

**AREA PROGRAM AS LME
AND DIRECT SERVICE
PROVIDER**

**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
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Submission Date	April 1, 2003

Item: III. Qualified Provider Network Development: Appendix A

Goal: Required elements if requesting to provide services

Effective Date: July 2004 – June 2007

STEPS TAKEN	STEPS PLANNED	BARRIERS
a) 1. The Area Program has requested and currently been authorized to continue to provide direct services through June 30, 2003. The Area Program has evaluated all services currently being provided and has identified services and timeframes for divestiture, some of which may occur prior to June 30,	a) Initial steps and timeframes are included in Divestiture Plan subject to availability of Qualified Providers interested in providing service. b) The Agency requested permission to continue case management services; however, based on recent communiqués, this will need to be	Service definitions, provider requirements, rates and target population criteria have not been fully established and adopted. It is difficult to identify providers without complete information to give to them in these areas.

<p>2003. Tentative plan is to divest of DWI, ADETS and CBS paraprofessional services (child mental health) by June 2003, contingent on community providers being willing to serve the consumers.</p> <ol style="list-style-type: none">2. The Area Program has developed a divestiture of services plan that includes transitioning out additional services over the next three years, contingent on available, qualified and culturally competent providers being identified who are willing to serve the target population clients and meet all performance indicators.3. The Divestiture Plan proposed would include transitioning out of Employee Assistance Services (EAP), closing two child residential treatment Level III facilities and transitioning out of non-specialized therapeutic home services between January 2004 and June 2004. The plan also proposes working with the Mental Health Association to identify another provider to assume on site management and clinical responsibilities for the Adult Apartments operated by the Mental Health Association between January 2005 and June 2005. In 2006 the plan would propose to identify a suitable provider for the Adult DD Day	<p>revisited. There are few case management resources outside of the area program in the community. Thus, there will need to be training and technical assistance to those interested in learning about this service. This training and technical assistance will be provided with guidance from the State and clarification on service definitions.</p>	
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programs at Fuller, for the Roxie Avenue Facility Based Crisis Center and transitioning out additional outpatient treatment services in all disability areas. The Area Program would request to maintain some clinical providers to provide services to consumers in highly specialized cases, to ensure there is a safety net for consumers who are “abandoned” in some manner by a provider and to provide services to individuals served with non-State dollars. The transitioning of these services would be dependent on providers being available and competent per guidelines developed.

4. Providers involved in the Local Business Planning Process have indicated that they will need until 2004 and some until 2005 in order to meet performance indicators and other standards outlined in mental health reform for providers.
5. The Area Program is requesting to continue providing psychiatric and medication management services as well as some specialized residential services (owned by the County), developmental day services (partnership with the schools), ECI services (under contract with DEC) and other grant funded services.

<p>6. There are few psychiatrists in the community willing to serve Medicaid or Champus individuals. Thus, the Area Program becomes the primary provider of services for consumers who cannot afford to pay the full fee for services.</p> <p>7. Services provided by the Area Program are in compliance with Best Practices models.</p> <p>8. There are community providers who have limited knowledge of and experience with Best Practices models utilized by the Area Program and proposed by the State.</p> <p>b) A policy has been written reflecting the Area Program's intent to divest of services in accordance with the parameters of the State Plan.</p> <p>c) Area Program sent out approximately 600 surveys to solicit community provider's interest in learning more about the State Plan and to assess their interest in becoming a part of the QPN. Two public forums were held in December to provide an update on mental health reform and to answer questions. Less than 10 providers attended; however, there were consumers in attendance, with excellent attendance from the deaf community.</p>	<p>All services provided by the Area Program as well as providers will be assessed according to Best Practices standards outlined by the State.</p> <p>Training and technical assistance will be provided to providers in areas of Best Practices as part of the development of a Qualified Provider Network.</p> <p>b) Obtain Area Board approval of policy</p> <p>c) Continue to sponsor public forums to educate public, consumers and community providers of the progress of the plan and service needs. LME will also in future provide technical assistance to help grow providers to meet specialty needs of consumers served.</p>	
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<p>The Area Program has held weekly meetings that are open to all providers in the area, since August. Standards, performance indicators, best practices, target populations, etc. have been discussed. The group is working to identify mechanisms for the network to be as inclusive as possible, ensure best practices, measurable outcomes and broad consumer choice/information to assist in network development. The Area Program also recognizes that there are gaps in the service array. Work will need to be done with providers to cultivate them to develop services that will better meet identified community needs.</p> <p>d) The Area Program has discussed strategies for establishment of a firewall between the LME and case management functions. Currently we have an internal fire wall as follows. Services are reviewed by a clinical/management staff outside of the chain of command for the service that is being requested. The review team looks at medical necessity and level of care criteria for the service, based on information presented and documented. A decision is made based on this information. If the request is approved, an authorization is provided. If the request is denied, appeals procedures are provided.</p>	<p>Schedule of RFA/RFP documents for each service that is being considered for divestiture will be developed and published. This process will occur between July and December 2003.</p> <p>Continue to work with community providers to expand QPN to ensure needs of the community are appropriately met.</p> <p>The Area Program will meet all standards identified for a firewall between service provision and case management functions as they are updated with the State. The Area Program has discussed with Lee Harnett MHC possible future partnerships across area program lines for service authorization and/or case management as transition into an LME occurs. The Division has provided new definitions for case management. All information will be included in the continued development of a complete firewall between services provided and the authorization process. Further discussions to occur with</p>	<p>There is a need for clarification from the Division about Provider Network Development. Questions around open or closed network, state standardized contract or contracts negotiated between area programs and providers, defining contractual relationships between providers and the area program, “any willing provider” etc. need to be answered in order to determine information for RFP/RFA documents. Currently there are some components to contracts approved by County Management that exceed standards required by other programs.</p>
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<p>e) The CFAC has discussed services, providers and community needs in addition to concerns about mental health reform and evaluation.</p> <p>A report from the CFAC re: service provision by the LME is attached along with summary of consumer/family member input.</p> <p>f) The County owns all property utilized by the Mental Health Center; however the Mental Health has long term bonded debt that extends into the year 2009 for the Executive Place facility and 2014 for the Roxie Avenue Center.</p> <p>g) The Area Program has been reviewing all services provided and comparing them to models of Best Practice. The only area identified thus far that does not meet Best Practices standards is in service provision to Adult Mental Health Consumers. Some consumers are receiving outpatient treatment services that should and are being transitioned to intensive case management or ACT Team providers.</p> <p><i>See Attachment III. Appendix A. 1. – Divestiture of Services Policy(Section 70)</i></p> <p><i>See Attachment III. Area Program as LME and Service Provider, including Divestiture</i></p>	<p>Division staff and LME for clarification.</p> <p>Quarterly updates on divestiture will be provided to the CFAC. The CFAC will provide reports on the necessity for service provision by the LME.</p> <p>The Area Program will negotiate with providers willing to assume services provided in these two locations to assume the space as well as service provision.</p>	<p>The Area Program has long term bonded debt extending into the years 2009 and 2014.</p>
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<p><i>Proposal and Time Line</i></p> <p><i>Attachment:</i> <i>Report from CFAC on Divestiture Plan</i> <i>Summary of Consumer and Family Member</i> <i>Input Meeting: March 12, 2003</i></p>		
<p>REVIEWER'S COMMENTS:</p>		

**APPENDIX A:
AREA PROGRAM AS LME AND DIRECT SERVICE PROVIDER**

The Area Board for Cumberland County Mental Health Center has requested that the Area Program continue to be a provider of services, in compliance with the guidelines in the State Plan and House Bill 381. It is understood that the State Plan views the Area Program as the Management Entity and not the primary provider of services; however, until such a time that qualified providers using best practices are available to serve the target populations, according to the array of services, the area program requests approval to continue the provision of direct services. It is critical to ensure that services continue to be available to individuals in our community, both those currently receiving services and those who will be assessed as in need in the future.

Divestiture will be undertaken in a very deliberate and planned manner. Involvement of all stakeholders, particularly consumers, family members, other human services agencies and providers, will be critical. There have been over 75 providers involved in the business planning process thus far, representing over 100 facilities and services. As information on best practices, outcomes, cultural competence, target populations and array of services, competencies, data sets needed for performance indicators, provider report cards, etc. has been reviewed, discussions on the readiness of the community to assume provision of many of the services historically provided by area programs have occurred. Based on these discussions, the consensus has been that it will be 2004-2005 before many of the providers will be ready to meet the standards, although some are indicating that they are in compliance and serving target populations already.

There are other providers who have questioned the incentive for them to serve the most seriously disabled consumers, who typically have problems in many areas of their lives and are not always the most motivated or responsible about their treatment. These providers have indicated that their practices cannot withstand failed appointments, late arrival for appointments, consumers with transportation difficulties, volatile and aggressive individuals, and the need for consultation with multiple other providers of services on behalf of a consumer. Further, concerns have arisen about the documentation requirements for serving individuals with Medicaid or State funding. Thus, though there are providers in the community for some of the services in the benefit package, there is a great need to assess the community capacity to meet the needs of target populations utilizing standards outlined in the State Plan.

Consumers, family members and advocates as well as staff in other human service agencies, have expressed concerns about some of the providers and have requested that a careful analysis be done of criteria used to determine eligibility to be in a provider network. Some have had negative experiences with providers while others have questioned how they can really choose a good provider from a list if there is no basis to judge those providers. Having a license is not enough. There is excitement about the concept of provider report cards, similar to the star rating for day care centers. Having

such a rating tool will enable consumers and family members to feel more confident as they choose their provider. They want assurance that all on the list are truly “qualified” providers.

Because of all of the factors outlined above, the area program is requesting approval to continue providing services at this time, with divestiture occurring based on the time line attached. The divestiture process will include certain elements:

- (a) Identification and adoption of best practices for all services to target populations by providers.
- (b) Identification of consumer and system outcomes to be measured
- (c) Determination of service gaps and needs within the community to address target populations.
- (d) Identification of and development with providers of those services deemed necessary in order to allow consumers to live successfully within their communities. This will require a shift for some providers from current services to development of new services.
- (e) Planning to address barriers to services as identified by all stakeholders.
- (f) Development of services that are culturally diverse with providers who are culturally competent
- (g) Identification of training and competency needs within the existing community providers that may impact on the ability to meet standards
- (h) Analysis of the community capacity to meet the needs of non-target populations, including those who previously may have been eligible for services using public funds.
- (i) Analysis of current contractual agreements, building and equipment issues, employees, funding and cost of service delivery, county, state and federal regulations
- (j) Consideration of consumer choice of the area program as the provider of services and how this impacts on divestiture by the area authority

It is our plan to be divested of the majority of services within the next 3-4 years based on being able to identify and develop qualified, culturally competent providers for the target populations. Some service provision will continue as a safety net for those consumers who are rejected by providers and for those who are the most challenging and complex. Services will also continue in areas not funded with state or Medicaid funds. These are areas in which services have been developed in collaboration with community partners and their request has been for the area program to continue services to these individuals (examples include services provided for the Partnership for Children, Department of Social Services, Community Corrections and Juvenile Justice). We also currently have Coordinators for Services to Deaf and Hard of Hearing Adults and Children as well as Case Managers for the Homeless using PATH funds. Individuals identified by these components fit into the target populations. Many of the duties performed by the staff fall under the core services of screening, assessment, referral and crisis response. Other services provided fall under those noted to be most challenging and for consumers who

have very complex needs, which matches criteria noted for continuation of service provision.

The appropriate firewall will be developed between the LME and any services provided directly to consumers. The plan as outlined will be reviewed on an ongoing basis and revised based on community readiness, capacity and consumer/family/stakeholder choice.

Proposed Divestiture of Services

The Mental Health Center will provide or facilitate access to all core services as outlined in the business plan. When fully operational as a Local Management Entity, Cumberland County Mental Health Center will also request to continue providing services as detailed below. Divestiture of other services will occur following the time lines outlined, contingent on the availability of qualified and culturally competent providers to assume the services listed. The divestiture process will be reviewed at least quarterly with time frames being modified as appropriate.

SERVICES TO CONTINUE WITH THE LME AS PROVIDER

- Case Management
- Psychiatric Services (including psychiatric and medication evaluations, medication monitoring, crisis services)
- Outpatient treatment for the most difficult and complex cases in adult and child mental health and substance abuse services
- Specialized therapeutic homes for dually diagnosed children as well as for respite/crisis services
- Residential Services (specialized: Bacote Treatment Center for high risk youth, including sexually aggressive youth, Sprucewood Treatment Center for dually diagnosed children (SED/MR) and Strickland Bridge for adolescents with severe psychiatric disorders, i.e. Schizophrenia, Psychotic Disorder NOS)
- Early Childhood Intervention (ECI) Services (we will actually deliver these under a contractual arrangement with the DEC)
- Spainhour Developmental Day (funded primarily with categorical funds)
- Categorical funded programs: Juvenile Court Outreach Services (Department of Juvenile Justice funds- clients also meet target population); Smart Start Early Intervention Team (Partnership for Children funds); Intensive Family Preservation Services (contract with DSS); Treatment Alternatives to Street Crimes (TASC- we are the regional coordination site for TASC and the service is primarily assessment and case management to a target population); Cumberland County EAP Services (provided with County funds for employees of the County); MAJORS (block grant funds for target population in substance abuse services)

Divestiture is proposed for other areas as outlined below:

January 2003 for complete divestiture by July 2003

- DWI
- ADETS
- CBS-paraprofessional in child mental health services

January 2004 for complete divestiture by July 2004

- Child residential: Crossroads, Lakewood
- EAP services
- Therapeutic home services- (non-specialized)

January 2005 for complete divestiture by July 2005

- Adult Supervised Apartments

January 2006 for complete divestiture by July 2006

- Fuller Program: ADS and ABLE
- Roxie Avenue Facility Based Crisis Services
- Outpatient treatment: child and adult mental health and substance abuse services
(*Note: some outpatient services will continue for highly specialized cases, as a safety net for consumers as well and for individuals whose services are not paid for with State or Medicaid monies)

January 2007 for complete divestiture by July 2007

- Psychosocial Rehabilitation Services (PSR)

**LOCAL BUSINESS PLAN: TIMELINE
CUMBERLAND COUNTY MH/DD/SAS**

TARGET DATE	DESCRIPTION
September 2002	<ul style="list-style-type: none"> ◆ Consumer Family Advisory Committee Policy approved by Committee and sent for Area Board approval
November 2002	<ul style="list-style-type: none"> ◆ Policies to ensure that service array is culturally diverse, providers are competent to treat co-occurring disorders and skilled at providing one stop comprehensive services settings, dedicated to delivering consumer directed supports and complies with the federal Synar amendment are drafted and approved by Committees ◆ Policy on Use of Independent Practitioners is approved by Committees and sent for Area Board approval
January 2003	<ul style="list-style-type: none"> ◆ Draft Qualified Provider Network Plan is developed. Final plan to be approved for implementation no

	<p>later than July 2004.</p> <ul style="list-style-type: none"> ◆ Identification of individuals who will qualify as target populations and those who will need alternative service systems is completed. Review draft of proposed resource guide for non-target populations. ◆ Policy to adopt State identified Best Practices will be discussed in Committees and forward to Area Board for approval. ◆ Services to be divested by the MHC in FY 2002-2003 will be identified
March 2003	<ul style="list-style-type: none"> ◆ Consumers and stakeholders will be involved in the planning and implementation activities of mental health reform per requirements outlined in the State Plan. ◆ Assessment of divestiture of proposed services by July 2003, including DWI, ADETS and CBS-paraprofessional services (day parent services) in child mental health services
July 2003	<ul style="list-style-type: none"> ◆ Full divestiture of DWI, ADETS, and CBS paraprofessional services ◆ Identify staff resources needed for transition into a local management entity
January 2004	<ul style="list-style-type: none"> ◆ Identify appropriate community resources to continue divestiture process ◆ Begin divestiture of EAP services, identified therapeutic home services and three child residential treatment facilities. ◆ Staff for operation of the LME will begin assuming duties
March 2004	<ul style="list-style-type: none"> ◆ Assess progress in divestiture of identified services and success in transitioning consumers into appropriate treatment resources ◆ Qualified Provider Network Plan

	will begin implementation
July 2004	<ul style="list-style-type: none"> ◆ Full divestiture of EAP, identified therapeutic home placements and identified child residential treatment services ◆ Begin duties and responsibilities of the LME
January 2005	<ul style="list-style-type: none"> ◆ Identify suitable providers in the Provider Network to assume responsibility for next phase of services to be divested ◆ Begin divestiture of staff assigned to Adult Supervised Apartments and
March 2005	<ul style="list-style-type: none"> ◆ Assess progress toward divestiture of Adult Supervised Apartments Services
July 2005	<ul style="list-style-type: none"> ◆ Full divestiture of Adult Supervised Apartments
January 2006	<ul style="list-style-type: none"> ◆ Identify providers for next phase of services to be divested ◆ Begin divestiture, based on providers, of ABLE and ADS Programs and some outpatient treatment services in adult and child mental health and substance abuse services as well as Roxie Avenue Center
March 2006	<ul style="list-style-type: none"> ◆ Assess progress in transitioning consumers to identified service providers for ABLE, ADS, Roxie avenue Center and outpatient treatment services
July 2006	<ul style="list-style-type: none"> ◆ Full divestiture of ABLE, ADS, Roxie Avenue Center and targeted outpatient treatment services
January 2007	<ul style="list-style-type: none"> ◆ Identify provider for PSR services for adult MI consumers and dually diagnosed consumers
March 2007	<ul style="list-style-type: none"> ◆ Transition consumers to identified community provider for PSR services
July 2007	<ul style="list-style-type: none"> ◆ Full divestiture of services as outlined above

	◆ Full implementation of LME functions in Cumberland County
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