland County are below the state-wide average in most categories and length of stay in out of home placement is typically shorter. There is also a lower utilization of state placements and inpatient hospitalization. This matches the philosophy of service delivery that embraces providing services in the least restrictive, most clinically appropriate and closest to home setting.

Amounts shown are the average cost per person

Age/Disability	Cumberland County	Statewide
Adult Mental Health	**$881** *(median cost per person = $168: higher than State)*	**$1309** (median cost per person = $147)
Adult Substance Abuse	**$1152** (median cost per person = $253)	**$1325** (median cost per person = $304)
Adult Developmental Disabilities	**$44,677** *(median cost per person = $45,806: higher than State)*	**$39,360** (median cost per person = $34,117)
Child Mental Health	**$1934** (median cost per person = $280)	**$3329** (median cost per person = $308)
Child Substance Abuse	**$1141** *(median cost per person = $332: higher than State)*	**$2049** (median cost per person = $324)
Child Developmental Disabilities	**$9605** (median cost per person = $706)	**$10,221** (median cost per person = $1241)

The average cost per person is lower in all areas except the Adult Developmental Disabilities category. 74.2% of Medicaid expenditures for Adult DD were for CAP-MR and ICF-MR services. For CAP-MR, 100% received case management, 82.1% received supported living day, 69.7% received supported living periodic but only 47.6% received respite services. Respite services have been identified as a gap that needs to be addressed by our community across all ages and disabilities. Analysis will reveal if dollars spent on CAP consumers in other areas might better be spent for respite services if they were available in a larger quantity. It should also be noted that a high percentage of the DD consumers received some type of outpatient individual counseling (89.7% of persons served in Adult DD compared to 61.3% Statewide). This will not be a benefit under the new array of services unless the individuals also qualify for a target population in the mental health or substance abuse categories. Very few Adult DD consumers received CBS services, even though many are on waiting lists for CAP services. The community will need to look at how to increase the provision of CBS services to eligible individuals, particularly those who are waiting for more intensive services that may not be available.

The percentage of Child DD consumers receiving outpatient services is similarly high (82.4% compared to 66.3% Statewide). There are also a lower percentage of clients served in CAP (19.6% vs. State 21.1%) and ICF-MR (2.3% vs. 3.4% State). 65.8% of Child DD consumers are receiving CBS services and 5.2% were dually diagnosed and able to access residential treatment services through child mental health. Again, the community will need to look at those consumers waiting for services and determine if there are alternative ways to utilize Medicaid and State revenues in better meeting the needs of consumers and their families.

Overall analysis shows that our community, though high in risk factors and low in dollars allocated for services to mental health, developmental disabilities and substance abuse services, is going in the right direction. Those being served with public funds appear to be primarily those most in need based on diagnostic constructs and other criteria outlined in the target populations. Data also supports that services are provided in a more cost effective manner overall and in the least restrictive setting whenever possible. Analysis also shows that the race/ethnicity of those served matches the demographics in our community in most areas but our Hispanic and Native American populations are not accessing services through Substance Abuse and Developmental Disabilities, with reasons not being clear. More outreach will need to occur to better understand these gaps and provide appropriate outreach, screening and treatment services. As the business planning process continues and gaps and needs are better defined, the community will need to look at all resources and determine how to reallocate resources when indicated.

Analysis of Service Needs

Throughout the business planning process, services needs have been discussed with all stakeholders. Part of this process has included a review of how the current state and Medicaid monies have been spent in Cumberland County. The majority of the Medicaid funds have been spent for ICF-MR services (37%) and CAP services (33.7%). The remaining 27.3% of the funds have been split between Area Program Billed 20.5%), Other Community Billed (5.2%) and Inpatient Hospitalization (3.6%). The CFAC and other committees are reviewing the specific types of services that have been provided with these funds and started to compare this to how needs are perceived and outcomes. Some consumers are expressing concerns that the monies are not being spent in the areas in which they are really needed. This further points to the need to look carefully at historical utilization, outcomes, best practices, system of care principles and person-centered planning.

Beginning analysis of the types of providers currently in our community reveals that we have an overabundance of some services in our community, particularly Residential Treatment Level III for child mental health consumers but limited to no resources in other areas. As the community capacity is being studied, dialogue with providers around developing alternative services is occurring. Another dynamic for our community is that although there are many providers of certain types of services, far in excess of what our community needs in some areas, many providers do not want to diversify as their client population is primarily from other counties. It will be critical to obtain guidance from the State on the monitoring aspects of providers in a catchment area and delineation of monitoring responsibilities (programmatic and consumer oriented).

Discussions on existing resources, historical expenditure of funds and gaps has led to a list being developed of all gaps/needs that have been identified thus far. This listing will be an evolving document as more information is obtained from consumers and family members about what really works and as best practices are further defined by the State. Gaps/needs have been categorized as either being needed by adults only, children only or all consumers. It is also noted that items are listed that are not under the purview of the mental health system but the lack of the service certainly impacts on a person's ability to function to their maximize benefit.

There has been no specific prioritization at this time of the items listed, other than to distribute the listing to consumers, family members, agency staff, providers, community representatives, advocates and anyone interested in community services, and ask each person to rate how important they think an item is. Individuals have been asked to rate with a score of "1" meaning that this item would have the highest priority and a score of "5" indicating that the service is important but not as important if funding is limited and decisions may have to be made re: resource utilization and allocation. Some of the services are for a specific disability but many of the needs cross over all of the disabilities. This further supports the need to ensure that providers are competent across disabilities if the consumer is going to receive services in more than one target population.

The following gaps or needs have been identified thus far.

Gap/Need	Adult: needed for consumers over age 18	Child: needed for consumers under the age of 18	Needed by both Adult and Child consumers
Independent living services- age 16+		X	
Transition Services: From child services to adult services Between disabilities Between levels of care			X
Transportation			X
Respite			X
Adult MH high management residential services	X		
Literacy programs			X
Social/enrichment activities			X
Placements for substance abusing women with children	X		
Supported employment: all disabilities	X		
Vocational Services			X
Day Reporting/Day Treatment for children/adolescents		X	
Cross disability access to services			X
Micro-enterprises	X		
Specialized preschool programs		X	
Social Detox programs	X		
Services for multiply diagnosed consumers			X
Crisis Services: Hospital Diversion 24/7 assessments Crisis placements 23 observation beds			X
Culturally diverse/sensitive resources			X
Community Education activities			X
Day Programs: Adults	X		

Next steps will include further analysis of the community's present providers and comparing this to historical utilization, determining what is needed for the community now and in the future as institutions close, and hearing from consumers and families what really makes things better for them. There will also need to be ongoing discussions with providers about their role in the Cumberland County service delivery system versus being service providers to out of county residents. Our goal would be to have our providers serving our residents primarily. This creates less of a strain on the community, particularly agencies and the school system, and also allows for more integration of the consumer back into his family and community. There will need to be partnerships for development of services that may be "high cost-low incident." For those services, plans will be to develop regional relationships and meet the needs across county lines.

Note: Additional statistics on Cumberland County will be available on site for review if indicated. These include the Census Bureau data, Council on Aging Reports, Population Growth Components, Statistics on Health Insurance, child abuse and neglect rates, etc.

POLICY

CUMBERLAND COUNTY MENTAL HEALTH CENTER	Section No. 67 Page 29 of 1
Subject: Consumer Family Advisory Committee (CFAC) Effective Date: Responsible Official: Area Director	Supersedes: N/A Dated:
Approved by the Area Board on ___. Recorded in Area Board Minutes, dated_____, paragraph ______, page __.	

Cumberland County Mental Health Center will establish a local Consumer Family Advisory Committee (CFAC) in accordance with directives for development of the Local Business Plan. This Committee will be appointed by the Planning and Collaboration Committee of the Area Program. The Mental Health Center in its role as a Local Management Entity will assure opportunities for meaningful involvement of consumers and families. The emphasis for the Agency and all stakeholders will be on recognizing the important contributions of consumers, maintaining a non-judgmental environment and providing the CFAC timely and advance notification of actions proposed that will impact on their role on the CFAC with the Mental Health Center.

Report of the Cumberland County Mental Health Center Consumer and Family Advisory Committee Regarding the Local Business Planning Process

The Consumer and Family Advisory Committee of Cumberland County Mental Health Center (CCMHC) was formed in October, 2002. Participation in this and all committees of the local business planning process was solicited through surveys of interest that were mailed to consumers, provider groups, and advocacy groups, local agencies and to consumers involved in mental health services in Cumberland County. Surveys of interest were provided at public forums held in July 2002 and October 2002 as well as to active consumers of agency services.

The Consumer and Family Advisory Committee (CFAC) met officially for the first time on October 9, 2002. The group was composed of representatives from Mental Health, Developmental Disabilities, and Substance Abuse with Adult, Child & Family member categories, for a total of eighteen members. Referrals were made to the Planning and Collaboration Committee of the local business planning process based on age and disability representation and interest expressed through surveys and personal contact. The group was excited to be able to have input into the development of our county's Mental Health Business Plan.

CCMHC staff has provided technical assistance and education about the State Plan and the role of the CFAC in developing the local business plan. The committee was initially tasked with beginning to look at gaps in services in the area. Adherence to confidentiality guidelines were covered and ground rules established.

The first elements addressed by the group: access to services, current service array, public awareness and the statistics of the client profile. Organization/structure of the committee developed with the decision made to have co-chairs for the committee. The issue of bylaws addressed and more time felt to be needed to decide about establishing bylaws.

Throughout the process the Committee has continued to look at gaps in service and the critical need for an ongoing formal "needs assessment" and for relevant service outcomes. Of prime concern-ensuring continuity of care and quality of care to county residents needing MH/DD/SAS services.

A visit from the Division staff member assigned to provide technical assistance in the local business planning process helped the group clarify and solidify the role of the CFAC. Our role in the planning process was validated within the context of the discussion with the consultant.

Cumberland County CFAC has had the opportunity to review and comment on the Strategic Plan sections submitted to the State Division of MH/DD/SAS in January 2003 as well as the April 2003 submissions. Staff appears to have been forthcoming in answering questions we might have as well as providing resources to get needed information and clarification. Throughout the process, we have received reports of the

work of the various committees for our review and feedback. CFAC members also routinely participate in these other committee meetings

The Committee understands that one of the biggest changes is the fact that some will no longer qualify for mental health services provided with public dollars. There is concern that some people in need of services will "fall between the cracks" of the system. CFAC wants assurance that there will be a seamless, coherent service system of services that will address the needs of that "non-target" population.

Input from CFAC is incorporated into the Strategic Plan showing an integral role for CFAC. In the Planning section, CFAC identified concerns about outreach efforts, provider qualifications and lack of needed services. The group wants to ensure ongoing needs assessment and active consumer involvement continues to be key parts of the Plan. It appears that staff has put mechanisms in place to work toward making these functions occur as needed. Best practice guidelines are what we as a committee do endorse in planning for services in the future.

The decision to maintain the agency as an Area Authority LME is supported by the committee. We stress the need for re-education of staff, consumers, providers and the community-at-large about the change in role for the area Authority. The LME reorganization does need to be structured to match State guidelines. This needs to be carried out with careful planning considerations. It is critical that CFAC participation is enhanced and continues in all levels of the organization as we move toward LME status.

CFAC places great emphasis on the need to have providers with the necessary experience and credentials to work with consumers and meet, if not exceed, standards of care. Concern is raised regarding how this network will be developed and how well monitored. CFAC wants to have an active role in developing criteria for the QPN as well as monitoring services through the proposed Quality Assurance Program being designed. Of great concern for the Committee is the process for identifying qualified providers as referral sources. Providers will need to be educated about best practice guidelines to ensure old processes are not brought to the new world. Monitoring is also an issue we have concern about. It is unclear what role/authority CFAC and the local program will have for this function to adequately protect consumers as well as support good providers. The committee has provided significant input as to the need for realistic and relevant monitoring of the quality of services provided. There continues to be concern about the strength of the monitoring role the LME will have with local providers. Consumers and families feel strongly that CFAC members and others in the consumer network must have a meaningful role in monitoring services in a standardized manner. The Committee supports the concept of provider performance outcomes or "report cards" to work toward better consumer outcomes.

We as a committee support integrated service delivery systems that allow "one-stop shopping" so that consumers will not have to travel to multiple service sites for care. CFAC must serve a large role in this function to assist in developing this integrated service system.

Service Management and access function must address ease of access to services for consumers and most appropriate level of care. Appropriate referrals and coordination of care has to be an essential part of this plan. Input from the committee has been addressed by the Agency in the restructuring of the current access to services procedure to streamline the process to make it less frustrating for those seeking services. This type of feedback helps the group feel that we are being heard.

CFAC is actively involved in developing the evaluation process for the LME. Multiple meetings have been held with CFAC and interested consumers and family members in the area of evaluation. We continue to meet around this critical issue and will secure input from providers as well. A staff member from a local stakeholder agency has volunteered time to work with the Committee to develop a meaningful evaluation process. The process involves CFAC, providers and other stakeholders providing input into what needs to be evaluated and what outcomes are important. The evaluation plan will be submitted through the QI process for approval and implementation.

The committee has questions about how services will be funded across the board. Concerns are raised regarding what the costs of services will be. It is also critical that information can be transmitted in a timely manner in order for funds to be received for service delivery. Questions continue to be raised regarding how soon providers can be ready to conduct this process of information gathering/sharing and fiscally sound services. There are also questions about how providers will interface with the LME around costs of and billing for services.

CFAC membership has been involved in planning and collaboration dialogue with providers, local agencies, faith-based organizations and advocacy groups to look at ways to ensure continuity of care for target population as well as non-target population consumers. A major concern continues to be continuity of care across all disabilities. CFAC representation in the planning, collaboration and development of the Strategic Plan is overall a positive one. The committee has received and continues to receive constant updates on new information regarding the plan process. We feel we have been given an important opportunity in helping shape a plan that will ultimately benefit us.

Respectfully Submitted on behalf of the Cumberland County Mental Health Consumer and Family Advisory Committee

Alejandro Vazquez, Co-Chairperson

Nicole Reynolds, Co-Chairperson

County of Cumberland

Consumer Family Advisory Committee

P.O. Box 3069 711 Executive Place Fayetteville, NC 28302-3069

Strategic Planning Goals and Objectives:
CUMBERLAND COUNTY MH/DD/SA AUTHORITY

Cumberland Area Authority developed a strategic planning process during its original COA accreditation and has continued to enhance this process over the years. There has been a commitment to involve all stakeholders in the process to ensure that the needs of consumers, family members and the community, as it relates to public behavioral healthcare services, are addressed. We will incorporate the goals, objectives and strategies required to function as an LME into this process over the next few years as we implement the State Plan and mental health reform.

Building on information from multiple area programs and the State, we agree that there are five key areas: Services, Quality, Finances and Administration, Education and Building Partnerships Through Collaboration. These areas will be addressed by the LME as well as the committees working on implementation of mental health reform. These committees include providers, community agency representatives, non-profit and faith based representatives, the corrections and judicial systems, consumers, family members, advocates and other stakeholders directly or indirectly impacted by the public mental health system.

Goal One – Service Initiative
To develop and administer a seamless, market competitive, provider network representing a full continuum of Mental Health, Developmental Disabilities and Substance Abuse Services that meets the needs of both the target population and other consumers as defined by the Agency and the community.

Goal Two – Quality Initiative
To modify our existing quality improvement system to involve all stakeholders more in the process and assist the Agency as it converts its system into more of a management entity and less of a service delivery system. Principles of Continuous Quality Improvement, as outlined in the generic standards for COA will be incorporated. It will be critical to not sacrifice quality for cost as a provider network is developed and to ensure that all aspects of the LME and its provider network focus on outcomes and satisfaction.

Goal Three – Financial and Administrative Initiative
To examine our current and financial structures and modify them as we transition into the roles of the LME to ensure that we achieve long-term financial viability and administrative stability.

Goal Four – Education Initiative
To promote the development and the education of our staff, our Consumers and their families, our providers and our community, in the understanding, the presentation, and the treatment of mental health, developmental disabilities and substance abuse.

Goal Five – Collaboration/ Partnership Initiative
To build partnerships with all stakeholders, both internal and external, in order to successfully carry out the mission and vision of the LME.

The following strategic plan outline lists by goals, objectives and activities, some of the more crucial steps, which need to be accomplished in each of the time periods noted in order to achieve the results we want as we transition into the role of a Local Management Entity (LME).

Strategic Plan- CCMHC:

	Year 2002-2003			
GOAL	**OBJECTIVE**	**ACTIVITIES**	**RESPONSIBLE PARTY**	**TIME FRAME**
Goal One – Service Initiative	Objective One – Assess all existing consumers and those entering service delivery system for eligibility for target population and services in benefits package Perform an analysis of current service provider capacity and interest in expansion based	Analyze all consumers currently in services for compliance to target population criteria Assign target population status to all consumers Identify resources for those no longer eligible for services and establish appropriate referrals Survey providers regarding interest in providing additional services Analyze current service delivery patterns Meet with Providers to discuss service needs / willingness to develop needed resources	Clinical Services Management Team (Disability Directors) Clinical Services Management Qualified Provider Network Committee Senior Management Team	September 2002 -January 2003 January 2003 January – June 2003 August 2002 and ongoing August 2002 and ongoing
	Objective Two – Perform Analysis of current services accessibility	Develop maps that show number and locations of providers and practitioners Perform two-year analysis of data regarding access to emergent, urgent and routine care Identify the location of facility based services	Area Program MIS staff in conjunction with County Planning Dept. Planning/ QI/MIS staff of LME	April 2003-updated on regular basis April 2003 – April 2005
	Objective Three – Develop new contract language for LME	Review current contract language for its applicability for the LME and write new contract language as appropriate Determine whether State contract to be operationalized or if area authority will continue to establish standards	Contracts Management Staff Quality Improvement	July 2002 – June 2003
Goal Two – Quality Initiative	Objective One - Develop a Quality Improvement Process for the LME and Providers	Enhance existing process on monitoring of incident reports Develop method to collect consumer satisfaction data Develop complaint monitoring process with providers Analyze role of area program in monitoring for SB163 Incorporate into Quality Improvement process	Clinical Risk Management Quality Improvement Committee CFAC Qualified Provider Committee	January – June 2003

	Objective Two - Development of Credentialing System	Begin process of analyzing credentials and competencies with providers and comparing to State guidelines Obtain feedback from providers on use of Best Practices Standards Begin development of credentialing process and/or competency based process based on State guidelines	Quality Improvement Committee CFAC Qualified Provider Network Committee	January – June 2003
Goal Three – Financial and Administrative Initiative	Objective One – Determine which services to contract out or spin off if Area Board deems it appropriate to do this	Conduct an in-depth analysis of all services and determine which services to keep together Establish time frames for divestiture of services and analyze those to be contracted out and those for referral only	Senior Management Team Area Board Senior Management Team CFAC	August 2002 – June 2003 January 2003
	Objective Two – Develop process to assist in creating provider entity if indicated	Determine role of Cumberland Area Authority in assisting spin off if one is created Assist in creation of new entity board if proposed Look at allocation of resources dedicated to establishing new entity if this is recommended	Administrative and Financial Management Staff/Area Board CFAC/Advocates	January – June 2003
	Objective Three – Negotiate new contracts with Providers as appropriate	Finalize Contracts for providers and release and negotiate contracts with all providers, those previously under contract and those for whom new services are being negotiated	Contracts Management Staff Senior Management Team	January – June 2003
	Objective Four – Develop a financial management plan for the LME	Assure appropriate internal controls Assure compliance by providers and the LME with state and federal fiscal requirements Provide adequate audit trail and accounting of all real assets of the LME	Administrative and Financial Management staff County Finance Staff	January – June 2003

	Objective Five – Perform analysis of Information Technology Capacity of Cumberland Area Authority to be the LME as well as provider capacity to interact with LME	Perform System Survey of Cumberland Area Authority and providers and complete analysis of Information Technology capacity	Management Information Staff QPN Committee	January – June 2003
Goal Four – Education Initiative	Objective One – Development of Consumer and Family Advisory Council (CFAC)	Bring current advisory committees up to speed and train the CFAC on roles and responsibilities	CFAC Liaison staff CFAC members	September 2002 – June 2003
	Objective Two- Development of Communications Public Awareness Strategy	Develop newsletter, web pages and other means to communicate with the public Conduct public forums	LBP Core Committee Public Relations Staff	January – June 2003

Strategic Plan- CCMHC:

	Year 2003-2004			
GOAL	**OBJECTIVE**	**ACTIVITIES**		
Goal One – Service Initiative	Objective One – Assess compliance to Target Populations Eligibility Criteria and IPRS	Continue process of establishing eligibility for Target Populations for all consumers presenting for services using public / Medicaid funds	Clinical Management Team Management Information	July 2003 and ongoing
	Objective Two – Continue Non- Target Consumer Transition Planning Process	Insure ongoing development of clinical/service transitions plans for non target consumers	Clinical Management Team Network Management CFAC	July 2003
Goal Two – Quality Initiative	Objective One – Development of access to care system	Develop information to assist consumers with access to services and development of process to track referrals and their timeliness	Planning, Public Relations, Consumer Relations CFAC	July – September 2003
	Objective Two – Analyze impact of changes in access system ; clarify role of area program and providers	Determine utilizing Division and Medicaid accessibility standards, appropriate locations for access centers	Planning Network Management CFAC	July – December 2003
	Objective Three – Implement a coordinated Quality Improvement (QI) Program	Survey Providers on their QI Plans and establish QI committee involving providers, LME and consumers Establish more comprehensive QI program for LME	Quality Improvement Administrative and Network Management CFAC	July 2003 – March 2004

Goal Three – Financial and Administrative Initiative	Objective One – Divest Cumberland Area Authority of all direct service/ treatment provider activities in which there are qualified, available providers recommended by the QPN panel and CFAC; continue service provision as outlined above	Implement Contracts with providers for all services and spin off new provider entity if decision is made to do this	Network Management Financial and Administrative CFAC	December 2003 – June 2004
	Objective Two – Develop the systems to manage the provider network	Design electronic method for provider management Establish core data requirements Establish systems committee (LME and providers)	Network Management Management Information Systems	December 2003 – June 2004
	Objective Three – Develop a common, single, shared electronic case record for providers and the LME	Review state data requirements Review CMHC data capturing capacity Establish ERC committee Develop common electronic case record	Management Information Utilization Management Quality Improvement CFAC	July 2003 – June 2004
	Objective Four – Develop a strategy for managing admissions, discharges and payments for service area consumers in state institutions	Review current consumers in state care Develop plan to have dollars follow client Consult with State representatives to discuss plan Receive approval from state	Clinical Services Management Network Management Planning CFAC	October 2003 – June 2004

	Objective Five – Implement a comprehensive locally based Utilization Management (UM) System	Train all involved in the UM system Develop and implement the electronic UM system	Network Management Administration Management Information Systems CFAC	January – June 2004
Goal Four – Education Initiative	Objective One – Implementation of Communications Strategy with providers, consumers and other stakeholders	Establish regular meetings of advisory committees Develop ongoing communications with providers and others Develop regular training sessions for providers	Public Relations Consumer Relations CFAC Planning	January 2004 and ongoing

Year 2004-2005

GOAL	OBJECTIVE	ACTIVITIES		
Goal One – Service Initiative	Objective One – Collect baseline data on all services purchased, performance of the LME, and provider performance	Review performance of system in all core function areas for purpose of establishing baseline data Set benchmarks for all areas	Quality Improvement Quality Management Planning /Evaluation CFAC	July 2004 – December 2004
	Objective Two – Review policies and procedures regarding all aspects of the LME	Quality Improvement review of policies and procedures and plans Review accessibility plan for consumers Review provider credentialing plan Review provider management plan	Administration Quality Improvement Planning CFAC	January 2005 – June 2005
Goal Two – Quality Initiative	Objective One – Monitor the efficacy of the decentralized access to care system	Review access performance indicators Establish new performance targets	Quality Improvement and Management Planning /Evaluation CFAC	January 2005 June 2005
	Objective Two – Monitor Coordinated Quality Improvement Program	Review coordinated QI program Survey providers and consumers on efficacy of QI program	Quality Improvement Network Management Planning / Evaluation	January 2005 – June 2005
Goal Three – Financial and Administrative Initiative	Objective One – Implement a Single, Shared Common Electronic Case Record	Develop an information schedule for Common Electronic Record Develop training schedule Develop help desk	Network Management Management Information	January 2005 – June 2005

	Objective Two – Implement a plan to take over financial responsibility of consumers in state institutions	Develop the financial models Set up systems to track consumers Develop community based alternatives to state institutions	Administration Financial Management CFAC Planning	July 2004 – June 2005
	Objective Three- Review of locally based delegated Utilization Management (UM) approach	Conduct on site review of agencies involved in UM Refine UM system based on feedback	Network Management Utilization Management Planning	January 2005 – June 2005
Goal Four – Education Initiative	Objective One – Review communications strategies between the LME, providers, consumers and providers	Review efficacy of provider meetings and training sessions Survey stakeholder on LME communications performance	Planning Public Relations Consumer Relations CFAC Network Management	January 2005 – June 2005

	Year 2005-2006			
GOAL	**OBJECTIVE**	**ACTIVITIES**		
Goal One – Service Initiative	Objective One – Develop annual QI work plan	Analyze performance of LME against baseline performance and benchmarks Make changes based on review	Administration Quality Improvement and Management Planning CFAC	July 2005 – June 2006
	Objective Two – Refine policies and procedures of the LME	Refine accessibility plan for consumers Refine provider credentialing plan Refine provider management plan	Quality Improvement and Management Administration Planning	July 2005 – June 2006
Goal Two Quality Initiative	Objective One Monitor the efficacy of access to care systems established Determine effectiveness and efficiency of multiple points of access	Review performance of access centers Refine performance targets	Quality Improvement CFAC Planning / Evaluation	July 2005 – June 2006
	Objective Two Monitor Coordinated Quality Improvement Program	Review coordinated QI program Survey providers on efficacy of QI program Survey consumers regarding QI program Make any revisions as necessary	Quality Improvement Network Management Planning CFAC	July 2005 – June 2006
Goal Three Financial and Administrative Initiative	Objective One Refine the use of the common, single shared electronic case record	Survey users of electronic case record Modify based on user feedback if necessary	Management Information Network Management	July 2005 – June 2006
	Objective Two Monitor plan to take over financial responsibility of consumers in state institutions	Monitor and refine financial models Continue development of community based alternatives to state institutions	Administration Financial Management Planning CFAC	July 2005 – June 2006

	Objective Three Ongoing review and refinement of locally based Utilization Management (UM) System	Conduct on site review of agencies involved in UM Refine UM system based on feedback	Utilization Management Network Management Planning	July 2005 – June 2006
	Objective Four Negotiate new contracts with providers	Review all contracts with current providers Review provider performance Review service needs Develop new contracts Release and negotiate contracts with all providers	Network Management Contracts Management Financial Management CFAC	January 2005 – June 2006